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Empathy in Narcissistic Personality Disorder: From Clinical and Empirical Perspectives

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Abstract

Narcissistic personality disorder (NPD) is associated with an assortment of characteristics that undermine interpersonal functioning. A lack of empathy is often cited as the primary distinguishing feature of NPD. However, clinical presentations of NPD suggest that empathy is not simply deficient in these individuals, but dysfunctional and subject to a diverse set of motivational and situational factors. Consistent with this presentation, research illustrates that empathy is multidimensional, involving 2 distinct emotional and cognitive processes associated with a capacity to respectively understand and respond to others' mental and affective states. The goal of this practice review is to bridge the gap between our psychobiological understanding of empathy and its clinical manifestations in NPD. We present 3 case studies highlighting the variability in empathic functioning in people with NPD. Additionally, we summarize the literature on empathy and NPD, which largely associates this disorder with deficient emotional empathy, and dysfunctional rather than deficient cognitive empathy. Because this research is limited, we also present empathy-based findings for related syndromes (borderline and psychopathy). Given the complexity of narcissism and empathy, we propose that multiple relationships can exist between these constructs. Ultimately, by recognizing the multifaceted relationship between empathy and narcissism, and moving away from an all or nothing belief that those with NPD simply lack empathy, therapists may better understand narcissistic patients' behavior and motivational structure.

Keywords

narcissistic personality disorder; emotional empathy; cognitive empathy; grandiose; vulnerable

Narcissism and empathy have long been considered interrelated. From the early clinical conceptualizations of narcissistic personality disorder (NPD) to the introduction of NPD in

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the *DSM–III* (APA, 1980), impaired empathic processing has been considered a hallmark of pathological narcissism and NPD (Adler, 1986; Akhtar, 1989, 2003; Cooper, 1998; Kernberg, 1983, 1985; Kohut, 1966; Ronningstam, 2005; Watson, Grisham, Trotter, & Biderman, 1984; Watson & Morris, 1991). Most often, "lack of empathy" is included as a signifier of the diagnosis and is highlighted in both the clinician's and lay public's impression of narcissistic individuals.

However, clinical research efforts using self-report and interview measures have failed to identify lack of empathy as a distinguishing characteristic in patients with NPD (Ronningstam & Gunderson, 1988, 1990; Ronningstam, Gunderson, & Lyons, 1995). Moreover, a growing body of work indicates that several factors (e.g., low self-esteem, sense of internal control, self-enhancement, emotion intolerance, self-centeredness) may cooccur and affect the narcissistic individual's empathic capability and functional pattern (Campbell, Reeder, Sedikides, & Elliot, 2000; Fonagy, Gergle, Jurist, & Target, 2002; Fonagy & Luyten, 2009; Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Nezlek, Schutz, Lopes, & Smith, 2007; Ronningstam, 2009; Schore, 1994; Watson, Little, Sawrie, & Biderman, 1992). This accumulation of evidence spurred the description of empathic dysfunction to change from the *inability* to recognize how others feel in the *DSM–III* classification, to the *unwillingness* to recognize or identify with the feelings and needs of others in *DSM–IV* (APA, 1994). This shift underscored a specific motivational aspect of empathy in narcissistic personality functioning. Stone (1998), however, further qualified this narcissism–empathy relationship, suggesting that there could be separable aspects of ability and willingness that affect narcissistic individuals' empathic functioning. That is, some narcissistic individuals may have intact empathic ability, but choose to disengage from others' pain or distress, while others may have a deficient ability in the recognition of others' feelings.

From a theoretical and clinical perspective, growing evidence suggests that the narcissism–empathy relationship is not all or none, but instead is a more complex relationship reflecting fluctuations in empathic functioning within and across narcissistic individuals. Consistent with the understanding that narcissism may reflect variations in empathic functioning, the *DSM-5* Personality Disorder Work-Group introduced a new conceptualization of empathy. Considered a dimensional component in Interpersonal Functioning (Criterion A), empathy is defined as a capability that may be deficient and entail moments of fluctuation depending on the specific situation. For NPD, the following conceptualization of empathic functioning was suggested: "Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimate of own effects on others." Although the diagnostic criteria for personality disorders will remain unchanged in *DSM-5* Section II, an alternative Section III, representing the significant work on reconceptualizing and improving the diagnosis of personality disorders including NPD, has been incorporated awaiting additional empirical validation (Skodol et al., in press).

The purpose of this review is to examine the current empirical work on empathic functioning as it relates to pathological narcissism and NPD in order to better understand this relationship. In this review we: (a) provide a psychobiological overview of empathy and

its subcomponents; (b) summarize existing empirical findings on the empathy and narcissism relationship, and given the paucity of empirical work in this field, also review research on near-neighbor personality conditions (e.g., borderline and psychopathic); (c) present three case studies of narcissistic individuals, focusing on segments from developmental history and therapy sessions that highlight the relationship between narcissism and empathy; and (d) discuss clinical and treatment implications of the empathy–narcissism relationship within our proposed framework.

