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9 Narcissistic Personality Disorder

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Introduction

Clinical theorists across various orientations describe individuals diagnosed with narcissistic personality disorder as those 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 or haughty behaviors or attitudes (Westen & Shedler, 1999). Despite common

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clinical usage, the concept of narcissistic personality disorder is highly controversial and of uncertain validity (Frances, 1980; Maier, Lichtermann, Klingler, Heun, & Hallmayer, 1992; Siever & Klar, 1986; Vaillant & Perry, 1985). The vast majority of the literature on narcissistic personality disorder has been theoretical and clinical rather than empirical. The research that does exist, with a few important exceptions, has not been carried out programmatically. In this chapter, we will summarize and integrate the best available scientific evidence bearing on the etiology, assessment, diagnosis, course, and treatment of the disorder. We will begin with a brief history of the concept of narcissistic personality disorder, then review and evaluate a number of conceptualizations, and conclude with recommendations for further research on unresolved conceptual and methodological issues as we look toward DSM-V.

Brief History of the Concept

The term *narcissism* is derived from the Greek myth of Narcissus, who, mistaking his own image for another, fell in love with that image and died when it failed to love him back.[1] The legend of Narcissus, originally written as Homeric hymns in the seventh or eighth century BCE (Hamilton, 1942) and popularized in Ovid's *Metamorphoses* (8/1958), has arisen from a relatively obscure beginning to become one of the prototypical myths of our times, with the coining of such terms as "culture of narcissism" and "me generation" (Lasch, 1979; Wolfe, 1976).

Pioneering English psychologist and sex researcher Havelock Ellis (1898) first invoked this myth in a case study of a man who engaged in excessive masturbation to illustrate a psychological state whereby an individual becomes the object of his own sexual desire. Following Ellis, Freud first used the term "narcissistic" in a footnote in his 1905 paper (Freud, 1905/1957) entitled *Three Essays on Sexuality* in discussing the choice of sexual partners that have qualities similar to oneself. Thus, one of the earliest psychiatric meanings of narcissism had to do with sexual behavior (see Pulver, 1970, and van der Waals, 1965, for reviews). In 1911, Otto Rank wrote the first paper exclusively on narcissism, linking it to vanity and self-admiration. In 1914, Freud published *On Narcissism: An Introduction* (Freud, 1914/1957), in which he noted the dynamic characteristic in narcissism of consistently keeping out of awareness any information or feelings that would diminish one's sense of self. In this paper he also discussed, from a developmental perspective, the movement from the normal but relatively exclusive focus on the self to mature relatedness. In all of these early papers, narcissism was described as a dimensional psychological state in much the same way that contemporary trait theorists describe pathological manifestations of normal traits (although Rank and Freud viewed narcissism as dynamic—that is, they saw grandiosity as a defense against feeling insignificant). In all these writings, narcissism was conceptualized as a process or state rather than a personality type or disorder.[2]

The concept of a narcissistic personality or character was first articulated by Waelder in 1925. Waelder 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 apparent in their sexuality, which is based on purely physical pleasure rather than combined with emotional intimacy. Although Freud had not discussed narcissism as a personality type in his 1914 paper, in 1931, following Waelder, he described the narcissistic character type. In 1939, Karen Horney distinguished healthy self-esteem from pathological narcissism and suggested that the term *narcissism* be restricted to unrealistic self-inflation. Following this work, Jones (1955) described pathological narcissistic traits, Abraham (1924/1949) drew a link between envy and narcissism, and Reich (1960) suggested that narcissism is a pathological form of self-esteem regulation in which self-inflation and aggression are used to protect one's self-concept.

In 1961, Nemiah explicitly described narcissism not only as a personality type but as a disorder when he coined the term "narcissistic character disorder." In 1967, Kernberg, as part of his articulation of borderline personality organization, presented a clinical description of what he called "narcissistic personality structure." In a later paper, Kernberg (1970) further articulated explicit descriptions of clinical characteristics and the bases for the diagnosis on readily observable behavior, distinguishing between normal and pathological narcissism. Kernberg's (1967) initial paper was followed by a paper by Kohut (1968), who introduced the term "narcissistic personality disorder." Kernberg's (1967) and Kohut's (1968) writings on narcissism were, in part, a reaction to increased clinical interest in treating these patients. Their papers in turn stimulated increased clinical interest in the concept. However, these clinical trends also paralleled trends in critical social theory (Adorno, 1967, 1968; Blatt, 1983; Horkheimer, 1936; Horkheimer & Adorno, 1944/1998; Lasch, 1979; Marcuse, 1955; Nelson, 1977; Stern, 1980; Westen, 1985; Wolfe, 1976).

Although Kohut and Kernberg disagreed on the etiology of narcissistic personality disorder, they agreed on much of its expression, particularly for those patients in the healthier range. Both of these authors have been influential in shaping the concept of narcissistic personality disorder, not only among psychoanalysts but also among contemporary personality researchers and theorists (Baumeister, Bushman, & Campbell, 2000; Campbell, 1999; Dickinson & Pincus, 2003; Emmons, 1981, 1984, 1987, 1989; John & Robins, 1994; Raskin & Hall, 1979; Raskin, Novacek, & Hogan, 1991a, 1991b; Raskin & Terry, 1988; Robins & John, 1997a, 1997b; Rose, 2002; Wink, 1991, 1992a, 1992b).

