

Attachment and the Narcissistic Self

The psychological study of narcissism has traveled from classical psychoanalysis to contemporary dimensional models of personality pathology. In Freud's metapsychology, narcissism described libidinal investment in the self that could become excessive and defensive. Later theorists elaborated its clinical forms (Caligor, 2023). Kohut's self-psychology reframed narcissism as a developmental disorder of the self that arises when caregivers fail to provide empathic "self object" functions (mirroring, idealization, twinship) necessary for consolidating a cohesive, stable self (Caligor, 2023). Kernberg, by contrast, located pathological narcissism within an object-relations framework, emphasizing a brittle grandiose self that defends against underlying fragmentation and aggression (Caligor, 2023). Treatment, from his view, aims to analyze the pathological grandiose self in the transference and integrate split representations. Contemporary summaries of object-relations formulations underscore this spectrum conception, organizing personality by level of structural integration and characteristic defenses, while integrating empirical constructs such as identity diffusion and reality testing into case formulation (Caligor, 2023).

During the past decade, classification systems have moved decisively toward dimensional models. Both the DSM-5 Alternative Model for Personality Disorders (AMPD) and the ICD-11 framework conceptualize personality pathology along separable dimensions of severity (self/interpersonal dysfunction) and maladaptive trait domains, with narcissistic features captured by antagonism (e.g., grandiosity) and related profiles rather than a single categorical label. This shift improves coverage of grandiose and vulnerable expressions and aligns diagnosis with trait-based assessment and mechanism-informed treatment planning (Day, Tangney, & Rauthmann, 2024). Recent work specifically examining narcissism in the ICD-11 highlights how severity and trait qualifiers can flexibly represent diverse presentations while encouraging clinicians to assess impairments in identity, self-direction, empathy, and intimacy alongside antagonistic traits (Hualparuca & Dienstmaier, 2023). Convergence research further suggests conceptual and empirical overlap between ICD-11 and the DSM-5 AMPD, strengthening confidence in dimensional approaches (Hualparuca & Dienstmaier, 2023). Finally, contemporary cognitive-affective and neuroscientific accounts complement psychodynamic and nosological perspectives by emphasizing self-regulatory processes (e.g., threat reactivity to ego injury, envy–contempt cycles, and fluctuating self-esteem) and their neural correlates (Ash & Robinson, 2023). These literatures converge on a portrait of narcissism as an inherently self-

regulatory adaptation, sometimes confident and socially agentic, sometimes brittle and defensive (Ash & Robinson, 2023).

Attachment theory provides a developmental lens on self-functioning and interpersonal regulation that dovetails with contemporary models of narcissism. Bowlby proposed that early caregiver interactions are internalized as “internal working models” (IWMs) of self and others, shaping expectations about accessibility of support and one’s worthiness of care; Ainsworth operationalized patterns of security and insecurity that, in adulthood, map onto styles of emotion regulation and intimacy (Ren, Topakas, & Patterson, 2024). Modern evidence reaffirms these foundations: secure attachment is reliably associated with flexible, balanced emotion regulation, whereas insecure patterns (anxious, avoidant, or disorganized) correspond to hyperactivating or deactivating strategies that carry forward into adult relationships and contexts (Eilert, Kuehn, & Zajenkowski, 2023). With respect to narcissism, attachment research increasingly documents systematic links between insecurity and both vulnerable and grandiose forms. Individuals with secure attachment tend to report lower vulnerable narcissism, fewer identity disturbances, and fewer interpersonal problems than fearful/avoidant or anxious/preoccupied counterparts (Sagone, De Caroli, & Fichera, 2023). Cross-sectional studies in community samples similarly observe that insecure dimensions (anxiety, avoidance) correlate positively with grandiose and vulnerable narcissism (Sagone et al., 2023). These attachment–narcissism associations also carry interpersonal consequences: for example, trait narcissism, especially antagonistic components, has been linked to intimate partner difficulties, including higher risk for aggression and control, consistent with models in which impaired empathy and contingent self-esteem promote coercive regulation of closeness and status (Oliver & Khan, 2023).

Integrating these lines of work suggests a developmental-mechanistic account of narcissism grounded in attachment, self-functioning, and dimensional pathology. Early caregiving that is inconsistent, unempathic, or excessively evaluative can engender IWMs in which the self is conditionally worthy and others are unreliable or exploitive. Within Kohut’s terms, chronic failures of mirroring or idealizable presence leave gaps in self-cohesion and self-soothing capacities; within Kernberg’s terms, this history fosters identity diffusion, reliance on splitting, and externalization of aggression to preserve a grandiose self (Caligor, 2023). Dimensional nosology translates these legacies into measurable impairments in identity (e.g., contingent self-esteem, vacillating standards), self-direction (e.g., status-driven goals), empathy (e.g., instrumental mentalizing), and intimacy (e.g., exploitative or avoidant patterns), accompanied by antagonistic traits (grandiosity, entitlement, callousness) or, in vulnerable forms, negative affectivity and withdrawal (Day et al., 2024; Hualparuca & Dienstmaier, 2023). At the level of moment-to-moment

regulation, insecure IWMs bias attention and appraisal toward ego-threat (e.g., rejection, criticism), activating defensive scripts that aim to restore self-worth and control, boasting, contempt, devaluation, or withdrawal, while dampening receptivity to care. Contemporary evidence on adult attachment shows that insecurity is linked to dysregulated emotion strategies (hyperactivation or deactivation), aligning closely with clinical observations of narcissistic reactivity: anger or coldness in response to perceived slights, competitive status-seeking under evaluative stress, and oscillations between exhibitionism and avoidant detachment (Eilert et al., 2023; Ash & Robinson, 2023). This regulatory picture is supported by emerging affect-process models of narcissism (e.g., envy–contempt spirals) and by neuroscientific findings implicating self-relevant threat processing (Ash & Robinson, 2023).

Importantly, the integrative model identifies leverage points for assessment and treatment. First, evaluate dimensional severity in self/interpersonal functioning alongside antagonistic (and, when present, negative affectivity) traits to capture both grandiose and vulnerable profiles (Day et al., 2024). Second, assess attachment history and current relational patterns: indicators of contingent self-esteem, sensitivity to shame, reliance on devaluation, and difficulty accepting care should cue exploration of unmet self-object needs (mirroring, idealization, twinship). Third, address emotion-regulation biases linked to insecure IWMs by cultivating secure-base experiences in therapy (consistent, accurate attunement and collaborative repair), while making explicit how grandiose or avoidant defenses temporarily protect against unmet needs yet perpetuate isolation and contempt. Finally, because antagonism undermines empathy and mutuality, interventions benefit from parallel targets: enhancing reflective functioning about others, building toleration for dependency and imperfection, and reinforcing pro-social goal pursuit—consistent with ICD-11/AMPD emphases on self and interpersonal functioning as primary outcomes (Hualparuca & Dienstmaier, 2023; Day et al., 2024).

Contemporary theory and data converge on a view of narcissism as a self-regulatory adaptation to insecure attachment and unmet self-object needs, expressed along dimensional axes of severity and antagonistic traits. Classic psychoanalytic insights (Kohut; Kernberg) and attachment constructs (Bowlby; Ainsworth) remain conceptually vital, but modern frameworks translate them into operational domains (identity, empathy, intimacy; trait antagonism) with increasing empirical traction and clinical utility (Caligor, 2023; Sagone et al., 2023).

Developmental Origins

Early relational experiences form the bedrock of self-regulation, interpersonal functioning, and personality development. In the case of pathological narcissistic

adaptations, these developmental processes often include relational trauma, failures of caregiving mirroring, compromised mentalization by the caregiver, and resultant distortions of attachment and self-object regulation.

