# Building hope for treatment of narcissistic personality disorder

Igor Weinberg[1]

[1]McLean Hospital Gunderson Personality Disorders Institute

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**Abstract**

Historically, patients suffering from pathological narcissism, including narcissistic personality disorder (NPD), were considered challenging and hard to treat. Since the second half of the 20th century new treatments have been developing heralding a growing hope that transformative treatment of patients with pathological narcissism is possible. Recent developments of phenomenology, childhood antecedents, longitudinal course, and putative mechanisms inspired a greater hope as well. This invites clinicians and researchers to take an approach that is evidence-based, destigmatizing, and collaborative that considers that at least some of the treatment challenges as co-created by both the therapist and the patient. Further, new treatments add hope by ameliorating such challenges of patients with pathological narcissism as fragile alliance, limitations of reflectiveness and grieving. Novel treatments are evidence- and principles-based and different approaches to effective treatment development are described. Inspired by these developments in the field, this Issue of the Journal of Clinical Psychology: In Session was conceived as an opportunity for clinicians from different treatment approaches to come together and share their experiences in treating patients with pathological narcissism. The hope is to find common language to understand these patients and their treatment, understand what contributes to change, as well as learn from commonalities and differences among these treatments. In doing so, this Issue is hoping to promote destigmatizing, pragmatic approach that prioritizes evidence-based efforts to understand the patient and collaborative approach to promoting change.

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Historically, patients suffering from pathological narcissism, including narcissistic personality disorder (NPD), were considered challenging and hard to treat. Since the second half of the 20$^{th}$century new treatments have been developing heralding a growing hope that transformative treatment of patients with pathological narcissism is possible. Recent developments of phenomenology, childhood antecedents, longitudinal course, and putative mechanisms inspired a greater hope as well. This invites clinicians and researchers to take an approach that is evidence-based, destigmatizing, and collaborative that considers that at least some of the treatment challenges as co-created by both the therapist and the patient. Further, new treatments add hope by ameliorating such challenges of patients with pathological narcissism as fragile alliance, limitations of reflectiveness and grieving. Novel treatments are evidence- and principles-based and different approaches to effective treatment development are described. Inspired by these developments in the field, this Issue of the Journal of Clinical Psychology: In Session was conceived as an opportunity for clinicians from different treatment approaches to come together and share their experiences in treating patients with pathological narcissism. The hope is to find common language to understand these patients and their treatment, understand what contributes to change, as well as learn from commonalities and differences among these treatments. In doing so, this Issue is hoping to promote destigmatizing, pragmatic approach that prioritizes evidence-based efforts to understand the patient and collaborative approach to promoting change.

**Key words:** Narcissistic personality disorder, pathological narcissism, psychotherapy, evidence-based treatment, principles of change

Building hope for treatment of narcissistic personality disorder

*"Matthew, a single man in his early twenties came to therapy due to chronic unhappiness, poor self-esteem, isolation, and a difficulty getting along with others. He was seemingly engaged in therapy, actively exploring his fantasies of success and what seemed like a perfect life scheme – graduate school in a promising field, making "all the right connections with all the right people" that would eventually catapult him to the top of the professional hierarchy, resulting in wealth, recognition, and power. He expressed pervasive devaluation of others who he experienced as 'irredeemably stupid and incompetent.' He repeatedly recognized an exploitative attitude toward others, when he would fake close relationships only to elicit some benefits from the other person. These patterns were acknowledged, though Matthew continued to excuse them in the context of past trauma. Alienating colleagues and friends through haughty and critical behaviors, he was left in total isolation and was enraged and humiliated when nobody showed up for his graduation party. Blaming his therapist and feeling hopeless about the possibility of changing the cycles of mutual rejections, Matthew stopped therapy and refused to pay the balance."*