Narcissistic personality disorder (NPD) was first introduced into the official diagnostic system in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association [APA], 1980), owing to clinicians' widespread use of the concept and the

identification of narcissism as a personality factor in a number of psychological studies (Ashby, Lee, & Duke, 1979; Block, 1971; Cattel, Horn, Sweney, & Radcliffe, 1964; Exner, 1969, 1973; Eysenck & Eysenck, 1975; Harder, 1979; Leary, 1957; Murray, 1938; Pepper & Strong, 1958; Raskin & Hall, 1979; Serkownek, 1975; see Frances, 1980). Nevertheless, the DSM-III definition of and criteria for NPD were developed by consensus of a committee of psychiatrists and psychologists from a summary of the pre-1978 literature, without the benefit of empirical evaluation by clinical study groups. The criteria represented amalgamations of the theoretical and clinical work of Kernberg (1966, 1970, 1975a), Kohut (1968, 1971), and Millon (1969), with "expert" input (see Frances, 1980, for description). DSM-III-R (APA, 1987) followed the criteria for DSM-III rather closely. However, the criteria were changed from mixed polythetic and monothetic criteria to entirely polythetic criteria. The interpersonal criterion, which had originally included four parts (entitlement, interpersonal exploitativeness, alternation between extremes of overidealization and devaluation of self and others, and lack of empathy), was reduced to three parts through the elimination of the part regarding alternation between extremes of overidealization and devaluation of self and others. The criterion that included both grandiosity and uniqueness was split into two separate criteria, and a criterion about preoccupation with feelings of envy was added. Recently, Westen and Shedler (1999) surveyed a large group of experienced psychiatrists and psychologists of varying clinical orientations regarding the personality characteristics of patients with varying personality disorders, including narcissistic personality disorder. Using factor-analytic procedures to derive an empirical profile, they found that the Axis II work groups captured most of the important features of narcissistic personality disorder as seen in clinical practice. However, they noted that narcissistic patients as described by clinicians appear to be more controlling, more likely to get into power struggles, and more competitive than DSM-IV suggests. (Of course, these findings may have resulted from a referral bias, and thus DSM would be accurate.)

Prevalence

The prevalence of narcissistic personality disorder in the general population is estimated to be between less than 1% and 5.3%, with an estimated median rate of 0.8% and a mode of 0.0% (Black, Noyes, Pfohl, Goldstein, & Blum, 1993; Bodlund, Ekselius, & Lindström, 1993; Drake, Adler, & Vaillant, 1988; Ekselius, Tillfors, Furmark, & Fredrikson, 2001; Klein et al., 1995; Maier et al., 1992; Moldin, Rice, Erlenmeyer-Kimling, & Squires-Wheeler, 1994; Reich, Yates, & Nduaguba, 1989; Samuels, Nestadt, Romanoski, Folstein, & McHugh, 1994; Torgersen, Kringlen, & Cramer, 2001; Zimmerman & Coryell, 1990). In clinical populations, the estimated

prevalence has ranged from 1.3% to 17%, with prevalence rates being reported as higher in samples of personality-disordered patients (Andreoli, Gressot, Aapro, Tricot, & Gognalons, 1989; Clarkin, Levy, Lenzenweger, & Kernberg, 2004; Crosby & Hall, 1992; Dahl, 1986; Frances, Clarkin, Gilmore, Hurt, & Brown, 1984; Grilo et al., 1998; Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Loranger et al., 1991; Loranger et al., 1994; McGlashan et al., 2000; Skodol, Buckley, & Charles, 1983; Zanarini, Frankenburg, Chauncey, & Gunderson, 1987).

In a survey of a community sample in Baltimore, Maryland, approximately 0.1% of the sample met criteria for NPD (Samuels et al., 1994). The use of NPD as the primary clinical diagnosis is probably relatively unusual in outpatient clinic settings compared to inpatient settings. For instance, Fabrega, Ulrich, Pilkonis, and Mezzich (1992) found that less than a 0.3% of 18,179 individuals screened while seeking outpatient psychiatric evaluation over a 6-year period were assigned a diagnosis of NPD. Only 10 individuals were given a primary diagnosis of NPD. In contrast, Grilo et al. (1998), in a consecutively admitted inpatient sample, found that 4% of adolescents and 6% of adults were diagnosed with NPD using structured interviews. Clarkin et al. (2004) found that 17% of patients reliably diagnosed with borderline personality disorder were also diagnosed with NPD using a structured interview (the International Personality Disorder Examination [Loranger, 1999]). In a study of military personnel, Crosby and his colleagues (Bourgeois, Crosby, Drexler, & Hall, 1993; Crosby & Hall, 1992) found that 20% (60 of 300) of active-duty outpatients had significant narcissistic features and that 4% met criteria for narcissistic personality disorder. NPD was the most common personality disorder in this sample, representing 39% of patients with any personality disorder, and narcissistic traits were the most prevalent personality traits among those referred for psychiatric evaluation by superior officers. Fava, Grandi, Zielezny, Rafanelli, and Canestrari (1996) found that NPD was significantly more common in patients with early-onset depression than in those with late-onset depression.

However, given the extensive literature within psychoanalytic and psychotherapeutic journals, the prevalence of NPD may be higher in outpatient private practice settings than in hospital outpatient departments. For example, Westen (1997) found that 76% of 1,901 clinicians (838 psychodynamic, 300 cognitive-behavioral, and 639 eclectic) randomly selected from the American Psychiatric Association and American Psychological Association reported treating patients with NPD. Doidge et al. (2002) surveyed 510 psychoanalytically oriented clinicians, who reported on over 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 overall in the U.S. and Ontario and the second-ranked disorder overall in Australia. Westen and Arkowitz-Westen (1998) 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. Using a diagnostic Q-sort procedure, these clinicians evaluated 714 patients, of whom 8.5% were reported to have NPD. Psychodynamic clinicians reported that 11.2% of their patients had narcissistic personality disorder, whereas eclectic clinicians reported that 5.7% of their patients had NPD and cognitive-behavioral clinicians reported that 3.9% of their patients had NPD. This difference in rates among clinicians of different orientations may reflect greater sensitivity to the disorder by psychodynamic clinicians, an overdiagnosis of or selective attention to the disorder by psychodynamic clinicians, or different conceptualizations of the disorder. Alternatively, it may reflect relatively accurate base rates in different types of clinical practices. Interestingly, DiGiuseppe, Robin, Szeszko, and Primavera (1995) reported that 107 of 742 patients (14.4%) presenting over an 18-month period met the cutoff for NPD on the Millon Clinical Multiaxial Inventory—II (MCMI-II; Millon, 1987) in a private nonprofit cognitive-behavioral outpatient clinic in Manhattan.