Empathy: Psychobiology and Subtypes

Empathy is a multifaceted construct that involves both the affective experience of the other person's actual or inferred emotional state *and* the recognition and understanding of another's emotional state (Decety & Moriguchi, 2007). It also involves the ability to monitor oneself and to maintain and regulate self-other awareness (Funder & Harris, 1986). Unlike related processes such as sympathy, the essence of empathy reflects the ability to separate oneself from others' experiences and recognize possible emotions and alternative perspectives. Empathy typically emerges within the second year of life and greatly depends on the nature of human interactions (e.g., caregivers' style, family environment) to support self-other awareness and conscious concern for others (Decety & Svetlova, 2012; Svetlova et al., 2010; Vaish et al., 2009). Other factors such as temperament and genetics also influence the development of empathy (Zahn-Waxler et al., 2001). Thus, both genetic and environmental effects shape empathetic processing.

From a neuroscience perspective, there are multiple empathic processes that, to a certain extent, are associated with dissociable neural systems. Specifically, there are two main subdivisions of empathy: emotional and cognitive. Emotional empathy includes response to affective displays by others (e.g., facial expressions) and emotionally evocative stimuli (e.g., phrases, stories). Cognitive empathy, or Theory of Mind, refers to the understanding and representation of mental states (i.e., belief, desire, and knowledge) that enables an individual to explain and predict others' behavior. Moreover, some researchers add a third division of empathy, motor empathy, which is associated with mirroring the motor responses of other's (Preston & de Waal, 2002). However, due to the current inability to measure individual (e.g., mirror) neurons in humans, we will not review motor empathy (see Blair, 2005 for review).

Emotional empathy is associated with partially separable systems (all requiring superior temporal cortex) that are activated (show increased activation) depending on whether the individual is responding to fearful/sad/happy (amygdala), disgust (insula), or angry (ventrolateral prefrontal cortex) expressions. Adolphs et al. (2005) examined amygdala-lesioned patients and found that consistent with the role of the amygdala in facilitating the fear expression, these patients showed impairment in the recognition and experience of fear. Similarly, damage to the insula, a region crucial in monitoring body state, can impair both the experience of disgust and the recognition of social signals (e.g., facial expression) that convey disgust. Consistently, functional neuroimaging studies show that observing facial expressions of disgust and feelings of disgust activated very similar sites in the anterior insula and anterior cingulate cortex (see Decety & Jackson, 2004, for review).

Factors such as attachment style and temperament moderate the development of emotional empathy and its related neural capacities. From an early age, even prior to the onset of language, infants communicate with others in their environment by reading and generating facial expressions (Leppänen & Nelson, 2009). These components of emotion are present at birth, relying on close connections between perceptual processing and emotion-related neural circuits, and prepare the individual for later empathic connections through affective interactions with others. Given that infants' social interactions begin with a primary caregiver, the empathic capability of the caregiver is crucial for secure and healthy attachment to develop. To the extent that children develop secure attachment, they develop more responsivity to the needs of others (Mikulincer et al., 2003). Additionally, infant arousal in response to other's affect can influence social learning and reinforce the infant's own emotionality. Consequently, temperamental emotionality (i.e., degree of physiological and affective reactivity) is purported to underlie the genetic heritability of emotional empathy and neural reactivity in the amygdala (Davis, Luce, & Kraus, 1994; Vrtička et al., 2008). For example, 4-month-old infants who showed relatively low levels of affective responses to novel sensory stimuli, were found to respond less empathically to a stranger simulating distress at age 2 (Young et al., 1999). The low reactivity to sensory stimuli in infancy and others' distress in toddlerhood may be early signs of underarousal that influences the development of insensitivity and antisocial behavior.

In contrast to the affective neural basis (i.e., subcortical) of emotional empathy, cognitive empathy is associated with a network of cortical regions, which include the medial prefrontal cortex, the temporal-parietal junction, and the temporal poles (Brunet, Sarfati, Hardy-Bayle, & Decety, 2000; see Frith, 2001 for review). For example, Saxe and Kanwisher (2003) developed four conditions (i.e., stories that examine false belief, human action, nonhuman inferences, and mechanical inferences) to isolate Theory of Mind-related neural processing. More specifically, only the false belief and human action stories elicited Theory of Mind reasoning and stimulated greater activity in the superior temporal sulcus, precuneus, and the temporal-parietal junction (see also Saxe & Powell, 2006; Mitchell, 2008). Additionally, the anterior superior temporal sulcus and the temporal-parietal junction were also activated in a condition designed to assess the participant's understanding of the protagonist's desire (Saxe & Powell, 2006).

There is ample evidence demonstrating that the emotional component of empathy develops earlier than the cognitive component, and that cognitive empathy is primarily related to the development of executive functioning (e.g., working memory, inhibitory control), language capabilities, metacognition, and cortical brain maturation (Carlson et al., 2004; Eisenberg & Eggum, 2009; Meins et al., 2002; Tamm et al., 2002; Zelazo et al., 2004). For example, in a study with 3- and 4-year-old children, performance on inhibitory control tasks was significantly related to Theory of Mind capabilities (Carlson & Moses, 2001) and executive functioning at 3–4 years predicted quality of Theory of Mind processing 1 year later (Hughes, 1998). Together, these studies suggest that the development of cognitive-based processes, such as inhibitory control, is crucial for cognitive empathy.

From a psychobiological perspective, it is evident that empathy is a complex process influenced by both biological and environmental factors, and attributed to partially separable

neural systems (e.g., all empathic processes appear to activate the superior temporal cortex, but each subprocess then activates additional regions). Identifying separable cognitive and affective processes is important when considering the relationship between empathy and psychopathology, particularly as these processes relate to narcissism.

