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Review Article

Narcissistic Personality Disorder: Understanding the Origins and Causes, Consequences, Coping Mechanisms, and Therapeutic Approaches

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Abstract

Narcissistic Personality Disorder (NPD) is a mental health condition that involves excessive self-importance, unrealistic fantasies, and constant admiration-seeking. The origins of NPD are unclear, but some possible factors are genetics, childhood, personality, and culture. NPD can be divided into 2 subtypes: grandiose and vulnerable. Grandiose narcissists display arrogance, dominance, and aggression, while vulnerable narcissists show insecurity, sensitivity, and defensiveness. NPD individuals often struggle with interpersonal and functional problems. NPD can negatively affect the person who has it and those who interact with it. NPD individuals may have low self-esteem, mental health issues, substance abuse, and suicidal thoughts. They may also act violently or abusively when they feel threatened. However, some NPD individuals may also have some positive traits, such as creativity, charisma, and leadership. NPD is diagnosed by the DSM-5 criteria, which require at least 5 out of 9 symptoms. The diagnosis of NPD is based on the requirements outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). However, diagnosing NPD can be challenging because many NPD individuals do not seek help or acknowledge their problems. The primary treatment is psychotherapy, aimed at addressing underlying insecurities, improving self-awareness, and promoting healthier interpersonal skills. This therapy can help NPD individuals become more realistic and empathetic. Medication may also help with some symptoms or disorders related to NPD. This research investigates, summarizes, and simplifies NPD's causes, consequences, and cures.

Keywords: *Countertransference; Grandiosity; Mental Health Condition; Narcissism; Schema-Focused Therapy; Self-Centeredness; Suicide; Transference-Focused Psychotherapy; Violent Crime*

Abbreviations

arPFC: Anterior Rostral Prefrontal Cortex; CAM: Complementary and Alternative Medicine; CCT: Client Centered Psychotherapy; DIPD-IV: DSM-III: Diagnostic and Statistical Manual of Mental Disorders; DSM-IV Personality Disorders; DSM-5: Diagnostic and Statistical Manual of Mental Disorders; EPA: Eicosapentaenoic Acid; fMRI: Functional Magnetic Resonance Imaging; NESARC: National Epidemiologic Survey on Alcohol and Related Conditions; NPD: Narcissistic Personality Disorder; ORT: Object Relations Theory; PET: Positron Emission Tomography; PNI: Pathological Narcissism Inventory; STIPO-R: Structured Interview of Personality Organization

Introduction

Narcissistic personality disorder (NPD) is a cluster B disorder that involves 3 elements: a high and unrealistic self-image, a lack of empathy in relationships, and various ways to protect the self-image. NPD individuals have a general and specific sense of being exceptional, unique, superior, and entitled [1]. NPD has historical roots in ancient Greek mythology, specifically the story of Narcissus. In this tale, Narcissus, a young man, becomes infatuated with his reflection and eventually perishes as a result [2]. Many philosophers and thinkers like Plato, Aristotle, and Shakespeare also studied extreme self-love and arrogance.

Narcissism as a clinical entity was first described by Ellis (1898) in terms of autoerotism or self-sexualization [3]. However, the Austrian psychoanalyst Otto Rank gave the first psychological account of narcissism in 1911, who linked it to self-admiration, vanity, and libido development [4]. Freud (1910) linked narcissism to libido development. He said infants are in a state of primary narcissism, where they focus all their libido on themselves, and that healthy adults can balance their libido between themselves and others [5].

In his influential paper "On Narcissism," published 4 years later, Freud introduced essential concepts, including primary and secondary narcissism, narcissistic object choices, and the role of narcissism in shaping the ego ideal. While Freud did not delve into character typology in that paper, he did acknowledge individuals who consistently protect their ego from anything that might diminish it. However, it was not until 1931 that he explicitly described the "narcissistic character type." These individuals prioritize self-preservation, display independence, and are resistant to intimidation. They possess significant aggressiveness, which fuels their readiness for action. In their romantic life, they prefer being the one who loves rather than being loved. People of this type leave a strong impression as "personalities" and are particularly suited to support others, assume leadership roles, and either bring about fresh cultural developments or disrupt established norms. This description is widely considered the pioneering depiction of NPD. However, it is worth noting that 2 earlier papers by Jones and Waelder also provided significant insights into the phenomenology of this condition. While the term "narcissistic personality disorder" was not explicitly mentioned, Jones' 1913 portrayal of individuals with a "God Complex" can be regarded as one of the earliest detailed descriptions of this disorder [6].

Kernberg and Kohut initially introduced NPD in the late 1960s. Kernberg (1975) and Kohut (1971) defined NPD as a pathological self-structure characterized by abnormal transference development. They described narcissists as individuals who develop grandiose self-perceptions due to unsatisfactory social relationships in childhood that result in a complex psychological reliance on others in adulthood [7]. The concept of pathological narcissism gained significant recognition among clinicians influenced by psychoanalysis, leading to the inclusion of NPD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 [8]. Over time, NPD was refined and modified in subsequent editions, such as DSM-III-R (1987) and DSM-IV (1994), incorporating empirical findings from psychological studies that identified narcissism as a personality trait. However, these revisions faced criticism for potentially overlooking dynamic elements present in the phenomenological expressions of the disorder [3].

Cain., *et al*. (2008) reported that the DSM-IV focused on the grandiose features of NPD and ignored the underlying vulnerability of many narcissists [9]. The inconsistencies in how narcissism was conceptualized, such as its nature, phenotype, expression, and structure, were also reflected in the DSM-IV definition of NPD. A new model of personality disorder that combined categorical and dimensional

aspects was proposed for DSM-5 to address these issues [3]. The current DSM-5 defines NPD as a personality disorder with grandiosity, a need for admiration and a lack of empathy [8].

