

# Narcissistic Pathology: Empirical Approaches

Kenneth N. Levy, PhD; Preeti Chauhan, MA; John F. Clarkin, PhD; Rachel H. Wasserman, MS; and Joseph S. Reynoso, PhD  
Psychiatric Annals, Volume 39, Issue 4, APRIL 2009

## CME EDUCATIONAL OBJECTIVES

1. Describe the historical context for development of the *Diagnostic and Statistical Manual of Mental Disorders*-based narcissistic personality disorder diagnosis.
2. Identify the empirical literature on the prevalence, comorbidity, subtypes, gender differences, and assessment procedures for narcissistic personality disorder.
3. Identify the treatment literature regarding narcissistic personality disorder.

## ABOUT THE AUTHOR

*Kenneth N. Levy, PhD; and Rachel H. Wasserman, MS, are with the Department of Psychology, Pennsylvania State University, University Park, Pennsylvania. Preeti Chauhan, MA; and John F. Clarkin, PhD are with Weill Cornell Medical College, New York, New York. Joseph S. Reynoso, PhD, is with Furman Counseling Center, Barnard College, New York.*

*Address correspondence to: Kenneth N. Levy, PhD, Department of Psychology, Pennsylvania State University, University Park, PA 16802; or e-mail klevy@psu.edu.*

*Dr. Levy and Dr. Chauhan have disclosed no relevant financial relationships.*

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## EDUCATIONAL OBJECTIVES OVERVIEW

In this second edition of *Psychiatric Annals* on Narcissistic Personality Disorder, the authors explore further implications of this disorder. A successful and sustained marriage (along with mature reciprocal loving) is difficult enough to achieve, and NPD makes it even more so. With love and marriage, parenting frequently follows (and many of us know the challenges of that task); here, too, NPD interferes. NPD can contribute to continuous dysfunction, distress, and difficult-to-treat comorbid mood disorders, perhaps in part because of persistent difficulties in relationships. With those particular difficulties in relationships with NPD, behavior also can become unmoored from ethical constraints and lead to criminality. Finally, groups can act in ways consistent with NPD with disastrous results.

These articles run the gamut from traditional psychoanalytic methods along with empirical and data-based studies that assess NPD. Integrating these two traditions can challenge clinicians but can mirror the rich complexity of trying to understand and help people with this troubling personality disorder.

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*Address correspondence to: Kenneth N. Levy, PhD, Department of Psychology, Pennsylvania State University, University Park, PA 16802; or e-mail klevy@psu.edu.*

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**N**arcissistic personality disorder (NPD) is characterized by a pervasive pattern of grandiosity, a sense of privilege or entitlement, an expectation of preferential treatment, an exaggerated sense of self-importance,

and arrogant, haughty behaviors or attitudes.<sup>1</sup> Although the concept of narcissism is often used in clinical and social settings, the actual diagnosis of NPD is controversial and of questionable validity.<sup>2,3</sup> Empirical investigations on NPD

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are limited, with much of the available literature being of a theoretical or clinical nature. With a few exceptions, the existing literature consists of sporadic studies rather than a cohesive line of research addressing a particular issue within NPD. In this article, we summarize and integrate the empirical literature on NPD focusing on the prevalence, assessment, and treatment. We conclude with recommendations for further research on unresolved



conceptual and methodological issues, with a particular focus on the diagnosis of this disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-V).

#### **BRIEF HISTORY OF THE CONCEPT**

The term narcissism originates from the Greek myth of Narcissus, a man who fell in love with his own image believing it to be of another and subsequently died when it failed to love him back. The legend of Narcissus has gone from being a relatively obscure story to becoming a popular, current day myth,<sup>4,5</sup> (with the coining of such terms as the “culture of narcissism” and the “me generation.”)

In 1925, Waelder was the first to articulate the concept of a narcissistic personality or character.<sup>6</sup> He described individuals with narcissistic personality as condescending, feeling superior to others, preoccupied with themselves and with admiration, and exhibiting a marked lack of empathy, often most ap-

parent in their sexuality, which is based purely on physical pleasure rather than combined with emotional intimacy. Although Freud wrote a paper on narcissism in 1914, he did not discuss it as a character type until 1931, after Waelder.<sup>7</sup> Between 1930 and 1960, several theorists including Horney,<sup>8</sup> Abraham,<sup>9</sup> and Reich<sup>10</sup> described narcissistic traits and speculated on its etiology and concomitant characteristics.