Empirical Evidence for Compromised Empathy in Narcissism

As noted above, from a phenotypic perspective, compromised empathic processing is a hallmark of narcissism. However, only a few empirical studies have closely examined the association between empathy and narcissism (Munro, Bore, & Powis, 2005; Porcerelli & Sandler, 1995; Trumpeter et al., 2008; Watson & Morris, 1991; Wiehe, 2003; Watson et al., 1995, 1992, 1984). Little research has been done with narcissism to directly measure the neural processes implicated in empathy, but a handful of studies have explored the resultant behaviors associated with emotional (e.g., viewing facial expressions, questionnaires directed to asses this component) or cognitive (e.g., Theory of Mind tasks or questionnaires) empathy. Although results are mixed, there is growing evidence that individuals with pathological narcissism or NPD display significant impairments in emotional empathy, but display little to no impairment in cognitive empathy (Ritter et al., 2011; Wai & Tiliopoulos, 2012; Watson et al., 1984).

Studies have shown that individuals with NPD display deficits in recognition of emotion when viewing facial expressions (Marissen, Deen, & Franken, 2012) and in empathic concern and mirroring emotions when viewing emotionally charged situations (Ritter et al., 2011). However, there is not enough evidence to make definitive conclusions that pathological narcissism is associated with differences in cognitive empathy. When completing the video-based Movie for the Assessment of Social Cognition, a measure of Theory of Mind, patients diagnosed with NPD did not differ from healthy controls. Additionally, patients with NPD and healthy controls showed no differences in cognitive empathy as indexed by the Multifaceted Empathy Test (Ritter et al., 2011). Consistent with this specific deficit in emotional empathy, a recent neuroimaging study presented pictures of emotional faces and asked participants to empathize with the person in the picture. Participants high on narcissistic traits displayed decreased deactivation of right anterior insula during processing of emotional faces (Fan et al., 2011). The authors interpreted this pattern of activation as indicative of an increased self-focus among narcissistic individuals. Another study measuring respiratory sinus arrhythmia and cardiac preejection period reported that pathological narcissism was associated with a decrease in respiratory sinus arrhythmia and preejection period shortening while viewing happy images (Sylvers, Brubaker, Alden, Brennan, & Lilienfeld, 2008). This finding was generally interpreted as a negative reaction to watching others in positive experiences. Lastly, individuals high in narcissism displayed lower electrodermal reactivity in anticipation of aversive events (e.g., noise blast; Kelsey, Ornduff, McCann, & Reiff, 2001), which has been interpreted as insensitivity to contextual anticipatory demands. Taken together, these findings provide preliminary neural and physiological evidence of decreased empathy, specifically emotional empathy, among individuals with NPD.

Although the experimental research on empathy and narcissism is limited, generally, it indicates a stronger deficit in emotional rather than cognitive empathy. An interesting pattern emerges, however, when individuals high on narcissism are asked about their empathic functioning. Research using self-report questionnaires that measure components of empathy, reports that narcissism (both trait and pathological) is inversely related to cognitive empathy (Watson et al., 1992). More specifically, individuals high on narcissism report lower levels of perspective taking on the Interpersonal Reactivity Index (Davis, 1983), particularly in response to questions that assess willingness to engage in empathic concern. Conversely, narcissistic individuals tend to overestimate their capacity for emotional empathy (Ritter et al., 2011). This pattern may indicate that narcissistic individuals, as suggested above, have a motivation-based impairment in their cognitive empathic functioning in addition to compromised emotional empathy. That is, individuals with pathological narcissism may be capable of processing affective information, but don't *want* to engage in empathic processing so as not to lose control or appear vulnerable (Ames & Kammrath, 2004). Combined with their inability to respond to other's emotions, this may leave narcissistic individuals at a loss for how to connect with others and manage interpersonal interactions.

Empirical Evidence for Compromised Empathy in Related Psychopathologies

Two pathologies that have been linked to narcissism are psychopathy and borderline personality disorder (BPD). Each of these syndromes appears on a continuum with NPD that highlights patterns of impulsivity, emotion dysregulation, and self-centered, goal-focused behaviors. The phenotypic overlap in these pathologies contributes to their moderate levels of comorbidity, with NPD and psychopathy co-occurring at rates of approximately 21% (Blackburn, Logan, Donnelly, & Renwick, 2003) and NPD and BPD comorbidity estimated at 37% – 39% for BPD (Stinson et al., 2008). Given the paucity of empathy-based work on pathological narcissism, research in other related pathologies may highlight specific empathy-pathology relationships.

Bearing resemblance to NPD, psychopathy is associated with grandiosity, compromised empathic functioning, and callousness. Although a pattern of deceitful, manipulative, and impulsive behavior is inherent in the syndrome of psychopathy, these features are not necessarily a component of NPD. However, exploring the relationship between a psychopathic individual's ability to lie and manipulate and their empathic functioning may provide a context for understanding how those with narcissism also can appear callous and grandiose. Similar to research in narcissism, individuals with psychopathy display difficulties with emotional empathy, but display intact cognitive empathy on experimental tasks (Blair, 2005; Hare, 1993; cf., Brook & Kosson, 2013). Psychopathic individuals show reduced autonomic responses to stimuli associated with other's distress (House & Milligan, 1976) and sad expressions (Blair et al., 2005). There is also some evidence of psychopathy-related amygdala dysfunction during emotional memory (Kiehl et al., 2001) and conditioning tasks (Birbaumer et al., 2005). These deficits in amygdala activation along with

reduced reactivity to other's distress supports the proposal that psychopathy is related to deficient emotional empathy.