Is there hope of helping Matthew? Can treatment help him address patterns related to pathological narcissism? What interventions are likely to invite his curiosity and reflection and help him open to the process of change? These questions are at the heart of this Issue of the Journal of Clinical Psychology: In Session, and they have a long history in psychotherapy. Narcissistic personality disorder (NPD), associated with the concept of pathological narcissism, historically has been related to limits of treatability. Originally, Sigmund Freud (1914) theorized that pathological narcissism limits the ability of patients to benefit from treatment. The predominant opinion among his followers was that pathological narcissism was one of the major negative prognostic predictors (Etchegoyen, 1991; Greenson, 1967). "Narcissistically oriented... patients are generally not suitable for psychoanalysis", Greenson authoritatively wrote in the 1960s (Greenson, 1967).

Earlier pessimism gradually gave way to more hopeful clinical observations that treatment of pathological narcissism was possible. This has been related to discussions of the "scope of analyzability" – or treatability (for a review see Etchegoyen, 1991) – and spurred developments of new theories and modifications of intervention techniques to better understand and treat pathological narcissism. This led to seminal contributions of Heinz Kohut (1971) and Otto Kernberg (1975) both of whom reformulated earlier understanding of pathological narcissism. These developments inspired original contributions of James Masterson (1983), Gerald Adler (1985), Herbert Rosenfeld (1987), John Steiner (1993), John Fiscalini (1993), Andre Green (2001), Arnold Rothstein (1984), Arnold Model (1975), and Andrew Morrison (1993), to name just a few. These contributions proposed novel theoretical formulations of pathological narcissism and suggested modifications of treatment technique. In doing so, they introduced a notion, revolutionary at that time, that treatment of pathological narcissism was possible and that meaningful changes can occur in the lives of these patients as a result of psychotherapy.

*Challenges in treatment of NPD*

Was this budding optimism supported by the experiences of other clinicians treating patients suffering from pathological narcissism? Unfortunately, patients with NPD were generally viewed by treating clinicians as challenging (Table 1). Changes in NPD patients, while possible, required a lengthy and difficult process. How real was the initial optimism? What made these changes possible? Were those new theories and techniques generalizable to other patients or were they the elusive skills of especially gifted therapists who became enthusiastic following their treatment successes?

To explain frequent difficulties in such treatments, empirical and clinical reports continued to document specific challenges in treatments of NPD that undercut effectiveness of these treatments (for reviews see Weinberg & Ronningstam 2020, 2022). Initially, the literature emphasized *individual challenging characteristics* of NPD patients. For instance, such characteristics of NPD patients as dismissive attachment (e.g., the tendency to dismiss reliance on others in times of distress), perfectionism, shame, and devaluation worsen the outcome (Black et al., 2013; Blatt et al., 1998; Dozier et al., 2001; Guile et al., 2004). NPD patients tend to provoke negative feelings in their therapists (Tanzilli et al., 2017). Typically, therapists of NPD patients struggle with such powerful reactions as feeling annoyed, used, close to losing one's temper, mistreated, resentful, and walking on eggshells. They experience sexual tension or feel dread or dislike of the patient,

feel criticized, dismissed, competitive and envious, bored, hopeless, and cruel or mean toward the patient. Clinical literature documented the following difficulties that NPD patients bring into therapy (for a review see Weinberg & Ronningstam, 2020): (i) NPD patients' motivation to come treatment is commonly related to crises and external circumstances, rather than internal and durable reasons for change. Furthermore, it is not uncommon for their motivation to be further undercut by overreliance on the financial support of family and the misuse of status or money. (ii) NPD patients present challenges due to intolerance of alternative points of view, lack of curiosity, pathological certainty about their conclusions, and poor recognition of inner states. (iii) Emotional challenges include difficulty naming and recognizing emotions, persistent boredom as well as excitement seeking, and a sense of meaninglessness and fear. (iv) Interpersonal challenges include impoverished relationships, competitiveness, fear of reliance on the therapist, and paranoid reactions toward the therapist. Some patients report superficially stable relationships with others. However, once the patient faces inevitable disillusionments or the relationship invites deeper commitment and intimacy, their dream-like interest evaporates and they plunge into a state of meaninglessness, until they repeat this cycle all over again. (v) Challenges related to self-esteem regulation consist of seeking self-affirmation as opposed to self-understanding, externalization of responsibility, chronic self-criticism, and perfectionism. (vi) Lastly, compromised moral functioning – another treatment challenging factor – includes lack of responsibility or commitment, dishonesty, lack of capacity for remorse, and exploitation of others.

