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Narcissistic Personality Disorder in *DSM-5*

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The criteria for personality disorders in Section II of *DSM-5* have not changed from those in *DSM–IV*. Therefore, the diagnosis of Section II narcissistic personality disorder (NPD) will perpetuate all of the well-enumerated shortcomings associated with the diagnosis since *DSM–III*. In this article, we will briefly review problems associated with Section II NPD and then discuss the evolution of a new model of personality disorder and the place in the model of pathological narcissism and NPD. The new model was intended to be the official approach to the diagnosis of personality pathology in *DSM-5*, but was ultimately placed as an alternative in Section III for further study. The new model is a categorical-dimensional hybrid based on the assessment of core elements of personality functioning and of pathological personality traits. The specific criteria for NPD were intended to rectify some of the shortcomings of the *DSM–IV* representation by acknowledging both grandiose and vulnerable aspects, overt and covert presentations, and the dimensionality of narcissism. In addition, criteria were assigned and diagnostic thresholds set based on empirical data. The Section III representation of narcissistic phenomena using dimensions of self and interpersonal functioning and relevant traits offers a significant improvement over Section II NPD.

Keywords: narcissistic personality disorder, *DSM-5,* narcissism, personality disorder, personality functioning

Narcissistic personality disorder (NPD) in *DSM–IV* (and now also in Section II of *DSM-5*) describe "a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy . . .," indicated by five or more of the following: (a) a grandiose sense of self-importance; (b) preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love; (c) beliefs of being special and unique; (d) requirements of excessive admiration; (e) a sense of entitlement; (f) interpersonal exploitativeness; (g) lack of empathy; (h) envy of others; and (i) arrogant, haughty behaviors or attitudes. Many problems with this representation of NPD have been enumerated. The criteria describe primarily manifestations of grandiose narcissism, and ignore vulnerable aspects that inevitably coexist; this can have profound effects on treatment practice and outcome (Cain, Pincus, & Ansell, 2008; Ronningstam, 2012). They also describe primarily overt narcissism, missing the well-recognized covert presentation (Levy, 2012). In their review of the concept, Pincus and Lukowitsky (2010) noted numerous potential inconsistencies in the conceptualization of narcissism, including variants in describing its nature (normal, pathological), phenotype (grandiosity, vulnerability), expression (overt, covert), and structure (category, dimension, prototype). In all four of these areas of conceptualization, *DSM* descriptions of the concept have been limited.

As defined by the *DSM*, NPD is also one of the less common personality disorders (PDs) in community (Torgersen, 2009) and clinical (Stuart et al., 1998; Zimmerman, Rothchild, & Chelminski, 2005) samples, despite the general clinical perception that pathological narcissism is a common form of character pathology. Also, as currently defined, NPD is only moderately impairing relative to other PDs, such as borderline or antisocial PDs, raising issues regarding its clinical significance (Skodol et al., 2011a). Finally, NPD has a modest research base as a diagnostic *category*, and what research exists indicates that the category has limited clinical utility (Alarcon & Sarabia, 2012; Morey & Stagner, 2012). A thorough recent review of these issues, as well as treatment implications of pathological narcissism, can be found elsewhere (Bender, 2012).

In this article, we will discuss the evolution of a new model of personality disorder and the place in the model of pathological narcissism and NPD. The new model was intended to be the official approach to the diagnosis of personality pathology in *DSM-5*, but was ultimately placed as an alternative in Section III, "Emerging Measures and Models," for further study.

Background

In the introduction to *A Research Agenda for DSM-V*, Kupfer, First, and Regier (2002) questioned the validity of traditional categorical diagnoses of mental disorders. Epidemiological and

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clinical studies showed high rates of comorbidity between disorders and short-term diagnostic instability. No laboratory marker had been found to be specific for any *DSM*-defined syndrome and treatment specificity for different types of disorders was rare. Regarding PDs, Rounsaville et al. (2002) said: "There is a clear need for dimensional models to be developed and their utility compared with that of existing typologies in one or more limited fields, such as personality." Increasing the validity mental disorder diagnosis by incorporating dimensional assessment was, in fact, one of the major rationales for *DSM-5*.