Early Relational Trauma and Mirroring Failures

From an object-relations and self-psychology perspective, the infant's investment in the caregiver as a "self-object" begins with the caregiver's capacity to mirror, idealize, and twin with the child in the service of building a cohesive, regulated self. When caregivers are inconsistent, emotionally unavailable, rejecting, or traumatized, infants may internalize a self that is unworthy, un-mirrored, and chronically threatened. Such relational failures constitute early trauma, often not overt abuse, but chronic neglect of emotional attunement, failure of mirroring responses, or hostile/alienated caregiving, that compromise the development of a stable self and increase vulnerability to compensatory self-regulatory strategies such as narcissistic grandiosity or vulnerability.

Empirical work supports the link between childhood relational trauma and subsequent difficulties in mentalizing, self-regulation and insecure attachment. For example, in a large sample, anxious attachment was positively linked to vulnerable narcissism, mediated by impaired self-compassion and self-regulation (Özbay et al., 2025). This suggests that early caregiving failures are plausibly upstream of attachment-based vulnerabilities that manifest as narcissistic strategies. Further, meta-analytic work indicates that insecure internal working models correlate with pathological narcissism (Mohay et al., 2025), pointing toward early relational vulnerabilities as a risk factor. While this literature does not specify self-object mirroring per se, the developmental logic aligns: failure of attuned caregiving leaves the self under-regulated and the attachment system hyper- or de-activated, driving narcissistic compensatory structure.

Role of Caregiver Sensitivity and Mentalization

Caregiver sensitivity, defined as the caregiver's capacity to notice, interpret correctly, and respond promptly and appropriately to the infant's signals, has been long established as a predictor of secure attachment formation. When sensitivity is low, infants learn relational strategies of either hyperactivation (anxious/preoccupied) or deactivation (avoidant/dismissive) to maintain proximity or reduce threat. Moreover, caregiver capacity for mentalization, recognizing and reflecting the infant's internal states, plays a critical role in the child's self-regulation and narrative coherence. Without adequate mentalizing from the caregiver, the child may internalize a fragmented or defensive self-state, leading to vulnerability in self-object regulation and interpersonal functioning.

Recent studies further clarify these mechanisms in the context of narcissistic traits. In a sample of emerging adults, dismissing and preoccupied attachment styles were fully mediated by vulnerable narcissism and emotion dysregulation on the path to lower perceived social support (Sagone, De Caroli, & Fichera, 2023). This underscores how deficient caregiving may disrupt emotion regulation and self-esteem, creating fertile ground for narcissistic compensatory strategies. From the developmental self-psychology view, each missed mirroring encounter leaves a gap in self-cohesion; from the attachment view, each inconsistent caregiver response contributes to IWMs of unworthiness and unreliability. The overlap of these frameworks suggests that low caregiver sensitivity and poor mentalization constitute proximal causes of both insecure attachment and maladaptive narcissistic adaptation.

Attachment Subtypes and Narcissistic Adaptations

Attachment theory categorizes patterns into secure, anxious (preoccupied), avoidant (dismissive), and disorganized (or fearful) subtypes, each with characteristic internal working models (IWMs) and corresponding regulation strategies. In the context of narcissistic adaptation, these attachment patterns provide a useful typology for understanding variant presentations of narcissism.

- Avoidant (Dismissive) attachment: The child learns that needs for closeness are inconsistently or overtly rejected, so the strategy becomes deactivation, minimizing dependency, suppressing hurt, and maintaining self-reliance. In narcissistic terms this may map onto a grandiose self that externally dismisses neediness, projects self-sufficiency, and devalues vulnerability. Some research suggests grandiose narcissism may correlate weakly with dismissive attachment but the findings for vulnerable narcissism are stronger (Mohay et al., 2025).
- Anxious (Preoccupied) attachment: The child experiences inconsistent caregiving and therefore hyper-activates attachment behaviors, seeking approval, proximity, constant reassurance, and fearing abandonment. Within narcissistic adaptation this may translate into a vulnerable narcissistic style: contingent self-esteem, hypersensitivity to evaluation, shame, envy, and persistent need for admiration (Sagone et al., 2023). Indeed, preoccupied attachment shows one of the strongest correlations ($r \approx .43$) with vulnerable narcissism in recent meta-analysis (Mohay et al., 2025).
- Disorganized/Fearful attachment: Arising from chaotic, frightening, or traumatizing caregiving, this subtype represents an overwhelmed regulation system, contradictory strategies, dissociation, and fear of both closeness and

independence. In narcissistic conceptualization, this may link to unstable self-representations, rapid oscillation between grandiosity and shame, rage and withdrawal, and high severity of self/interpersonal dysfunction. While direct empirical studies linking disorganized attachment and narcissism remain limited, the integrative framework plausibly locates severe narcissistic pathology within this subtype.

Clinically, this typology suggests that treatment of narcissistic pathology should assess not only trait features (grandiosity, entitlement, vulnerability) but also underlying attachment strategies driving defensive regulation. For example, a dismissive-avoidant narcissistic client may benefit from interventions that gently challenge the self-sufficiency façade and explore vulnerability, whereas a preoccupied-vulnerable client will benefit most from interventions that help them manage shame, contingent self-esteem, and enable more secure agency.

Neurobiological and Epigenetic Correlates

Beyond caregiving and attachment strategies, the developmental origins of narcissistic adaptations involve neurobiological and epigenetic pathways. Childhood relational trauma and disrupted attachment experiences place stress on the developing organism, activating the hypothalamic-pituitary-adrenal (HPA) axis, altering cortisol regulation, and affecting brain circuitry underlying self-regulation, threat monitoring, and social cognition. For instance, in a recent study individuals high in vulnerable narcissistic traits exhibited elevated cortisol responses during psychosocial stress, pointing to HPA dysregulation in the relational-trauma-to-narcissism pathway (Borráz-León et al., 2023). Although not exclusively focused on narcissism, meta-analytic data on attachment and stress-response systems show that insecure attachment is associated with elevated physiological stress markers and altered interoceptive processing, consistent with a biological embedding of early relational adversity. Moreover, research into mirror-neuron systems and social cognition suggests that early relational deficits (such as lack of attuned mirroring) may interfere with the neural basis of empathy, imitation, and self/other distinction, key elements in both attachment and narcissistic functioning (Zhang et al., 2024). Emerging epigenetic work further posits that early adversity may “program” stress-responsive genes (e.g., glucocorticoid receptor genes) and attachment-related biomolecular pathways thereby shaping vulnerabilities to narcissistic self-regulation deficits.

Taken together, these findings support a multi-level developmental model of narcissism: early caregiving failures → insecure attachment/IWM of self/other → dysregulated stress and self-regulatory biology → compensatory narcissistic strategies (grandiose or vulnerable) to manage self-threat and interpersonal instability.

Narcissistic adaptations do not emerge purely from willful self-aggrandizement or cultural narcissism; rather, they are grounded in early relational trauma, mirror-failures, deficient caregiver sensitivity and mentalization, attachment adaptations (avoidant, anxious, disorganized), and biological embedding of relational failure. These origins help explain why narcissism often involves contingent self-esteem, fragile identity, external validation seeking, and interpersonal antagonism or detachment.

Typologies of Narcissism

Understanding narcissism requires differentiation among its multiple forms, ranging from adaptive, socially functional expressions to maladaptive, personality-disordered manifestations. Over the last two decades, research has converged on a multidimensional view, recognizing grandiose and vulnerable narcissism as distinct yet dynamically related patterns of self-regulation (Kealy & Ogrodniczuk, 2023; Miller et al., 2024). In parallel, the DSM-5-TR and ICD-11 have adopted dimensional frameworks that conceptualize narcissistic pathology in terms of underlying personality functioning and maladaptive traits, rather than a single categorical disorder. A third and emerging focus involves the recognition of adaptive narcissism, the set of confidence, ambition, and self-enhancing tendencies that can serve resilience and achievement when balanced with empathy and self-reflectivity (Weinberg et al., 2024). These typologies, viewed together, clarify how narcissism spans a continuum from healthy self-esteem to disordered self-structure.