In 1961, Neimah described narcissism not only as a personality type but as a disorder coining the term “narcissistic

transitioned from a mixed polythetic/monothetic criteria set to an entirely polythetic criteria set. The interpersonal criteria, which originally included four parts (entitlement, interpersonal exploitativeness, alternating between extremes of overidealization and devaluation of self and others, and lack of empathy), were reduced to three parts through the elimination of alternating between extremes of overidealization and devaluation of self and others. The criterion that included grandiosity and uniqueness was split into two separate criteria, and a cri-

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### *Research suggests some discrepancy between the DSM-IV criteria of NPD and descriptions provided by clinicians.*

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terion about preoccupation with feelings of envy was added.<sup>11</sup> In 1967, Kernberg presented a clinical description of what he called narcissistic personality structure within a broader borderline personality organization.<sup>12</sup> He subsequently described the clinical characteristics of the disorder and provided that the diagnoses be made on readily observable behavior by distinguishing between normal and pathological narcissism.<sup>13</sup> Kernberg’s initial paper was followed by Kohut,<sup>14</sup> who introduced the term “narcissistic personality disorder.” Kernberg and Kohut’s writings on narcissism were prompted by an increased clinical interest in treating these patients, which in turn, stimulated further interest in the concept. Indeed, these two authors have been pivotal in shaping our current day understanding of NPD.

The DSM-III was the first to introduce NPD into official nosology.<sup>15</sup> Its inclusion stemmed from the widespread use of the concept by clinicians and emerging studies demonstrating its existence as a personality factor.<sup>16</sup> The criteria for NPD were mainly derived from the theoretical and clinical work of Kernberg, Kohut, and Millon,<sup>17</sup> with little empirical input. Since the DSM-III, the NPD criteria have

terion about preoccupation with feelings of envy was added.

Research suggests some discrepancy between the DSM-IV criteria of NPD and descriptions provided by clinicians. Westen and Shedler surveyed a large group of psychiatrists and psychologists from varying clinical orientations regarding the personality characteristics of their patients.<sup>1</sup> They found that the Axis II criteria captured most of the important features of NPD as seen in clinical practice. However, clinicians described narcissistic patients as more controlling, more likely to get into power struggles, and more competitive than the DSM-IV criteria suggests. Notably, these findings could be product of a referral bias rather than an inaccuracy in the DSM.

#### **PREVALENCE**

Not surprisingly, the prevalence rates for NPD vary by population, with estimates being the lowest for community samples, followed by those in outpatient settings, and then those in inpatient settings. For example, in the Baltimore Epidemiologic Catchment area, only about 0.1% of the sample met criteria for NPD,<sup>18</sup> while Zimmerman and col-



leagues found a prevalence of about 2.3% in psychiatric outpatients. Both studies utilized semi-structured clinician administered interviews.<sup>19</sup> In a consecutively admitted inpatient sample, 4% of adolescents and 6% of adults were diagnosed with NPD using structured interviews.<sup>20</sup> Clarkin et al found that 17% of patients reliably diagnosed with borderline personality disorder (BPD) were also diagnosed with NPD using a structured interview.<sup>21</sup> Similarly, Zimmerman and colleagues found significant overlap between NPD and other cluster B personality disorders.<sup>16,19</sup>

Studies of clinicians indicate that the prevalence of NPD may be higher in outpatient private practice settings than in hospital outpatient departments. For instance, in a survey of 1,901 clinicians (838 psychodynamic, 300 cognitive-behavioral, and 639 eclectic), randomly selected from the American Psychiatric Association and American Psychological Association, 76% reported treating patients with NPD.<sup>22</sup> Doidge and colleagues surveyed 510 psychoanalytically oriented clinicians, reporting on more than 1,700 patients in the United States, Australia, and Ontario, Canada. Psychoanalysts across the three countries reported that about 20% of their patients suffered from NPD, making it the top-ranked disorder in the United States and Ontario and the second-ranked disorder in Australia.<sup>23</sup> Westen and Arkowitz-Westen surveyed 238 experienced clinicians (36.4% psychiatrists, 63.6% psychologists; 44.8% psychodynamic, 16.1% cognitive-behavioral, and 34.3% eclectic) about patients in their practices. These clinicians utilized a diagnostic Q-sort procedure and reported on 714 patients.<sup>24</sup> Overall, 8.5% of the patients were reported to have NPD. Differences emerged between orientations with psychodynamic clinicians reporting the highest presence of NPD in their case load (11.2%); followed by eclectic (5.7%), and then cognitive-behavioral clinicians