As the field shifted toward understanding that stalemates in treatment are jointly co-created by the patient and the therapist (Bromberg, 1992), there was a growing recognition that some of the difficulties in treatments of NPD patients are *jointly co-created* as well. They stem from specific relational configurations that develop in treatments of NPD patients that lead to non-treatment treatments – therapies that continue even though they do not accomplish treatment goals (Weinberg & Ronningstam, 2022). Such relational configurations form obstacles to the productive use of therapy and process of change, and they tend to develop with mutual contributions of the therapist and the patient. Usually, such contributions occur outside of awareness of both parties as they develop interlocking patterns in terms of styles of managing self-esteem, processing emotions, relating to each other, or their cognitive processes. (i) Lack of goals. Some therapies proceed without measurable realistic goals. In these cases, therapies turn into a form of a psychic retreat (Steiner, 1993) in which the patient is invested in perpetuating the *status quo* , avoiding emotional experiences and the pursuit of reality-based goals. With some patients, this challenge appears gradually. They attend the sessions and always have something to discuss. However, after a while one start having a sense of *de je vu* : there is no change in what is being talked about, no change in problems that brought them into therapy in the first place, and they sessions feel devoid of distress. In some cases, this is related to an assumption that the patient will develop inner ability and desire to change as a result of psychotherapy. (ii) Joint collusion with protracted states of mutual idealization. In these cases, both the patient and the therapist co-create a form of mutual idealization as a form of avoidance of discussion of meaningful experiences or pursuit of treatment goals and focus on "how great they are" (Slochower, 2006). (iii) Collusion with protracted devaluation, competitiveness, or envy. At other times treatment stalls when the patient is developing a pattern of devaluation, competition, or envy in relationship to the therapist who is contributing to these dynamics or colluding with them. For instance, mutual enactment of devaluation, competitiveness, or envy due to underlying narcissistic vulnerability in both therapist and patient can gradually escalate these dynamics to treatment interfering proportions. In other words, the patient and therapist continuously provoke each other and escalate the dynamic as a result. For instance, the patient might be dismissing therapist's interventions, deeming them stupid. At first, the therapist might be channeling feelings of frustration and hurt into efforts to impress the patient by increasingly complex interventions, trying to "prove" his or her worthiness. Later, losing patience, the same therapist might lapse into chronically critical tone in interventions. (iv) Allowing the patient to control the treatment. While patients need to feel and be in control of their therapies, once they start dictating major treatment decisions, their treatment is at risk of a stalemate. Sometimes, this is related to refusal to participate in additional components of treatment (e.g., homework, self-help meetings, pharmacotherapy), or refusal to provide consent to communicate with other treatment providers or significant others, or at times direct suggestions of how their therapy needs to be conducted. In one way or another these patterns interfere with effective treatment (Hendin et al., 2006). It is not uncommon for the

