

Pathological Narcissism: A Front-Line Guide

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Pathological narcissism represents a significant mental health issue that social workers are likely to encounter in general and counselling practice settings. Although a vast conceptual literature exists, practical reviews for non-specialist social workers are limited. This paper provides an overview of pathological narcissism, including the grandiose and vulnerable sub-types of this self-regulation impairment. Key points regarding interventions for pathological narcissism are highlighted, with case vignettes illustrating these issues in clinical practice.

Keywords: narcissism; social work; counselling; psychotherapy

Introduction

Social workers in front-line practice are likely to routinely encounter clients with narcissistic problems. Although the term 'narcissist' is commonly used pejoratively, clients with pathological narcissism face very real suffering and impairment. Various other psychiatric disorders, interpersonal problems, emotional distress and functional impairment are all associated with narcissistic pathology (Miller, Campbell, and Pilkonis 2007; Ogrodniczuk et al. 2009; Stinson et al. 2008). Narcissistic dysfunction has also been linked with disagreeable post-separation parenting arrangements (Ehrenberg, Hunter, and Elterman 1996) as well as with the perpetration of child abuse (Wiehe 2003). Thus, there are good reasons for social workers to be alert to pathological narcissism and develop opportunities to ameliorate it. However, narcissism is considered difficult to comprehend, let alone to remedy. For social workers in counselling or community agency settings, pathological narcissism calls for concerted understanding and intervention.

Social workers who seek to learn more about narcissism will find an enormous and confusing literature, largely drawn from psychoanalytic theory. Recent reviews have addressed pathological narcissism from the perspectives of psychiatric pathology and diagnosis (Ronningstam 2011a), construct refinement and assessment (Pincus and Lukowitsky 2010), personality psychology research (Bosson et al. 2008) and psychodynamic psychotherapy within psychiatric

practice (Ronningstam 2011b). Psychoanalytic contributions continue to accrue, and the social work literature has integrated and refined many such conceptualisations of narcissism (Bennett 2006; Consolini 1999; Goldstein 1995; Hotchkiss 2005; Imbesi 1999; Palombo 1976). Clearly, much is available to practitioners who wish to become immersed in a complex theoretical literature. Less available, however, is a succinct guide to pathological narcissism for the front-line social worker who does not specialise in either psychoanalytic psychotherapy or the treatment of personality disorders.

The present paper seeks to enhance social workers' capacity to assist clients with narcissistic problems, particularly in community agencies and counselling services. We aim to provide a practical overview, including key principles to consider in working with clients who suffer from pathological narcissism. Though derived from the theoretical literature, our recommendations aim to be practically focused, featuring clinical vignettes for illustrative purposes.

General Features of Pathological Narcissism

The ancient Greek myth of Narcissus exemplifies some of the core features of narcissism. The handsome hero Narcissus becomes mesmerised upon seeing his reflection in a pool of water. His entrancement with his own image renders him completely impervious to the lovelorn pleas of the nymph Echo. His inability to escape the rapture of his self-involvement ultimately leads to a tragic ending: Narcissus withers away in self-enthralment and Echo eternally repeats the words of others, having been unable to reach the object of her infatuation.

As suggested by the ancient myth, narcissism refers to self-investment. Normal narcissism involves an essential, healthy degree of self-investment, entailing a realistically positive self-regard, self-preservation and agency, and capacity for interpersonal relatedness (Stone 1998). In contrast, the distorted self-investment of pathological narcissism detracts from interpersonal relations. This is due to features associated with pathological narcissism such as self-inflation, compromised empathic abilities, and attitudes involving envy and entitlement. These attitudes may include a sense of being above the usual conventions and norms that bind society, or an entitlement to success and recognition without having expended the necessary efforts to achieve it. Such attitudes have been identified as mechanisms of self-enhancement: a means of constantly maintaining a positive sense of self-esteem (Pincus and Lukowitsky 2010). Self-enhancement can also be directly expressed interpersonally, such as in constantly seeking praise or competitively triumphing over others. Consequently, relationships with others may be shallow and one-sided, with more regard for the self-enhancing properties of the relationship than for mutuality and reciprocity. This can result in compromised empathic abilities. Although a degree of self-enhancement may be considered normative and healthy, individuals with narcissistic problems seem driven by such needs, often reacting with either despair or rage upon the frustration or failure of self-enhancement efforts. Accordingly, contemporary

conceptualisations of pathological narcissism focus on the unstable self-esteem that is thought to underlie maladaptive self-investment and self-enhancement (Ronningstam 2011a).