The Personality and Personality Disorders Work Group was charged to develop a new approach to the PDs section of *DSM-5* that would begin to rectify some of the problems associated with *DSM–IV*. When the Work Group began its deliberations, a study endorsed by two of the most influential national (Association for Research on Personality Disorders) and international (International Society for the Study of Personality Disorders) PD research organizations surveyed PD experts: 74% thought that the *DSM–IV* categorical approach to PDs should be replaced, 87% stated that personality pathology was dimensional in nature, and 70% supported a mixed categorical–dimensional approach to PD diagnosis as the most desirable alternative to *DSM–IV* (Bernstein, Iscan, Maser, & the Boards of Directors of the Association for Research in Personality Disorders and the International Society for the Study of Personality Disorders, 2007).

Such a categorical–dimensional hybrid had been developed in a *DSM-5* planning meeting (Krueger, Skodol, Livesley, Shrout, & Huang, 2007), which preceded the formal constitution of the Work Group and the start of discussions. A mixed model was intended to improve on the existing system by striking a balance between introducing new elements called for by the field (i.e., dimensional elements) and preserving continuity (i.e., *DSM–IV–TR* PD categories)—an approach that would be minimally disruptive to clinical practice and research, yet still taking research developments since the time of *DSM–III* into account.

Model Evolution

In its earliest iterations, the *DSM-5* hybrid model did not include NPD as a specific type. A literature review conducted by the Work Group found a paucity of data supporting the validity of NPD as a discrete diagnostic category (Alarcon & Sarabia, 2012). Instead the literature portrayed a PD with extensive comorbidity with other mental disorders, including other PDs, and narcissism as a trait dimension that appeared in many other conditions. Another review by Morey and Stagner (2012) found a modest literature on NPD since the publication of *DSM–IV* in 1994, roughly one tenth of the comparable number of articles addressing borderline personality disorder (BPD). Of the 10 official *DSM–IV* personality disorders, only paranoid, schizoid, and histrionic had fewer citations.

Furthermore, using data from the Collaborative Longitudinal Personality Disorders (CLPS) study, Hopwood et al. (2011) examined the validity of *DSM–IV* diagnostic categories in predicting functional outcomes after 3 years of follow-up, in particular examining the incremental contribution of specific categories above and beyond a general dimension of personality pathology. For the most part, a general personality functioning dimension accounted for the majority of valid variance in outcome relative to that contributed by *DSM–IV* diagnostic categories. Also, in predicting a variety of outcomes across the 10 years of the CLPS project, Morey et al. (2012) found that NPD was the sole *DSM–IV* PD concept that did not increase the predictive utility of factor-analytically derived pathological personality factors at ANY observation period of the project. In attempting to statistically cluster specific *DSM–III–R* features of personality disorder, Morey (1988) found that the features of NPD (identical to *DSM–IV* except for one criterion) were not grouped statistically, but appeared to be scattered across other symptom clusters, unlike most other *DSM–III–R* personality disorders whose features largely clustered together.

In early deliberations, the Work Group tested a series of "broad" versus "narrow" narrative clinical prototypes in a number of workshops with professional groups. The narrow prototypes closely represented existing *DSM–IV* PDs and included BPD, antisocial personality disorder (ASPD), schizotypal personality disorder (STPD), avoidant personality disorder (AVPD), and obsessive–compulsive personality disorder (OCPD). The broad prototypes, which sometimes combined features of more than one *DSM–IV* PD, were called "dysregulated," "ego-centric," "vigilant," "avoidant," and "controlling" and included mild as well as severe manifestations. The broad ego-centric prototype encompassed both typical antisocial and psychopathic characteristics, as well as narcissistic characteristics, which were viewed as the milder manifestations of this prototype. All prototypes were rated on 5-point "matching" scales, ranging from 5 = *Very Good Match: patient exemplifies this type* to 1 = *No Match: description does not apply*. Prototype matching, a patient-centered dimensional approach to diagnosis, had been found to be rated higher by clinicians on measures of clinical utility than categorical, criteria count, or trait dimensional approaches (Spitzer, First, Shedler, Westen, & Skodol, 2008). In addition, a series of 8–10 pathological personality traits were rated in conjunction with the prototypes or independently. Traits associated with the ego-centric type included grandiosity, manipulativeness, aggression, callousness, hostility, deceitfulness, irresponsibility, recklessness, and impulsivity.