Discussion

NPD has not been well-researched from an empirical perspective, and most of the existing literature on NPD primarily relies on clinical experience and theoretical formulations rather than empirical evidence [10]. NPD individuals tend to have a distorted sense of self-importance and self-centeredness, which makes them insensitive and competitive in their relationships with others. They also have trouble with commitment, collaboration, and mutual respect. NPD individuals may not show their internal suffering to others but often feel insecure and unhappy. They may also engage in unethical and manipulative behavior, such as lying, cheating, corrupting, or exploiting others [11]. Individuals with NPD typically display a range of signs and symptoms, as shown in Figure 1 [8,12,13].

Figure 1: *Characteristic signs and symptoms of NPD [8,12,13]*

NPD is a human phenomenon that has not been observed in other species. However, some animals may display behaviors that resemble some aspects of NPD, such as self-admiration, vanity, entitlement, or exploitation of others. For example, some studies have suggested that dolphins may recognize themselves in mirrors, indicating a sense of self-awareness and self-importance [14]. Some primates, such as chimpanzees, baboons, or macaques, may also exhibit dominance hierarchies and aggressive behaviors involving taking advantage of or harming lower-ranking individuals, which could indicate a lack of empathy or entitlement [15]. However, these behaviors do not necessarily indicate NPD, as they may have different evolutionary, ecological, or social functions and meanings for the animals. Moreover, NPD involves a complex and pervasive pattern of personality traits that impair the person's functioning and relationships in various contexts [16]. Due to differences in cognitive, emotional, and social complexity between humans and animals, NPD is considered a human-specific phenomenon without a direct equivalent in other species.

Epidemiology

NPD has been mainly studied using clinical samples, and few studies measure its prevalence in the general population [3]. Estimates suggest NPD prevalence of up to 6% in the general population, up to 17% in clinical populations, and 8.5% to 20% in outpatient private

practice [17–18]. NPD can occur in children and adolescents and has been empirically verified. The presence of NPD in both children and adolescents has been empirically verified. Pathological narcissism and features of NPD are more frequent among people in their late teens and early twenties due to the specific developmental challenges in the transition from adolescence to adulthood [18]. The DSM claims that 50% to 75% of NPD patients are male. NPD does not remit with advanced age, and middle age is an especially critical period for its development or worsening [7]. The prevalence of NPD also has been found to vary across genders, with some studies indicating higher rates in men.

The most comprehensive and nationally representative epidemiological study is the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), which assessed 34,653 civilians in the USA between 2004 and 2005. This study showed an overall prevalence of NPD of 6.2%, with higher rates for men (7.7%) than women (4.8%). Men scored higher due to a lack of empathy (83.1%), a sense of entitlement (82.6%), and exploitation (65.5%). NPD was also significantly more common among Black men and women (12.5%) and Hispanic women (7.5%), younger adults (20 to 34 of age), and people who were separated or divorced (7.3%), widowed or never married (9.6%) [19,20]. NPD was also associated with high rates of co-occurring substance use, mood, anxiety, and other personality disorders. With additional comorbidity controlled for, associations with bipolar I disorder, PTSD, and schizotypal and borderline personality disorders (BPD) remained significant [21].

NPD may be influenced by cultural differences and migration [18]. However, no conclusive evidence exists that NPD is more prevalent in any geographical region. Western societies, with their emphasis on autonomy, assertiveness, competition, and mobility, have been suggested to foster narcissistic functioning and potentially contribute to the development of pathological narcissism [7]. NPD may have genetic and environmental factors, such as parenting style, childhood experiences, and social context. Still, no specific gene or marker has been identified to indicate a heightened risk for NPD in any particular genetic group or ethnicity [3]. NPD does not directly affect mortality but may increase the risk of abusing substances, behaving recklessly, or having other mental health issues such as depression or anxiety. These factors may increase the mortality risk of NPD individuals rather than NPD itself.

Etiology

The etiology of NPD is complex and involves multiple factors. Genetic predisposition is suggested by studies highlighting inherited variations associated with hypersensitivity, strong and aggressive drive, low anxiety or frustration tolerance, and defects in affect regulation. Incongruence between a child's emotional state and the mirroring and misperception by caregivers may contribute to the development of NPD. Negative developmental experiences, such as childhood rejection and a fragile ego, can also contribute to NPD in adulthood [7,18,22]. Epigenetic modifications, such as DNA methylation or histone modifications, may further influence gene expression patterns related to narcissistic traits, potentially mediating the long-term effects of these experiences [23]. Dismissive, preoccupied, or avoidant attachment patterns are associated with the development of pathological narcissism and NPD [11].

NPD subtypes

While DSM-5 presents a single syndrome for NPD, research suggests the existence of different subtypes. The grandiose "overt" subtype closely aligns with DSM-5 criteria, while the vulnerable "covert" subtype receives less attention in current diagnostic criteria. Both subtypes exhibit high levels of self-absorption. Individuals with NPD may alternate between grandiose and depleted states based on life circumstances, and some may present with mixed features [3,17,22,24] (Figure 2).