In sum, the prevalence of NPD appears to vary according to clinical setting and type of practice. The ambiguity in defining and interpreting the criteria may lead some clinicians to be reluctant to use the diagnosis, whereas other clinicians, who find the clinical formulations of Kernberg, Kohut, and others useful, may make more frequent use of the diagnosis. In addition, the diagnosis is more likely to be used in private practices and small clinics than in larger psychiatric hospital clinics and inpatient units. Finally, there may be geographic differences in the rates of NPD.

Diagnosis

The diagnosis of NPD has been the focus of controversy since its introduction in the DSM-III. One of the major issues in this controversy has been whether NPD is a distinct diagnostic entity. Studies have generally confirmed the validity of some of the overt characteristics of NPD as defined in DSM-IV, such as grandiosity, grandiose fantasy, desire for uniqueness, need for admiring attention, and arrogant, haughty behavior (Morey & Jones, 1998; Ronningstam & Gunderson, 1990; Westen, 1990a). In addition to the DSM criteria set for NPD, a number of other diagnostic schemes have been developed. Gunderson and his colleagues developed the Diagnostic Interview for Narcissism (DIN; Gunderson, Ronningstam, & Bodkin, 1990), a semistructured interview that evaluates 33 characteristics of pathological narcissism. Using the DIN, Ronningstam and Gunderson (1991) found that the following characteristics could 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. There are a number of psychoanalytic conceptions of NPD, although those of Akhtar

and Thomson (1982) and Kernberg (1983) are probably the most systematically described.

Beck and Freeman (1990) have proposed a cognitive model for diagnosing and assessing personality disorders based on the assumption that each personality disorder can be classified by the unique cognitive content of cognitive distortions and maladaptive core and conditional beliefs. The cognitive contents are inferred on the basis of the patients' behaviors and traits. According to Beck and Freeman (1990), the 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" (pp. 50–51). Nelson-Gray, Huprich, Kissling, and Ketchum (2004) examined the relationship between specific dysfunctional thought patterns (or beliefs) and personality disorder. Although specific dysfunctional thought patterns were generally related to corresponding personality disorders, most thought patterns lacked specificity. For example, in addition to narcissistic thought pattern scores, histrionic, avoidant, dependent, paranoid, and obsessive-compulsive thought pattern scores were also significantly related to NPD scores (histrionic thought pattern scores being the most highly correlated). Beck, Butler, Brown, Dahlsgaard, and Beck (2001) also reported on the relationship of dysfunctional beliefs to personality disorders. They found that narcissistic dysfunctional beliefs were higher in patients diagnosed with NPD compared to those diagnosed with avoidant, dependent, obsessive-compulsive, and paranoid personality disorders. However, they did not examine whether narcissistic dysfunctional thought patterns were higher in patients with NPD compared to histrionic, antisocial, and borderline patients, which would have provided a more stringent test of specificity. Narcissistic dysfunctional thought patterns were highly correlated with histrionic and antisocial dysfunctional thought patterns. Young (1994) developed a schema-focused approach to the treatment of personality disorder by hypothesizing that personality disorders are the result of one of 18 early maladaptive schemas. Young (1998) suggested that those with NPD are characterized by three core maladaptive schemas (entitlement, emotional deprivation, and defectiveness) and a number of secondary schemas (e.g., approval seeking, subjugation, mistrust, avoidance) that are clustered into separate aspects of the self (special self, vulnerable child, and self-soother), which all alternate in reaction to changes and events in the environment. Although Young (1994) developed a measure to assess which schemas are present or active, he was not specific regarding the association between a particular schema and its corresponding personality disorder, nor has there been any research examining the validity of this model.

A number of authors have recently described assessment and diagnosis of personality disorders from a radical behavioral framework (Koerner, Kohlenberg, & Parker, 1996; Nelson-Gray & Farmer, 1999; Turkat, 1990; Turkat & Maisto, 1985; Turner, 1994; van Velzen & Emmelkamp, 1996).

Koerner et al. (1996) describe a functional analytic assessment procedure in which, in addition to patient reports of their behavior toward others, the therapist's private reactions and feelings are central to diagnosis. They note that if a therapist feels demeaned and belittled, the patient may have features of NPD. It is interesting to note that the approach advocated by these authors is very similar to traditional psychoanalytic approaches in which clinicians are encouraged to improve their diagnostic accuracy by focusing on their own countertransference responses to patients (Gunther, 1976; Kernberg, 1975a; Wolf, 1979).[3]

Assessment

There have been several attempts to construct measures to assess narcissism. The earliest measure was a self-report questionnaire developed by Henry Murray: the Thematic Apperception Test (TAT; Murray, 1943). Broadly speaking, clinicians and researchers can draw from six information sources when assessing personality disorders: self-report inventories, rating scales and checklists, clinical interviews and ratings, projective techniques, informants, and physiological measurements (neurotransmitter or hormone levels; Millon & Davis, 2000). Only the first three methods will be discussed here, as little data exist on the last three sources.

The self-report instruments for personality disorders most widely used in assessing NPD are the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, Davis, & Millon, 1997), the Personality Diagnostic Questionnaire—Revised (PDQ-R; Hyler, Kellman, Oldham, & Skodol, 1992), the Personality Assessment Inventory (PAI; Morey, 1992), and the Dimensional Assessment of Personality Pathology—Basic Questionnaire (Livesley, Reiffer, Sheldon, & West, 1987). Other personality disorder measures with narcissism scales include the Schedule of Nonadaptive and Adaptive Personality (SNAP; Clark, 1989), the OMNI Personality Inventory (OMNI; Loranger, 2000), the Personality Inventory Questionnaire (PIQ-II; Widiger, 1987), the Wisconsin Personality Disorders Inventory–IV (WIPSI-IV; Klein et al., 1993), and the Minnesota Multiphasic Personality Inventory 2—Personality Disorder Scales (MMPI 2-PD; Morey, Waugh, & Blashfield, 1985). There have been a number of self-report scales developed specifically to assess narcissism. Some have been based on DSM-III criteria. These include the Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979) and the Narcissistic Personality Disorders Scale (NPDS; Ashby et al., 1979). A number of scales have been developed based on MMPI items (Ashby et al., 1979; Morey et al., 1985; Pepper & Strong, 1958; Raskin & Novacek, 1989; Serkownek, 1975; Wink & Gough, 1990). Raskin and Novacek's scale consists of 42 items selected from the MMPI item pool, using the NPI as an empirical criterion. Two scales, Serkownek's (1975) Narcissism-Hypersensitivity Scale and Pepper and Strong's (1958) Ego-Sensitivity Scale, were based on factor analyses of MMPI items. Wink and

Gough also developed scales from the California Psychological Inventory (CPI; Gough, 1957, 1987). The most widely investigated narcissism scale is probably the NPI.