In contrast to the proposed deficit in emotional empathy, a number of studies report normative performance in psychopathic individuals on Theory of Mind (i.e., cognitive empathy) tasks (Blair et al., 1996; Mullins-Nelson, Salekin, & Leistico, 2006; Richell et al., 2003; Widom, 1978). Moreover, recent imaging studies indicate that psychopathic individuals display overactivation of (pre)frontal regions, which in turn, inhibits amygdala reactivity (Larson et al., 2013; Muller et al., 2003). Thus, it may be that psychopathic individuals rely on cognitive inputs (and potentially Theory of Mind processes) to perceive emotions, but have difficulties processing them, resulting in deficient emotional empathy.

In addition to psychopathy, BPD exists within a similar nomological network as NPD. Although BPD is characterized by low tolerance for aloneness, impulsive behavior, and tendencies toward regressive fragmentation; this pattern differs from the tendency of narcissistic individuals to engage in self-enhancement and display a cohesive sense of self. However, both individuals with BPD and those with NPD are reactive to criticism, have trouble keeping healthy relationships, and become easily hurt or rejected (Miller et al., 2010). Although some studies on BPD indicate that these individuals also have a deficit in emotional empathy (Dziobek et al., 2011; Levine, Marziali, & Hood, 1997; Ritter et al., 2011), others show that BPD is related to normative or even hyperreactive emotional empathy (Harari et al., 2010; Lynch et al., 2006; Wagner & Linehan, 1999). Additionally, there is some evidence that BPD is associated with a deficit in cognitive empathy (Dziobek et al., 2011; Harari et al., 2010). Consistent with this imbalance in emotional and cognitive empathy, a number of imaging studies report hyper-reactivity in the amygdala and insula when viewing emotional evocative pictures during a psychological distancing task, or an affective empathy task (Donegan et al., 2003). There is also evidence of hyporeactivity in prefrontal cortices and superior temporal sulcus and gyrus during aggression regulation tasks, possibly highlighting deficient self-relevant reflection in BPD (Dziobek et al., 2011; see Schmahl & Bremner, 2006 for review). Despite the evidence of deficient prefrontal activation, some work reports that borderline individuals perform as well as healthy controls in Theory of Mind tasks (e.g., Reading the Mind in Eyes; Fertuck et al., 2009; Ripoll, Snyder, Steele, & Siever, 2013). Taken together, in the context of empathy, individuals with BPD appear to be overwhelmed by their own emotions, have difficulty regulating those emotions, and as a result have impairment in inferring the mental state of and being emotionally attuned to another.

Across psychopathy, BPD, and NPD, current research suggests that deficient emotional empathy is a key to the problematic empathic functioning in these individuals. Slight variations and comparisons with different disorders suggest that multiple relationships between cognitive and emotional empathy are plausible in NPD. On the one hand, despite being able to perceive emotions in a manner similar to psychopathy, individuals with NPD may have compromised empathic functioning because of a deficit in emotional empathy (e.g., neurobiological evidence) and a deliberate attempt to avoid feeling vulnerable (e.g., self-report data). On the other hand, it is also possible that those with NPD, like individuals with BPD, experience intense emotions (e.g., anger, shame, fear; Cooper, 1998; Gramzow &

Tangney, 1992) that impair their ability to attend and react to other's emotions (i.e., deficient emotion tolerance and regulation). Ultimately, the examination of psychobiological, behavioral, and neural underpinnings of empathy provides a basis for future research that may identify the specific dysfunction(s) responsible for the potential disingenuous and indifferent inter- and intrapersonal behaviors of narcissistic individuals.

Clinical Implications

This review highlights evidence for compromised empathic functioning, but not an inability or absence of empathy, in people with pathological narcissism and NPD. Overall, research suggests a neural deficiency in emotional empathy, despite the tendency for narcissistic individuals to overestimate their own emotional empathic capability. At this time, there is little evidence to suggest a reliable deficit in cognitive empathy among narcissistic individuals. Examination of related pathologies, like BPD and psychopathy, however, provide alternatives for the variability observed in empirical and clinical observations of empathy in narcissism. As such, the complexity of narcissism and empathy may suggest that multiple pathways or relationships between these constructs are possible. Below, we present illustrative case studies, from individuals who met five or more of the *DSM-5* diagnostic criteria for NPD, that highlight the multidimensional nature of narcissism and empathy.

Case Study #1

Mr. S is a married man and father of two children. Mr. S described to his therapist how he learned to benefit from people, thrive socially, and professionally through his special ability "to attend to and understand" other people. He gave numerous examples of how his "intuition" has led to business opportunities, special privileges, and admiration. Despite his ability to connect with other people, Mr. S. often described his impatience and contempt, especially with some colleagues and with his wife, when they bothered him with anxieties over seemingly trivial things.

Growing up, he had always felt torn between his anxious and demanding father and his friendly and very successful mother. Early on Mr. S learned that in order to gain his mother's appreciation, he would have to avoid his father. In a couples' therapy session, Mr. S's wife reported that their friends see him as interpersonally unpredictable. Sometimes he is quiet, distant, and condescending, and at other times, especially with people who are perceived as prestigious or important, he is very friendly and attentive. His wife went on to say, "I thought I married the most empathic man in the world. He helped me understand and outgrow my problematic relationships with my mother and brothers by pointing out how their behavior affected me. He helped our friend's sort out a marital conflict, and instead of getting a divorce they are now on a second honeymoon. But in our own relationship he just seems indifferent, especially to the difficulties I experience. He can't see or take on my perspective. When I tell him about how I feel in specific situations or when we interact, he seems to space out or get numb. At times he seems helpless, but he can also get irritated if I insist on his attention. I have felt shocked and confused by his unresponsiveness." While his wife was talking, Mr. S sat quietly with his eyes covered, and then he responded: "I don't know what happens to me, I

just feel put on the spot. I hear you, but I can't think. I don't know what to say. I don't want to talk about this now!!"

