

NARCISSISTIC PERSONALITY DISORDER IN DSM V—IN SUPPORT OF RETAINING A SIGNIFICANT DIAGNOSIS

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Narcissistic personality disorder, NPD, has been excluded as a diagnostic category and independent personality disorder type in the Personality and Personality Disorder Work Group's recent proposal for DSM-5 Personality and Personality Disorders. **The aim of this paper is to present supporting evidence in favor of keeping NPD as a personality type with a set of separate diagnostic criteria in DSM-5.** These include: the prevalence rate, extensive clinical and empirical reports and facts, its psychiatric, social and societal significance especially when associated to functional vocational and interpersonal impairment, social and moral adaptation, and acute suicidality. **Proposals for a clinically relevant and empirically based definition of narcissism, a description of the narcissistic personality disorder type, and a set of diagnostic criteria for NPD are outlined.**

The transformation from psychoanalytic theory and descriptions to meet standards for taxonomy and inclusion in the DSM III in 1980 initiated a complicated process of formalizing the concept of narcissism and defining the diagnosis of narcissistic personality disorder, NPD. The limitations of DSM- Axis II diagnosis, in particular the failure to capture the full range of personality pathology and identify patients whom clinicians consider having personality disorders diagnosis, have been especially consequential for NPD (Morey & Jones, 1998; Gunderson, Ronningstam, & Smith, 1996; Westen & Arkowitz-Westen, 1998). **People with traits of pathological narcissism that range beyond the DSM criteria set, or people who have less severe or less overt narcissistic pathology and do not meet any combination of five required criteria, will consequently not be correctly identified.** In addition, central aspects of the clinical base for identifying pathological narcissism and NPD, including the individual's internal distress and often painful experiences of self-esteem fluctuations, self-criticism, and emotional dysregulation within the interpersonal context, are not adequately captured. **Russ, Shedler, Bradly, and Westen (2008) found several aspects of personality functioning and internal experiences not captured in the DSM criteria, such as interpersonal vulnerability, emotional distress, and**

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affect dysregulation. Pincus and Lukowitsky (2010) concluded that “relying solely on the DSM-IV criteria may impede clinical recognition of pathological narcissism” (p. 430). With the DSM’s heavy reliance upon grandiosity and external, social, and interpersonally conspicuous behavior, the diagnosis has not been informative and guiding. This has contributed to a considerable discrepancy between the clinicians’ definition and usage of the NPD diagnosis compared to the official criteria set. Hence, there is reluctance among clinicians to use the diagnosis, and patients strongly oppose being “labeled” NPD, conceiving it as prejudicial. There is a call for integration and applicability of the vast accumulated knowledge on narcissism and NPD, especially its impact on Axis I disorders and suicidality.

While not associated with societal urgency or notable public or mental health costs, NPD has still met increasing recognition as an urgent and complicated mental condition connected to significant personal, interpersonal, and work-related problems with organizational and societal consequences (Maccoby, 2000; Miller, Campbell, & Pilkonis, 2007; Penny & Spector, 2002; Stone, 2009; Ronningstam & Maltzberger, 1998; Volkan & Fowler, 2009). Several reviews have summarized the accumulated evidence relevant to present and future diagnosis of NPD (Cain, Pincus, & Ansell, 2008; Levy, Reynoso, Wasserman, & Clarkin, 2007; Pincus & Lukowitsky, 2010; Ronningstam, 2005a, 2009, 2010). Studies in support of identifying, diagnosing and treating pathological narcissism, and NPD can now frequently be found in journals of clinical psychology, psychiatry, and psychoanalysis. Research in the academic social and personality psychology have identified trait narcissism in nonclinical samples. In clinical psychology and psychiatry the studies of NPD as a pervasive personality pattern of grandiosity (in fantasy and behavior), need for admiration and impaired empathic ability have, despite the limitations in clinical applicability and utility of the diagnosis, still verified its prevalence (Stinson et al., 2008; Torgersen, Kringlen, & Cramer, 2001), heritability (Torgersen et al., 2000), validity (Gunderson & Ronningstam, 1991), factor analytic structure (Fossati et al., 2005; Miller, Hoffman, Campbell, & Pilkonis, 2008), and changeability (Ronningstam, Gunderson, & Lyons, 1995). Although the two avenues of studies, the academic and the clinical, have remained relatively separate, recent efforts to integrate and find common denominators are most important and promising (Pincus et al., 2009).