There have been a number of self-report scales developed from theoretical perspectives other than that of the DSM. Murray's (1938) narcissism scale assesses the dual dynamics of self-absorption and vulnerability.[4] The O'Brien Multiphasic Narcissism Inventory (O'Brien, 1987) is based on Alice Miller's (1981) conception of narcissism, which includes a healthy authentic experience of seeing how the world relates to oneself and a more dependent, controlling, self-serving way of relating. Robbins and his colleagues developed the Superiority and Goal Instability Scales based on Kohut's (1971) theory (Robbins, 1989, Robbins & Patton, 1985, Robbins & Schwitzer, 1988). Millon's narcissism scale from the MCMI is based on his own social learning theory. Phares and Erskine (1984) have developed a 28-item scale designed to measure the construct of "selfism" within a social-learning framework. The Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, Billington, & Becker, 1986) includes an egocentrism scale. Other narcissism measures include the Margolis-Thomas Measure of Narcissism (MTMN; Mullins & Kopelman, 1988), the narcissistic-competitive items of the Interpersonal Checklist (ICL; LaForge & Suczek, 1955), and the Dynamic Personality Inventory (DPI; Grygier & Grygier, 1976).

Some theorists have recently suggested that the five-factor model of personality may be relevant to conceptualizing personality disorders. Although this model is controversial (see Davis & Millon, 1993, and Westen, 1996, for critiques), review of a number of studies (Ball, Kranzler, Poling, Rounsaville, & Tennen, 1997; Blais, 1997; Bradlee & Emmons, 1992; Cloninger & Svrakic, 1994; Coolidge, Aksamit, & Becker, 1994; Costa & McCrae, 1990; Duggan et al., 2003; Duijsens & Diekstra, 1996; Dyce & O'Connor, 1998; Hendin & Cheek, 1997; Hyer, Matheson, Ofman, & Retzlaff, 1994; Lehne, 1994; Soldz, Budman, Demby, & Merry, 1993; Trull, 1992; Yeung, Lyons, Waternaux, Faraone, & Tsuang, 1993; see Saulsman & Page, 2004, for a review) suggests that there is a strong positive correlation between NPD and extraversion, a strong negative correlation between NPD and agreeableness, and a moderate negative correlation between NPD and conscientiousness. Findings regarding NPD's relationship with neuroticism and openness to experience are inconsistent. Some researchers have found that NPD is positively related to neuroticism, whereas others have found a negative relationship (Bradlee & Emmons, 1992; Buss & Chiodo, 1991). The inconsistent findings regarding NPD's relationship to neuroticism 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). The overall picture of the narcissistic individual in the five-factor model is that of one who is extraverted yet disagreeable, and low in anxiety. This profile can be distinguished from antisocial and histrionic patterns, but not from a passive-aggressive one (Trull, 1992).[5]

Research examining the facets underlying the five factors could provide a sharper picture of the disorder and better validity data. 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. If this is so, NPD can be discriminated from histrionic personality disorder. Likewise, research examining more differentiated aspects of NPD may help to better characterize the disorder (see Bradlee & Emmons, 1992). For example, in examining the relationship between the NPI subscales and the five-factor model's neuroticism, extraversion, and openness measure (NEO-PI; Costa & McCrae, 1985), Bradlee and Emmons (1992) found that the authority subscale of the NPI was positively related to the conscientiousness factor on the NEO-PI and that the superiority subscale of the NPI was positively related to the openness to experience factor on the NEO-PI. Loranger (2000), using factor analysis, found that exhibitionism, assertiveness, and ambition loaded positively on the narcissism scale and that modesty and sincerity loaded negatively.[6]

Shedler and Westen (2004) examined the comprehensiveness of the five-factor model compared to an expanded criteria set. Using the items restricted to the five-factor model, they could replicate the factor structure on a clinical sample. However, they found that the expanded criteria set provided a conceptually richer factor solution that did not resemble the five-factor model but instead resulted in 12 factors: psychological health, psychopathy, hostility, narcissism, emotion dysregulation, dysphoria, schizoid orientation, obsessionality, thought disorder, histrionic sexualization, dissociation, and sexual conflict. They concluded that although the five-factor model is useful for layperson descriptions of normal-range personality features, it omits important clinical constructs and does not capture the complexity of personality pathology.

Overall, self-report measures appear best suited either to assessing NPD at the dimensional level, particularly examining multidimensional aspects of narcissism, or as a screening measure for identifying individuals who might be likely to have a personality disorder. However, they are much less useful for identifying a specific disorder, such as NPD, due to problems with overendorsement of items, especially among distressed individuals, and the potential for underendorsement of items by defensive individuals.

There are also a number of observer-rated measures. Wink (1992a) developed a California Q-Set narcissism prototype. Patton, Connor, and Scott (1982) developed 10 observer-rated scales to measure Kohut's (1971) formulations of narcissism based on self-psychology, although this measure is not well researched.

There are a number of structured interviews for DSM personality disorders that assess NPD, including the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl, Blum, & Zimmerman, 1997), Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II; First, Spitzer, Gibbon, & Williams, 1995), International Personality Disorder Examination (IPDE; Loranger, 1999), Personality Disorder Interview—IV (PDI-IV; Widiger, 1995), Diagnostic Interview for Personality Disorders (DIPD; Zanarini, Frankenburg, Chauncey, & Gunderson, 1987; Zanarini et al., 2000), and Personality Assessment Schedule (PAS; Tyrer et al., 1988).