Narcissistic Personality Disorder

Pathological narcissism is represented in the psychiatric nomenclature as Narcissistic Personality Disorder (NPD) in the ICD-10 (World Health Organization [WHO] 2010), the DSM-IV-TR (American Psychiatric Association [APA] 2000) and the proposed DSM-5 (APA 2011). Narcissistic Personality Disorder in ICD-10 is included under 'other specific personality disorders'. The North American criteria for NPD is undergoing a proposed revision, shifting from an almost-exclusive focus on grandiosity and arrogance (in DSM-IV-TR) to criteria which emphasise compromised self-regulation and exaggerated validation needs (in the proposed DSM-5). These changes reflect current research and conceptualisation of pathological narcissism (see below). In the long run, they may result in improved identification of a condition with varying rates of recognition and prevalence (Levy et al. 2009). More importantly, the proposed emphasis on self-regulation and validation needs may help to reduce the stigma and exclusion of NPD – a problem faced by many individuals with personality disorder (Kealy and Ogrodniczuk 2010). Efforts such as the publication of 'No Longer a Diagnosis of Exclusion' (National Institute for Mental Health in England [NIMHE] 2003) and the www.personalitydisorder.org.uk website (National Personality Disorders Programme 2011) are positive steps in promoting awareness and inclusion of personality disorder. Pathological narcissism, however, may require particular attention in order that those suffering from it may be afforded appropriate care. This is partly due to negative reactions to clients suffering from narcissistic problems (Betan et al. 2005), and partly due to confusing inconsistencies between research, diagnostic and clinical renderings of pathological narcissism (Pincus and Lukowitsky 2010).

Narcissistic Sub-Types

Pathological narcissism can be considerably problematic for individual and interpersonal functioning (Miller, Campbell, and Pilkonis 2007) and in organisational and occupational performance (Campbell et al. 2011) without necessarily constituting a full-blown NPD. Furthermore, contemporary perspectives on narcissism suggest a broader range of self-regulation difficulties than the arrogance and exploitativeness typically associated with the term. These include the recognition of a narcissistic sub-type characterised by deficient self-esteem and inordinate sensitivity to criticism (Pincus and Lukowitsky 2010; Ronningstam 2011a). In a thorough review of the narcissism literature, Cain and colleagues (Cain, Pincus, and Ansell 2008) identified two consistent themes of narcissistic

dysfunction which have found support within the clinical and empirical literature. These themes, known by various descriptive labels, have been classified as (1) grandiosity and (2) vulnerability. Table 1 shows some of the core elements of these two narcissistic sub-types.

Grandiosity is embodied in the DSM criteria for NPD. Grandiose narcissism is comprised of self-inflation, arrogance and entitlement, reflecting intrapsychic regulatory processes such as fantasies of unlimited success and repression or disavowal of negative self-representations (Cain, Pincus, and Ansell 2008). Grandiosity may also involve displays of prowess in order to obtain admiration. Domineering, vindictive and intrusive interpersonal behaviours have been found to characterise grandiose narcissism (Dickinson and Pincus 2003; Ogdorniczuk et al. 2009). Narcissistic vulnerability refers to feelings of helplessness, suffering and anxiety regarding threats to the self, reflecting inner feelings of inadequacy, emptiness and shame (Cain, Pincus, and Ansell 2008). Interpersonally, narcissistic vulnerability involves hypervigilance to insult, and excessive shyness or interpersonal avoidance in order to retreat from perceived threats to self-esteem. As useful as sub-typing may be for heuristic purposes, grandiosity and vulnerability likely do not exist in pure form. Instead, some degree of fluctuation between grandiose and vulnerable elements is likely to occur for most clients with narcissistic problems. Indeed, these themes may simply be two sides of the same coin, with grandiose features serving to mask underlying self-esteem deficits.

Contributing Factors

Chronic shame and vulnerability have been theorised as core self-esteem issues, against which grandiose mechanisms defend and compensate (e.g., Morrison 1983; Reich 1960). Psychoanalytic theories have tended to look toward early caregiver interactions – characterised by coldness, frustration or excessive expectations – as fostering the development of narcissistic pathology (Kernberg 1970, 1974; Kohut 1968, 1972). However, it has been suggested also that excessive praise and indulgence by parents may influence narcissistic development (Millon 1981). In both cases, the degree of psychological fit between parent and child is salient, with unstable self-esteem developing out of chronic misattunement to one's true emotional needs.