(3.9%). This difference in rates between clinicians of different orientations might reflect: 1) greater sensitivity to the disorder by psychodynamic clinicians; 2) an overdiagnosis of, selective attention to, the disorder by psychodynamic clinicians; or 3) different conceptualizations of the disorder. Alternatively, it may reflect relatively accurate base rates in different types of clinical practices. Notably, DiGiuseppe, Robin, Szeszko, and Primavera reported a prevalence of 14% (out of 742 patients) using the cut-off for NPD on the Millon Clinical Multiaxial Inventory, second edition (MCMI-2) in a cognitive-behavioral outpatient clinic.<sup>25</sup>

#### DIAGNOSIS

Since its introduction in the DSM-III, considerable controversy exists on whether NPD is a distinct diagnostic entity. The overt characteristics of NPD as defined in DSM-IV, such as grandiosity, a desire for uniqueness, a need for admiring attention, and arrogant, haughty behaviors, have generally been confirmed by research.<sup>26-28</sup> For instance, research using the Diagnostic Interview for Narcissism (DIN)<sup>29</sup> found that certain characteristics discriminate narcissistic patients from other psychiatric patients: boastful and pretentious behavior, self-centered and self-referential behavior, and the belief that other people envy them because of their special talents or unique abilities.<sup>30</sup> In addition to the DSM criteria, several others diagnostic schemes have been proposed in the literature. Akhtar and Thomson<sup>31</sup> as well as Kernberg<sup>32</sup> have provided the most systematic conception of NPD from a psychoanalytic standpoint, while Beck and Freeman<sup>33</sup> have proposed a cognitive conception. According to the cognitive model, each personality disorder can be classified by the content of the individual's cognitive distortions, conditional beliefs, and maladaptive core beliefs. They theorize that narcissistic individual's core beliefs include "Since I am special,

I deserve special dispensations, privileges, and prerogatives;" "I am superior to others, and they should acknowledge this;" and "I'm above the rule."<sup>33</sup> Research has found that specific dysfunctional thought patterns were generally related to corresponding personality disorders, although most thoughts patterns lacked specificity.<sup>34</sup> For example, narcissistic thought patterns were significantly associated with NPD but also with histrionic, avoidant, dependent, paranoid, and obsessive-compulsive thought patterns. Beck and colleagues found that narcissistic dysfunctional beliefs were higher in patients diagnosed with NPD as compared with those diagnosed with avoidant, dependent, obsessive-compulsive, and paranoid personality disorders.<sup>35</sup> However, whether narcissistic dysfunctional thought patterns were higher in patients with NPD compared with histrionic, antisocial, and borderline patients was not examined but would have provided a more stringent test of specificity. Narcissistic dysfunctional thought patterns were highly correlated with histrionic and antisocial dysfunctional thought patterns.

#### ASSESSMENT

Clinicians and researchers draw from five main sources when assessing personality disorders: 1) self-report inventories, rating scales and checklists, 2) clinical interviews and ratings, 3) projective techniques, 4) informants, and 5) physiological measurements (neurotransmitter or hormone levels).<sup>36</sup> The first three methods will be discussed here, as little data exist on the last two sources.

The most widely used self report instruments in assessing personality disorders including NPD are the MCMI-3,<sup>37</sup> the Personality Diagnostic Questionnaire-4th Edition (PDQ-4),<sup>38</sup> the Personality Assessment Inventory (PAI),<sup>39</sup> and the Dimensional Assessment of Personality Pathology-Basic Questionnaire.<sup>40</sup> Self-report scales have been developed

specifically to assess narcissism. Some have been based on DSM-III criteria and include the Narcissistic Personality Inventory (NPI),<sup>41</sup> and the Narcissistic Personality Disorders Scale (NPDS).<sup>42</sup> Others have been developed from theoretical perspectives and include the Superiority and Goal Instability Scales,<sup>43,44</sup> and the Bell Object Relations and Reality Testing Inventory (BORRTI).<sup>45</sup> Recently, Pincus and colleagues developed the Pathological Narcissism Inventory (PNI), which in initial validity studies performed superior to the NPI.<sup>46</sup>

Theorists have suggested that the five-factor model of personality may be helpful in conceptualizing personality disorders. Although controversial,<sup>47,48</sup> a review of a number of studies suggest that there is a strong, positive correlation between NPD and extraversion, a strong negative correlation with agreeableness, and a moderate negative correlation with conscientiousness.<sup>16,49</sup> Findings regarding the relationship with neuroticism and openness to experience have been inconsistent and may be related to the distinction between overt and covert narcissism (with covert narcissism being positively related to neuroticism and overt narcissism being negatively related to neuroticism).