Two additional instruments with unique properties are the Personality Assessment Form (PAF; Shea, Glass, Pilkonis, Watkins, & Docherty, 1987) and the Shedler-Westen Assessment Procedure (SWAP; Westen & Shedler, 1999). The PAF presents a brief paragraph that describes important features of each personality disorder, and the individual's similarity to the description is rated by an evaluator using a six-point scale. The PAF is not a structured interview in that it does not provide systematic assessment or questions for evaluation. The SWAP is a 200-item Q-set of personality-descriptive statements designed to quantify clinical judgment. Clinicians are directed to arrange the 200 items (presented on separate index cards) 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. One important finding with use of the SWAP is a reduction of comorbidity with other personality disorders, especially Cluster B personality disorders. This reduction in comorbidity appears important, because lack of discreteness of Axis II disorders has been a frequent criticism of the construct validity of these disorders. Gunderson's DIN (discussed above) appears to be the only interview measure designed to exclusively assess NPD.

In terms of projective measures, Exner (1969) discussed the pair response as an indicator of narcissism and later developed the Egocentricity Index (EGOI) as an index of excessive self-concern. Harder (1979) constructed a projective narcissism scale for use with the Early Memory Test, the TAT, or the Rorschach. The validity of the EGOI scale as a measure of narcissism is equivocal at best (Exner, 1995; Hilsenroth, Fowler, Padawer, & Handler, 1997; Nezworski & Wood, 1995), and the Harder scale has not been used widely by other investigators. A number of studies have examined Rorschach variables as they relate to the diagnosis of narcissism (Berg, Packer, & Nunno, 1993; Farris, 1988; Gacono, Meloy, & Berg, 1992; Hilsenroth, Hibbard, Nash, & Handler, 1993; Hilsenroth et al., 1997). Findings from these studies are difficult to interpret; however, consistent with the writings of Kernberg and Kohut, narcissistic patients generally look healthier psychologically on various outcome measures than patients with borderline personality disorder.

In sum, both self-report and interview measures have satisfactory reliability; however, at present the evidence for the concurrent validity of these methods to the diagnosis of NPD is only limited. In addition, there is only poor to moderate agreement across personality disorder diagnostic measures and methods (Perry, 1992). Generally, self-report measures result in much higher frequencies of NPD diagnosis than do clinicians or structured interviews. Structured interviews may underdiagnose NPD because of the face validity of the questions and the tendency of individuals with the disorder to deny pathology. Therefore, interviews that allow for the use of clinical judgment may have more validity for NPD diagnosis. Likewise, observation of behavior may be needed and more useful than self-report.

Some interviews specifically utilize behavioral observation. For further discussion of the psychometrics of these measures, see Hilsenroth, Handler, and Blais (1996).

Subtypes

The definition of NPD articulated in the DSM-III and its successors, DSM-III-R, DSM-IV (APA, 1994), and DSM-IV-TR (APA, 2000), has been criticized for failing to capture the intended clinical phenomena (Cooper & Ronningstam, 1992; Gabbard, 1989; Gunderson, Ronningstam, & Smith, 1991). These authors have noted that the DSM criteria, following the conceptual approaches of Kernberg and Millon, have emphasized a more overt form of narcissism. More recently, Cooper (1981), Akhtar and Thomson (1982), Gabbard (1989), and Wink (1991) have suggested that there are two subtypes of NPD: an overt form, also referred to as grandiose, oblivious, willful, exhibitionist, thick skinned, or phallic; and a covert form, also referred to as vulnerable, hypersensitive, closet, or thin skinned (Bateman, 1998; Britton, 2000; Gabbard, 1989; Masterson, 1981; Rosenfeld, 1987). 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 narcissist is hypersensitive to others' evaluations, inhibited, manifestly distressed, and outwardly modest. Gabbard (1989) describes these individuals as shy and "quietly grandiose," with an "extreme sensitivity to slight" which "leads to an assiduous avoidance of the spotlight" (p. 527). Both 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 using factor analyses and correlational methods (Dickinson & Pincus, 2003; Hendin & Cheek, 1997; Hibbard & Bunce, 1995; Rathvon & Holmstrom, 1996; Rose, 2002; Wink, 1992b). Rather than distinguishing between overt and covert types as discrete forms of narcissism, Kernberg (1992) notes that the overt and covert expressions of narcissism may be different clinical manifestations of the disorder, with some traits being overt and others being covert. Kernberg contends 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. The covertly narcissistic individual will often present as shy, timid, and inhibited, but, upon closer contact, reveal exhibitionistic and grandiose fantasies.

Using cluster analysis, DiGiuseppe et al. (1995) found three clusters of narcissistic patients in an outpatient setting. 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 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.

Other distinctions in the expression of NPD have been noted. Bursten (1973) proposed four types of narcissistic personalities: craving individuals, who are clinging, demanding, and needy; paranoid individuals, who are critical and suspicious; manipulative individuals, who derive satisfaction from conscious and deliberate deception of others; and phallic narcissists, who are aggressive, exhibitionistic, reckless, and daring. These distinctions seem overly broad and may include other disorders but generally correspond to the overt-covert distinction (e.g., paranoid and phallic correspond to the grandiose type and craving corresponds to the vulnerable type). In addition, these distinctions lack the complexity and sophistication of the dynamics noted by Kernberg and others. When discussing narcissism in the context of interpersonal relations, Kohut and Wolf (1978) distinguished among "merger-hungry" individuals, who must continually attach and define themselves through others; "contact shunning" individuals, who avoid social contact due to fear that their behaviors will not be admired or accepted; and "mirror-hungry" individuals, who tend to display themselves in front of others. Millon (1998) conceptualized NPD as a prototype and distinguished among several variations, or subtypes, in which the basic personality style may manifest itself. These subtypes represent configurations of a dominant basic personality style (e.g., NPD) and traits of other basic 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, and 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.