Table 1. Core elements of narcissistic sub-types.

Grandiose sub-type	Vulnerable sub-type
Exaggerated self-importance and arrogance	Shyness and constraint
Overt displays of self-enhancement	Hypervigilance to insult
Entitlement; anger at disappointment	Feelings of shame and inadequacy
Fantasies of brilliance and admiration	Feelings of helplessness
Denial of weaknesses	Covert and disavowed feelings of specialness

From a developmental perspective, narcissism may well beget narcissism. Children whose parents have healthy self-esteem and genuine relatedness are more likely to develop abilities in self-regulation, empathy, concern and interdependence. By contrast, children whose parents are narcissistically preoccupied may suffer from a lack of affirming responses to their unfolding self. Over time, such an environment has a traumatic effect, generating chronic feelings of shame and emptiness, from which an escape is sought via grandiose fantasies and self-enhancing behaviour (Morrison 1983). In attachment terms, the children of parents with pathological narcissism could be said to have lacked a 'secure base', developing instead an insecure internal working model of the self (Bowlby 1988), propelling maladaptive searching for security and validation.

Attachment theory contributes to the understanding of psychopathology, including narcissistic dysfunction, by placing the security of primary relational bonds at the centre of psychological health (Bennett 2006; Howe 2006). Disruptions in early attachment relations impede the development of stable representations of the self in relation to others. Inconsistent or threatening responses from parents result in children feeling chronically inhibited, fearful, and in desperate search for security and validation (Howe 2006). In this light, some of the self-centred and dominating aspects of narcissistic pathology may be viewed as efforts to obtain mastery over being made to feel chronically weak and insecure. Theorists also suggest that attachment trauma inhibits the development of mentalisation, the capacity to reflect on mental processes in oneself and others (Fonagy and Target 2006). Mentalisation is fostered within secure attachment relationships in which the child experiences his or her mind being reflected and re-presented by attachment figures. This process essentially affords the individual a theory of mind in which behaviours and emotions can be thought about beyond their face value. Impaired mentalisation involves a lack of flexibility in interpreting mental experiences: the individual's interpretation *is* the interpretation. For example, when confronted with situations that trigger shame and insecurity, the client with narcissistic problems may have great difficulty in taking a step back to consider potential alternative perspectives or responses.

Broader social forces have also been suggested as contributing to narcissistic problems. Lasch's popular 'Culture of Narcissism' (1979) critiqued modern society, especially in North America, for the promotion of narcissistic values, including the norming of exhibitionism and self-aggrandisement. The high valuation of celebrity status, material wealth and physical appearance in contemporary society seems to lend itself well to such an interpretation. Consumerism may in particular contribute to narcissistic difficulties, by promoting a cultural axiom of 'you are what you buy' rather than valuing the development of self within a greater relational social matrix. Fromm (1964) argued this point further, suggesting that narcissism is influenced by social and economic values that foster conformity and suppress true freedom and self-development. He suggested that capitalist and consumerist ideals encourage the commodification of the self: individuals are valued for what they produce rather than for who they are. According to Fromm (1976), such value structures promote

the prioritisation of 'having' over 'being', with an ultimate cost to healthy self-regulation and social relatedness.

Assessment and Treatment

Assessing pathological narcissism is considered to be challenging, even in formal psychiatric settings. For social workers in other practice areas, there are even greater barriers to identifying this condition. First of all, clients seldom approach service providers to seek help for what they feel is a NPD. For many such clients, help-seeking of any kind may represent to them an unbearable sense of frailty that must be avoided. To admit that their problems could be at least partly connected with their own personality may be even less acceptable. Consequently, other clinical or social service needs are typically presented. These too may be significant problems in their own right, such as other psychiatric disorders, marital discord, or unemployment. Practitioners often do not recognise the presence or extent of narcissistic dysfunction until interventions are well underway for the presenting problem. For example, a social worker providing case management might observe after a while that the client consistently monopolises their meetings with self-aggrandising stories that have little to do with the task at hand; efforts to redirect the client toward service goals might be met with hostility and criticism.