Research examining the facets underlying the five factors could provide a more nuanced picture and better validity data for NPD. For instance, it is likely that within the overarching extraversion factor, the facet of dominance is related to narcissism but the facet of warmth is not. Likewise, research examining more differentiated aspects of NPD may help to better characterize the disorder.<sup>50</sup> For example, Bradlee and Emmons found that the authority subscale of the NPI was positively related to the conscientious factor and that the superiority subscale of the NPI was positively related to the openness to experience factor. Lorange found that exhibitionism, assertiveness, and ambition loaded positively

on the narcissism scale and that modesty and sincerity loaded negatively.<sup>51</sup> Shedler and Westen found that an expanded criteria set provided a conceptually richer factor solution that resulted in 12 factors, relative to the five-factor model. They concluded that the five-factor model is useful for layperson descriptions of normal range personality features, but it omits important clinical constructs and does not capture the complexity of personality pathology.<sup>52</sup>

There are a number of structured interviews for DSM personality disorders that assess NPD, including the Structured Interview for DSM Personality Disorders-Revised (SIDP-R),<sup>53</sup> Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II),<sup>54</sup> International Personality Disorders Examination (IPDE),<sup>55</sup> Personality Disorder Interview-IV (PDI-IV),<sup>56</sup> Diagnostic Interview for Personality Disorders (DIPD),<sup>57</sup> and the Personality Assessment Schedule (PAS).<sup>58</sup> Gunderson's DIN appears to be the only interview measure designed to exclusively assess NPD.<sup>29</sup> There is some concern among clinicians and researchers that structured interviews may under diagnose NPD because of the face validity of the questions and the tendency of narcissistic individuals to deny undesirable symptoms and traits. Interviews like the IPDE account for this issue in two ways. First, they often have a criterion that is explicitly observer based (eg, haughty behavior during the interview). Second, the interviewer can rate a criterion based on all available information during the interview or from an informant (informant information is often useful in assessing narcissistic individuals). With regard to additional information during the interview, it is common for an interviewee to deny a criterion but provide evidence that contradicts their denial.

Two observer- or clinician/interviewer-rated instruments have been developed for assessing personality disorders broadly but can be used specifically for

assessing NPD. These are the Personality Assessment Form (PAF)<sup>59</sup> and the Shedler-Westen Assessment Procedure (SWAP).<sup>60</sup> The PAF provides a brief paragraph describing important features of each personality disorder and asks the evaluators to rate an individual on a six-point scale. While clinically rich, this instrument does not allow for systematic assessments. The SWAP is a 200-item Q-set of statements describing personality traits and is designed to quantify clinical judgment. Clinicians are directed to arrange the items into eight categories with a fixed distribution, ranging from those that are not descriptive of the patient to those that are highly descriptive of the patient. The SWAP has demonstrated a reduction in comorbidity with other personality disorders, especially among cluster B personality disorders.

## SUBTYPES

Theoretical and empirical work suggests that NPD is not a homogenous disorder, and subtypes likely exist within this group. Distinguishing between NPD subtypes may assist with diagnostic clarity, assessment, course, and treatment. Several prominent theories and a few empirical studies are summarized here.

Kernberg classified narcissism along a dimension of severity from normal to pathological and distinguished between three levels of pathological narcissism: high-, middle-, and low-functioning groups.<sup>61</sup> At the highest level, patients are able to achieve the admiration necessary to gratify their grandiose needs. These patients may function successfully during their lifetime, but are susceptible to breakdowns with advancing age as their grandiose desires go unfulfilled. At the middle level, patients present with a grandiose sense of self and have little interest in true intimacy. At the lowest level, patients present with comorbid borderline personality traits. These patients sense of self is generally more diffuse and less stable; they are frequently vacillating be-

tween pathological grandiosity and suicidality. Finally, Kernberg also identified an NPD subtype known as malignant narcissism. These patients are characterized by the typical NPD; however, they also display antisocial behavior, tend toward paranoid features, and take pleasure in their aggression and sadism toward others. Malignant narcissists are at high risk for suicide, despite the absence of depression, given that suicide for these patients represents sadistic control over others, a dismissal of a denigrated world, or a display of mastery over death.