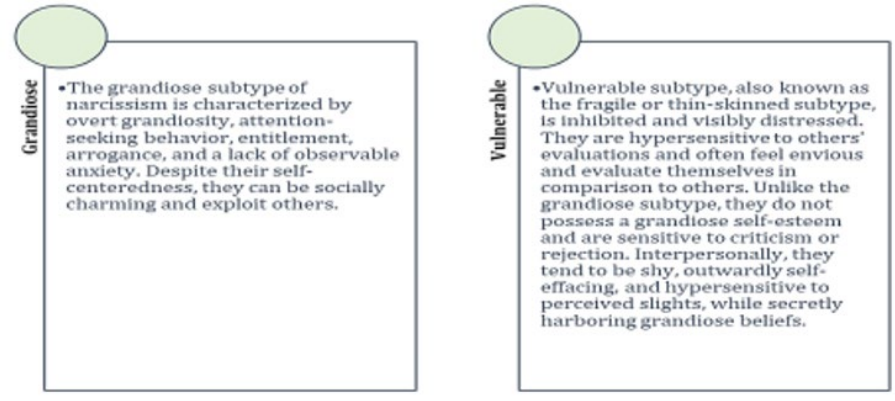

Figure 2: *Types of NPD [3,17,22,24]*

Detrimental effects of NPD

The detrimental effects of NPD on individuals and society are shown in Figure 3 [13,25,26].

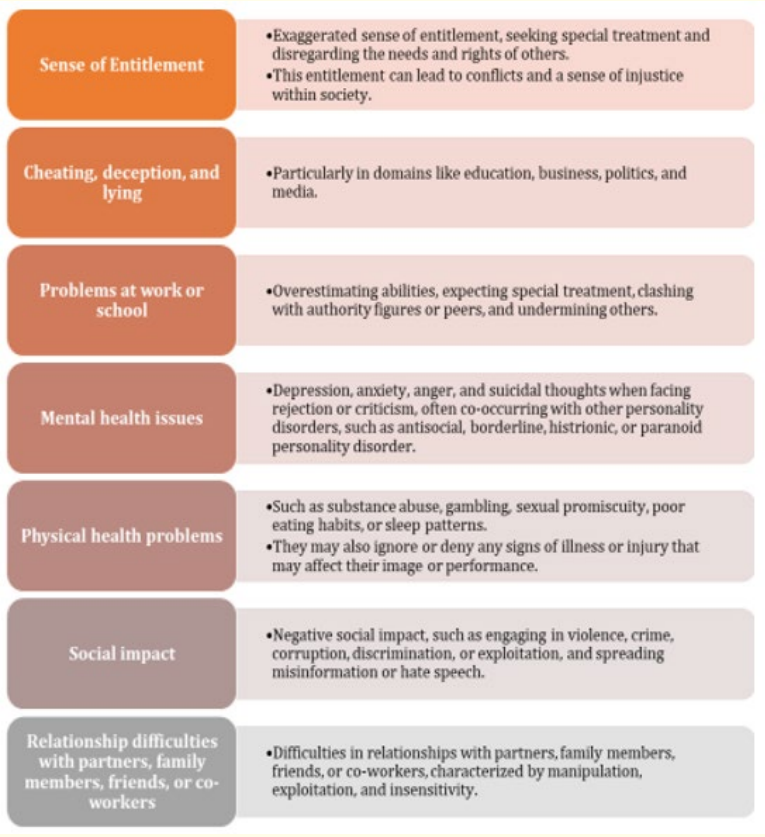

Figure 3: *Detrimental effects of NPD [13,25,26]*

"Beneficial" effects of NPD

Narcissists might be self-important attention seekers, but annoyingly, they are more likely to be highly functioning and successful individuals. Their confidence can be attractive, and high self-efficacy and a competitive nature yield professional and personal achievements [27]. According to new research, narcissists may have the personality traits that make them more likely to succeed. They are often destined to do well in all areas of their lives, including education, work, and romance [28]. Also, Queen's University Belfast researchers have found that people with grandiose narcissistic traits are more likely to be 'mentally tough', feel less stressed, and are less vulnerable to depression [29]. The benefits/positive qualities that an NPD individual may show are shown in Figure 4 [13,28–31].

Figure 4: *Benefits of and positive qualities of an NPD individual [13,28–31]*

Complications and comorbidities

NPD can cause many complications that affect individuals' lives. These include relationship problems, work or school difficulties, depression and anxiety, anorexia, health problems, substance abuse, and suicidal thoughts or behaviors [13]. NPD is associated with high rates of substance abuse (24% to 64.2%) [16,22], mood disorders (28.6%), and anxiety disorders (40%) [21]. The intense emotional distress associated with NPD can contribute to suicidal thoughts or behaviors.

NPD people face complications that significantly affect their lives [32–33]. The severity of NPD is related to the degree of comorbidity [17]. The most common mental health comorbidity is major depressive disorder (45% to 50%) [32]. Other mental health comorbidities include bipolar disorder (5% to 11%) [16] and other personality disorders such as antisocial, borderline, histrionic, passive-aggressive, and schizotypal [34– 35]. Antisocial personality disorder has the most negative effect [30,36]. NPD is also associated with gastrointestinal conditions [32].

Neurobiological underpinnings of NPD: Brain abnormalities

The connection between NPD and nerves/neural tissue must be better understood. It is believed that the development and manifestation of NPD involve complex interactions within the brain's neural networks. NPD is associated with abnormalities in brain regions that regulate emotions, process self-referential information, empathize, and understand social cues. These regions are the prefrontal cortex, anterior cingulate cortex, insula, amygdala, and temporal poles. Research has shown that NPD individuals may have less gray matter in

the anterior rostral prefrontal cortex (arPFC), which helps with self-referential processing and empathy; in the left anterior insula, which is responsible for self-referential processing and empathy; weaker connections between the arPFC and other brain regions, such as the amygdala, which helps with emotion regulation and social cognition; more activity in the left anterior insula, which helps with interception and self-awareness; different activity in the ventral striatum, which helps with reward processing and motivation. Complementary whole-brain analyses also yielded smaller GM volume in front paralimbic brain regions comprising the rostral and median cingulate cortex and dorsolateral and medial parts of the prefrontal cortex in the NPD individual. These brain factors may relate to the main characteristics of NPD, such as grandiosity, lack of empathy, hypersensitivity to criticism, and entitlement [37–39].