Case Study #2

Mr. H, a manager of a department in a large corporation, had been asked by his boss to seek psychotherapy to attend to his collaborative inattentiveness and insensitivity. He has a long history of interpersonal problems stemming from his feelings of superiority, tendency to be intolerant of rules and authorities, experiences of being easily irritated and moody, and feeling envious and resentful when others advanced ahead of him.

Mr. H grew up in a dysfunctional family with alcoholic parents, and learned early in life to be independent, take charge of his own activities, and not rely on other people for support. Mr. H felt divided, with a part of him feeling independent and accomplished outside of his home, and another part of him feeling subordinate, unseen, and powerless inside of his home. He did very well in school and sports, but he always felt conflicted about his family background. On the one hand he felt resentment and shame about his parents' behavior. On the other hand he struggled with a wish to be appreciated and accepted, especially by his family, but realized that was never going to happen in the way he wanted. As he advanced professionally, Mr. H demonstrated increasing intolerance for what he perceived as others inadequacies or demands.

Mr. H came to therapy reluctantly, reporting that his supervisors are "out to find faults" in him. One of the executive directors recently told Mr. H that he is insensitive to the company's concerns about customers' complaints. "I don't know what he is talking about," said Mr. H. "I do what I am supposed to do, I have moved my department from a crisis situation into a prosperous, well-functioning part of the company, but they always seem to point out things I am missing, and that makes me really angry." Mr. H also reported that his staff often confide in him, even with their personal problems outside of work, which he appreciated. He also mentioned that he enjoys stepping in and resolving acute conflicts between members of the staff. This makes him feel competent, valuable, and in charge, as he notices the satisfaction from those involved. However, Mr. H revealed that in some circumstances, particularly with his wife and elderly parents, he can't tolerate their complaints or stressors. He readily gets frustrated, burdened, and even angry. "Whatever I do, nothing is good enough, so I don't give a shit, I don't care if something happens … they don't listen, and I can't do anything."

Case Study #3

Ms. T, a shy and timid single woman in her mid-30s, who described herself as extremely competent and perceptive, but also struggling with hypervigilance and deep internal insecurity and agony. While she had perfectionist standards and felt very certain about what she considered as her special potentials and capabilities, she was experiencing problems with the rest of the staff in her office. When she

was forced to interact with her coworkers, she felt resentful because they were intruding upon her space and time.

Ms. T's father left the family when she was two years old. Shortly after leaving, he remarried and Ms. T only saw him a few times a year. Ms. T was in awe of the new life her father had; he was successful and built a new harmonic family with several children. For Ms. T, every time she would visit her father, her experiences were in sharp contrast to her daily life with her complaining and depressed mother. As Ms. T grew up, she noticed she was constantly measuring herself vis-á-vis others, looking for indications of others' praise and approval, and feeling painfully upset when facing ignorance, criticism, or lack of reciprocity and positive attention.

In therapy, Ms. T described her recent experience at work, stating, "I cannot handle all these personal problems my coworkers bring to the office. One woman lost her mother in a car accident and another's son got an acute type of cancer. They tell me that I am insensitive and unempathic, but I can't stand listening to them talking about this. They take up all my time. It becomes unbearably painful and I get angry. I don't know why I get so angry, and that makes me feel ashamed and like an outsider. Every time they are talking, I end up saying nothing, just avoiding them, and leave the room. I did sign the cards for them, and I donated some money to a cancer foundation, so I know I do care. But I can't tolerate their presence and to hear about their grief and worries."

Across the three case studies, it is easy to focus on the difficulty these patients have connecting to others and the clear examples of their deficient displays of empathy. It seems hard to say that any of these individuals are "lacking empathy" or are even "unwilling" to engage in empathic processing; yet, each of these individuals are classic examples of pathological narcissism. These case studies highlight the importance of recognizing intervening factors that can create a context whereby a narcissistic individual may or may not display empathy. On the one hand, narcissistic people may be able to appropriately empathize when feeling in control, that is when their self-esteem is enhanced and when displaying empathy is in their best self-interest (Ronningstam, 2009). On the other hand, opportunities for self-enhancement or situations that may expose compromised emotion tolerance can result in self-serving empathic disengagement. To the extent that empathic processing can vary and fluctuate across and even within narcissistic individuals, it may be useful to consider the unique characterizations of grandiose and vulnerable narcissism.

Grandiose and Vulnerable Narcissism

Given that there is no existing empirical work that delineates fluctuations in grandiose and vulnerable expressions of narcissism with relation to empathy, these states did not warrant mention in earlier sections of this review. However, recent phenotypic conceptualizations of pathological narcissism and NPD suggest that the states of grandiose and vulnerable narcissism (Pincus, 2011; Pincus & Lukowitsky, 2010) indicate variations in self-regulatory and interpersonal functioning that may relate to differential patterns in empathic functioning. Grandiose narcissism is described as a pattern of arrogant, self-centered, and domineering beliefs and behaviors. Conversely, vulnerable narcissism is reflected in patterns of low self-

esteem, anger, shame, and suicidality. The existence of these two phenotypic expressions, which indeed can co-occur within each individual and fluctuate across time and context, cannot only begin to clarify some of the variation in the clinical presentation of pathological narcissism, but also may aid in developing a more nuanced understanding of the relationship between empathy and narcissism.