Decisions regarding the extent to which one might address pathological narcissism will depend upon the client's interest and motivation, the practice setting, the social worker's preparedness and the presence or absence of factors that would preclude treatment (such as tendencies for acute violence). In some cases, the client may only wish to resolve their initial complaint. For others, doing so might be nearly impossible *unless* their narcissistic dysfunction is modified, especially if their concerns involve interpersonal relationship issues. Regardless of whether the front-line worker intends to take on the long-term psychotherapy of pathological narcissism, becoming familiar with general treatment recommendations can prevent service disruption or abrupt termination, issues that are commonly associated with narcissism. Furthermore, utilisation of these guidelines can promote a positive working relationship that may facilitate the achievement of other service goals. At the same time, the possibility of modifying pathological narcissism is fostered as this working relationship evolves. Unfortunately there is a complete lack of empirical treatment trials regarding NPD. We therefore will highlight general recommendations derived from the theoretical and clinical literature on addressing pathological narcissism as a dimensional phenomenon.

Different Approaches

One of the major psychotherapeutic approaches to pathological narcissism was conceived by Kohut and his collaborators (Kohut 1968; Kohut and Wolf 1978).

Kohut formulated the psychoanalytic approach known as self-psychology, oriented around what he regarded as the self's profound need for empathic attunement. Self-psychology conceptualises narcissism as a line of development involving normal childhood grandiosity and idealisation of others (i.e. caregivers), which under optimal conditions evolve into healthy ambitions and ideals, respectively. In contrast to healthy ambitions and ideals, repeated empathic failures lead to the self feeling chronically empty and on the verge of fragmentation. Grandiosity, entitlement and rage serve to avert such experiences. Central to treatment is the therapist's empathic recognition of the client's narcissistic needs. This allows the therapeutic relationship to provide an essential, restorative function for the client, known as selfobject experience (Bacal 1994). The selfobject relationship in psychotherapy roughly overlaps with Bowlby's (1988) notion of the therapist serving as a secure base and with Winnicott's (1965) theory of the holding environment (Bacal and Newman 1990). The client's subjective experience of the self-affirming qualities of the selfobject relationship is given priority over the uncovering of historical material or the interpretation of interpersonal problems. Eventually, the responsiveness of the therapist is internalised, with a strengthening effect on the client's self.

In contrast, Kernberg's (1970, 1974) object relations model draws upon psychoanalytic ego psychology and Kleinian/British object relations theory. This conceptualisation of narcissism emphasises the role of aggressive derivatives of internalised representations of self and other, linking pathological narcissism with borderline personality pathology. According to this model, grandiosity and vulnerability correspond to contradictory self-representations, split-off from one another and often projected onto others. For instance, dependency feelings are disavowed by the 'independent' self, and are instead assigned to the individual's 'clingy' partner. Kernberg's approach aims toward integration of these disparate aspects of the self along with a toning down of the negative affects that fuel their projection and enactment in interpersonal relations (Kernberg et al. 2008). This involves the consistent interpretation of the client's object relations as they manifest in the transference with the therapist.

An Integrated Approach

Despite important differences, the contributions of Kohut and Kernberg, along with other authors, originate from a shared conceptual heritage (see Bacal and Newman 1990), and in our view can be integrated in day-to-day practice. Drawing from these perspectives, we have selected three major points around which to organise an integrated approach to working with clients suffering from pathological narcissism: (1) maintaining an empathic ambience; (2) using a range of supportive and interpretive interventions; and (3) managing countertransference. Though far from comprehensive, these principles can serve as a basic framework within a range of treatment models and across various service settings.

An Empathic Ambience

For a client who struggles with narcissistic problems, the experience of being consistently empathised with may be powerfully therapeutic and transformative. Building on Kohut's self-psychology, Wolf (1988) highlights the importance of creating and maintaining an 'ambience' in the therapy relationship that provides for the strengthening of a weakened self. An ambience of empathy – the effort to understand from the client's perspective – and non-intrusiveness – the allowance of the treatment process to unfold according to the client's needs – is thought to reduce the client's perceived need for defensiveness and self-enhancement (Wolf 1988). The practitioner accepts that simply his or her empathic presence may, at least for some time, primarily provide a strengthening and sustaining function for the client (Bacal 1994). Part of this empathic attunement involves a framing of the client's narcissistic difficulties as arising from self-vulnerability, relational trauma and efforts to master painful affects. Eventually, the client's fears about being retraumatised, humiliated or exposed may lessen as the client develops an internal representation of the therapist's empathy and responsiveness (Wolf 1988).