same patients to later blame the resultant lack of progress on the therapist as if they have no part in that outcome. (v) Use of treatment for secondary motives. All patients participate in therapy for a host of reasons, ranging from change-motivated and those driven by less adaptive motives. For some patients, their ability to effectively participate and benefit from treatment is limited by the predominance of maladaptive motives and agendas. For instance, some patients participate in treatment to appease worried family members or work supervisors, without having an actual interest in change. Others come to treatment only to prove that they are beyond help and therefore either are unable to change as they can now externalize responsibility on treatment or celebrate triumph as they demonstrate superiority over their therapist (Kernberg, 2007). (vi) Pseudo-engagement. In such cases there is an appearance of effective psychotherapy, but the real engagement is lacking. In some cases, it stems from an overly intellectual focus of treatment (Dimaggio, 2022), a mutual avoidance of painful emergence of emotions by both patient and therapist that a deeper engagement entails (Cooper, 2016), or the development of misalliance around the power differential. For instance, the patient creates a façade of engagement to keep the therapist at bay. Sometimes, this pattern reflects a repetition of power dynamics from the patient's past and lack of trust in the therapist. (vii) Some treatments persist beyond the productive stage and turn into non-treatment treatments, or the patient avoids termination and attends treatment to maintain patient role or because of avoidance of grieving by either or both parties. The avoidance of termination helps them avoid mourning losses, including accepting that therapy could not solve all of their difficulties. This is not to be confused with "lifers" – patients that stay in treatment for life but use treatment productively (Wallerstein, 2000).

However, yet another reason for these challenges in treating NPD patients may have to do with the status of our understanding of NPD. Is it the NPD or, maybe, our own expectations, biases and narratives about NPD patients that affect treatability? Similarly,*destigmatization* of other personality disorders improved treatment outcomes (Ferguson, 2016; Sheehan et al., 2016). Looking at social media and popular culture, one cannot help to notice that it is an unfortunate *zeitgeist* to vilify anyone suffering from pathological narcissism. In that narrative narcissism is associated with exclusively negative attributes and adjectives, that inviting blaming and negative mindset. Not only does this demotivates patient to seek professional help, but also interferes with therapists' ability to learn from each patient from *his or her* internal point of view. Could better understanding of NPD patients through empirical research and the development of novel treatments decrease stigma and improve treatment outcomes?

*Possibility of change in NPD*

Empirical studies of the longitudinal course of NPD are especially informative regarding the question of possibility of change. The conclusions from the studies of longitudinal course of patients suffering from NPD are the following: (i) NPD improves over time, (ii) changes are slow and gradual and sudden improvements were not documented, and (iii) symptomatic improvements occur faster than improvements in pathological narcissism as a dimension. No studies in clinical samples focused on vulnerable narcissism (Weinberg & Ronningstam, 2022). Studies of pathological narcissism in non-clinical samples complement and extend the findings from the studies of NPD in clinical samples. The findings from these studies highlight that different facets of pathological narcissism improve at a different pace. The facet of hypersensitivity, that includes such characteristics as resentment, depletion, sense of entitlement, and roughly corresponds to vulnerable narcissism, continues to improve throughout the person's life, while the facet of willfulness that includes external grandiosity and exhibitionism, and roughly corresponds to grandiose narcissism, improves until middle age and tends to plateau thereafter (Cramer 2011; Edelstein et al., 2012). Taken together these studies show that pathological narcissism is associated with a slow pace of change and that compared to vulnerable narcissism traits, traits associated with grandiose narcissism are more persistent.

While longitudinal studies demonstrated that NPD patients change, the question remains what processes are responsible for change. So far, research has documented that some of these changes occur as a result of life events (Ronningstam et al., 1995; Wenzel et al., 2020). Improvement in pathological narcissism has been associated with new relationships, achievements, or disillusionments, especially if those are being processed in a sympathetic context, including therapy (Ronningstam et al., 1995). Realistic jobs (e.g., engineering, me-

dicine) are more likely to be associated with improvements in pathological narcissism compared to leadership positions or enterprising jobs (Wenzel et al., 2020).

Some studies documented changes in NPD patients in therapy, reporting symptom reduction and improvement of functioning (Callaghan et al., 2003; Riordan, 2012; Kramer et al., 2018; Weinberg et al., under review). While conclusions from these reports are limited by small sample sizes, pre-post designs, and lack of uniformity in the use of measurement, they provide hope that treatments can help NPD patients change.