The overt type is characterized by grandiosity, attention seeking, entitlement, arrogance, and little observable anxiety. These individuals can be socially charming despite being oblivious of others' needs, interpersonally exploitative, and envious. In contrast, the covert type is hypersensitive to others' evaluations, inhibited, manifestly distressed, and outwardly modest. Gabbard described these individuals as shy and "quietly grandiose," with an "extreme sensitivity to slight," which "leads to an assiduous avoidance of the spotlight."<sup>65</sup> Both

the Compensating group reported high levels of emotional vulnerability. The True and Detached groups were similar except that the Detached group was characterized by extreme interpersonal avoidance. More recently, using Q-factor analysis for all patients meeting criteria for NPD, Russ, Shedler, Bardley and Westen also found three subtypes: 1) Grandiose/Malignant, 2) Fragile, and 3) High Functioning/Exhibitionistic.<sup>74</sup>

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*The overtly narcissistic individual most frequently presents with grandiosity, exhibitionism, and entitlement.*

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Kohut and Wolf described three subtypes based on interpersonal relationships.<sup>62</sup> "Merger-hungry" individuals must continually attach and define themselves through others; "contact shunning" individuals avoid social contact because of fear that their behaviors will not be admired or accepted; and "mirror-hungry" individuals tend to display themselves in front of others.

Millon conceptualized NPD as a prototype and distinguished among several variations or subtypes in which the basic personality style may manifest itself.<sup>63</sup> These subtypes represent configurations of a dominant personality style (eg, NPD) and traits of other personality styles. For example, in addition to meeting criteria for NPD, his Amorous subtype would show elevations in histrionic traits; his Unprincipled subtype would show elevations in antisocial traits; his Compensatory subtype would show elevations in avoidant and/or passive-aggressive traits. To date, little research has been performed to establish the reliability or validity of Millon's distinctions.

Several researchers have suggested that there are two subtypes of NPD: an overt form and a covert form.<sup>31,64-66</sup>

types are extraordinarily self-absorbed and harbor unrealistic, grandiose expectations of themselves. This overt-covert distinction has been empirically supported in at least six studies.<sup>67-72</sup> Kernberg noted that the overt and covert expressions of narcissism may actually be different clinical manifestations of the disorder, rather than discrete subtypes.<sup>73</sup> He contended that narcissistic individuals hold contradictory views of the self, which vacillate between the clinical expression of overt and covert symptoms. Thus, the overtly narcissistic individual most frequently presents with grandiosity, exhibitionism, and entitlement. Nevertheless, in the face of failure or loss, these individuals will become depressed, depleted, and feel painfully inferior.

DiGiuseppe, Robin, Szeszko, and Primavera found three clusters of narcissistic patients in an outpatient setting.<sup>25</sup> They named these clusters: 1) the True Narcissist; 2) the Compensating Narcissist; and 3) the Detached Narcissist. Patients in all three clusters exhibited self-centeredness and entitlement. However, patients in the True and Detached groups reported experiencing little emotional distress. In contrast, patients in



Grandiose narcissists were described as angry, interpersonally manipulative, and lacking empathy and remorse; the grandiosity is not defensive or compensatory. Fragile narcissists demonstrated grandiosity under threat (defensive grandiosity) and experience feelings of inadequacy and anxiety indicating that they vacillate between superiority and inferiority. High-functioning narcissists were grandiose, competitive, attention seeking and sexually provocative. They tended to show adaptive functioning and utilize their narcissistic traits to succeed.