Kernberg (1975a) classified narcissism along a dimension of severity from normal to pathological and distinguished among three levels of pathological narcissism based on the degree of differentiation and integration of representation. These three levels correspond to high, middle, and low functioning groups. At the highest level are those patients whose talents are adequate to achieve the levels of admiration necessary to gratify their grandiose needs. These patients may function successfully for a lifetime, but they are susceptible to breakdowns with advancing age as their grandiose desires go unfulfilled. At the middle level are patients with NPD proper, who present with a grandiose sense of self and little interest in true intimacy. At the lowest level are the continuum of patients who have comorbid borderline personality, whose sense of self is generally more diffuse and less stable and

thus more frequently vacillates between pathological grandiosity and suicidality. These individuals' lives are generally more chaotic. Finally, Kernberg distinguished a type of NPD that he called "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. Kernberg (1992) posited that these patients are at high risk for suicide, despite the absence of depression. He suggested that suicidality for these patients represents sadistic control over others, a dismissal of a denigrated world, or a display of mastery over death. Despite the richness of Kernberg's descriptions, we could find no direct research on malignant narcissism. It will be important to differentiate malignant narcissism from NPD proper (as well as from antisocial, paranoid, and borderline personality disorders) and to show that patients meeting Kernberg's criteria for malignant narcissism are at risk for the kinds of difficulties Kernberg described.

Comorbidity

A number of authors have suggested the importance of understanding the co-occurrence or comorbidity of theoretically discrete disorders (Blatt & Levy, 1998; Caron & Rutter, 1991; Carson, 1991; Clarkin & Kendell, 1992; Westen & Shedler, 1999). NPD has had problematically high overlap with other Axis II disorders, most notably antisocial, histrionic, borderline, and passive-aggressive personality disorders (Becker, Edell, Grilo, & McGlashan, 2000; Gunderson, Ronningstam, & Smith, 1991; Morey, 1988; Oldham et al., 1992; Stuart et al., 1998; Widiger et al., 1991; Zanarini et al., 1998), with rates often exceeding 50%. Most patients (80%) meeting criteria for NPD also meet criteria for borderline personality disorder (Pfohl, Coryell, Zimmerman, & Stangl, 1986). Of course, the comorbidity between NPD and borderline personality disorder is not surprising, given that Kernberg's original clinical formulations of NPD, from which many of the DSM-III criteria were adopted, were based on a selected clinical sample of patients with a primary diagnosis of borderline personality disorder (Kernberg, 1967, 1970, 1975a). However, the co-occurrence or comorbidity of NPD with other disorders, although not unique to NPD, is a major problem in justifying and maintaining its validity as a distinct clinical entity (McGlashan & Heinssen, 1989; Morey & Jones, 1998; Ronningstam & Gunderson, 1989).

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 (1989), in two samples of NPD patients—38 inpatients and outpatients and 34 consecutively admitted outpatients—reported that 42% and 50% of the patients, respectively, had comorbid depressive mood disorder, 24% and 50% had comorbid substance abuse disorder, and 5% and 11% had comorbid bipolar disorder.

Ronningstam (1996) reviewed the available literature on concomitant NPD and Axis I disorders and found that between 12% and 38% of patients with substance use disorder and between 4% and 47% of those with bipolar disorder were diagnosed with NPD. Thus a lot of variation exists in the comorbidity between NPD and other disorders. The reasons are unclear, but one interpretation that can be distilled from these findings is that no single Axis I disorder is most often associated with NPD. A number of studies have examined the comorbidity of NPD with bipolar disorder (Bieling et al., 2003; Brieger, Ehrt, & Marneros, 2003; Carpenter, Clarkin, Glick, & Wilner, 1995; Corruble, Ginestet, & Guelfi, 1996; George, Miklowitz, Richards, Simoneau, & Taylor, 2003; Kutcher, Marton, & Korenblum, 1990; O'Connell, Mayo, & Sciutto, 1991; Pica et al., 1990; Pesslow, Sanfilipo, & Fieve, 1995; Stormberg, Ronningstam, Gunderson, & Tohen, 1998; Turley, Bates, Edwards, & Jackson, 1992). Generally, these studies found higher than average prevalence rates for NPD. These prevalence rates were much higher when the patients were actively hypomanic or manic compared to when they were euthymic, suggesting that mania should be considered in the differential diagnosis of NPD or that the criteria for NPD and mania need to be more clearly differentiated.

With regard to Axis II disorders, McGlashan and his colleagues (McGlashan et al., 2000), in conducting the Collaborative Longitudinal Personality Disorder Study, found that 8% of borderline personality disorder patients had comorbid NPD. This percentage did not differ from the percentage of patients with comorbid schizotypal personality disorder or the percentage of those with obsessive-compulsive personality disorder but was significantly higher than the percentage of patients with comorbid 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 of male patients (Kernberg, 1975a; Kohut, 1971, 1977).[7] Consequently, several theorists have raised questions regarding whether narcissism as defined by the DSM can be generalized to women (e.g., Akhtar & Thomson, 1982; Philipson, 1985). A number of authors (Haaken, 1983; Harder & Lewis, 1987; Harder & Zalma, 1990; Hárnik, 1924; O'Leary & Wright, 1986; Philipson, 1985; Reich, 1953, 1960; Richman & Flaherty, 1988, 1990) have suggested that the distinction between covert and overt narcissism may exist along gender lines, with the grandiose type being stereotypically male and the hypersensitive type being stereotypically female. However, the empirical support for this contention remains equivocal.

Although a number of studies have found greater prevalence rates for NPD in men (Alnaes & Torgerson, 1988; Golomb, Fava, Abraham & Rosenbaum, 1995; Grilo et al., 1996; Ronningstam & Gunderson, 1991; Stone, 1989), these findings are inconsistent with many studies failing to find gender differences in the rates of NPD (Black, Noyes, Pfohl, Goldstein, & Blum, 1993; Grilo et al., 1996; Kass, Spitzer, & Williams, 1983; Plakun, 1989; Reich, 1987; Torgersen, Kringlen, & Cramer, 2001; Zimmerman & Coryell, 1989). Torgersen et al. (2001) found no differences between men and women in the prevalence of NPD, and Grilo et al. (1996), in an adult sample, found no gender differences in NPD. Ekselius, Bodlund, Knorring, Lindstrom, and Kullgren (1996) and Richman and Flaherty (1990) 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 (1990) found that men scored significantly higher on five of the six traits, whereas women scored significantly higher only on the criterion of becoming upset over slights. Ekselius et al. (1996) found gender differences on five criteria: (1) self-importance; (2) fantasies of unlimited power, success, beauty; (3) believes self to be special or only understood by special people; (4) lacks empathy; and (5) envious of others or believes others are envious of them. However, women scored higher on three of the four criteria, the exception being criterion 3 (believes self to be special or only understood by special people).