Grandiose and Vulnerable Narcissism

The grandiose–vulnerable distinction remains the dominant organizing framework in contemporary narcissism research. Grandiose narcissism (GN) is characterized by overt arrogance, entitlement, dominance, and an inflated self-image. These individuals often appear confident, extraverted, and socially assertive, yet are highly defensive to ego threat. Vulnerable narcissism (VN), by contrast, reflects hypersensitivity, shame proneness, insecurity, and contingent self-esteem masked by withdrawal or covert self-importance (Pincus et al., 2024).

Recent meta-analytic evidence supports the empirical separation of these forms while emphasizing their shared self-regulatory core. In a 2024 systematic review, Miller and colleagues found GN strongly associated with extraversion and low neuroticism, whereas VN correlated with introversion, high neuroticism, and anxious attachment patterns. Both dimensions, however, share antagonism (e.g., entitlement, lack of empathy) as a unifying feature, aligning with dimensional personality models (Miller et al., 2024).

Neurobiological findings reinforce this differentiation. Functional MRI studies show that grandiose traits correlate with increased activation in reward and salience networks (e.g.,

ventral striatum, anterior insula), reflecting heightened sensitivity to status cues. Vulnerable narcissism, on the other hand, shows stronger activation in default-mode and limbic regions associated with self-referential threat and shame (Zhang et al., 2024). Together, these data support a dual-process model: grandiose forms are driven by approach-oriented, dominance-seeking regulation, whereas vulnerable forms are dominated by avoidance, withdrawal, and affective instability (Pincus et al., 2024).

Clinically, this distinction has major implications. Grandiose narcissists may present as charming, high-functioning, or even charismatic until confronted with criticism, which triggers rage or contempt. Vulnerable narcissists, conversely, often appear anxious, depressive, or self-doubting but harbor covert entitlement and envy (Kealy & Ogrodniczuk, 2023). Psychodynamically, both can be conceptualized as opposite poles of the same regulatory system, a compensatory mechanism for developmental deficits in mirroring, empathy, and self-cohesion (Kernberg, 2023).

A longitudinal study by Peters et al. (2024) found that vulnerable narcissism predicted later depressive symptoms and interpersonal withdrawal, whereas grandiose traits predicted interpersonal conflict and aggression, yet both shared underlying instability of self-esteem. This reinforces the conceptualization of narcissism as oscillation between grandiosity and vulnerability rather than a fixed trait dichotomy.

Diagnostic Clarifications: DSM-5-TR and Dimensional Models

The DSM-5-TR retains Narcissistic Personality Disorder (NPD) as a categorical diagnosis characterized by pervasive grandiosity, need for admiration, and lack of empathy. However, categorical approaches have long struggled to capture clinical heterogeneity, comorbidity, and the dynamic oscillation between grandiose and vulnerable states (Caligor, 2023). Consequently, the Alternative Model for Personality Disorders (AMPD) within Section III of DSM-5 introduced a hybrid dimensional–categorical framework, operationalizing personality pathology through (1) level of personality functioning (identity, self-direction, empathy, intimacy) and (2) pathological traits (antagonism, disinhibition, negative affectivity).

Within this model, narcissistic pathology manifests as impairments in self-functioning (e.g., contingent identity, unrealistic standards, unstable goals) and interpersonal functioning (e.g., exploitation, lack of empathy), combined with antagonistic traits such as grandiosity and attention seeking (American Psychiatric Association, 2022). The AMPD thus allows clinicians to rate both severity (self/interpersonal impairment) and style (trait expression), accommodating both grandiose and vulnerable variants.

Similarly, the ICD-11 framework defines personality disorder primarily by severity of dysfunction and then specifies prominent trait qualifiers, most relevantly, dissociality/antagonism. Day et al. (2024) demonstrated that ICD-11 trait profiles align closely with DSM-5 AMPD antagonism, offering convergent validity. Both models move beyond static typologies toward a dimensional continuum, situating narcissism along axes of self-functioning and antagonistic traits rather than as a discrete entity.

Empirical findings support this dimensional shift. In a comparative analysis, Hualparuca-Olivera and Vega-Dienstmaier (2023) found significant convergence between ICD-11 severity ratings and DSM-5 AMPD domains across multiple clinical samples, particularly for narcissistic pathology. This allows for more nuanced assessment, such as identifying narcissistic features within borderline or antisocial presentations and quantifying subthreshold narcissistic traits that predict interpersonal dysfunction.

These dimensional clarifications have improved clinical reliability and research utility. For example, in psychodynamic assessment, dimensional tools such as the Level of Personality Functioning Scale (LPFS) correspond well to observed narcissistic fragility and oscillation between grandiosity and vulnerability (Caligor, 2023). Meanwhile, trait-based measures such as the PID-5 Antagonism scale map onto overt and covert narcissistic themes, providing a standardized vocabulary for both clinical and research settings.

In short, DSM-5-TR and ICD-11 conceptualize narcissism not as a monolith but as a profile of self-regulatory dysfunction encompassing identity diffusion, empathy deficits, and maladaptive antagonism. This dimensional perspective integrates psychoanalytic, attachment, and neurobiological findings into a coherent diagnostic framework.

Adaptive Narcissism and Resilience

While pathological narcissism denotes dysfunction, adaptive or “healthy” narcissism refers to self-enhancing traits that promote confidence, persistence, and resilience. Conceptually, adaptive narcissism aligns with positive self-regard and assertiveness balanced by empathy and authenticity (Kaufman, 2023). It allows for ambition, leadership, and self-efficacy without tipping into exploitation or fragility.

Recent empirical work distinguishes between agentic and antagonistic narcissism. Agentic narcissism, anchored in self-confidence and initiative, correlates with well-being, creativity, and psychological resilience (Kaufman, 2023). Antagonistic narcissism, rooted in entitlement and hostility, predicts maladaptive outcomes. This bifurcation underscores that not all narcissistic traits are pathological; rather, context and regulation determine adaptiveness.

Neuroscientific findings also hint at adaptive pathways. Individuals high in adaptive narcissism show greater functional connectivity in self-referential and executive control networks, supporting flexible self-monitoring and emotion regulation (Zhang et al., 2024). Similarly, a longitudinal cohort study found that moderate self-enhancement predicted lower depressive symptoms and higher life satisfaction over ten years (Peters et al., 2024). These findings align with the idea that healthy narcissism buffers against stress by maintaining a coherent, optimistic self-narrative.

Clinically, recognizing adaptive narcissism is essential to avoid pathologizing confidence or ambition. Psychotherapy for narcissistic traits aims not to eliminate self-enhancement but to integrate it with empathy, reality testing, and authentic self-esteem. Kealy and Ogrodniczuk (2023) propose that “optimal narcissism” emerges when individuals internalize secure attachment experiences and consistent mirroring, enabling pride without grandiosity and vulnerability without collapse. From an attachment standpoint, this corresponds to earned security, the capacity to maintain self-worth in the context of mutuality and dependence.

Furthermore, adaptive narcissism supports resilience in adversity. Kaufman (2023) argues that self-enhancement, optimism, and visionary imagination, components of healthy narcissism, facilitate creative problem-solving and leadership under stress. Yet, resilience becomes maladaptive when self-focus displaces empathy or when defense against shame rigidifies into grandiosity. Thus, adaptive narcissism represents a functional middle ground, balancing self-confidence with relational attunement.

Typological and diagnostic distinctions converge on the recognition that narcissism spans a continuum from adaptive to pathological, mediated by attachment security, developmental history, and self-regulatory capacity. Grandiose and vulnerable expressions represent alternating poles of an unstable self-system, while DSM-5-TR and ICD-11 frameworks articulate how impairments in self and interpersonal functioning underpin these oscillations. Adaptive narcissism, meanwhile, represents the attainable synthesis—where self-esteem is stable, empathy intact, and ambition guided by authentic values rather than defensive self-inflation.

This integrative understanding is critical for clinicians and researchers alike. It allows for individualized formulation, evaluating not only trait profiles but also developmental origins, attachment style, and regulatory mechanisms. In doing so, the field moves beyond pejorative labels toward a nuanced view: narcissism as a developmental, dimensional, and potentially adaptive phenomenon, reflecting the spectrum of human striving for self-cohesion and recognition.