Research has been lagging in identifying mechanisms of change in psychotherapy. From a theoretical standpoint, some of the candidates for such mechanisms are treatment alliance, development of reflective ability, and mourning. How do these concepts apply to treatments of NPD?

(i) Alliance. Treatment alliance has been identified as the most powerful predictor of change in treatment (Muran & Barber, 2010). Alliance provides a leverage for change but also provides patients with a lived experience of a collaborative, respectful, and emotionally attuned relationship that on its own is conducive to emotional growth and self-exploration, and the discovery of new forms of relating (Lowald, 1980). In fact, numerous meta-analyses estimated that treatment alliance is the most significant predictor of treatment outcome, contributing moderately to its prediction (Barber et al., 2010; Baier et al., 2020; Fluckiger et al., 2018), including behavioral treatments (Sauer-Zavala et al., 2018; Ovenstad et al., 2020).

However, alliance in NPD is undercut by several factors, including dismissive and avoidant attachment styles (Diamond et al., 2014) as well as such characteristics as avoidance of reliance on the therapist, competitive relationship with the therapist, envy, and attribution of malintent to the therapist (for a review see Weinberg & Ronningstam, 2020). This limits the ability of the patients to benefit from therapy. One approach suggests that treatment alliance can be built through curiosity about the patient's experiences, an exploratory approach, helping the patient understand and develop a sense of agency about their behaviors (Ronningstam 2012). These interventions encourage the patient to take ownership of their capabilities, and not only their maladaptive behaviors. Alliance develops based on these interventions as well as a conveyed understanding that the patient's experiences can be understood in context of complex interactions between limitations, capabilities, motivations, and fears. Another approach, transference-focused psychotherapy (Diamond et al., 2022), is viewing alliance development as both a treatment goal in its own right and a mediator of change. This approach consists of developing a treatment contract to contain treatment interfering behaviors and careful exploration and interpretation of negative projections that undermine more positive reliance on the therapist. Others have suggested that the use of autonomous motivation that is based on investment in treatment goals (Zuroff et al., 2007) is an alternative to the fragile alliance of NPD patients (Weinberg & Ronningstam, 2020). These interventions suggest that while treatment alliance is fragile in patients with pathological narcissism, certain treatment modifications can help these patients engage in treatment and develop alliance as one of the treatment outcomes.

(ii) Reflective function. Reflective ability – thinking about one's own psychological processes, such as thoughts, feelings, and motivations – overlaps with metacognition – thinking about thinking (Dimaggio et al., 2007). Many treatments encourage the development of reflective capacities and view such developments as instrumental in the process of change (Fonagy et al., 2002). Many treatment interventions are designed to promote such capacity in patients – exploration of antecedents of problem-behaviors as well as of progress, exploration of functions of different behaviors, exploration of thoughts, feelings, and behaviors to promote pattern recognition and insight into their functions, motivations, and developmental antecedents (Castonguay & Hill, 2007). However, research has shown that patients with NPD have decreased reflective function (Diamond et al, 2014), and clinical observations describe propensity for detached, intellectual - pseudo-mentalizing (Drozek & Unruh, 2020), intellectualized reflectiveness (Dimaggio, 2022), and the difficulty to think in a meaningful and reflective way (Shoshani & Shoshani, 2016). This has led to development of treatments that promote the development of reflective and mentalizing capabilities (Choi-Kain et al., 2022; Drozek & Unruh, 2020), thus increasing the potential of NPD patients to benefit from treatments that rely on reflective capacities. In fact, preliminary observations confirm that reflectiveness can improve at least in some therapies, such as transference focused psychotherapy (Diamond et al., 2014).