The findings regarding gender differences in dimensional scores on narcissism are also inconsistent (Auerbach, 1984; Emmons, 1984, 1987; Jackson, Ervin, & Hodge, 1992; Raskin et al., 1991a; Rhodewalt & Morf, 1995, 1998; Weirzbicki & Goldade, 1993). One somewhat consistent finding is that men score higher on average than women on dimensional measures of narcissism (Carroll, 1987; Farwell & Wohlwend-Lloyd, 1998; Gabriel, Critelli, & Ee, 1994; Narayan, 1990; Stangl, Pfohl, Zimmerman, Bowers, & Corenthal, 1985; Tschanz, Morf, & Turner, 1998; Watson, Grisham, Trotter, & Biderman, 1984). In a sample of predominantly Mormon men and women, Tschanz et al. (1998) found that although men and women showed highly similar patterns of narcissism, the NPI exploitativeness-entitlement factor was not as well integrated into the profile of narcissism for women. Some studies have found that women score higher on dimensional measures than men (Hynan, 2004; McCann et al., 2001). When gender differences were found, these tended to be small and of questionable meaningfulness (e.g., Buss & Chiodo, 1991; Carroll, 1987; McCann & Biaggio, 1989). In addition, it is unclear if and how gender moderates the relationship between narcissism and behavior, or other important variables, in systematic ways. In sum, the empirical support for gender differences remains ambiguous.

Age

The presence of narcissistic disturbances has been demonstrated in both children (Abrams, 1993; Bardenstein, 1994; Weise & Tuber, 2004) and adolescents (Bernstein et al., 1993; Grilo et al., 1998; Kernberg, Hajal, & Normandin, 1998; Westen, Shedler, Durrett, Glass, & Martens, 2003). In a consecutively admitted inpatient sample of adolescents, Grilo et al. (1998) found that 4% of the inpatients were reliably diagnosed with NPD using structured interviews. Bernstein et al. (1993), in a longitudinal study, found that the rates of NPD decreased from ages 11–14 to ages 18–21. NPD has been found in the elderly (Abrams, Alexopoulos, & Young, 1987; Abrams, Rosendahl, Card, & Alexopoulous, 1994; Ames and Molinari, 1994; Berezin, 1977; Kernberg, 1977).

Etiology

The empirical data on the etiology of NPD are extremely limited. The theoretical causes of narcissism are mainly derived from the psychodynamic object relations theories of Kernberg (1975a), Kohut (1971, 1977), and Masterson (1990). Most of the work by psychoanalytic theorists in this area has been based on inferences drawn in the clinical setting from patients' recollections of childhood family dynamics and/or analysis of how patients relate to therapists during session. More recently, Fonagy, Gergely, Jurist, and Target (2002) and Schore (1994) have discussed the development of narcissism from a psychoanalytic perspective, using a combination of object relations theory and more explicit integration of empirical findings from developmental psychology.

From an attachment theory perspective, Bowlby (1973, 1979) conceptualized narcissism as the result of an insecure attachment style between child and caretaker, which affects the child's emerging self-concept and developing view of the social world. Bowlby postulated that insecure attachment lies at the center of disordered personality traits and linked the overt expression of felt insecurity to specific characterological or personality disorders. Bowlby (1979) believed that attachment difficulties increase the vulnerability to psychopathology and that different types of insecure attachment patterns are linked to specific types of difficulties that may arise later in development. For instance, Bowlby (1973) connected anxious ambivalent attachment to "a tendency to make excessive demands on others and to be anxious and clingy when they are not met, such as is present in dependent and hysterical personalities" and avoidant attachment to "a blockage in the capacity to make deep relationships, such as is present in affectionless and psychopathic personalities" (p. 14). Avoidant attachment, Bowlby (1973) postulated, results from constantly being rebuffed in one's appeals for comfort or protection, and such individuals "may later be diagnosed as narcissistic" (p. 124).

In Kernberg's (1966, 1975a, 1975b, 1984, 1992) view, narcissism develops as a consequence of parental rejection, devaluation, and an emotionally invalidating environment in which parents are inconsistent in their investment in their children or often interact with their children to satisfy their own needs. For example, at times a parent may be cold, dismissive, and

neglectful of a child, and then at other times, when it suits the parent's needs, be attentive and even intrusive. This parental devaluation hypothesis states that because of cold and rejecting parents, the child defensively withdraws and forms a pathologically grandiose self-representation. This self-representation, which combines aspects of the real child, the fantasized aspects of what the child wants to be, and the fantasized aspects of an ideal, loving parent, serves as an internal refuge from the experience of the early environment as harsh and depriving. The negative self-representation of the child is disavowed and not integrated into the grandiose representation, which is the seat of agency from which the narcissist operates. This split-off unacceptable self-representation can be seen in the emptiness, chronic hunger for admiration and excitement, and shame that also characterize the narcissist's experience (Akhtar & Thomson, 1982).

What Kernberg (1975a) sees as defensive and compensatory in the establishment of the narcissist's grandiose self-representation, Kohut (1971) views as a normal development process gone awry. Kohut sees pathological narcissism as resulting from failure to idealize the parents because of rejection or indifference. For Kohut, childhood grandiosity is normal and can be understood as a process by which the child attempts to identify with and become like his idealized parental figures. The child hopes to be admired by taking on attributes of perceived competence and power that he or she admires in others. In normal development, this early grandiose self eventually contributes to an integrated, vibrant sense of self, complete with realistic ambitions and goals. However, if this grandiose self is not properly modulated, what follows is the failure of the grandiose self to be integrated into the person's whole personality. According to Kohut, as an adult, a person with narcissism rigidly relates to others in "archaic" ways that befit a person in the early stages of proper self-development. Others are taken as extensions of the self (Kohut's term is "selfobject") and are relied upon to regulate one's self-esteem and anxieties regarding a stable identity. Because narcissists are unable to sufficiently manage the normal fluctuations of daily life and its affective correlates, other people are unwittingly relegated to roles of providing internal regulation for them (by way of unconditional support admiration and total empathic attunement), the same way a parent would provide internal regulation for a young child.