Social work has embraced an increasingly complex approach to empathy (Gerdes and Segal 2011; Raines 1990). This is all the more necessary when faced with the complex shifts in self-regulation and affects associated with pathological narcissism. Continuous effort is required to observe and experience – partially and vicariously – the client's subjective emotional states, including any negative reactions to the social worker. A successful empathic ambience allows the client to feel understood, safe and hence more able to access vulnerable thoughts and feelings. As well, disruptions in the client-worker relationship can be better repaired through an ongoing focus on empathic attunement.

The Expressive-Supportive Continuum

The experience of consistent empathic understanding within a therapeutic relationship may in itself contain powerful healing properties. At the same time, this empathic stance toward the client's narcissistic needs can guide the social worker in selecting from a range of additional interventions. Psychodynamic therapy advocates a continuum of interventions from those of a purely supportive nature at one end, to highly expressive and interpretive interventions on the other end (Gabbard 1994; Piper et al. 2002) (see Table 2). Although conceptualised for a range of problems, it would be a mistake to regard these interventions as inherently problem-focused. Addressing client problems, such as narcissistic dysfunction, is not out of line with an overall strengths-based perspective (McMillen, Morris, and Sherraden 2004). Furthermore, supportive interventions are often targeted at recognising, reinforcing and enhancing existing client strengths and capacities. Empathic use of interpretive interventions can also help clients to reframe narcissistic problems in light of their

Table 2. Interpretive and supportive features of therapy (Piper et al. 2002).

Interpretive features	Supportive features
Create pressure on the client to talk by being non-directive.	Relieve pressure on the client to talk by being directive and conversational.
Provide interpretations.	Provide reflections, questions, clarifications.
Focus on the client-therapist relationship.	Focus on client relationships that are external to therapy.
Explore and interpret positive and negative transference.	Facilitate positive transference and redirect negative transference.
Focus on early relationships.	Focus on current relationships.
Explore the client's subjective impressions of others.	Focus on realistic impressions of others.
Focus on unconscious processes.	Focus on conscious processes.
Explore the meaning of uncomfortable emotions.	Allow the expression of uncomfortable emotions.
Explore and interpret mature and immature defences.	Facilitate mature defences and discourage immature defences.
Internalise responsibility for difficulties.	Externalise responsibility for difficulties.
Make links among therapist, parental and significant other relationships.	Engage in structured problem solving.
	Provide guidance and advice.
	Offer praise.
	Provide self-disclosures about personal information, opinions and values.

developmental origins rather than (as many clients experience such issues) as a fundamental badness or moral flaw.

'Reading' the client's fluctuating self-states can cue the social worker to the most appropriate intervention at any given time; strict or formulaic adherence to any one type of intervention could potentially alienate the client or render the therapy ineffective. For example, confrontation regarding the client's tendency to devalue others might be experienced as a painful affront. Empathy for the client's sensitivity can assist the social worker to avoid 'pushing' the relinquishment of valued narcissistic defences. On the other hand, simply reinforcing the client's positive attributes might be experienced as a granting of permission for maladaptive interpersonal behaviours. The client might also infer that the social worker cannot handle any dissent or unrest, and thus avoid bringing difficult material into the sessions. Some evidence suggests that empathically delivered exploratory and interpretive interventions can promote enhanced mentalisation. A study comparing Kernberg's transference-focused psychotherapy (TFP) with supportive therapy found that TFP, which emphasises interpretive interventions, produced significant changes in reflective function and attachment patterns in patients with borderline personality disorder (Levy et al. 2006).