#### **COMORBIDITY**

Empirically examining the co-occurrence or comorbidity of personality disorders allows researchers to determine whether theoretically discrete disorders exist.<sup>1,75-77</sup> NPD has had problematically high overlap with other Axis II disorders, most notably antisocial, histrionic, borderline, and passive-aggressive personality disorders, with rates often exceeding

50%.<sup>78-84</sup> For instance, Pfohl et al found that 80% of patients meeting criteria for NPD also meet criteria for BPD.<sup>85</sup> Of course, the comorbidity between NPD and BPD is not surprising given that DSM-III criteria were derived from Kernberg's clinical formulations of NPD, which were based on a sample of patients with a primary diagnosis of BPD.<sup>12-13,61</sup> Nonetheless, the co-occurrence or comorbidity of NPD with other disorders,

uals with bipolar disorder.<sup>16</sup> Prevalence rates were much higher when the patients were actively hypomanic or manic compared with when they were euthymic. A recent study using cross lag associations found that hypomanic symptoms predict narcissistic personality disorder features among suicidal young adults.<sup>89</sup> These studies suggest that mania should be considered in the differential diagnosis of NPD, the criteria for NPD and mania

tive type (covert) being stereotypically female.<sup>16</sup> Empirical support for this contention remains equivocal.

Although some studies have found a greater prevalence rate of NPD among men,<sup>30,94-97</sup> others fail to find such gender differences.<sup>98-103</sup> Ekselius and colleagues<sup>104</sup> and Richman and Flaherty<sup>105</sup> found no differences between men and women in narcissism at the categorical diagnostic level; however, both groups of researchers found gender differences at the criteria level. Richman and Flaherty found that men scored significantly higher on five of the six traits, with women scoring significantly higher only on the criteria of becoming upset over slights.<sup>105</sup> Ekselius et al found gender differences on four criteria: 1) self-importance; 2) fantasies of unlimited power, success, beauty; 3) believes self to be special or only understood by special people; and 4) lacks empathy; and envious of others or believes others are envious of them.<sup>104</sup> Women scored higher on three of the four criteria, the exception being criteria number 3.

The findings regarding gender differences in dimensional scores on narcissism are also inconsistent. Although research has demonstrated that men typically score somewhat higher on average than women on dimensional measures of narcissism,<sup>106-112</sup> other studies have found that women score higher on dimensional measures than men,<sup>113,114</sup> while Tschanz et al found highly similar patterns of narcissism.<sup>111</sup> However, the NPI exploitiveness/entitlement factor was not as well integrated into the profile of narcissism for women. When gender differences were found, they tended to be small and of questionable meaningfulness.<sup>106,115-116</sup> In addition, it is unclear if, or how, gender moderates the relationship between narcissism and behavior, or other important variables, in systematic ways. Therefore, the empirical support for gender differences remains ambiguous.

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*Although grandiosity had differentiated NPD patients from BPD in an earlier study, it did not predict stability of the disorder over time.*

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although not unique to NPD, is a major problem in justifying and maintaining its validity as a distinct clinical entity.<sup>26,86-87</sup>

Comorbidity can be examined within samples of patients diagnosed with NPD or by examining the rates of NPD among individuals with other disorders. Using the former approach, Ronningstam and Gunderson, in two samples of NPD patients (38 inpatients and outpatients and 34 consecutively admitted outpatients) reported that 42% and 50% of the patients, respectively, were comorbid with a depressive mood disorder, 24% and 50% were comorbid with a substance abuse disorder, and 5% and 11% were comorbid with bipolar disorder.<sup>87</sup> Ronningstam reviewed the available literature on NPD and Axis I disorders and found that 12% to 38% of patients with substance use disorder, and 4% to 47% of those with bipolar disorder were also diagnosed with NPD. Thus, this suggests that there is considerable variability in the comorbidity rates of NPD and Axis I disorders.<sup>88</sup> The reasons why are unclear, however, one interpretation that can be distilled from these findings is that no single Axis I disorder was most often associated with NPD. Studies have found higher than average prevalence of NPD among individ-

need to be more clearly differentiated, and mania or hypomanic symptoms may lead to an increase in NPD traits.

With regard to Axis II disorders, McGlashan and colleagues, in the Collaborative Longitudinal Personality Disorder Study, found that 8% of BPD patients were comorbid for NPD.<sup>90</sup> This percentage did not differ from schizotypal or obsessive-compulsive personality disorders, but was significantly higher than for avoidant personality disorder.