Related endocrine disorders

NPD and endocrine disorders have little research. However, some studies suggest links. Endocrine disorders can affect mental health, and mental disorders can alter hormones. Hormonal imbalances, insulin resistance, and inflammation can damage neurons and cause mood and cognitive problems. Depression, anxiety, mania, and eating disorders are common in endocrine diseases. Psychosis and suicide may occur in severe cases. Some mental disorders persist after hormonal correction, suggesting lasting neuronal damage. Body appearance changes (e.g., acromegaly, polycystic ovary syndrome, obesity) contribute to psychiatric issues. Chronic conditions like diabetes and obesity, requiring self-monitoring, relate to psychological problems [40]. It is crucial to note that while these endocrine disorders may influence behavior or mood, they do not directly cause the development of NPD.

Dubey., *et al*. (2021) reported that women with PCOS had a higher risk of having children with neuropsychiatric disorders or other disorders, such as autism, ADHD, anxiety, and depression [41]. Another study found that NPD individuals had higher levels of oxidative stress, a chemical imbalance that can damage cells and tissues [42], and that oxidative stress may be related to endocrine dysfunction [43].

NPD and suicide

NPD is a significant predictor of suicidal behaviors, including multiple suicide attempts, using lethal means, and making attempts during challenging life situations [32,44]. However, the prevalence of suicidal behaviors in NPD is unknown [16]. Paul Links has pointed out that with patients on the narcissistic spectrum, the wish to kill oneself can emerge without a depressed state [45]. Some personality traits are closely associated with the risk of suicide in NPD. Stressful life events and vulnerability of self-esteem, especially in response to life events that challenge habitual ways NPD patients sustain their lives, make these patients particularly susceptible to suicide [16]. Negative emotional states stemming from narcissistic vulnerability contribute to feelings of shame, defeat, entrapment, and meaninglessness, which can lead to suicidal behaviors [46].

Suicidal behavior is a clinically significant but often overlooked cause of mortality in narcissistic personality disorder. In a study comparing suicide attempters with cluster B personality disorder diagnoses, individuals with NPD were 2.4 times less likely to attempt suicide than non-NPD patients. This finding may indicate a protective effect of narcissistic grandiosity or a lack of reporting low-lethality attempts by narcissistic individuals [47]. Another study involving individuals with mood disorders found that 7% had NPD. These individuals were more likely to be male, have a substance use disorder, and display high levels of aggression and hostility. NPD showed a moderate protective effect against suicide attempts, suggesting a lower tendency for suicidal ideation than individuals with mood disorders [44].

Violent crime against others

Narcissistic traits are linked to aggression and violence [48]. Samenow (2023) reported narcissists as “criminals” who harm and exploit others to boost their self-image. They ignore and violate others’ rights and may react violently to perceived challenges or insults [49]. However, the empirical evidence on the role of NPD diagnostic traits as a specific risk factor for violent behavior remains limited [50].

Ullrich., *et al*. (2014) explored the relationship between specific delusions, emotions, and violence in 1136 male and female civil psychiatric inpatients after discharge. The study was initially selected for the review because it mentioned "grandiose delusions". However, the study referred to a psychotic delusion of possessing special abilities or powers. Nevertheless, the study was still relevant as it suggested that emotion can influence the content and intensity of delusions. The study revealed that grandiose delusions alone did not predict violence. Still, when combined with joy or anger, they were associated with severe acts of violence, regardless of the effect due to the belief [48]. Another study of 261 female offenders in a high-security prison found that antisocial, borderline, and narcissistic traits were associated with threats and physical assaults. Women with narcissistic traits showed more aggression, anger, fragile self-esteem, and a lack of remorse. They were 8 times more likely to commit violence, especially murder [51].

Countertransference

NPD poses significant challenges in psychotherapy, particularly in establishing a vigorous therapist-patient relationship [52]. Countertransference, the therapist's emotional reactions and attitudes toward the patient, is commonly observed in interactions with individuals with NPD. Countertransference is the therapist's emotional reaction to the patient during psychotherapy. It can be positive or negative and vary by the patient's personality disorder [53].

Freud introduced the concept of countertransference, highlighting its potential to interfere with treatment due to the patient's influence on the therapist's unconscious feelings [52,54–56].

Countertransference occurs in non-NPD individuals when working with NPD because patients with NPD can elicit potent and adverse reactions from therapists, such as poor boundaries, cognitive distortions, anger, frustration, criticism, devaluation, manipulation, seductive, hostility, inadequacy, idealization, devaluation, splitting, denial, and disengagement. These responses can interfere with the therapeutic alliance and the treatment process [52,54–56].

Tanzilli., *et al*. (2017) studied how patient, therapist, and therapy factors influence therapists' feelings toward patients with NPD. They surveyed 67 psychiatrists and psychologists who rated patient personalities, functioning, and the therapists' countertransference. The NPD was linked to more negative (hostility, anger, criticism, devaluation, helplessness, inadequacy, and disengagement) and less favorable countertransference, regardless of patient personality pathology and psychosocial functioning. They also found that NPD patients with more cluster B traits triggered more varied and negative countertransference than those without. The only therapist or therapy factor that mattered was a clinical experience. The study shed light on countertransference in NPD, showing the role of patient characteristics and clinical experience [52].

Object relations theory: Framework for diagnosing, classifying, and assessing NPD

Object relations theory (ORT) can provide insights into understanding narcissistic individuals. ORT suggests that early attachment experiences play a significant role in developing personality traits and interpersonal relationships. According to this theory, the self is formed through early interactions with primary caregivers, usually the mother, who provides the child with a sense of security, identity, and belonging. The child internalizes these interactions and forms mental representations of self and others, called object relations, that guide their subsequent relationships throughout life [55,57–59].