Also introduced at the time of the early Work Group deliberations was a Levels of Personality Functioning Scale (LPFS). The rationale for the LPFS was that PDs shared common core features (Bender, Morey, & Skodol, 2011; Livesley & Jang, 2000) and that the more severe the impairment in personality functioning, the worse the prognosis and treatment outcome. Hopwood et al. (2011) demonstrated empirically that the *DSM–IV* personality disorder items that loaded most highly on a PD severity dimension were preoccupation with social rejection, fear of social ineptness, feelings of inadequacy, anger, identity disturbance, and paranoid ideation. The nature and importance of these elements are consistent with the proposition that at the core of PDs of all types is disturbance in how one views one's self and other people. Similarly, previous analyses by Morey (2005) demonstrated that difficulties in empathic capacity, at varying levels, can be found at the core of all types of personality psychopathology.

Formulation of the core impairments in personality functioning central to PDs began with a literature review (Bender et al., 2011) that considered a number of reliable and valid clinician-administered measures for assessing personality functioning and psychopathology, and demonstrated that a self–other dimensional perspective has an empirical basis and significant clinical utility. Numerous studies using measures of self and interpersonal func-

tioning have shown that a self–other approach is informative in determining the existence, type, and severity of personality pathology. Reliable ratings can be made on a broad range of self–other constructs, such as identity and identity integration, agency, self-control, sense of relatedness, capacity for emotional investment in and maturity of relationships with others, responsibility, and social concordance. The most reliable (ICC $\geq$ .75) dimensions found in the measures considered in the Bender et al. (2011) review were *identity*, *self-direction*, *empathy*, and *intimacy*. The LPFS, therefore, represents a core dimension of narcissism that cuts across all personality pathology (Bender, 2012).

The initial *DSM-5* Web site posting of the new PD model included the LPFS, the five "narrow" narrative prototypes (without NPD), associated and independent pathological traits, and a revised set of general criteria for personality disorder (GCPD) to replace those in *DSM–IV*, which were not specific for PD and had no published rationale and no empirical basis (Skodol et al., 2011b). The initial proposal by the PD Work Group to eliminate NPD as a specific diagnosis was based on the contention that narcissism was better represented by specifying severity of dysfunction in self and interpersonal functioning, in addition to whatever prominent personality traits were present. For example, the *Psychodynamic Diagnostic Manual*'s (PDM Task Force, 2006) Arrogant/Entitled and Depressed/Depleted subtypes could be described as patients with moderate or severe impairment in self–other functioning (both subtypes) with either grandiosity or depressivity as distinguishing pathological personality traits. This diagnosis was among those referred to as personality disorder-trait specified (PD-TS) in the new model—a diagnosis for all of those *DSM–IV* PDs that were not included as a specific type and any other specific or mixed PD types (e.g., depressive, masochistic) that would have been called personality disorder not otherwise specified (PDNOS) in *DSM–IV*. With further integration of the LPFS and the pathological trait system into revised GCPD, this model was incorporated into the *DSM-5* Large Academic Center Field Trials for reliability and clinical utility testing.

However, the elimination of NPD as a specific PD "type" generated considerable controversy (e.g., Shedler et al., 2010). In responses to the first Web site posting, deletion of any of the *DSM–IV* PD types was one of the major objections to the proposal. Although all of the PDs had some advocates, regardless of the level of evidence to support them, NPD had by far the most supporters. At approximately the same time, the *DSM-5* Task Force initiated a review of the PD proposal and specifically requested that the Work Group focus their efforts on a mixed or "hybrid" approach with *diagnostic criteria* that combined dimensional elements and *DSM–IV–TR* PD types, instead of prototypes, which were viewed as too much like *DSM–II*. As a result of these processes, NPD was reinstated as a sixth specified type with criteria based on the combination of core self–other impairments and the specific pathological personality traits of grandiosity and attention seeking.

Final Model

The final model proposed for *DSM-5* included general criteria consisting of moderate or greater impairment in personality (self/interpersonal) functioning (criterion A) and the presence of one or more pathological personality traits (criterion B). The impairments in personality functioning and personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations (Criterion C), relatively stable across time with onsets that can be traced back to at least adolescence or early adulthood (Criterion D), not better explained by another mental disorder (Criterion E), not attributable to a substance or another medical condition (Criterion F), and not better understood as normal for an individual's developmental stage or sociocultural environment (Criterion G). All *DSM-5* Section III PDs described by criterion sets and PD-TS meet these general criteria, by definition.