Clinical Example: Empathically Guided Interventions

Mr. J. complained bitterly of repeated social rejections: no one seemed to understand him properly. He progressively found subtle ways of devaluing the services he was receiving by dropping backhanded compliments to his social worker and showing up late for sessions. Rather than reacting, the social worker sensed and silently noted Mr. J.'s hypersensitivity to perceived criticism, choosing to address some of Mr. J.'s interpersonal problems at work. Some real improvements seemed to be occurring in the client's life, indicating a possible effect of the services. Eventually, however, Mr. J. began missing sessions without adequate notice. The worker intervened by confronting Mr. J. regarding the absences and inquiring into his consideration of the effects of – and potential meaning of – such actions. At the subsequent session, Mr. J. expressed angry feelings at having been 'called out' on his behaviour. 'I was so mad at you when you brought that up. But I needed that', he said, 'Nobody ever calls me on anything, they just leave. I'm sure I have something to do with driving them away, but I could never have admitted that six months ago'. In this vignette, the social worker's empathic, non-intrusive stance allowed the client to feel safe as a recipient of care, a highly charged and potentially threatening situation for him. The worker understood Mr. J.'s devaluation and control as his attempts to manage perceived threats to his self. In time, however, the social worker empathically understood Mr. J. to be acting out a need for confrontation and limit-setting, which was ultimately confirmed as an attuned and necessary intervention.

Managing Countertransference

Self-reflection – already a cornerstone aspect of ideal social work practice – deserves special mention when dealing with narcissism. It may be all too easy to conceive of the helping relationship as one in which only one person – the client – has to grapple with narcissistic issues. Some of the difficult feelings stirred up in response to pathological narcissism can take a toll on the social worker's professional sense of self (Buechler 2010). For example, being persistently degraded (as a defence against narcissistic envy) may feel like a distressing affront to social workers who value their altruism and helpfulness. Betan and colleagues (2005) found that expert clinicians frequently identified negative reactions to clients with NPD, including: 'I feel annoyed in sessions with him/her'; 'I feel used or manipulated by him/her'; and 'I lose my temper with him/her'. Although countertransference may provide a partial window into clients' unconscious dynamics (see Gabbard 2001), our emphasis here is on the potential for inadequately managed countertransference to interfere with service. Problematic actions based on countertransference feelings can occur along a continuum of severity from, for example, disengaged boredom to overt rejecting behaviour or boundary violations (Gabbard 1994). Supervision and peer consultation can be extremely useful to keep such reactions in check, preventing them from subtly creeping into care decisions and interventions.

Clinical Example: Managing Countertransference

Ms. K. spent each session lamenting the bleak state of her life, including the therapy. The whole treatment situation seemed to her to be pointless, a last-ditch and progressively failing effort to revive a semblance of hope for herself. The social worker increasingly felt frustrated at having to endure Ms. K.'s disparaging attitude toward both her life and the therapy: couldn't Ms. K. see that she had been making improvements and clinical work had been helpful? He decided to tell her that she should consider some of the accomplishments she had made since she started therapy; the bleak world she described was starting to become more half-full than half-empty. Ms. K. lapsed into silence. During the next session, her expectable complaints continued and escalated, the only exception being that she refrained from mentioning her experience of the therapy itself. In this vignette, the social worker consciously intended for his intervention to challenge some of the client's negative impressions about her life, including her treatment. At another level, he may have been equally concerned with Ms. K.'s implicit and ongoing devaluation of him, feeling this unconsciously as a personal rejection. In this way, his intervention constituted an enactment based on his countertransference sensitivity, having the initial effect of silencing the client. As well, the intervention added fuel to Ms. K.'s complaints regarding her bleak world: now even her therapist could no longer understand or accept her.

At a broad level, negative reactions to persons with personality dysfunction have led to this population being stigmatised and excluded by health care providers (Aviram, Brodsky, and Stanley 2006; Kealy and Ogrodniczuk 2010). Individuals with pathological narcissism are perhaps at increased risk of being maligned and written off as selfish and undeserving of human services. Such clients may present to social work services without overt, externally driven oppression or marginalisation. Instead, their oppression comes from within, in the form of long-standing distorted self-experience and interpersonal problems. Social workers who are responsive to narcissistic pathology are in a position to assist these clients to feel understood, to acknowledge their vulnerabilities and to find alternatives to their self-esteem dilemmas.

Conclusion

Social workers in generalist and counselling practice settings are likely to encounter clients who suffer from pathological narcissism. A broad perspective, encompassing vulnerability and grandiosity, increases the complexity in dealing with narcissistic problems. This paper has provided a practical overview, including general treatment guidelines, for social workers encountering pathological narcissism on the frontlines of human service work. Three key points can be considered in guiding work with clients who suffer from narcissistic dysfunction: (1) maintain an empathic ambience; (2) utilise a range of interventions, from supportive to expressive, guided by empathy for clients'

self-states; and (3) manage potentially problematic countertransference responses.

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