## **GENDER AND AGE DIFFERENCES**

### **Gender**

The DSM-IV states that NPD is more common in men than in women. The analysis of gender differences in narcissism is complicated by the fact that the DSM's definition of NPD is based on clinical descriptions of case studies on male patients.<sup>61,91-92</sup> Consequently, several theorists have raised questions with regard to narcissism, as defined by the DSM, being generalized to women.<sup>31,93</sup> Several authors have suggested that the distinction between covert and overt narcissism may divide along gender lines, with the grandiose type (overt) being stereotypically male and the hypersensi-



## Age

The presence of narcissistic disturbances has been demonstrated in both children<sup>117-119</sup> and adolescents.<sup>20,120-122</sup> In a consecutively admitted inpatient sample of adolescents, Grilo et al<sup>20</sup> found that 4% of the inpatients were reliably diagnosed with NPD using structured interviews. Bernstein et al, in a longitudinal study, found that the rates of NPD decreased from 11 to 14 years to ages 18 to 21 years.<sup>120</sup> NPD has also been found in the elderly.<sup>123-127</sup>

## COURSE AND LONG-TERM OUTCOME

There is little systematic data on the long-term course and outcome of NPD. Studies that do exist reveal inconsistent findings. For instance, Plakun compared the long-term (approximately 14-year) outcome of NPD and BPD.<sup>100</sup> NPD patients demonstrated worse outcomes; they were more likely to have been readmitted and had poorer overall functioning and sexual satisfaction. On the other hand, McGlashan and Heinssen found no differences over time in global functioning between NPD and BPD patients (provided there was no antisocial comorbidity) but did find that individuals with NPD demonstrated a decrease in destructive interpersonal behaviors.<sup>86</sup> Ronningstam, Gunderson, and Lyons found that the majority of their patients (60%) who initially had NPD showed significant improvement in their levels of pathological narcissism at the 3-year follow-up.<sup>128</sup> Although grandiosity had differentiated NPD patients from BPD in an earlier study, it did not predict stability of the disorder over time.<sup>30</sup>

A more recent longitudinal study by Cramer and Jones found that willful and hypersensitive narcissists who also use identification as a defense mechanism experience negative psychological health.<sup>132</sup> On the other hand, autonomous narcissists did not demonstrate this decrease in psychological health.

Three events might promote change in narcissistic pathology: 1) corrective achievements; 2) corrective disillusionments; and 3) corrective relationships.<sup>128</sup> With regard to stability of NPD, Ferro et al found low stability in a 30-month follow-up of depressed outpatients, particularly compared with other personality disorders.<sup>129</sup> In fact, baseline NPD was more highly correlated with the other disorders than with itself. In contrast, Grilo, Becker, Edell, and McGlashan found that dimensional scores of narcissism were stable over a 2-year follow-up.<sup>130</sup> These findings may be highly sample-dependent, which makes them difficult to interpret and may limit their generalizability. Some of the studies involved inpatient samples, whereas others involved outpatients. For some patients, NPD was the primary or only disorder, and for other patients NPD was a comorbid disorder (with depression or borderline personality disorder). The use of non-consecutive samples complicates the interpretation of the data because the groups may be skewed in some undefined way. For example, those patients agreeing to participate may be more engaged with their therapists or may be more distressed, both of which are patient factors that have been related to better outcome.<sup>131</sup>

## TREATMENT RESEARCH

Treatment recommendations for patients with NPD are based primarily on clinical experience and theoretical formulations. Clinical case studies illustrate that some patients with NPD can be treated successfully while others often fail to respond to treatment. Patients with NPD are often difficult to treat because they are unable to admit weaknesses, appreciate the effect of their behavior on others, or fail to incorporate feedback from others.

Although there are no randomized, controlled treatment studies on NPD, there are a number of studies of patients with personality disorders or Axis I disorders that have included patients with

NPDs.<sup>133,134</sup> The heterogeneous nature of the samples makes these studies difficult to interpret. The naturalistic study by Teusch, Bohme, Finke, and Gastpar is an exception.<sup>135</sup> They examined the impact of client-centered psychotherapy (CCT) for personality disorders alone and in combination with psychopharmacological treatment. For NPD, they found that CCT, as compared with CCT + Medication, led to greater reductions in depression. The authors speculated that the CCT-only group experienced more autonomy and self-efficacy. Further, the medication regimens may have a negative effect on PD patients given the relative difficulty in medicating these patients. Callaghan, Summers, and Weidman presented single-subject data on a patient with histrionic and narcissistic behaviors who was treated with functional analytic psychotherapy.<sup>136</sup> They found significant changes in in-session narcissistic behaviors. Using lag sequential analysis, they linked these changes to therapist responses to in-session patient behavior. However, the researchers did not assess any external outcomes and thus these in-session changes were not linked to any external measures of improvement. In terms of the course of psychotherapy, Hilsenroth et al found that NPDed patients had the largest percentage of drop-out (64%), with the criterion "requires excessive admiration" being significantly related to drop-out.<sup>137</sup>