(iii) Mourning. Mourning is related to the ability to grieve losses, unmet needs, and unfulfilled fantasies or dreams, and accept reality, personal limitations, and realistic expectations, and give up maladaptive solutions or unrealistic fantasies – all important – if not critical - aspects of psychotherapy. Traditionally, pathological narcissism was thought to be associated with a limitation in the ability to mourn (Kernberg, 1975; Steiner, 1993; Shoshani & Shoshani, 2016), as pathological narcissism was seen as a complex form of avoidance of the process of mourning. In that way, narcissistic functioning can be seen as antithetical to the mourning process, thus introducing challenges to treatments that rely on intact capacity to grieve. On the other hand, our understanding of the grieving process has changed. Traditionally, it was assumed that grieving involves gradual acceptance of the loss and redirecting the investment into the lost relationship into new ones (Freud 1917); current findings demonstrate however that giving up connection with the lost person does not always occur (Bonnano 2009). For some people such transformation manifests itself in the feeling that the lost person is still present in their lives through internal dialogue or through their commitment to make room in their own lives for what was important to the lost person. For instance, a bereaved husband might feel connection to his deceased wife though dedicated care for their grandchildren, viewing them as extension of her. Rather than viewing treatment as giving up maladaptive aspects of narcissistic functioning, it can be seen as transformation of them into more adaptive ones, echoing Kohut's notion of transformation of narcissism (Kohut, 1966). For instance, a patient might be able to transform aspirations to become a top scientist in their respective field, into a dedication to their mentees and students.

*New directions for treatment of NPD*

The burgeoning empirical research on pathological narcissism provided very much needed information on a wide spectrum of areas related to it (Table 2; Weinberg & Ronningstam, 2022). It introduces a new perspective that views the patient in context of multifactorial etiology and mutually influencing areas of functioning. This invites the clinician to be attuned to multilayered and fluctuating experiences and functioning of the patient, to avoid making assumptions, and recognize the uniqueness of each patient. This introduces an evidence-based and more optimistic approach to NPD.

This renewed optimism resulted in novel treatment developments, including formulation of principles of psychoanalytically-oriented therapy for NPD (Crisp & Gabbard, 2020), transference-focused psychotherapy for NPD (Diamond et al., 2020), mentalization based treatment for NPD (Drozek & Unruh, 2020; Choi-Kain et al., 2022), adaptation of good psychiatric management to NPD (Weinberg et al., 2019), Metacognitive Interpersonal Therapy (Dimaggio et al., 2020; Centonze et al., 2023) and formulation of general principles of treatment for NPD (Weinberg & Ronningstam, 2020; Dimaggio, 2022). Guided by a pragmatic focus on change, informed by recent research developments, while keeping an open mind for revision necessitated by clinical experience, these treatments herald a new era in the treatment of pathological narcissism.

Another area of optimism is shifting the perspective from the one that views the patients as holding all the challenges to effective treatment, to a transactional approach that views challenges at least in part co-created. Instead of viewing patients' treatability in context of their personality factors, the field is moving to the perspective that treatability is related to patient-therapist match (Kantrowitz, 2020) and stalemates – are at least in part co-created (Bromberg, 1992). Treatability is not only a characteristic of a patient but of a therapist-patient dyad and their capacity to work together. Certain experiences and characteristics of therapists make them more likely to succeed with certain patients that might not be treatable by others. Destigmatization and evidence-based perspective on pathological narcissism are another component. One aspect of this is avoiding the "one size fits all" approach, imposing theory, our biases or personal reactions onto the patient, and judging internal experiences based on external manifestations. Instead, clinicians are invited to recognize the uniqueness of each person and seek understanding that aspires to integrate inner experiences of the patients, their overt behaviors, as well as the reactions they evoke.