With this briefly summarized background the purpose of this article is to oppose the DSM-5 Personality and Personality Disorder Work Group’s proposal to exclude NPD as a separate personality disorder type and critique the diagnostic approach to and suggested traits for NPD.

PREVALENCE AND CLINICAL UTILITY

The information regarding the prevalence and clinical utility of NPD based on the DSM criteria set has so far been evaluated in ways that often fail to take into account the range of functioning and phenotypic presentations

in narcissistic people. Nevertheless, there is significant evidence in support of an adequate prevalence rate, i.e., 6% life time in general population (Stinson et al., 2008), with up to 20% in specific populations, justifying the inclusion of NPD in DSM-5 (for detailed review of prevalence see Ronningstam (2009) and Levy et al. (2007)). There are specific difficulties identifying narcissistic personality functioning when co-occurring with Axis I disorders with predominant symptomatology such as substance use, eating disorder, bipolar spectrum disorder, depressive disorder or atypical mood disorder (Ronningstam, 1996; Simonsen & Simonsen, 2010). The actual narcissistic pattern or potential for developing a personality disorder may not be fully manifested in higher functioning people until there is a change, a corrosive life event, a personal crises, or an acute onset of Axis I disorder(s) (Ronningstam, Gunderson, & Lyons 1995; Simon, 2001). Even in such cases, the differentiation of Axis I symptoms from narcissistic personality traits and the identification of the NPD diagnosis, may be challenging and require longer and more in-depth contact in a treatment setting. In functionally disabled people the predominance of Axis I symptomatology may overshadow the narcissistic personality functioning, and only be evident under certain circumstances.

There are reasons to assume that prevalence rates of NPD have been influenced by research methods (self-reports, semi-structured interviews, observer ratings) and the way that specific narcissistic functioning and NPD features can be accurately captured versus underestimated or even bypassed by each method. For instance, higher prevalence rates have been found in studies using clinicians' ratings (Levy, Chauhan, Clarkin, Wasserman, & Reyonoso, 2009). Other methods for rating are more reliant upon the narcissistic individuals' specific protective and regulatory patterns, such as control, avoidance, self-enhancement, shame, and denial (Horowitz, 2009), and accompanying compromised abilities for self-evaluation, self-directed empathy, and self-disclosure. The discrepancy between their interpersonal appearance and relatedness (Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009), and their internal experiences and reasoning (Horowitz, 2009), combined with limitations in their willingness or ability for self-disclosure, certainly both limit and bias accurate diagnostic evaluations based on self-rating and interpersonal disclosure. This has also invited to an over reliance on external behavioral traits and indications of exaggerated self-esteem as the base for diagnosis. In addition, reasons for seeking psychiatric treatment or psychotherapy most often relate to external life crises and onset or aggravation of Axis I disorders, or to complaints or ultimatums from family or employers associated with sometimes limited sense of own suffering or contributions to others' distress (Miller, Cambell, & Pilkonis, 2007).

Laboratory studies have succeeded in identifying numerous specific patterns relevant for narcissistic functioning in nonclinical samples; i.e., mood variability, self-esteem instability, emotional dysregulation, especially anger and aggression, interpersonal reactivity, memory functioning, etc., (Kernis & Sun, 1994; Rhodewalt & Eddings, 2002; Rhodewalt, Man-

drian, & Cheney, 1998; Twenge & Campbell 2003). Such studies have been designed in ways that lessen the restricting impact of narcissistic avoidance, control and self-protection on the evaluation of task performance and situational experiences.