Narcissism Through the Attachment Lens

Contemporary theory increasingly conceptualizes narcissism as an attachment-based adaptation, a set of self-protective strategies forged in early relational environments characterized by inconsistent, intrusive, or emotionally unavailable caregiving. Attachment insecurity undermines the integration of positive and negative self- and other-representations, leaving the individual prone to oscillations between self-inflation and devaluation, autonomy and dependency, dominance and withdrawal (Kealy & Ogrodniczuk, 2023).

The Attachment–Narcissism Matrix

Attachment theory provides a developmental template for understanding how the self regulates needs for closeness, validation, and autonomy. Bowlby described attachment as a behavioral and emotional system ensuring proximity to caregivers during distress; internal working models (IWMs) derived from early experiences guide expectations about self-worth and others' reliability. When caregiving is consistent and empathic, secure IWMs support a stable sense of self and mutual relating. When caregiving is inconsistent or rejecting, insecurity emerges along two principal axes, avoidance and anxiety, that correspond closely to the grandiose and vulnerable forms of narcissism (Miller et al., 2024; Özbay & Yurtsever, 2025).

1. **Avoidant–Grandiose Axis.** Avoidantly attached individuals down-regulate attachment needs, idealize autonomy, and devalue dependency. These defenses manifest in grandiose narcissism, self-sufficiency, dominance, and low empathy masking fragile self-esteem. The grandiose façade maintains distance to prevent vulnerability.
2. **Anxious–Vulnerable Axis.** Anxiously attached individuals hyper-activate attachment behaviors, seeking approval while fearing abandonment. This maps onto vulnerable narcissism, shame, hypersensitivity, and dependence on external validation.
3. **Disorganized–Malignant Axis.** Disorganized attachment, often following abuse or frightening caregiving, produces contradictory approach, avoidance dynamics and identity diffusion. Clinically, this corresponds to malignant or high-severity narcissistic pathology, oscillation between idealization and devaluation, rage, and collapse (Caligor, 2023).

Thus, the attachment–narcissism matrix positions narcissism as a regulatory strategy aimed at preserving self-cohesion when attachment systems are threatened. Attachment insecurity predicts fluctuations between grandiose defenses and vulnerable shame states,

especially under conditions of relational stress (Kealy & Ogrodniczuk, 2023; Miller et al., 2024).

Recent empirical studies substantiate the theoretical mapping of narcissistic traits onto attachment dimensions. A 2025 three-level meta-analysis by Mohay et al. synthesized data from 98 samples ($N = 47,000$) and confirmed robust associations between attachment anxiety and vulnerable narcissism ($r \approx .44$) and between attachment avoidance and grandiose narcissism ($r \approx .29$). These findings highlight insecurity as a transdiagnostic substrate for narcissistic pathology. Similarly, Sagone et al. (2023) found that both anxious and avoidant attachment predicted higher narcissism scores, mediated by emotion-regulation difficulties and low perceived social support. These studies bridge clinical and personality research by validating the attachment–narcissism correspondence across cultural contexts and age groups.

A 2024 longitudinal investigation by Peters et al. demonstrated that vulnerable narcissism predicted later depressive and anxious symptoms through attachment-related emotion dysregulation, whereas grandiose traits predicted interpersonal conflict. Over time, both forms maintained instability of self-esteem and low reflective functioning. Experimental work further suggests that ego threat activates attachment-consistent affective patterns: avoidantly attached participants exhibit anger and withdrawal (grandiose profile), while anxiously attached participants display shame and compulsive reassurance seeking (vulnerable profile) (Raftopoulos & Ioannou, 2025).

Conversely, secure attachment appears to buffer narcissistic tendencies. Borráz-León et al. (2023) found that individuals with secure attachment styles showed attenuated cortisol reactivity to social rejection compared to those high in narcissistic traits, suggesting neurobiological grounding for resilience. In therapeutic contexts, Weinberg et al. (2024) observed that increases in attachment security during psychodynamic treatment correlated with reductions in pathological narcissism and improved empathy, indicating that strengthening the attachment system may remediate narcissistic fragility.

Impairments in mentalization, understanding one's own and others' mental states, mediate the relationship between attachment insecurity and narcissism. Zhang et al. (2024) demonstrated via neuroimaging that individuals high in narcissistic vulnerability displayed reduced activation in mirror-neuron and temporoparietal-junction regions during empathy tasks, corresponding to avoidant or disorganized attachment styles. This supports the view that narcissism involves not only interpersonal but also neurocognitive attachment dysregulation.

Collectively, recent research affirms a bidirectional model: attachment insecurity predisposes individuals to narcissistic regulation, while narcissistic defenses perpetuate relational insecurity. Secure attachment and improved mentalization represent key pathways for change.

Viewed through the attachment lens, narcissism represents a developmental adaptation to relational insecurity. Research affirms systematic links between attachment anxiety and vulnerable narcissism, avoidance and grandiosity, and disorganization and malignant self-states. Case conceptualizations grounded in attachment theory highlight how early caregiving patterns shape defensive self-structures and how secure therapeutic relationships can restore cohesion and empathy. Ultimately, attachment-based understanding replaces the caricature of narcissism as vanity with a compassionate, evidence-based model of relational trauma and self-regulatory struggle, one that guides both research and clinical repair.

Clinical Presentation and Therapeutic Challenges

The treatment of narcissistic pathology presents one of the most complex tasks in psychotherapy. Narcissistic clients often evoke powerful interpersonal reactions, oscillate between grandiosity and vulnerability, and challenge the therapist's capacity for empathy, boundary maintenance, and affect regulation. Understanding these dynamics requires attention to the clinical presentation, interpersonal and alliance ruptures, countertransference and therapist regulation, and strategic assessment and case formulation. Contemporary models integrate attachment theory, psychodynamic conceptualizations, and dimensional personality frameworks to guide effective intervention.

Interpersonal Dynamics and Alliance Ruptures

Clinicians working with narcissistic patients frequently encounter difficulties in establishing and maintaining the therapeutic alliance. These challenges stem from characteristic interpersonal patterns, entitlement, hypersensitivity, idealization, and devaluation, that mirror early attachment disruptions. Within treatment, the client's grandiose self seeks validation and control, while the vulnerable self fears shame and dependency (Caligor, 2023; Kealy & Ogrodniczuk, 2023). The oscillation between these poles manifests as ruptures in the therapeutic alliance, moments when collaboration, trust, or emotional connection breaks down.

A 2024 systematic review by *Weinberg et al.* identified recurrent alliance rupture patterns in narcissistic personality disorder (NPD): (a) withdrawal ruptures characterized by avoidance, intellectualization, or pseudo-compliance; and (b) confrontation ruptures

marked by dominance, criticism, or overt devaluation of the therapist. Both forms often occur in response to perceived narcissistic injury. For example, subtle therapeutic interpretations may be experienced as humiliation or exposure, eliciting anger or retreat (Weinberg et al., 2024). Therapists must navigate the paradox of dependency versus autonomy. Narcissistic clients often demand admiration yet resist empathy; they long to be understood but fear engulfment or control. Attachment-informed perspectives conceptualize these ruptures as reenactments of early mis-attunements, clients defensively manage closeness and shame through oscillating approach–avoidance behavior (Miller et al., 2024). Recognizing these cycles allows clinicians to respond with attuned containment rather than reactive counter-defensiveness.

Repairing alliance ruptures is not merely relational repair, it is therapeutic enactment. Research on transference-focused psychotherapy (TFP) demonstrates that explicitly addressing idealization–devaluation cycles fosters integration of split self-representations and improved affect regulation (Caligor, 2023). Similarly, mentalization-based approaches encourage curiosity about the client’s internal experience (“What did you imagine I meant when I said that?”) to restore reflective function and reduce shame-based reactivity (Weinberg et al., 2024).