For instance, many NPD patients discontinue treatment prematurely (Hilsenroth et al., 1998; Gamache et al., 2018). However, not all early terminations are the same and not all of them indicate that the treatment has not been productive. Terminations are related to enactment of various aspects of narcissistic functioning: dismissive attachment, need for control, fear of change, superiority, competition, envy, fear of closeness or

reliance on the therapist, withdrawal, devaluation, or entrapment. Terminations could be related to various treatment processes: fragile alliance, disagreements about goals or lack of attention to setting explicit shared goals (Dimaggio & Valentino, 2023; Dimaggio, 2023), overstimulation of attachment through overly empathic or dramatic interventions, retaliation against therapist, exclusive focus on treatment relationship or insufficient focus on it; use of interpretations to assert power differential or intrude and control the patient. For other patients the judgment of the therapist that the termination is an "early" one is a reflection of disagreement between the patient and the therapist about the continuation of the therapy. This could stem theoretical biases or unprocessed reactions of the therapist (e.g., anger or overprotectiveness) and may not necessarily indicate that the therapy itself was not helpful. With other patients, early terminations are expression of a pattern that consists of intermittent engagement in otherwise productive therapy (Paris, 2007). For others, despite early terminations, such treatments "plant the seeds" for future reflections, insight or change. These processes of change might occur in future treatments, or as a result of personal reflections of the patients, or as a result of inner integrations that might be happening outside of the patients' awareness.

Novel understanding of the disorder and renewed interest in understanding the patients suffering from it inspired the recognition that "NPD is a new BPD" (Choi-Kain, 2020). In other words, similar to how BPD became a treatable disorder due to advances in research and treatment development in the 80s and the 90s, it is now the turn of NPD to undergo the same transformation. This invites a few approaches to treatment development for pathological narcissism. Some of those approaches are listed below.

(i) *Modification of treatments for related conditions* , such as BPD. For instance, such treatments as TFP and MBT, that were previously supported for treatment of BPD were subsequently modified to treat a closely related condition – NPD (Diamond et al., 2022; Drozek & Unruh, 2020).

(ii) Eclectic treatments – *selection of effective principles* and interventions. Another strategy consists of the development of treatments that combine effective interventions from existing treatment modalities. The chosen interventions were identified because of the clinical utility and their ability to address characteristics of narcissistic patients (e.g., use of treatment contract to address difficulty stay in treatment; Weinberg & Ronningstam, 2020).

(iii) Development of treatments based on empirical understanding of*mechanisms of NPD* (Dimaggio, 2022). This strategy of treatment development targets putative mechanisms associated with NPD. For instance, dismissive attachment, that is the tendency to dismiss reliance on others during distress, in NPD patients invites the development of treatments that target dismissive attachment.

(iv) Development of treatments that target *mechanisms of change in therapies* of NPD. Such treatments address those areas of treatment undermined by pathological narcissism. For instance, difficulty forming alliance by NPD patients invites treatment approaches that help target this area in NPD patients (Ronningstam, 2012; Dimaggio, 2022).

(v) *Development of therapies based on cases of treatments associated with change* . Such an approach encourages treatment development based on therapies that went well. Such cases provide insight into what works with NPD patients and possibly can inform novel treatment developments (Weinberg & Ronningstam, in preparation). This perspective encourages treatment development using an experience driven approach, as opposed to theory driven approach. This approach is preferred by clinicians (Kealy et al., 2017) who tend to think in terms of principles of treatment rather than point by point interventions. This approach invites development of principle-based treatments. The tradition of principle-based treatment has a long history in clinical science (Castonguay et al., 2019). Treatment principles have the advantage of flexibility in addressing variability, fluidity, and complexity of cases (Castonguay et al., 2019), such as NPD (Weinberg & Ronningstam, 2022). Use of principles as opposed to treatment manuals is especially relevant to treatments of NPD in which therapists struggle with fragility of alliance. Research shows that for patients who have low motivation and form fragile alliance – typical for NPD – adherence to treatment is associated with worse outcome or not related to it at all; alliance is more predictive of the treatment outcome than adherence (Webb et al., 2010; Huppert et al., 2006).