ORT offers a comprehensive framework for diagnosing, classifying, and evaluating NPD. The framework focuses on NPD's defining characteristics, including identity, defenses, object relations quality, moral functioning, aggression, and reality testing. Clinical or semi-structured interviews can be used for diagnostic evaluation, and tools like the Structured Interview of Personality Organization (STIPO-R) can assess personality organization, including a narcissism scale. The assessment helps create a profile of personality functioning,

identifying impairments in various domains and determining the overall level of personality organization. The evaluation of NPD primarily revolves around evaluating identity formation, particularly regarding self-esteem regulation and the individual's perception of self and others. NPD individuals display a distinct pattern of responses reflecting the impact of their grandiose self on their psychological experience. Descriptions of the self tend to be relatively specific and realistic, though often inflated or deflated, similar to those of individuals with normal identity consolidation. NPD descriptions of significant others are marked by a lack of content and detail, being vague, superficial, and accompanied by idealized or devalued attributions.

Additionally, the assessment focuses on object relations, examining the transactional, need-fulfilling, and self-enhancing orientation to relationships and the tendency to fluctuate between highly valued and highly devalued relationship experiences. Once NPD is diagnosed, it becomes crucial to evaluate the severity of the pathology, differentiating between different levels of presentation. This assessment aims to distinguish between the transactional and healthier orientation toward relationships found in some NPD presentations and more severe forms of object relations pathology, characterized by exploitation, parasitism, bullying, intimidation, sadistic control, or withdrawal. Aggression, including self- or other-directed aggression, is also a central aspect of evaluation and treatment planning [60].

Diagnosis

NPD diagnosis involves a physical exam, a psychological evaluation with questionnaires, and a clinical judgment based on the LEAD method. The LEAD method uses expert raters who review all the data and rate each DSM-5 PD symptom for the patient [10]. To have NPD, a person must meet at least 5 of the 9 DSM-5 criteria [7] (Figure 5).

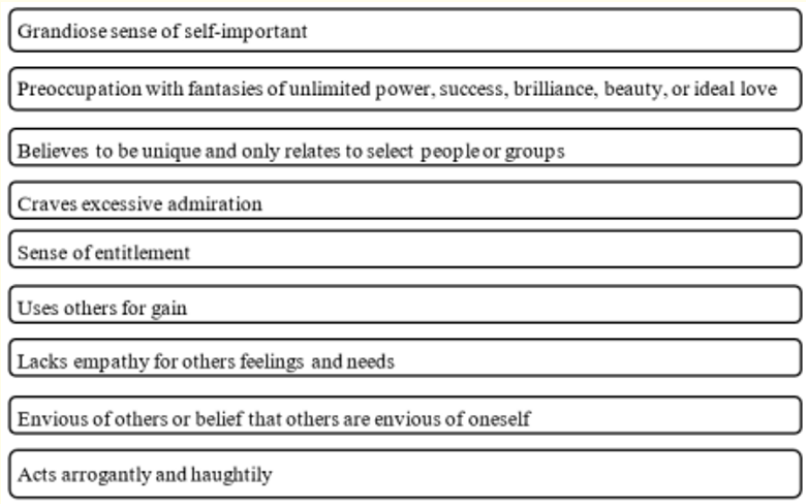

Figure 5: *DSM-5 diagnostic criteria for NPD*

Semi-structured interviews, such as the Pathological Narcissism Inventory (PNI) [61] and Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV) [62], also give some information about NPD features. However, collaborative diagnostic interviews, or a gradual diagnostic evaluation in collaborative exploration and alliance building, tailored to the patient's reflective ability, motivation, and life conditions, offer the best context and information for diagnostic assessment.

Vater A., *et al*. (2014) studied 96 patients with NPD for 2 years using 2 rating systems: categorical and dimensional. Categorical systems use yes/no criteria for NPD, such as feeling superior or wanting admiration. Dimensional systems measure how many of certain traits the

patients have, such as impulsivity or aggressiveness. The study found that half of the patients had no NPD after 2 years. However, different criteria for NPD had different prevalence and stability over time, which means some symptoms were more common or persistent than others. The study also found that the scores on the dimensional rating system remained stable over time, which means the patients did not change much in their personality traits. These findings concluded that NPD is a heterogeneous disorder that can be better understood using categorical and dimensional models [63].

Differential diagnosis

The differential diagnosis for NPD includes mood and anxiety disorders. Grandiose narcissism can resemble hypomanic/manic symptoms, but personality interaction is prominent.

Vulnerable narcissism may present with depressive features, but grandiosity and the need for admiration differentiate it from a major depressive disorder. NPD is distinguished from other cluster B personality disorders by the absence of impulsivity, self-destructiveness, and overt emotional responses (histrionic personality disorder). NPD shares similarities with antisocial PD in lack of empathy and charm but differs in moral aspects and history of conduct disorder [22]. NPD may co-occur with axis I disorder or show features similar to axis I disorders. A urine toxicology screen may be necessary to rule out substance abuse as a cause of the pathology [64].

Navigating relationships with NPD Individuals: practical coping techniques

Managing a relationship with someone with narcissistic personality traits can affect well-being and mental health [65]. Generally, NPD individuals have limited empathy and a heightened sense of superiority. Therefore, setting boundaries, learning about NPD, and developing a support network can help a person deal with someone with this condition [65]. Figure 6 shows some of the recommendations suggesting how to cope with NPD individuals.