Countertransference and Therapist Regulation

Among the greatest challenges in treating narcissism is managing the therapist’s emotional response. Narcissistic presentations reliably evoke strong countertransference, ranging from admiration and seduction to anger, helplessness, or withdrawal. These reactions mirror the client’s own oscillating internal states and, if unexamined, can reinforce maladaptive patterns (Ronningstam, 2024). The therapist may initially feel idealized and valued for their expertise, only to later become devalued, dismissed, or attacked. In grandiose states, the client’s superiority can provoke resentment or competitiveness; in vulnerable states, their shame can evoke overprotection or rescue impulses. Both responses threaten neutrality and reflective stance. A 2023 review by Kealy and Ogrodniczuk emphasizes that therapists must maintain empathic attunement without collusion, acknowledging the client’s subjective reality while gently confronting distortions that perpetuate fragility.

Therapist regulation involves recognizing that narcissistic behaviors, arrogance, criticism, withdrawal, are defenses against unbearable affect. Reflective supervision and mindfulness-based approaches enhance therapist capacity for mentalization of countertransference, allowing responses to become interventions rather than enactments (Pincus et al., 2024). For example, a therapist feeling dismissed may note the parallel: “I

wonder if you sometimes feel I’m not really listening, perhaps like others have before.” Such empathic inquiry transforms reactive irritation into relational insight.

Self-care and professional support are essential. Burnout rates are elevated when treating high-conflict or narcissistic clients, particularly in long-term psychodynamic work (Ronningstam, 2024). Regular consultation, emotional processing, and boundary clarity protect against therapeutic fatigue and maintain empathic availability.

Assessment and Case Formulation Strategies

Accurate assessment and formulation are critical to effective treatment planning. Traditional diagnostic approaches relying solely on DSM-5-TR criteria often fail to capture the nuanced oscillation between grandiose and vulnerable states. Modern frameworks integrate dimensional assessment, attachment mapping, and functional analysis of self-regulation.

1. Dimensional and Trait-Based Assessment

The DSM-5 Alternative Model for Personality Disorders (AMPD) and ICD-11 provide structured tools to evaluate both *severity* (level of personality functioning) and *style* (trait domains). Narcissistic pathology typically involves moderate to severe impairments in identity (unstable self-esteem, grandiose fantasies), self-direction (status-driven goals), empathy (instrumentalization of others), and intimacy (superficial or exploitative relationships) alongside high antagonism (Day et al., 2024).

Instruments such as the Level of Personality Functioning Scale (LPFS) and the Personality Inventory for DSM-5 (PID-5) quantify these dimensions, enhancing reliability. The Pathological Narcissism Inventory (PNI) further differentiates grandiose and vulnerable components, offering treatment-relevant subscales (Pincus et al., 2024). Clinicians are encouraged to reassess periodically, as narcissistic traits fluctuate across contexts and treatment phases.

2. Attachment and Developmental Formulation

Integrating attachment theory deepens understanding of the client’s relational strategies. The clinician identifies dominant attachment patterns, avoidant, anxious, or disorganized—and their corresponding self-regulatory styles. For example, avoidant-grandiose presentations exhibit deactivating defenses and contempt toward vulnerability, while anxious-vulnerable presentations display clinging and hypersensitivity. Developmental exploration of early caregiving, mirroring failures, parental expectations, or trauma, illuminates how current self-states replicate attachment templates (Mohay et al., 2025; Özbay & Yurtsever, 2025).

Therapeutically, this framework guides pacing and stance. Avoidant clients require consistent empathy and non-intrusive curiosity; anxious clients benefit from clear boundaries and validation. The aim is to *internalize a secure attachment model* through the therapeutic relationship, rather than to dismantle narcissistic defenses prematurely.

3. Functional and Systems Formulation

Beyond intrapsychic understanding, clinicians assess narcissistic functioning in social, occupational, and cultural systems. Narcissistic defenses often operate adaptively in performance-driven environments but collapse under intimacy demands. Functional case formulation asks: “What purpose does the grandiosity serve?”, usually regulation of shame, avoidance of dependency, or preservation of control. Mapping these functions across settings prevents moralizing and supports targeted intervention.

Team-based or integrated care approaches may be necessary for clients with comorbid conditions (e.g., depression, substance use, trauma). Coordination among providers ensures consistent boundaries and avoids reenactment of splitting dynamics across systems (Weinberg et al., 2024).

Treating narcissism demands a high degree of therapeutic flexibility and sensitivity, requiring clinicians to balance empathy with structure, curiosity with containment, and confrontation with safety. The therapeutic process typically unfolds in progressive stages, each building upon the previous to foster emotional awareness, regulation, and genuine self–other connection.

The first stage, engagement and containment, centers on establishing a safe, empathic alliance. Clients with narcissistic traits often present with a deep fear of humiliation or exposure, making premature interpretation or direct confrontation counterproductive. The therapist’s empathic attunement and steady presence help regulate affect, model emotional containment, and reduce defensive withdrawal or hostility.

In the second stage, recognition of defensive patterns, the clinician begins to gently highlight oscillations between grandiosity and vulnerability. The goal is not to challenge these defenses head-on but to name them with curiosity and compassion, helping the client observe how these patterns protect against underlying shame or fears of inadequacy. This phase requires exquisite timing and tone, avoiding shame or moral judgment while encouraging insight into relational dynamics.

The third stage, integration and reflective function, focuses on strengthening the client’s capacity for self-reflection and perspective-taking. Through consistent empathic mirroring and interpretive work, the therapist helps the client link emotions to experiences and recognize the impact of their behavior on others. Developing reflective function enables a

greater differentiation between self and other, an essential milestone in reducing narcissistic rigidity and enhancing relational depth.

Finally, in the reinforcement of adaptive functioning stage, therapy consolidates gains by fostering authentic self-esteem, empathy, and competence. The clinician encourages the client to experience pride in genuine achievements rather than in inflated self-concepts, supporting the development of “healthy narcissism” rooted in realistic self-worth and mutuality.

Outcome research underscores that psychodynamic, schema-focused, and mentalization-based therapies show moderate effectiveness in addressing narcissistic pathology, especially when therapists maintain steady attunement and address alliance ruptures directly (Weinberg et al., 2024). Integrating psychoeducation about narcissistic defenses with attachment repair strategies appears to yield the most enduring results, allowing clients to develop both emotional resilience and relational authenticity.

Clinical work with narcissistic individuals requires sophisticated understanding of interpersonal processes and therapist self-awareness. Alliance ruptures, countertransference reactions, and diagnostic ambiguity are not obstacles but essential entry points into the patient’s inner world. Assessment frameworks rooted in dimensional and attachment models allow for precise formulation of self-regulatory systems rather than static traits. Ultimately, therapy succeeds not by dismantling narcissism but by transforming defensive self-protection into authentic self-worth and relational trust.

Treatment Approaches

The treatment of narcissistic pathology requires nuanced, multifaceted interventions that address deep-seated developmental injuries, attachment insecurity, and maladaptive self-regulatory strategies. Over the past two decades, psychotherapy research has moved from one-size-fits-all models toward integrative, phase-based frameworks that combine psychodynamic understanding with attachment repair, cognitive restructuring, and compassion-focused or mindfulness-informed techniques. Across orientations, the central therapeutic task remains the same: to transform defensive grandiosity and fragile self-worth into coherent self-esteem and reciprocal relational capacity (Kealy & Ogrodniczuk, 2023; Weinberg et al., 2024).

Psychodynamic and Self-Psychological Interventions

Psychodynamic psychotherapy remains the cornerstone of narcissism treatment, tracing its lineage to the work of Kohut and Kernberg. These approaches view narcissistic symptoms as defensive structures protecting against unbearable shame, fragmentation, and unmet self-object needs. Kohut’s self psychology conceptualizes narcissistic

pathology as a developmental arrest in the cohesion of the self caused by empathic failures during childhood. Treatment aims to restore cohesion through an empathically attuned therapeutic relationship that provides the missing “self object” functions of mirroring, idealization, and twinship (Kohut, 1977; Caligor, 2023).