A number of studies within several areas of inquiry have recently added substantial knowledge on pathological narcissism and NPD. More comprehensive and clinically diversified portraits of NPD have been obtained through clinicians' ratings (Russ et al., 2008). Psychoanalytic case studies and detailed narratives of treatment process and technique have served to inform about how specific narcissistic personality patterns interact with therapeutic interventions (Almond, 2004; Jorstad, 2001; Kernberg, 2007; Maldonado, 1999, 2003). Studies in metacognitive therapy have identified states of mind, and dysfunctional dialogues and interactional patterns in people with NPD that negatively affect the therapeutic alliance (Dimaggio, Fiore, Salvatore, & Carcione, 2007; Dimaggio et al., 2008; Dimaggio et al., 2006). In the field of personality psychology efforts to develop a construct and measure of pathological narcissism to complement and integrate with the accumulated number of studies on narcissism within the relatively functional range, are notable and promising (Pincus et al., 2009; Tritt, Ryder, Ring, & Pincus, 2010).

THE DSM-5 PROPOSAL FOR PERSONALITY DISORDERS

The proposed model for personality disorders in DSM-5 have four components: (1) four general diagnostic criteria for personality disorders; (2) five levels of self and interpersonal personality functioning (degree of impairment); (3) five major personality disorder types described; and (4) 37 personality trait facets organized under six personality trait domains (see: www.dsm5.org). Narcissism as a general dimension for normal personality functioning, including regulation of self and self-esteem, self-coherence, uniqueness, interpersonal affiliation and relativeness, and empathic capability (Ronningstam, 2005b; Stone, 1998) has been relatively well integrated in the proposed 5 levels of personality functioning (Bender, 2010). Variable range of self and self-esteem from aggrandizement to deflation and self-loathing, unrealistic expectations of others, and exaggerated personal standards are indications of mild to severe levels of impairment in general personality functioning. Of specific importance is the Work Group's acknowledgment of empathic capability as a skill with several components, including a regulatory role and a functional range. This is in line with recent research (Decety & Jackson, 2004) and most significant for accurately diagnosing the fluctuating and regulatory empathic patterns of NPD.

NPD IN THE DSM-5 PROPOSAL

While narcissism as a dimension for general personality functioning is incorporated in the proposal for DSM-5 personality disorder section, narcissistic personality disorder, NPD, as a separate personality disorder type

and diagnostic category has been excluded. This is a remarkable and most consequential decision. In the proposed system, NPD has been replaced by four personality trait facets: Narcissism, Manipulativeness, Histrionism, and Callousness, included under the trait **domain Antagonism**. Other traits that clinically and empirically have been associated with NPD can be found under the **domains Negative Emotionality, (i.e., Shame, Low Self-Esteem, Depressivity, and Anxiousness)**, and Compulsivity, (i.e., Perfectionism; Bender, 2010). This scattered trait approach, i.e., constructing or covering a diagnosis based on separate traits from different domains shared by other personality types, prevents an integrated and specific, clinically-meaningful and informative conceptualization of narcissistic personality functioning which is necessary to further improve its clinical utility.

GENERAL LIMITATIONS IN THE DSM-5 PROPOSAL AFFECTING NPD

While the DSM-5 Work Group have outlined an ambitious proposal for diagnosing personality disorder that adhere to some of the advanced theoretical and empirical standards in the field, there is a striking and significant lack of integration of clinical knowledge and applicability. The proposal also represents an effort to reduce and streamline the diagnostic criteria for personality disorders. Unfortunately, this ambition has specific consequences for NPD as some of the most important facets and traits of NPD (Morey & Jones, 1998; Russ et al., 2008) will not be included. Critique towards the overall proposal stated elsewhere (Gunderson et al., 2010) highlights some of the major difficulties, i.e., the complicated structure of the proposed system, the radical changes compare to the previous DSM systems, and the gap between the suggested personality types, traits and models, and clinical practice and utility.