These two forms of narcissism tend to be influenced by different developmental pathways and environmental contexts. For example, grandiose narcissism is often related to dismissive/secure attachment and these individuals deny interpersonal distress, whereas vulnerable narcissism is associated with anxious/fearful attachment and empathic overarousal (Dickinson & Pincus, 2003; Miller et al., 2010; Meyer & Pilkonis, 2011; Otway & Vignoles, 2006; Sonnby-Borgström & Jönsson, 2004). Thus, for some, empathic functioning may be related primarily to egocentric motivation-based attachment security (grandiose), whereas for others, empathy may reflect unstable attachment and poor affect regulation (vulnerable).

For each of the cases above, early developmental experiences influence the primacy of a particular state, but for all, these early experiences generate coexisting internalized idealization, independence, and self-enhancement, contrasted with experiences of inadequacy, powerlessness, and self-devaluation. More specifically, Mr. S in relationship to his father (*Case Study #1*) developed a dismissive attachment and an idealized secure attachment with his mother, spurring his compartmentalized ability to engage in empathic processes when he could help strangers, but limited empathic engagement when he had to focus on dealing with his wife's problems. Similarly, Mr. H's (*Case Study #2*) competence and independence at a young age likely influenced his desire to engage with his staff, but need to retreat when the problems were more personal. Finally, Ms. T's fearful contrast of mother and father (*Case Study #3*), influenced her ability to produce great work and be goal-focused, but when directly faced with empathetic challenges and emotion, she became overwhelmed. Together, these case studies highlight the clinical reality that these internalized and phenotypic patterns of grandiosity and vulnerability affect empathic functioning.

People with NPD in their grandiose state may, like psychopathic individuals, possess the cognitive capacity to utilize empathy but have a motivation-based desire to disengage from empathic processing. Such disengagement is likely to co-occur with grandiose strivings that stem from idealized or enhanced experiences, internal grandiose fantasies, or a need to promote self-serving interpersonal behavior. In such situations, empathic engagement with other people's problems can be counterintuitive to the narcissistic individual's needs for self-centered avoidance or enhancement. Based on the empirical findings, it may be the case that narcissistic individuals can employ their empathic capability when they feel in control because they possess intact cognitive empathy (Ritter et al., 2011), but tend to have more difficulty in response to affectively charged situations due to deficiencies in emotional empathy. Notably, the empirical evidence demonstrating aberrant physiological and neural reactivity in response to emotional stimuli (which is similar to findings for psychopathy) and aversive situations may represent a defensive response to affective challenge (Fan et al., 2011; Sylvers et al., 2008; Kelsey et al., 2001). Thus, although grandiose narcissistic

individuals can overtly display an engaging attitude and invite emotional sharing, like with Mr. H and Mr. S (*Case Studies #1 and #2*), they may be unable to deeply and genuinely relate and respond to the other person's experiences. As such, these individuals can demonstrate strikingly overt indications of empathic disengagement, such as blatant rejection, aggressive criticism, and blame of others. This contrast between empathetic openness and disengagement is highlighted when Mr. H (*Case Study #2*) discusses his willingness to help his staff, but also his disdain for his supervisors and anger toward his family. Accordingly, when in a grandiose self-enhanced self-state, these empathic deficiencies may stimulate an abrasive pursuit of self-interests and advancements, or competitiveness without attention or awareness of others' reactions or well-being.

For example, in higher functioning people with pathological narcissism or NPD (Russ, Shedler, Bradley & Westen, 2008), especially those in decision making and leadership positions (Maccoby, 2003), such empathic deficits can (paradoxically) be temporarily beneficial. Under certain circumstances, empathic disengagement and insensitivity can enhance achievements and productive functioning by enabling risk taking and supporting the ability to stay focused, especially in emotionally challenging situations. When such ability leads to proactive desirable gains, it can be an extraordinarily valuable asset. However, empathic deficits can also pose negative or even devastating consequences if driven by self-serving goals/intentions, such as power, admiration, or competition (Munro, Bore & Powis, 2005; Schipper & Petersmann, 2013). For narcissistic individuals in leadership positions, these empathic deficits can co-occur with psychopathic, powermotivated functioning, leading to illegal actions and conscious exploitations of their position for exclusively personal gains (Kernberg, 1998; Maccoby, 2003). Ultimately, the self-serving focus of grandiose narcissistic individuals may influence fluctuations in empathy ranging from engagement to disengagement that respectively align with whether or not empathy is in service of their goal or interferes with attaining their goal.