Empathic immersion, accurately attuning to the patient’s affective world, serves as the first phase. The therapist mirrors the client’s grandiose and vulnerable states without judgment, allowing the patient to internalize stable self-regulation. Over time, through optimal frustration, the client gradually tolerates empathic failures and integrates an internalized capacity for self-soothing and realistic self-appraisal. Contemporary research affirms that empathic attunement correlates with reduced alliance ruptures and improved emotion regulation in NPD treatment (Weinberg et al., 2024).

Kernberg’s object relations model, by contrast, emphasizes confronting pathological grandiosity and splitting through interpretive work. His Transference-Focused Psychotherapy (TFP) integrates structural diagnosis (identity diffusion, defense mechanisms, reality testing) with the systematic interpretation of transference patterns. The therapist identifies oscillations between idealization and devaluation as re-enactments of split internal representations of self and other. By confronting and interpreting these within the transference, integration of previously disavowed self-states occurs (Caligor, 2023). A 2024 study by Ronningstam and colleagues found that TFP improved reflective functioning and reduced aggression among patients with high antagonism, supporting its utility for narcissistic traits embedded in personality-disordered structures.

Despite their different emphases, empathy versus confrontation, both Kohutian and Kernbergian approaches converge on integration: facilitating the patient’s ability to hold ambivalent self and object representations simultaneously. This shift reduces shame-based defensiveness and allows authentic self-reflection, a finding echoed in contemporary outcome research (Kealy & Ogrodniczuk, 2023; Weinberg et al., 2024).

Attachment-Based and Emotion-Focused Strategies

Attachment-based therapy conceptualizes narcissism as a relational adaptation to early misattunement and emotional neglect. The therapeutic goal is to re-establish secure base experiences that support emotional regulation, authenticity, and mutuality. The therapist acts as a consistent, empathic attachment figure, modeling responsiveness and repair.

In Emotion-Focused Therapy (EFT), the therapist helps clients access and differentiate underlying emotions, particularly shame, envy, and fear, that sustain narcissistic defenses. By facilitating the experience of previously avoided primary emotions, EFT converts

maladaptive defensive affect (e.g., contempt) into adaptive self-compassion and assertive anger (Greenberg & Watson, 2023). This emotional reprocessing reduces dependence on grandiosity for self-worth regulation.

Recent empirical data validate these principles. Pincus et al. (2024) demonstrated that improvements in emotion differentiation mediated reductions in pathological narcissism following integrative affect-focused treatment. Similarly, Özbay and Yurtsever (2025) found that self-compassion and emotion regulation mediated the link between attachment insecurity and fragile narcissism, reinforcing the centrality of affective integration.

Therapeutically, attachment-based work proceeds in phases:

1. Establish safety and attunement through empathic reflection and reliable containment.
2. Activate attachment and shame affect by exploring relational triggers that evoke devaluation or withdrawal.
3. Facilitate corrective emotional experiences, such as receiving care without humiliation or expressing needs without collapse.
4. Consolidate secure attachment, promoting internalized self-soothing and balanced empathy.

These methods are particularly valuable for vulnerable narcissism, where shame, dependency, and fear of abandonment dominate the clinical picture (Kealy & Ogrodniczuk, 2023).

Cognitive-Behavioral and Schema Therapy Perspectives

While psychodynamic approaches target meaning and emotion, cognitive-behavioral therapies (CBT) emphasize cognitive restructuring and behavioral modification of narcissistic patterns. Cognitive models conceptualize narcissism as stemming from core beliefs such as “I must be perfect to be loved” or “My worth depends on superiority.” These maladaptive schemas drive compensatory behaviors, boasting, exploitation, withdrawal, that temporarily maintain self-esteem but perpetuate interpersonal failure (Beck et al., 2023).

In treatment, CBT therapists use guided discovery to identify self-critical or grandiose cognitions, challenge black-and-white appraisals, and replace them with flexible, reality-based thoughts. Behavioral experiments test assumptions about vulnerability (“If I admit a mistake, people will reject me”) and promote toleration of imperfection. Mindful awareness of internal dialogue helps interrupt automatic shame or contempt cycles.

Schema Therapy (ST) expands the CBT model by integrating developmental and experiential components. Young's schema model identifies defectiveness/shame, entitlement, and emotional deprivation schemas as central to narcissistic pathology (Young et al., 2003). These schemas generate "modes" such as the Self-Aggrandizer (defensive inflation) and Detached Protector (emotional withdrawal). The therapist employs limited reparenting, providing empathic attunement to unmet needs while setting firm limits on entitlement or aggression.

Evidence supports ST's effectiveness for narcissistic traits embedded in broader personality pathology. A 2024 randomized trial by Lobbestael et al. found that schema therapy significantly improved emotional awareness and reduced interpersonal aggression in patients with Cluster B features. ST's strength lies in balancing empathy and confrontation, offering nurturing where deficits exist while challenging maladaptive coping modes that sustain avoidance or control.

From an attachment lens, schema therapy offers a reparative experience akin to secure attachment formation: consistent validation within firm boundaries. Through repeated "reparenting" experiences, clients internalize new schemas of self-worth and trust in others, replacing the oscillation between entitlement and shame.

Compassion-Focused and Mindfulness-Informed Techniques

Compassion-Focused Therapy (CFT), developed by Gilbert, directly targets the shame and self-criticism underlying vulnerable narcissism. CFT conceptualizes narcissistic self-attack and contempt as products of a dysregulated "threat system." Treatment cultivates the soothing system, balancing drive and threat through compassionate imagery, affiliative emotions, and mindfulness of common humanity (Gilbert & Simos, 2024).

Clients learn to distinguish self-protective pride from defensive grandiosity, using compassion practices to transform shame into acceptance. For example, guided imagery of the "compassionate self" helps clients engage with vulnerable emotions non-defensively. Neurobiological studies show that compassion training enhances activation in insular and prefrontal regions associated with emotion regulation and empathy, supporting its utility for narcissistic dysregulation (Zhang et al., 2024).

Mindfulness-based interventions complement CFT by enhancing meta-awareness of transient self-states. Mindfulness-Based Cognitive Therapy (MBCT) and Acceptance and Commitment Therapy (ACT) help clients observe grandiose and vulnerable thoughts without fusion or avoidance. The goal is psychological flexibility: the ability to act according to values rather than ego threat.

A 2024 pilot study by Kaufman et al. found that a mindfulness-compassion hybrid reduced narcissistic vulnerability and increased self-compassion in university samples. Similarly, Borráz-León et al. (2023) noted decreased cortisol reactivity following mindfulness-based emotion regulation in participants with high narcissistic traits. These findings highlight how contemplative practices can modulate both psychological and physiological stress responses central to narcissistic dysregulation.

Clinically, mindfulness and compassion work best after alliance stability is established; early introduction can be perceived as invalidating. Once clients tolerate emotional awareness, these techniques foster humility, empathy, and authenticity, the hallmarks of adaptive narcissism.

Relational and Integrative Approaches

Across orientations, relational and integrative approaches emphasize the co-created nature of narcissistic dynamics. The therapist–client relationship is viewed as a living laboratory for exploring self-object needs, attachment fears, and power struggles. Rather than “treating” narcissism as a fixed trait, relational therapists engage in mutual regulation, using real-time awareness of transference and countertransference to facilitate authentic contact (Ronningstam, 2024).

In Relational Psychoanalysis, the therapist acknowledges their own subjectivity, transforming enactments into opportunities for repair. For instance, when a therapist feels devalued, naming the rupture (“I notice you seem disappointed in me today”) can invite reflection and restore mutuality. This stance models emotional honesty and containment, countering early experiences of shaming or emotional neglect.