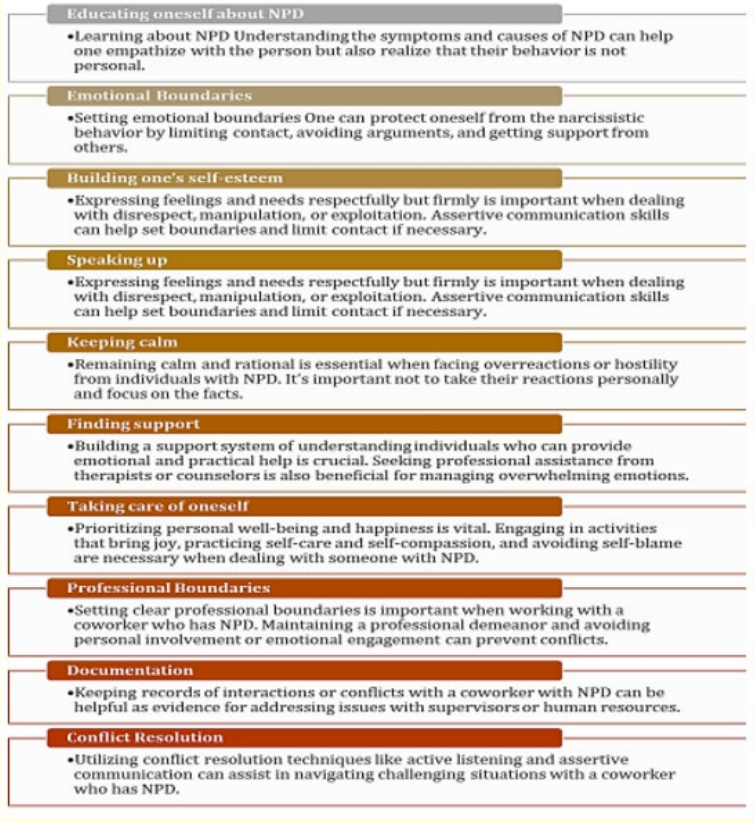

Figure 6: *Suggestions for coping with NPD individuals [8,65–69]*

Suppression of NPD traits

According to some experts, individuals with NPD can consciously suppress or hide their narcissistic traits in certain situations to manipulate others and achieve their goals. However, this strategic behavior does not indicate genuine empathy or personality change. It is common for them to revert to their typical behavior once they feel secure or challenged. This reversion explains why some individuals with NPD appear charming but later reveal their true colors when threatened or challenged [69–72].

NPD individuals may suppress or avoid some traits if they get treatment, such as psychotherapy. This research helped them to change their thoughts and beliefs, develop empathy and self-awareness, and cope with their emotions and impulses [69,70,73–74]. However, NPD individuals may have difficulty suppressing or avoiding some traits if they are unaware of their disorder, do not seek treatment, or do not cooperate with treatment. They may also have difficulty facing stress, trauma, loss, rejection, or failure, which triggers insecurity and defensiveness.

Wurst., *et al*. (2017) studied how narcissistic admiration and rivalry affect romantic relationships. They found that people with high narcissism could suppress or avoid some traits in short-term contexts by using admiration, seeking social esteem, and self-enhancement. However, they found that people with high narcissism could not suppress or avoid some features in long-term contexts because of rivalry, derogating others, and self-protection [75].

Treatment

NPD patients may seek treatment when they face severe problems or demands. However, they may have limited motivation and understanding of the therapy and personality change. These limitations can lead to an avoidant, critical, guarded interaction and early dropout from therapy [7]. Hilsenroth., *et al*. (1998) found that NPD patients had the highest dropout rate (64%), with the need for excessive admiration being related to dropout [76].

NPD has no cure—it is a lifelong mental health disorder [77], but psychotherapy and some medications can help control its symptoms, especially when comorbid conditions are present. There are no FDA-approved medications for NPD, but some patients can benefit from treatment for associated symptoms such as anxiety, depression, mood swings, transient psychosis, and impulse control issues. Antidepressants such as SSRIs and SNRIs have been used, and risperidone, an antipsychotic, has been effective in some patients. Also, mood stabilizers like lamotrigine may be prescribed for some individuals [22,64]. However, newer antidepressants like Prozac® are avoided because they can worsen NPD behaviors and symptoms [78].

Individuals with NPD may exhibit sensitivity to medication side effects, especially those affecting sexual function or cognitive abilities. They may resist relying on pharmacological interventions, potentially leading to poor treatment adherence. The primary treatment for NPD is psychological therapy. Various treatment modalities and strategies have been developed for pathological narcissism or NPD, but their efficacy and response rates have not been extensively studied. While emerging empirical evidence supports their effectiveness, no modality has been proven superior to others (Figure 7) [3,7,11,80–85]. Teusch., *et al*. (2001) compared the impact of client-centered psychotherapy (CCT) on personality disorders with or without psychopharmacological treatment. For NPD, they found that CCT alone led to more reductions in depression than CCT + Medication [79].

Notable changes in narcissistic personality functioning can also arise from the patient's exposure to corrective life events, such as achievements, relationships, or disillusionments, which may not be directly associated with treatment (Figure 7).