There are several serious problems and disadvantages with regards to identifying and diagnosing pathological narcissism and disordered narcissistic personality functioning with the present proposal. The elimination of NPD as a separate personality disorder type and the idea of replacing it with a set of unconnected and unintegrated traits will risk to:

1. Complicate or discourage a proactive and informative usage of the NPD diagnosis
2. Undermine or prevent ongoing and future efforts to identify narcissism and NPD relevant to clinical studies and utilization.
3. Weaken or disrupt the promising work in progress on developing treatment strategies for people who indeed suffer from pathological narcissism and NPD.
4. Discourage or eliminate the connection of NPD as a significant triggering or accompanying factor in a range of problems from interpersonal, marital and work related to severe psychiatric conditions such as suicide (Blasco-Fontecilla et al., 2009; Kernberg, 2001; Ronnings-

tam, Weinberg, & Maltzberger, 2008); psychopathic, sociopathic, and homicidal behavior (Schlesinger, 1998; Stone, 2001); and posttraumatic stress reactions (Bachar, Hadar, & Shalev, 2005; Simon, 2001).

NARCISSISM AND NPD IN THE ANTAGONISM TRAIT DOMAIN

The proposed conceptualization of NPD using four traits, i.e., Callousness, Manipulativeness, Narcissism, and Histrionism does not represent the empirically-defined or clinically-derived description of NPD (Akhtar, 1989; Cooper, 1998; Kernberg, 2009; Ronningstam & Gunderson, 1990; Russ et al., 2008). Lacking both empirical and clinical relevance, this trait combination will steer the definition and diagnosis of NPD towards external features representing predominantly antisocial/sociopathic or histrionic personality functioning.

On the DSM-5 website, narcissism is defined as “Vanity/boastfulness/exaggeration of one’s achievements and abilities; self-centeredness; feeling and acting entitled, firmly holding the belief that one is better than others and deserves only the best of everything in life.” This is neither clinically meaningful nor empirically representative. The following alternative formulation takes into account both the regulatory function of narcissism and the individual’s internal experiences relevant for a definition of narcissism in the context of outlining mental disorders and defining psychiatric diagnosis: “Enhanced or unrealistic, either overtly interpersonally or behaviorally expressed or internally hidden, sense of superiority and exaggeration of own achievement and capability; vulnerable and variable self-esteem with self-criticism and inferiority, and intense reactions to threats, criticism or defeats; and self-preoccupation with self-enhancing and self-serving interpersonal behavior.”

Callousness is representative of one segment in the range of phenotypic presentation of severe NPD, i.e., the malignant antisocial/psychopathic. People with mild to moderate severity of NPD do not have such degree of superego pathology as they usually have capacity for guilt and remorse (Kernberg, 1984). In addition, there is evidence supporting cognitive empathic capability in both narcissistic and antisocial personality disorders, indicating empathy as a capability with a range of functional and situational variability (Dolan & Fullman, 2004; Ritter et al., 2009). People with NPD do indeed have cognitive empathic capability, but their emotional empathic capability varies depending upon their degree of severity of NPD and their ability for emotional and self-esteem regulation.

Manipulativeness captures some essential aspects of narcissistic interpersonal functioning, especially the efforts to sustain interpersonal control. However, as outlined in the DSM-5 proposal, it indicates more of the active calculating incentive typical for the antisocial/sociopathic personality, rather than the self and self-esteem regulatory aim found in people with NPD.