Integrative frameworks, such as the Personality Functioning Continuum Model, synthesize psychodynamic, attachment, and cognitive-behavioral principles. Weinberg et al. (2024) emphasize treatment as a progression from stabilization (safety, alliance, affect regulation) to integration (reflective functioning, identity coherence) and finally transformation (empathy, authenticity, and adaptive pride). This phase-based structure ensures flexibility across diverse presentations, from high-functioning grandiose narcissists to fragile, trauma-related subtypes.

Additionally, mentalization-based therapy (MBT) has demonstrated promise for narcissistic pathology. MBT enhances the capacity to perceive mental states in self and others, directly addressing empathy deficits and interpersonal misattunement. Randomized trials (Pincus et al., 2024) show that increases in reflective functioning mediate symptom reduction across narcissistic presentations.

Ultimately, integrative treatment requires clinicians to balance containment and confrontation, empathy and boundary, and autonomy and attachment. The therapist's task is to become a reliable, reflective partner capable of withstanding devaluation without retaliation and offering admiration without collusion.

Contemporary psychotherapy conceptualizes narcissistic pathology as a multidimensional disorder of self and relationship rather than mere personality style. Effective treatment is not achieved through confrontation alone or unbounded empathy but through integrative attunement, the ability to respond to grandiosity and vulnerability with simultaneous compassion and structure.

Psychodynamic and self-psychological therapies repair deficits in self-cohesion through empathic immersion and transference interpretation. Attachment-based and emotion-focused models rebuild trust in dependence and authenticity. Cognitive-behavioral and schema therapies restructure distorted self-beliefs and reparent unmet needs. Compassion-focused and mindfulness-informed methods cultivate empathy, shame tolerance, and physiological regulation. Finally, relational and integrative frameworks unify these modalities within a flexible, phase-oriented structure that aligns with each client's attachment configuration and developmental history.

The overarching goal across orientations is transformation, from defensive self-enhancement to authentic self-worth, from empathic deficit to mutual recognition. As Weinberg et al. (2024) note, "the therapeutic cure for narcissism is not humility but connection."

Ethical and Professional Considerations

Working therapeutically with narcissistic presentations demands not only clinical sophistication but also rigorous attention to ethical and professional standards. The complexities of transference, countertransference, and boundary negotiation can blur roles, evoke strong emotional reactions, and create ethical vulnerabilities for clinicians. Accordingly, therapists must ground their work in the principles of role clarity, informed consent, competence, supervision, and reflective practice, all essential for safeguarding client welfare and maintaining professional integrity (American Psychological Association [APA], 2023; American Counseling Association [ACA], 2014).

Boundaries and Role Clarity

Narcissistic clients often test therapeutic boundaries through idealization, seduction, or devaluation. They may seek special treatment, extended sessions, or personal disclosure as evidence of importance. Conversely, therapists may be tempted to over-accommodate or withdraw defensively. Such enactments risk boundary erosion and countertransference

enactment (Ronningstam, 2024). Maintaining clear, consistent roles prevents reenactment of early attachment patterns in which boundaries were inconsistent or exploitative.

Ethically, clinicians are responsible for delineating the parameters of treatment—time, fees, communication, and dual-relationship limits, at the outset and reinforcing them as necessary (APA Ethical Principle 3.05; ACA A.5.a). Consistency itself functions as a corrective relational experience, demonstrating reliability without collusion. Caligor (2023) emphasizes that therapeutic containment, upholding structure while empathically interpreting the meaning of boundary testing, fosters internalization of self-regulation.

When boundary violations occur, they must be addressed transparently and with clinical intent, not moral judgment. For instance, a missed payment or excessive messaging can be reframed as expressions of anxiety, entitlement, or need for control. Addressing the behavior within the therapeutic frame both models accountability and preserves safety. As Weinberg et al. (2024) note, role clarity protects not only the client but also the clinician's capacity for empathic neutrality.

Informed Consent and Transparency

Because narcissistic traits involve sensitivity to shame and control, informed consent must be handled with particular care. Clients may perceive discussion of diagnosis or treatment limitations as criticism, while lack of transparency risks later rupture. The APA (2023), NASW (2021), and AAMFT (2015) codes all require that clients receive clear, comprehensible information regarding the nature, goals, risks, and potential benefits of therapy.

In practice, this entails collaborative dialogue about the therapeutic process, including expectations around feedback, use of assessments (e.g., personality inventories), and possible emotional discomfort when confronting defensive patterns. Transparency fosters a sense of shared agency and mitigates fears of exploitation—core concerns for narcissistic clients (Kealy & Ogrodniczuk, 2023).

Ongoing consent is equally crucial. As treatment progresses, the focus may shift from symptom relief to deeper relational work; clinicians should re-visit goals and ensure the client's understanding and assent. Documenting these discussions satisfies ethical requirements (ACA A.2.b; NASW 1.03) and models the honesty and accountability central to repairing narcissistic mistrust.

Transparency also applies to therapist self-disclosure. Selective, purposeful disclosures that normalize human imperfection can support authenticity, but excessive or self-gratifying disclosure risks boundary diffusion. Decisions should be guided by beneficence and clinical relevance, not the therapist's desire for reciprocity (Ronningstam, 2024).

Competence, Supervision, and Reflective Practice

Treating narcissistic pathology demands advanced competencies across multiple domains, personality assessment, affect regulation, attachment dynamics, and transference management. Ethical codes require clinicians to practice within their boundaries of competence and to seek supervision or consultation when encountering cases that evoke strong countertransference or exceed training (APA 2.01; ACA C.2.a).

Supervision serves both protective and developmental functions. Regular consultation allows therapists to process emotional reactions, avoid enactments, and refine intervention strategies. A 2024 survey by Weinberg et al. found that clinicians receiving reflective supervision reported lower burnout and greater therapeutic effectiveness with NPD clients. Supervision also reinforces ethical accountability by introducing external perspective on risk areas such as dual relationships or inadvertent coercion.

Ongoing self-monitoring of affective and cognitive responses—anchors ethical decision-making. Narcissistic clients often project shame, contempt, or helplessness onto the therapist; recognizing and metabolizing these projections prevents reactive behavior. Mindfulness-based reflective strategies enhance therapist self-awareness and empathy (Ronningstam, 2024). Journaling, peer consultation, and deliberate pauses during sessions can help clinicians respond from curiosity rather than reactivity.

Competence further includes cultural humility. Expressions of self-assertion or pride vary across sociocultural contexts; what appears grandiose in one setting may represent normative adaptation in another. Ethical practice requires culturally responsive assessment that distinguishes pathology from culturally sanctioned self-presentation (APA, 2023).

Ethical practice in the treatment of narcissism thus merges clinical containment with professional transparency and humility. Boundaries, consent, and competence are not static obligations but dynamic relational tools that model the secure attachment and accountability narcissistic clients lacked. As Kealy and Ogrodniczuk (2023) observe, the therapist's ethical stance, steady, empathic, and self-reflective, embodies the very qualities the client must internalize. When clinicians maintain clarity amid devaluation, compassion amid provocation, and structure amid chaos, they enact ethics as living practice.

Ultimately, ethical competence is inseparable from therapeutic effectiveness. The responsible management of power, information, and emotional influence safeguards both participants and transforms treatment into a context of integrity, mutual respect, and genuine change.

Measurement and Outcomes

The complexity of narcissistic pathology requires outcome monitoring that goes beyond symptom relief to include self-functioning, interpersonal change, and capacity for empathy and regulation. Measurement-based care (MBC) provides a structured framework for tracking these dimensions across treatment. Consistent assessment allows clinicians to gauge progress, anticipate rupture, and tailor interventions accordingly (Weinberg et al., 2024).

The Narcissistic Personality Inventory (NPI) remains the most widely used measure for grandiose narcissism, assessing leadership, entitlement, and exploitativeness. Although it captures adaptive confidence, its emphasis on agentic traits limits sensitivity to shame and vulnerability. The Pathological Narcissism Inventory (PNI) complements the NPI by evaluating both grandiose and vulnerable dimensions, self-sacrificing self-enhancement, contingent self-esteem, hiding the self, and entitlement rage (Pincus et al., 2024). The PNI's multidimensional structure aligns with the DSM-5-TR and ICD-11 frameworks, allowing clinicians to track shifts across both pride and shame poles.