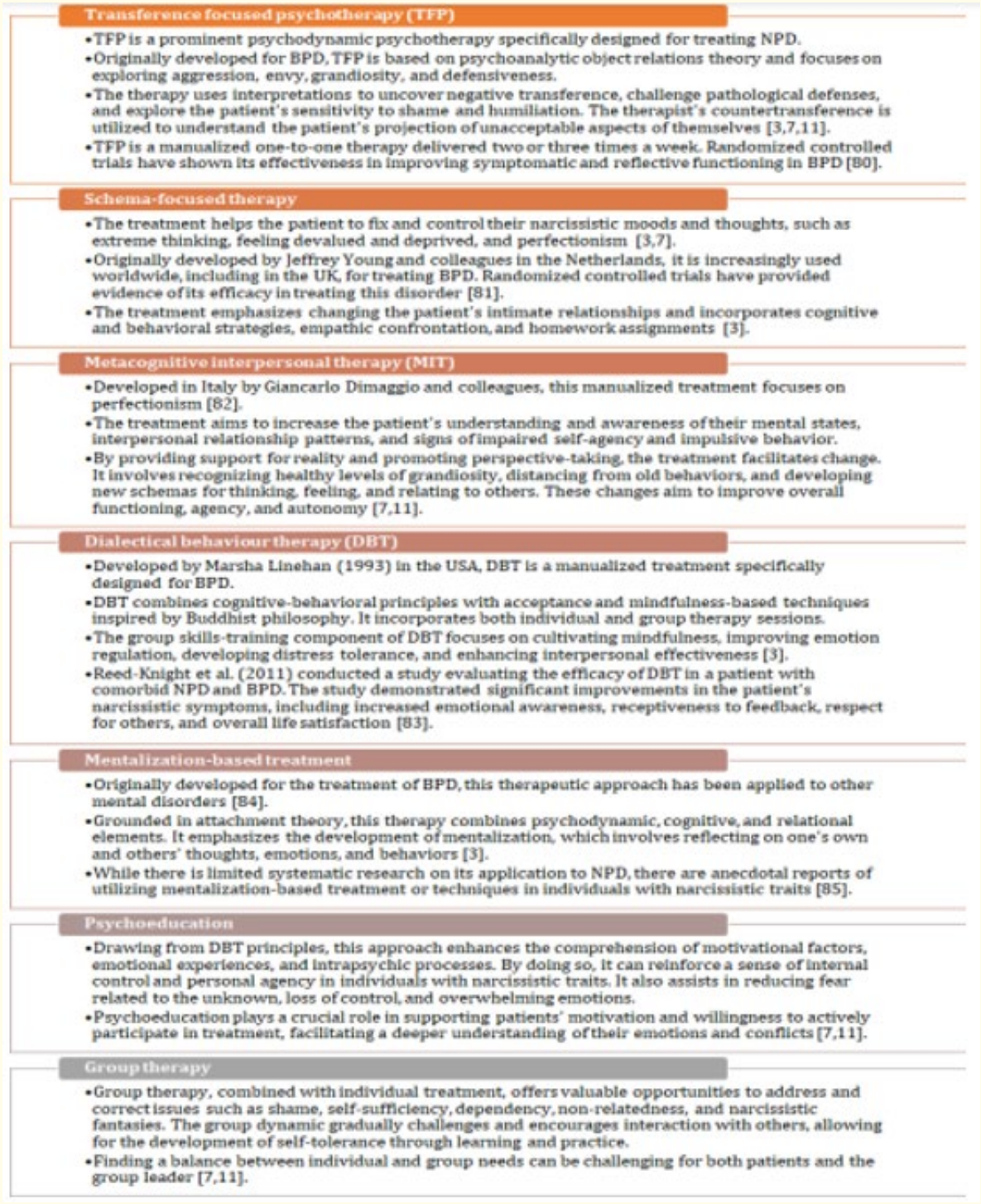

Figure 7: *Psychotherapies for NPD [3,7,11,80–85]*

Complementary and alternative (CAM) interventions

Complementary and alternative CAM treatment methods for NPD have not been extensively studied and are not supported by scientific evidence. As NPD is a complex and challenging disorder, psychotherapy remains the primary approach [86]. However, some NPD individuals may use or try alternative treatment methods and psychotherapy. These alternative methods may help improve well-being, reduce stress, and foster personal growth (Table 1) [87–94]. However, people interested in these methods must talk to their healthcare provider and use them as supplements, not substitutes, for psychotherapy.

Mindfulness and meditation	• Practicing mindfulness and meditation techniques may help individuals with personality disorders develop greater self-awareness, emotional regulation, and empathy. • These practices can also promote reduced stress and psychological well-being [87].
Yoga	• Yoga may help people reduce stress, improve mood, enhance self-awareness, or promote relaxation. • Some studies have also suggested that yoga may be beneficial for depression, which is a common co-occurring condition with NPD. • However, the quality and quantity of these studies are limited, and the results are inconsistent [88–89].
Exercise	• Exercise may have some benefits, such as reducing stress, improving mood, enhancing self-awareness, or promoting relaxation. However, there is not much scientific evidence to support the effectiveness or safety of exercise for treating personality disorders specifically [88,90].
Art therapy	• Art therapy is beneficial in private therapy settings. • Art therapy can provide an avenue to explore their emotions, thoughts, and self-perceptions in a non-confrontational and non-verbal manner. • Art therapy can be used as a complementary tool in conjunction with psychotherapy 91–92.
Herbal supplements	• Certain herbal supplements are known for their potential benefits in promoting overall well-being and reducing symptoms of stress and anxiety; however, their effectiveness in treating personality disorders is not supported by scientific research.Omega-3 fatty acids such as eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA) might have an impact on depression by containing amino acids that have been found to reduce symptoms, possibly because they are converted to neurotransmitters in the brain that help alleviate depression. • Kava kava is an herbal remedy that can be added to any beverage to help ease the symptoms of anxiety associated with personality disorder. Kava does, however, impact on other medicines metabolized by the liver. Passionflower is another herb said to have anxiety-relieving properties, and it's known for helping reduce the symptoms of mood disorders. Licorice root comes as sticks, tea, or extracts and can be taken orally to help fight anxiety. • Ginseng helps ease anxiety and improve concentration and focus. It can be taken as oral supplements daily [93–94].