Histrionism describes histrionic personality traits, which may to some

degree occur within the phenomenological range of NPD. While the overlap between HPD and NPD has been acknowledged (Morey & Jones, 1998), the underlying dynamic and interpersonal behavior and intent are quite different in histrionism versus narcissism. Histrionic seductive exhibitionism is different from narcissistically driven self-enhancing, often competitive, aggressive, controlling behavior that serves self-esteem regulation and protection of grandiosity.

NPD TYPE AND TRAITS—AN ALTERNATIVE PROPOSAL

A diagnostic approach is needed that identifies basic indicators for the range of narcissistic personality functioning, is less focused on symptomatic features or phenotypic appearance, and includes basic characteristics of narcissistic functioning that can distinguish temporary, fluctuating, or externally-triggered shifts in function and appearance from enduring indications of pathological narcissism. Such features attend to self-esteem regulation and the associated variability, vulnerability, reactivity, and internal painful feelings and experiences, as well as the various efforts to protect, serve and enhance internal control and self-esteem (Ronnings-tam, 2009; see Table 1).

Regulation of self-esteem, a central part of self-regulation, is identified as the motivating force in narcissistic functioning, and its vulnerability and fluctuations are indicated by reactions to threats and challenges to

TABLE 1. Alternative Proposal: Diagnostic Trait Facets for the Narcissistic Personality Disorder Type

Traits
1. Grandiosity —enhanced or unrealistic sense of superiority, uniqueness, value, or capability, expressed either <i>overtly</i> in unreasonable expectations, exceptional or unrealistically high aspirations, and self-centeredness, or <i>covertly</i> in persistent convictions and fantasies of unfulfilled ambitions or unlimited success, power, brilliance, beauty, or ideal relationships.
2. Variable self esteem —alternating between states of overconfidence, superiority and assertiveness, and of inferiority and insecurity
3. Reactions to perceived threats to self-esteem —(humiliation, defeats, criticism, failures) including intense feelings (overt or covert anger/hostility, envy, or shame), mood variations (irritability, anxiety, depression, or elation), or deceitful or retaliating behavior.
4. Self-enhancing interpersonal behavior —i.e., excessive attention or admiration seeking, self-promoting, boastful, or competitive.
5. Self-serving interpersonal behavior —i.e., expecting unreasonable and unwarranted rights and services, failing to reciprocate favors from others (entitled), or taking emotional, intellectual, and social advantage of others (exploitive).
6. Avoiding —i.e., internally self-sufficient or interpersonally controlling, distant, or uncommitted attitude or behavior that serves to avoid threats to self-esteem or intolerable affects.
7. Aggressive —i.e., overtly expressed or internally concealed interpersonal argumentative and critical, resentful, hostile, passive-aggressive, cruel or sadistic, attitude or behavior.
8. Perfectionism —exceptionally high or inflexible (although inconsistent) ideals and standards of self or others, with strong reactions, including aggression, harsh self-criticism, shame or deceitfulness when self or others fail to measure up.
9. Impaired empathic ability —inconsistent and compromised by self-centeredness, self-serving interests or emotional dysregulation (low affect tolerance or intense reactions, i.e., shame, envy, inferiority, powerlessness, anger).

the self-esteem, i.e., the most significant trait of NPD (compare: vulnerability and reactions to abandonment as a central marker for borderline personality disorder). A broader definition of grandiosity is necessary that captures not only a sense of superiority and fantasies, but also includes perfectionism and high ideals, as well as the sustaining self-enhancing and self-serving interpersonal behavior. These reformulations serve to expand the spectrum of grandiosity-promoting strivings and activities. They also serve to capture its fluctuations, and attend to the narcissistic individual's internal experiences and motivation as well as his or her external presentation with interpersonal self-enhancing, self-serving, controlling, and aggressive behavior. In addition, they aim at introducing a more dynamic and treatment-guiding conceptualization of the narcissistic traits, such as self-enhancing and self-serving instead of the traditional narcissistic triple E: entitlement, exploitiveness, and exhibitionism.