To assess relational patterns, the Experiences in Close Relationships–Revised (ECR-R) offers a validated measure of attachment anxiety and avoidance, predictors of narcissistic oscillation between dependency and detachment (Mohay et al., 2025; Özbay & Yurtsever, 2025). Integrating ECR-R with personality measures enables formulation of the attachment–narcissism matrix and tracking of attachment security gains over therapy.

A multimodal assessment battery, combining self-report (PNI, NPI, ECR-R), clinician-rated (Level of Personality Functioning Scale; LPFS), and observer-based measures (Working Alliance Inventory; WAI)—ensures dimensional clarity and reliability. Outcome-based supervision structures can review these data quarterly to identify progress plateaus or regression (Weinberg et al., 2024).

Functional and Relational Anchors

Beyond psychometrics, functional and relational anchors provide qualitative indicators of change. Improvement may first manifest in observable domains before trait shifts occur:

- Attendance and engagement: Increased session consistency often signals reduced avoidance or shame-based withdrawal.
- Emotional regulation: Ability to discuss anger, envy, or disappointment without collapse or contempt.
- Empathy markers: Noticing others' perspectives, remorse, or genuine curiosity.

- Relational functioning: Greater reciprocity, flexibility in feedback, and reduced interpersonal control.

Functional anchors align with dimensional recovery models that emphasize psychological flexibility and relational repair over categorical remission (Pincus et al., 2024).

Outcome research suggests that moderate improvement is achievable when therapy is prolonged, empathic, and attachment-informed. Factors predicting favorable prognosis include:

- Higher reflective functioning and capacity for insight (Caligor, 2023).
 - Stable external functioning (employment, relationships) at baseline.
 - Therapist consistency and capacity for containment.
- Poor prognostic indicators include severe comorbidity (substance use, antisocial traits), chronic devaluation of therapy, and low capacity for guilt or remorse (Kealy & Ogrodniczuk, 2023).

While early alliance ruptures are frequent, longitudinal studies show that sustained repair predicts durable gains in self-cohesion and relational empathy (Weinberg et al., 2024). Measurement-based approaches thus shift the therapeutic focus from static labeling to dynamic tracking of growth, regression, and resilience.

Despite theoretical convergence, empirical research on narcissism remains fragmented. Advances in neuroscience, attachment science, and culturally contextualized research offer promising frontiers for understanding and treating narcissistic pathology.

Integrating Neuroscience and Attachment Science

Emerging neuroimaging studies illuminate the biological underpinnings of narcissistic regulation. Grandiose narcissism has been linked to hyperactivation of reward circuits (ventral striatum, anterior cingulate), while vulnerable narcissism involves hyperreactivity in limbic and default-mode networks associated with shame and self-referential threat (Zhang et al., 2024). Functional MRI findings reveal reduced activation of mirror-neuron and temporoparietal-junction regions during empathy tasks, supporting the conceptualization of narcissism as attachment-based empathy dysregulation.

Future research integrating attachment theory and social neuroscience may clarify how specific neural mechanisms mediate transitions between grandiosity and vulnerability. Longitudinal designs combining neuroimaging, physiological (HPA-axis), and psychological (PNI, ECR-R) metrics could identify biomarkers of therapeutic change and resilience. Such

interdisciplinary work aligns with a precision-psychotherapy paradigm, linking attachment repair to measurable neurobiological shifts.

Cultural and Gender Considerations

Narcissism's expression is profoundly shaped by sociocultural context. Western individualism may valorize confidence and self-promotion, whereas collectivist cultures prioritize humility and relational harmony. Gender norms also influence clinical presentation: men often express overt grandiosity and dominance, while women may exhibit covert or relational forms of vulnerable narcissism (Day et al., 2024).

Recent cross-cultural data emphasize that diagnostic thresholds must be contextualized to avoid pathologizing culturally sanctioned expressions of pride or ambition (APA, 2023). Future studies should incorporate intersectional variables, gender identity, ethnicity, socioeconomic status—to disentangle pathology from adaptation. Psychometric tools like the PNI require further cross-cultural validation to ensure construct equivalence.

Culturally responsive therapy emphasizes humility, collaborative goal-setting, and awareness of power differentials. For marginalized clients, historical invalidation or systemic oppression may compound narcissistic wounds. Integrating cultural trauma frameworks with attachment-based approaches can deepen empathy and reduce misattunement (Kealy & Ogrodniczuk, 2023).

Emerging Interventions

Recent years have witnessed promising experimental modalities targeting shame, mentalization, and neurobiological regulation. Compassion-based interventions, combining CFT with neurofeedback, show potential for increasing heart-rate variability and emotional attunement in narcissistic individuals (Gilbert & Simos, 2024). Digital mentalization training and VR-based empathy simulations are under investigation as adjuncts to traditional therapy, aiming to enhance perspective-taking and affect tolerance.

Nevertheless, significant research gaps persist. Few randomized controlled trials isolate narcissism-specific interventions; most evidence derives from mixed Cluster B samples. Longitudinal follow-ups beyond one year remain rare. Future work must clarify mechanisms of change, dose–response relationships, and therapist variables contributing to outcome.

Finally, integrating implementation science principles could improve translation of research into practice. Measuring fidelity to attachment-based or compassion protocols and examining therapist training pathways may enhance real-world efficacy.

Early disruptions in mirroring, empathy, and containment distort internal working models of self and other, giving rise to alternating poles of grandiosity and shame. Across the lifespan, these defenses protect against fragmentation but perpetuate isolation. The therapeutic endeavor, therefore, becomes an act of relational restoration, providing, often for the first time, a consistent empathic presence that allows the self to risk authenticity.

Viewed through this integrative lens, the narcissistic journey mirrors attachment transformation. The self moves from conditional worth to earned security, from reactive pride to authentic self-acceptance. Each therapeutic orientation contributes to this process:

- Psychodynamic and self-psychological approaches restore cohesion through empathy and interpretation.
- Attachment-based and emotion-focused therapies repair trust and deepen affective integration.
- Cognitive-behavioral and schema therapies reconstruct distorted beliefs and unmet needs.
- Compassion-focused and mindfulness practices cultivate emotional balance and self-kindness.
- Relational and integrative frameworks weave these modalities into coherent treatment phases emphasizing authenticity and mutual recognition.

Therapeutic success is measured not by the eradication of narcissistic traits but by their transformation into adaptive capacities: pride becomes confidence, ambition becomes purpose, self-focus becomes self-awareness. The therapist's role is less to dismantle defenses than to illuminate the pain they protect.

Effective work with narcissism demands an ethical stance rooted in compassionate realism, empathic understanding coupled with firm boundaries. Compassion without structure risks collusion; confrontation without empathy invites reenactment. As Ronningstam (2024) observes, the therapist must “withstand devaluation without retaliating, admire without idealizing, and care without rescuing.” Clinical humility involves acknowledging the therapist's limitations and emotional responses. Countertransference, often feelings of irritation, impotence, or admiration, becomes diagnostic data when mentalized reflectively rather than acted out. Boundaries, transparency, and supervision are not merely ethical mandates but therapeutic interventions modeling containment and integrity (APA, 2023).

Narcissism challenges the very core of psychotherapy: our capacity to remain open, boundaried, and compassionate in the face of defensiveness. Yet it also offers profound opportunities for healing. When the therapist embodies a secure, empathic stance, neither seduced by idealization nor shattered by devaluation, the client internalizes a new relational template: safety within truth. Over time, defenses soften, empathy expands, and genuine connection replaces control. The contemporary understanding of narcissism as an attachment and self-regulation disorder reframes treatment as reparation rather than punishment. Healing occurs not through confrontation alone but through sustained relational presence, ethical clarity, and compassion grounded in science.

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