Narcissistic individuals in a vulnerable state may appear more similar to those with BPD (Gunderson, 2001; Miller et al., 2011; 2010; Ronningstam & Gunderson, 1991) with regard to empathic functioning and its relationship to emotion dysregulation (e.g., deficient emotion tolerance). Additionally, the similarities across these pathologies may extend to the pattern of neural activity that is marked by hyperactivity in limbic circuitry in response to emotional stimuli or events (Donegan et al., 2003; Schmahl & Bremner, 2006) in conjunction with hypoactivation in neural circuitry associated with selfregulatory function (Dziobek et al., 2011). When in a vulnerable state, both being exposed to others' feelings as well as facing one's own intense feelings can be overwhelming for people with NPD. For example, intense shame, envy, and rage can be intolerable, especially if accompanied by self-criticism and self-hatred, or by the perception of not measuring up or losing control in interpersonal situations. In these individuals, empathic dysfunction, then, may be expressed in a shame-driven withdrawal and avoidance of emotionally loaded interactions, like in the case of Ms. T (*Case Study #3*) in her interaction with coworkers in crises, or with self-serving defensive or aggressive behavior, like with Mr. S (*Case Study #1*) in his interaction with his wife, and Mr. H (*Case Study #2*) in relation to his wife, his parents, and to superiors at work.

For example, one study found that abusive parents, who lacked parental warmth and experienced difficulty in perspective taking, also reported lower levels of self-confidence and more narcissistic traits (Wiehe, 2003). Moreover, from a clinical perspective, the psychodynamic process of projective identification suggests that those with vulnerable narcissism and those with BPD project unpleasant characteristics of the self onto others (Higgitt & Fonagy, 1992; Kernberg, 1984). Difficulty engaging in perspective taking and the interpersonal style of placing a distressed mental state onto others are both consistent with deficient cognitive (e.g., prefrontal cortex) modulation of affective hyper-reactivity (e.g., amygdala reactivity). That is, vulnerable narcissistic individuals may be overwhelmed by their own emotions, have difficulty regulating those emotions, and as a result have impairment in empathic processes.

In basing the definition of pathological narcissism on the individual's motives, regulatory capacity, and empathic functioning, we can distinguish between the underlying construct of narcissism and how it is expressed in feelings, thoughts, and behaviors. Consideration of the states of grandiosity and vulnerability in NPD provides a functional and phenomenological context whereby empathy and other related processes are differentially expressed. More specifically, those in the state of grandiose narcissism may be best characterized by a motivational-based empathic disengagement when it serves their needs. Conversely, those with vulnerable narcissism may display a more deficit-based empathic disengagement, particularly as it relates to affective tolerance. Finally, in addition to impacting clinical conceptualization, acknowledging both motivational and deficit-based components in compromised empathic ability also has major implications for treatment of patients with pathological narcissism and NPD. Ultimately, by working to bridge empirical and clinical work, it is possible to develop more nuanced conceptualizations of narcissistic-empathic processes and more targeted treatment approaches.

Treatment Recommendations

Despite the evolution concerning the descriptive clinical characteristics of pathological narcissism and NPD, widely divergent views are still present regarding the optimal treatment approach, considering that people with these conditions often are viewed as resistant to treatment or indeed even can be untreatable (Almond, 2004; Ivey, 1995; Kernberg, 2007; Oldham, 1988; Shilkret, 2006; Stern, Yeomans, Diamond, & Kernberg, 2013; Young & Flanagan, 1998). However, bearing in mind the conceptual advances, particularly as it relates to clarifying the relationship between narcissism and empathy, more specified treatment approaches may emerge. Regardless of the specific form of deficient empathic processing in pathological narcissism, these two constructs are closely related and should not be ignored. Therefore, attention to deficits in the emotional empathy of patients and identifying the balance between their cognitive, motivational, perceptual, and accompanying emotional experiences is crucial to the therapeutic process.

Broadly speaking, the choice of specific therapeutic strategies has to be timely and adjusted to each individual patient and his or her level of motivation, psychological capabilities, and circumstance. There are a number of basic therapeutic strategies that can be useful when working with narcissistic patients. First, a collaborative approach is essential in order to

reach a mutual agreement and understanding of each individual patient's empathic functioning and goals. Second, validation serves to confirm the patients' experience and disarm any defensiveness (Schechter, 2007). Third, balancing validation with careful clarification and confrontation can be a useful part of exploring the patients' ability to take another's perspective and challenge their own (i.e., fostering empathic responses and encouraging the development of empathic responses). This strategy also serves to support the patient's sense of agency and active participation, as well as testing their ability for self-assessment and reflection (Knox, 2011). Lastly, providing interpretations that serve to increase patients' awareness and insight about fantasies, feelings, and conflicts can be helpful (Wolf, 1993). Importantly, interpretations should be formulated as questions or hypotheses, in order to promote the patient's introspective curiosity and minimize negative reactions (i.e., feeling shame, a sense of being intruded upon) to the interpretive statement.

In addition to these specific therapeutic styles, the use of psychoeducation (e.g., about the function of emotions) and skills work (e.g., distress tolerance, interpersonal effectiveness, mentalization) can be helpful in strengthening the therapeutic alliance, supporting the patient's sense of collaborative agency, and learning to master threatening or overwhelming experiences. More specifically, Dialectical Behavior Therapy, which includes distress tolerance and interpersonal effectiveness skills, is guided by the understanding that emotions can be overwhelming and at times, intolerable. This skills-based approach has been shown to help narcissistic individuals identify personal needs and values and more appropriately respond to feedback from others (Reed-Knight & Fischer, 2011). Additionally, Mentalization-Based Therapy skills serve to promote reflective functioning and an increase in understanding one's state of mind, which are processes akin to Theory of Mind (Bateman & Fonagy, 2012; Ha, Sharp, Ensink, Fonagy, & Cirino, 2013; Higgitt & Fonagy, 1992). Moreover, consistent with psychoanalytic approaches, this therapeutic approach originates from attachment theory and considers the repeated interactions with caregivers early in life as a model of the relationships that play out later in life. As such, given the importance of developmental history for understanding an individual's empathetic functioning, developmental accounts can provide essential information about early attachment patterns and how they are represented in the range of the patient's narcissism (Meyer & Pilkonis, 2011; Miller et al., 2010; Otway & Vignoles, 2006; Dickinson & Pincus, 2003).