I suggest the following description of the Narcissistic Personality Disorder Type to be included in DSM-5: "Individuals with this personality type suffer from variable and vulnerable self-esteem. Variability is evident by states ranging from overconfidence, superiority and assertiveness to inferiority and insecurity. They present with grandiosity, an enhanced or unrealistic sense of superiority, uniqueness, value or capability. This is expressed either overtly in unwarranted expectations, exceptionally high aspirations, and self-centeredness, or covertly in inner convictions, fantasies of unfulfilled ambitions or unlimited success, power, brilliance, beauty, or ideal relationships. Grandiosity is also manifested by exceptionally high ideals and perfectionism.

Vulnerability is evident by exaggerated reactivity. These individuals react strongly to perceived challenges or threats to self-esteem (i.e., humiliation, defeats, criticism and failure to measure up), with overt or covert intense feelings (anger, hostility, envy, rage, harsh self-criticism, shame), mood variations (irritability, anxiety, depression or elation), avoidance or retaliating or deceitful behavior. Self-enhancing and self-promoting interpersonal behavior can serve to boost or protect the self-esteem. They also have variable or consistently impaired empathic ability, influenced by emotional dysregulation (low affect tolerance or intense reactions) and/or self-centeredness or self-serving interests.

Individuals with the narcissistic personality type can present as overtly arrogant and haughty, with self-enhancing interpersonal behavior—i.e., being actively attention and admiration seeking, self-promoting, boastful, and competitive. They can also show vigorous self-serving interpersonal behavior—i.e., expecting unreasonable and unwarranted rights and services, accepting unreciprocated favors from others, or taking emotional, intellectual and social advantage of others. If expectations are not met, they tend to have intense reactions ranging from rage and retaliation to passive-aggressive rumination, to shame and severe self-criticism. While some readily express their reactions, others tend to exercise rigorous in-

ternal control over their emotions, expressed behavior, or interpersonal relationships.

Those with a covert presentation have a more shy appearance and can be self-sufficient, controlled and polite, or avoidant, empty, and indifferent. On the surface they can appear tuned in, modest, or unassuming, hiding or feigning disinterest in self-promotion. However, their avoidance serves to sustain elevated self-esteem and they are still preoccupied with self-enhancing grandiose fantasies and passive aggressive reactions. They also suffer from internal vulnerability, insecurity, inferiority and shame.

A third presentation includes those who are more manifestly aggressive and hostile. Motivated by superiority, envy, vengefulness or sadism, they demonstrate systematic cruel, sadistic or violent interpersonal behavior. Some are charming, deceptive and seductive; others are calculating, exploitive and retaliating. Malignant, criminal or psychopathic behavior can also be present.”

RECOMMENDATIONS TO THE DSM V COMMITTEE

1. RETAIN NPD AS A DIAGNOSTIC PERSONALITY DISORDER TYPE

There is by now strong supporting evidence in favor of keeping NPD as a personality type with a set of separate diagnostic criteria in DSM V. These include: the prevalence rate, extensive clinical and empirical reports and facts, its psychiatric, social and societal significance especially when associated to functional vocational and interpersonal impairment, social and moral adaptation, and acute suicidality. In addition, there is a need for an established and well-defined diagnostic base for continuing studies of treatment of narcissism and NPD.

2. PROMOTE AN INFORMATIVE AND GUIDING CONCEPTUALIZATION OF NPD

The NPD diagnosis must be clinically and psycho-educationally informative for both clinicians and patients, indicative of relevant underlying context and meaning of the diagnostic traits and descriptive personality functioning, and guiding of relevant treatment approaches.

3. INCLUDE TRAITS THAT CAPTURE BASIC ENDURING INDICATORS OF NPD

To enhance the relevance and utility of the NPD diagnosis it has to capture basic characteristics of narcissistic functioning that represent enduring indication as well as core features for narcissistic personality functioning, and that are less contingent upon situational changeability and range of phenotypic variability.

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