Criterion A: Level of Personality Functioning

Because disturbances in self and interpersonal functioning constitute the core of personality psychopathology (Bender et al., 2011), in this alternative diagnostic model they constitute the A criterion and are evaluated on a continuum. Self functioning involves identity and self-direction; interpersonal functioning involves empathy and intimacy. The LPFS uses each of these elements to differentiate five levels of impairment, ranging *from little or no impairment* (i.e., healthy, adaptive functioning, Level 0), to *some* (Level 1), *moderate* (Level 2), *severe* (Level 3), and *extreme* (Level 4) impairment.

Impairment in personality functioning predicts the presence of a PD, and the severity of impairment predicts whether an individual has more than one PD or one of the more typically severe PDs (Morey et al., 2011). A moderate level of impairment in personality functioning is required for the diagnosis of a PD based on empirical evidence that the moderate level of impairment maximizes the ability of clinicians to accurately and efficiently identify PD pathology (Morey, Bender, & Skodol, in press).

Criterion B: Pathological Personality Traits

Pathological personality traits in *DSM-5* Section III are organized into five broad domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism. Within the five broad trait domains are 25 specific trait facets that have been developed initially from a review of existing trait models and then through iterative research on samples of persons who sought mental health services (Krueger, Derringer, Markon, Watson, & Skodol, 2012). The B criteria for the specific PDs are comprised of subsets of the 25 trait facets, based on meta-analytic reviews (Samuel & Widiger, 2008; Saulsman & Page, 2004) and empirical data on the relationships of the traits to *DSM–IV* PD diagnoses (Hopwood, Thomas, Markon, Wright, & Krueger, 2012).

Criteria for Narcissistic Personality Disorder

The alternative Section III diagnostic criteria for NPD are found in Table 1. Typical features of NPD are variable and vulnerable self-esteem, with attempts at regulation through attention and approval seeking, and either overt or covert grandiosity.

The level of impairment in personality functioning in NPD is ordinarily expected to be in the moderate range. Any two of the four areas of characteristic self and interpersonal impairments are required. Individuals with NPD are typically self-centered with

Table 1
Diagnostic Criteria for Narcissistic Personality Disorder

Typical features of Narcissistic Personality Disorder are variable and vulnerable self-esteem, with attempts at regulation through attention- and approval-seeking, and either overt or covert grandiosity. Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy, as described below, along with specific maladaptive traits in the domain of Antagonism.

Diagnostic Criteria

A. Moderate or greater impairment in personality functioning, manifest by characteristic difficulties in two or more of the following four areas:
   1. ***Identity***: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal may be inflated or deflated, or vacillate between extremes; emotional regulation mirrors fluctuations in self-esteem.
   2. ***Self-direction***: Goal-setting is based on gaining approval from others; personal standards are unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.
   3. ***Empathy***: 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 effect on others.
   4. ***Intimacy***: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain.

B. Both of the following pathological personality traits:
   1. ***Grandiosity*** (an aspect of **Antagonism**): Feelings of entitlement, either overt or covert; self-centeredness; firmly holding to the belief that one is better than others; condescending toward others.
   2. ***Attention seeking*** (an aspect of **Antagonism**): Excessive attempts to attract and be the focus of the attention of others; admiration seeking.

Note. The complete Section III diagnostic criteria for narcissistic personality disorder include C through G of the general criteria for personality disorder (see above). These are omitted here to conserve space.

goals that are meant to gain approval or admiration from others. A significant difference between *DSM-5* Section II NPD and Section III NPD is that the latter explicitly acknowledges both inflated (grandiose) and deflated (vulnerable) presentations, as well as the possibility of vacillations between the two, although Section II perpetuates the inflated-only presentation. Section III also recognizes that an individual's personal standards may be either unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement and that he or she is often unaware of his or her own motivations. Characteristic lack of empathy is evidenced by an impaired ability to recognize or identify with the feelings and needs of others or, if attuned to reactions of others, it is only if they are relevant to oneself. Interpersonal relationships are characteristically superficial and exist to serve bolster self-esteem; mutuality in relationships is limited by the individual's little genuine interest in others' experiences and his or her need for personal gain.