(vi) Identification of *common factors* in different effective treatments. Such factors are likely putative effective interventions responsible for change. Building on common factor approach to therapy (Wampold & Imel, 2015), research identified such factors in evidence-based treatments for BPD (Weinberg et al., 2011). The identification of common interventions in various effective therapies, including case reports of therapies with NPD patients, will help with the development of novel effective treatments. This approach can be applied to case reports published in this Special Issue, thus formulating new hypotheses as to what interventions are likely effective in treatment of NPD patients.

The present issue of the *Journal of Clinical Psychology: In Session* was planned to address some of these urgent questions in the field. The current approach is based on (i) prioritizing evidence, including clinical evidence, over theory, (ii) collaborative, constructive approach, and (iii) pragmatic effort to identify factors responsible for change. (iv) destigmatization of NPD. Thus, five/six clinicians were invited to contribute treatments of NPD patients using descriptive atheoretical language, promoting an understanding of what allows change in each one of these therapeutic engagements. The goal is to start a dialogue between different treatments to learn from convergences and unique interventions and to learn what interventions worked. This is to inform clinicians and treatment developers regarding possible helpful interventions, leading to a more hopeful approach to treatment of NPD patients and spurring new effective treatments. At the end of the issue Dimaggio and Weinberg will comment the single case-based papers and try to distill common factors at work, outline differences and note if they increase our understanding how to best address the need of a condition like NPD which presents difficulties but is indeed treatable.

*"Going back to Matthew and the questions regarding the possibility of him having productive treatment, one might have the following reverie of an alternative therapy development inspired by this introduction. Accordingly, his treatment started with a careful discussion of his past experiences with psychotherapy and significant others. During that discussion he disclosed that many times he tended to end relationships when he felt angry or disappointed and, subsequently, put the blame on others. As a result, his therapist brought up the possibility that a similar situation might occur in treatment and that it would be important to work it through so he could have an opportunity to address this tendency to end relationships. Matthew agreed as he regretted some of these impulsive endings. As the treatment unfolded, he indeed voiced his inclination to leave after nobody showed up for his graduation party. That led to the discussion about the agreement he made at the outset of the treatment. Initially, Matthew was hesitant to honor it, but agreed to give it another try after the therapist emphatically recounted how much Matthew regretted many of his early endings. As they worked together, therapist noticed his own critical thoughts about Matthew's intolerant judgmental attitude to others. The therapist had a consultation with an experienced colleague, and they end up wondering whether these critical feelings correspond to how Matthew feels about himself and, also, reflect critical voices of his perfectionistic parents. That allowed the therapist to listen more closely to the internal experiences of Matthew, not just to their external manifestations. He started getting curious about the inner experiences of Matthew that we hid behind arrogance, condescending criticism of others and distrust. Gradually, Matthew started describing a profound sense of insecurity, distrust in himself, and a constant sense of not being good enough viz-a-viz unremitting self-criticism. He started noticing parallels between his self-criticism and the criticism of his parents that made him feel humiliated and inept throughout his unhappy childhood. Talking about his childhood feelings brought up fear regarding therapy as he worried that the "therapy was making him weak". Matthew explained that talking about his feelings made him feel vulnerable, which he equated with being weak. He felt angry at the therapist who was "weakening him" and making him "less prepared to deal with the hostile world out there". Invited to reflect on these judgments, he saw parallel with the stoic critical culture of his family that dealt with persecution and discrimination. He was also surprised that the therapist was not retaliating against him, despite Matthew's angry criticism. He shared that it made him feel accepted and cared for and indicated that he wanted to feel like that in his life. As he was more open to the side of him that wanted to be cared for and accepted, he started to consider that others might have the same desires as well. That invited him to consider that "maybe there is more to life than who hurts whom" and started considering building friendship on more genuine interest and support as his fear of criticism by others started to subside as well."*

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