Table 1: *CAM therapies [87–94]*

Challenges associated with NPD treatment

Clinical reports have documented various challenges to outcomes in therapies with NPD patients (Figure 8) [95].

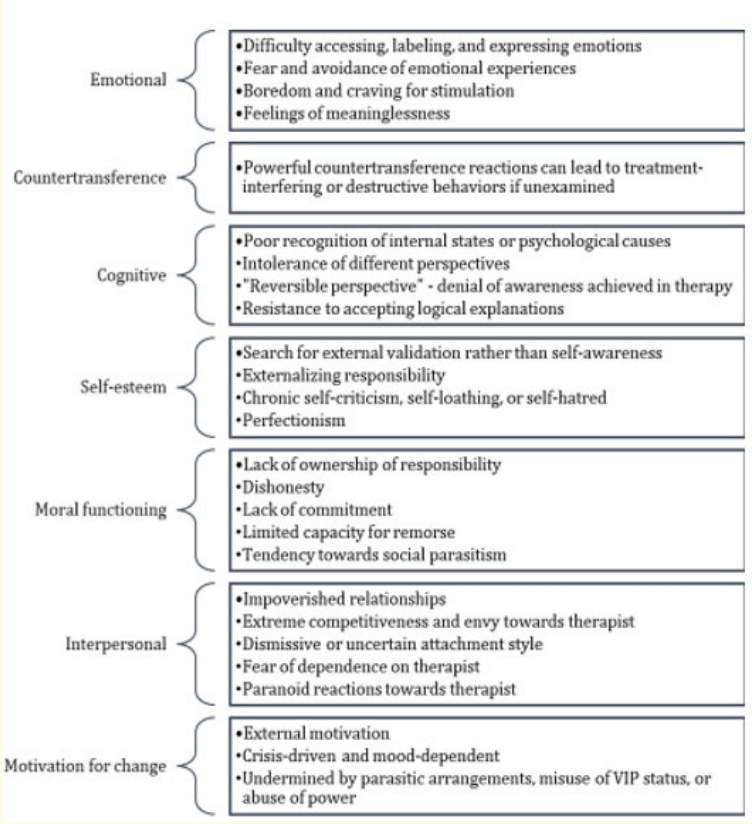

Figure 8: *Challenges of treating NPD patients [95]*

Future perspectives and research

Research on NPD is still in its early stages, primarily relying on systematic assessments of patient groups using structured clinical interviews for Axis II disorders. Available data support the inclusion of NPD in the DSM-5 due to its prevalence. However, certain limitations need to be addressed for the DSM-5. Firstly, research has not examined the concordance between DSM-IV criteria and the actual clinical presentation of NPD. Secondly, many NPD patients also meet the criteria for other Axis II disorders, suggesting the possibility of an NPD variant within these disorders. Future research will need to distinguish NPD from other axis II disorders or suggest that they have an NPD variant of these disorders. The value of the diagnosis will depend on whether it helps predict adult outcomes and treatment response [34]. Neuroimaging techniques, such as functional magnetic resonance imaging (fMRI) and positron emission tomography (PET), can reveal the brain correlates of personality disorders. Future research may explore brain abnormalities, neural networks, and potential biomarkers related to NPD [96].

There are no specific drugs recommended for the management of NPD. However, certain medications, such as SSRIs and SNRIs, have been used off-label to target symptoms like depression and anxiety in individuals with personality disorders. Risperidone, an antipsychotic, has shown effectiveness in reducing anger and irritability in some cases [97]. However, these medications are not FDA-approved for NPD. Future research is needed for these drugs and others to determine their safety and efficacy for NPD. There is a lack of good evidence to support the current treatment options (talk therapy) for NPD, and more research is needed to identify the best practices and guidelines

for treating NPD with psychotherapy [98]. The studies should also consider the heterogeneity and complexity of NPD [61,99] and use standardized and valid measures of narcissism.

NPD may have a genetic component, as it tends to run in families and is associated with certain genetic variations. However, the genes involved and environmental factors need to be better understood. More research is required to identify the genetic and environmental risk factors and protective factors for NPD and to know how they influence the development and expression of NPD across the lifespan [100]. There is some evidence that NPD may have a biological component also, such as increased oxidative stress in the blood and a connection to interpersonal hypersensitivity. Oxidative stress is a molecular imbalance between antioxidants and free radicals that can create stress on the body and affect the brain. More research is needed to understand how oxidative stress and other biological factors may contribute to the development and maintenance of NPD and whether they can be targeted for treatment [101].

Investigating the developmental trajectories of NPD may provide insights into its emergence, progression, and potential intervention points. Longitudinal studies that follow individuals from childhood through adolescence and into adulthood can contribute to a better understanding of the developmental pathways and inform early intervention strategies.

Conclusion

NPD is a complex and variable condition that is difficult to treat and diagnose as it often presents with other disorders. Recent research and clinical observations have shed light on some aspects of narcissistic functioning, such as self-centeredness, lack of empathy, and emotion regulation problems. These may be related to neurological, attachment, and trauma factors that affect self and self-esteem regulation, agency, and decision-making. A collaborative approach that explores the patient's unique personality functioning is suggested. The dimensional approach in DSM-5 has helped to focus on regulatory processes in self and interpersonal functioning. Treatment strategies are improving alliance building, the co-occurrence and interactions of grandiosity and vulnerability, cognitive and emotional narcissistic functioning, and the patient's life or interpersonal contexts. Improved social awareness about narcissism, pathological narcissism, and NPD is needed to reduce stigma and prejudice and to make treatment more accessible and effective.

Conflict of Interest Statement

The authors declare that this paper was written without any commercial or financial relationship that could be construed as a potential conflict of interest.

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