Cain, Levy, and Pincus found that subscales of narcissism impacted the course and outcome of psychotherapy in an outpatient population of Axis I disordered patients.<sup>138</sup> Specifically, they found that grandiosity was not related to treatment utilization but was related to symptom severity and course of treatment. On the other hand, narcissistically vulnerable individuals were more likely to seek treatment and their scores were associated with symptom change. The authors concluded that vulnerable

narcissists experience distress and seek treatment, whereas grandiose narcissists experience equal levels of distress but minimize or neglect their distress by not seeking treatment.

Follow-up studies in treatment samples, generally speaking, have demonstrated improvement over time. Ronningstam et al's prospective study obtained retrospective information about treatment experiences and found

interviews to assess Axis II disorders. Existing data demonstrates that NPD is prevalent enough to be included in the DSM-V. A number of limitations in the literature should be addressed for DSM-V. First, research on NPD has not examined the concordance between DSM-IV criteria and the essential features of the disorder as seen in clinical practice. Research by Westen and colleagues has begun looking at this process and if rep-

general agreement on the clinical presentation of narcissism, focusing on the feelings of exaggerated self-importance, privilege, grandiosity, and the expectation of special treatment, there is little consensus on the etiology, prevalence, assessment, and dynamics of the disorder. Even though the disorder has been officially recognized for almost three decades, there is a paucity of research on the course, treatment, and outcome, with the available studies typically based upon small or selected samples of patients with a relatively short follow-up. In general, these studies suggest that patients with NPD improve over time. One study suggests there may be meaningful subgroups of these patients with differential status over time. Given the clinical interest and the documented impairment of patients with NPD, more programmatic research on prevention and intervention are needed.

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### *Pharmacological treatment of NPD without Axis I comorbidity has not been sufficiently studied.*

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that treatment utilization was not differentially distributed among the patients who improved and those who did not.<sup>127</sup> However, the treatment reports were not sufficiently detailed or structured to draw valid conclusions.

Pharmacological treatment of NPD without Axis I comorbidity has not been sufficiently studied. Abramson presented a series of case studies in which he prescribed the benzodiazepine and lorazepam adjunctively in the treatment of patients with "narcissistic rage."<sup>139</sup> In all three cases, lorazepam resulted in relief from tensions associated with feeling slighted and angry, with minimal adverse effects. However, it is not clear from the case reports that any of the patients met criteria for NPD. In addition, there are a number of important limitations of case report methodology.<sup>140</sup> Given the absence of controlled trials, lack of data in general, and the limitations of the studies carried out thus far, treatment guidelines for the disorder are yet to be formulated.

#### **RECOMMENDATIONS FOR FURTHER RESEARCH**

Research on NPD is still in a nascent stage. The data that is available is based largely on systematic assessments of patient groups using structured clinical

interviews to assess Axis II disorders. Existing data demonstrates that NPD is prevalent enough to be included in the DSM-V. A number of limitations in the literature should be addressed for DSM-V. First, research on NPD has not examined the concordance between DSM-IV criteria and the essential features of the disorder as seen in clinical practice. Research by Westen and colleagues has begun looking at this process and if replicated suggests that DSM-V broaden the criteria set to include assessment of controlling behaviors, the tendency to engage power struggles, and the more competitive aspects of the disorder.<sup>1</sup> Second, patients who meet criteria for NPD often meet criteria for another Axis II disorder. Future research will need to discriminate NPD from other axis II disorders or may suggest that there is an NPD variant of these disorders. Again, research by Westen and colleagues has shown that broadening the NPD criteria set significantly reduces the overlap with other Axis II disorders.<sup>1</sup> In addition to these two issues there is a desperate need for methodologically sound studies that examine the etiology, course, and/or treatment response of NPD. Ultimately, the value of the diagnosis will rest with whether or not it is useful for predicting adult outcomes and treatment response.

#### **CONCLUSIONS**

Narcissistic character, disorder, and/or organization was first articulated in 1925 by Waelder, and further expanded by Nemiah, Kernberg, Kohut, and Milon. The diagnosis of NPD was introduced into the official diagnostic system in 1980 with the DSM-III and was heavily based upon clinical writings rather than research. Although there is

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