At this point, we choose to advocate for exploratory multimodal and individualized therapeutic strategies adjusted to the individual patient's functioning and ability to integrate interventions. The balance between grandiosity, vulnerability, self-reflective capability, lifecontext, and urgency has to be taken into consideration. It is also important to take into account that these forms of empathic processing can coexist within an individual and interact in certain situations (i.e., one can take precedence and be more predominant than the other). As noted above, depending on the individual, the narcissism–empathy relationship may take the form of a motivation-based disengagement or a deficit in emotional empathy.

Motivation-based empathic disengagement, as demonstrated by Mr. H (*Case Study #2*) in relationship to his wife and parents, and with his subordinates, would warrant a careful exploration of the patient's reasoning and understanding of interpersonal disadvantages and consequences. In addition, based on the patient's dismissive attachment pattern, looking

further at the patient's underlying motives such as avoidance of feelings of powerlessness, insufficiency and frustration, or dismissal of other people's weakness, reactions and help-seeking, can help increase the patient's awareness of reasoning and choices, and promote a better foundation for encouraging possible changes. Some people may also struggle with earlier conflicts or humiliating, threatening experiences that affect their willingness to invest in empathic functioning. The patient's ability for collaborative exploration of their current and previous experiences is an important enabling factor.

It is also important to consider that motivational-based disengagement can fluctuate with shifts between self-promoting grandiosity and underlying vulnerability. Hence, the ability in certain situations to access cognitive empathic capacity, which at the time can be supportive of the individual's self-esteem and sense of agency, may contrast with other ego-threatening situations that constrict or even exclude both emotional as well as cognitive empathy. Both Mr. H (*Case Study #2*) and Mr. S (*Case Study #1*) demonstrated such ability to engage empathically under certain circumstances when they felt in charge, capable, and interpersonally valued. However, when they faced situations that were more challenging, such as when their empathic and interpersonal functioning were especially exposed, they reacted with rejection, anger, and resentment (Mr. H), or with avoidance and withdrawal (Mr. S). Such fluctuations, when possible to process in treatment through exploration and mentalization-based skills, can provide superb opportunities for building awareness of both selfenhancing and vulnerable experiences and how they affect the patient's interpersonal functioning. Change in such self-regulatory empathic functioning may depend upon the patient's ability to address broader aspects of self-esteem and vulnerabilities in the context of interpersonal functioning. As mentioned earlier, the choice of strategies depend upon the patient's ability for self-reflection, affect tolerance, and processing of emotions.

Deficit-based empathic disengagement, as noted by Ms. T (*Case Study #3*) in her reactions to the troubled coworkers, requires a sensitive and careful exploration of the specific circumstances. The patient's degree of self-awareness and ability to recognize and accept deficits in their own empathic capability and functioning is crucial. Similarly, it is important to attend to the predominant anxious attachment pattern during alliance building. The patient's difficulties in processing self-criticism and feelings of shame, rage, and even fear when facing own incapacities and deficits can have a major impact on the therapeutic process and determine both its pace and outcome.

With deficit-based empathic disengagement, applying psychoeducation and skills-focused interventions are likely important. Narcissistic individuals with this type of empathy deficit find it difficult to tolerate their emotions. As such, distress tolerance skills can help the individuals to make it through these intense emotional reactions, so that empathetic engagement can feel secure. Similarly, strategies for optimizing interpersonal functioning are recommended, so that the individual can express their emotion, find ways to leave a situation more appropriately, and maintain a level of self-protection and self-respect.

In sum, treatment of compromised empathic functioning requires a careful and systematic collaborative exploration with the patient that attends to the patients' perspective and understanding of their empathic difficulties (whether motivational or deficit-based), as well

as of the personal and interpersonal consequences. Moreover, it is necessary to consider the various triggers and causes of the patient's empathic processing (e.g., whether it is related to compromised ability (deficits), balancing narcissistic grandiosity and vulnerability, interpersonal conflicts or competition, or rooted in earlier emotional conflicts).

Conclusion

The variability in empathic capability among narcissistic individuals highlights the inaccuracy in stating that narcissism is simply related to a lack of empathy. Foremost, it points to the need for informed exploratory and flexible therapeutic interventions as well as awareness of possible functional changes or adjustments. By adjusting the framework of the narcissism–empathy relationship, therapists may be better able to understand narcissistic patients' negative reactions to a therapist's well-intended efforts (Glasser, 1992; Kohut, 1972), and their difficultly accepting therapeutic interventions, as an indication of compromised empathic functioning. Similarly, acknowledging empathic fluctuations in terms of motivational disengagement or difficulty regulating an affective experience can also encourage therapists to recognize conditions that enable and motivate the patient's empathic engagement in order to encourage more flexible ways of interacting across interpersonal and social contexts. A shift to more proactive therapeutic understanding and interventions can ultimately replace the strong aura of condemnation that has been associated to prior views of narcissistic empathic functioning.

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