Only two pathological personality traits are listed under criterion B for NPD: grandiosity and attention-seeking. Both are required. Another major difference between Section II and Section III NPD is that Section III recognizes that grandiosity and feelings of entitlement may be either overt or covert, thus correcting the criticism that *DSM–IV* NPD emphasized only the overt presentation. Both grandiosity (.768) and attention-seeking (.535) have been shown to be highly correlated with *DSM–IV* NPD in a survey of 337 clinicians and patients conducted by Morey et al. (unpublished data) and also in other studies by Hopwood et al. (2012; NPD) and by Miller, Gentile, Wilson, & Campbell (2013; grandiose narcissism). Other traits from the antagonism domain, such as manipulativeness, deceitfulness, and callousness have also been shown to be highly correlated with NPD; however, the more antagonism traits that are included, the more NPD resembles ASPD, with greater comorbidity as a consequence (Hopwood et al., 2012; Morey & Skodol, 2013). In the Miller et al. (2013) study, the authors showed that traits from the negative affectivity (e.g., depressivity, emotional lability, anxiousness) and detachment (e.g., withdrawal, anhedonia) domains, were highly correlated with vulnerable narcissism, but not with grandiose narcissism. Traits of negative affectivity could have been included in the diagnostic criteria for NPD; doing so, however, markedly increased the prevalence of NPD, decreased the internal consistency of the NPD criteria set, and decreased discriminant validity with respect to BPD and STPD in the Morey survey (Morey & Skodol, 2013). Requiring only one trait instead of both was found to double the prevalence of NPD and to decrease its relationship to *DSM–IV* NPD. Thus, the diagnostic threshold of Section III NPD (and other PDs) has some rationale, although the Section II (*DSM–IV*) threshold remains completely arbitrary.

Specifiers

Trait and personality functioning specifiers may be used, according to Section III, to record additional personality features that may be present in NPD but are not required for the diagnosis. For example, other traits from the antagonism domain (e.g., manipulativeness, deceitfulness, or callousness) are not diagnostic criteria for NPD, but can be specified as appropriate in the presence of more pervasive antagonistic features (e.g., "malignant narcissism"). Other traits from the negative affectivity domain (e.g., depressivity or anxiousness) can be specified to describe more "vulnerable" presentations. In addition, although moderate or greater impairment in personality functioning is required for the diagnosis of NPD, the exact level of personality functioning can also be specified because the level of impairment may vary, not only across the various PDs, but also within a PD.

Future Directions

As a result of a vote of the American Psychiatric Association's Board of Trustees, the criteria for PDs in Section II of *DSM-5* have not changed from those in *DSM–IV*. Among the casualties of this decision is narcissistic personality disorder. Although Section III measures and models are intended primarily for research purposes and Section II disorders for clinical use, we hope that clinicians will use the Section III model, including the Level of Personality Functioning Scale and the criteria for NPD in patients assessments

because the Section III approach has been found to be considerably more clinically useful than the *DSM–IV* approach in a number of contexts, including the American Psychiatric Association's own Large Academic Center and Routine Clinical Practice Field Trials (unpublished data). We also encourage additional research on the reliability, clinical utility, and concurrent and predictive validity of all parts of the alternative PD model and note that such research is already underway by investigators in the United States and abroad.

Conclusions

A goal of *DSM-5* was to increase the validity of mental disorder diagnoses, by incorporating dimensional assessment. The Section III PD model is based on two dimensional measures—of personality functioning and of pathological personality traits—both of which are continuous in nature. The specific criteria for narcissistic personality disorder were intended to rectify some of the shortcomings of the *DSM–IV* representation by acknowledging both grandiose and vulnerable aspects, overt and covert presentations, and the dimensionality of narcissism. In addition, criteria were assigned and diagnostic thresholds set based on empirical data. Questions remain about the validity of NPD as a distinct personality *disorder*. However, the Section III representation of narcissistic phenomena using dimensions of self and interpersonal functioning and relevant traits offers a significant improvement over Section II NPD, which continues to perpetuate all of the shortcomings associated with the diagnosis since *DSM–III*. It is not clear what the PD field will do with this flawed diagnosis.

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