In contrast to Kernberg and Kohut, Millon (1981) articulated an evolution-based social learning theory of narcissism. Millon sees narcissism developing not as a response to parental devaluation but rather as a consequence of parental overvaluation. According to Millon, as a child, the narcissistic individual is treated as a special person, given much attention, and led by parents to believe he or she is lovable and perfect. Millon (1981) contends that such unrealistic overvaluation will lead to self-illusions that "cannot be sustained in the outer world" (p. 165). According to Millon, firstborn and only children are more vulnerable to narcissism because they tend to receive an abundance of attention and special treatment. However, the evidence is

mixed regarding birth order, and there is no evidence that only-child status is related to narcissism. Two studies found that narcissism was related to firstborn status (Curtis & Cowell, 1993; Joubert, 1989); however, two studies found that narcissism was not related to birth order (Eyring & Sobelman, 1996; Narayan, 1990). Watson and Biderman (1989) also did not find any relationship between only-child status and narcissism. It is likely that the constructs of firstborn status and only-child status are not sensitive enough to account for the multiplicity of reasons that a parent may identify and treat a child as special or as threatening.

Also from a psychoanalytic perspective but attempting to bridge theory and empirical research is the promising work of Peter Fonagy (Fonagy et al., 2002). In drawing from scientific research to propose etiologic theories of NPD that conform to the most modern understanding of child development, Fonagy's work escapes some of the heavy criticism inspired by the developmental inconsistencies implicit in Kernberg's and Kohut's models (Auerbach, 1993; Westen, 1985). Fonagy and his colleagues (Fonagy et al., 2002) rest their theory of affect regulation and mentalization on a social biofeedback model of development that grew out of infant observational research (Gergely & Watson, 1996). In this model, the infant's psychological self is built through a pattern of contingency detection linked to parental affect mirroring. This process of affect mirroring provides the cognitive-affective scaffolding that leads to the infant's burgeoning representational capabilities. Fonagy and his colleagues posit that the pathological form of this process could make one vulnerable to the development of narcissistic pathology. In short, when parental affect mirroring is noncontingent in that the infant's emotion is acknowledged but misperceived by the caregiver, the baby will feel related to in ways that can only be experienced as foreign. In other words, in the early development of a subjective sense of self, the baby looks toward the primary caregiver to see his or her emotional state mirrored, elaborated, and fully established, but in the case of incongruent parental mirroring, he or she instead finds a noncontingent "alien self" reflected. According to this theory, the narcissist is one whose core sense of agency and experience is only partially integrated into his or her total personality, since it remains obscured by the ongoing experience of the false self. Because of the lack of integration of these two competing self-representations, the narcissist lacks the range of representational capabilities to regulate his or her affect and hold on to a stable self-representation, which is independent of others' perceptions of him or her.

Alan Schore (1994, 2003) focuses on the connection between neurophysiological development and parent-infant interactional processes in relation to the etiology of pathological narcissism. He describes the normal psychophysiological function of shame, which begins to serve an important role after the first year of life and continues to serve as a modulator for states of high arousal and affect. With respect to narcissistic pathology, Schore posits that the initial difficulties in the caregiver-infant dyad occur

during the 16- to 24-month period. It is during this period, he suggests, that consistent improper parental modulating of infant affect, particularly during the infant's heightened affect states (which he sees as a form of grandiose hyperarousal), leaves the child without the ability to tolerate negative, shame-related affect resulting from normal narcissistic injury. Instead of being able to use shame to help regulate the self, the narcissist strives to evade the feeling of shame, which he or she experiences as intolerable and overwhelming. In many cases, Schore points out, misattunement takes the form of the mother hyperstimulating the child into dyscontrol, or failing to help the child recover from states of hypoarousal which she may have herself induced. As in Fonagy's model, what the narcissist lacked in childhood was the proper establishment of certain autoregulatory processes, mainly achieved within the infant-caregiver dyad during the first few years of life.

It is important to note that the theories of Kernberg, Kohut, Fonagy, Bowlby, and other psychodynamic theorists (e.g., Winnicott, 1960/1965) are probabilistic and not deterministic. That is, these theorists do not suggest that narcissistic personality develops in early childhood. Rather, each of these theories proposes that the potential for the disorder begins with early disruptions in the relationship with caregivers, but that these initial disruptions are elaborated over time due to the consistency of the caregiver's problematic behavior over the course of the child's development and the consistency created by the child's resulting expectations and behavior toward others. Fonagy's noncontingent parent is likely to continue to interact noncontingently with his or her child throughout the child's development, and the child is likely to experience ongoing difficulties in both integrating representations of the core and false selves and developing self-regulatory capacities. Likewise, Kernberg's cold and rejecting but intrusive parent is likely to continue to be cold, rejecting, and intrusive throughout the child's development, and the child is likely to continue to withdraw from the parent and increasingly attend to and depend on his or her defensively grandiose self-representation. Thus at each nodal point in development, the child experiences narcissism-inducing environments, and his or her range of behaviors and expectations is consistent with such environments. This idea that early vulnerabilities are maintained, reinforced, and possibly elaborated with subsequent experience is consistent with a number of current developmental theories of personality formation (Bowlby, 1979; Caspi, 2000; Cicchetti & Toth, 1998; Sroufe, Egeland, Carlson, & Collins, 2005) and the integrative work of Paul Wachtel (1977, 1994). Wachtel (1977, 1994) hypothesized that personality patterns, though heavily influenced by early experiences, are in large part sustained and perpetuated through current day-to-day interactions with others. He suggested that narcissistic individuals enlist others as "accomplices" in recapitulating experiences from the past and thus self-verifying beliefs about both oneself and others (Wachtel, 1987).

In a retrospective study of early parenting styles among college undergraduates, Watson, Little, and Biderman (1992) found that the Exploitativeness/Entitlement subscale of the NPI was negatively correlated with mature

authoritative parenting style and positively correlated with parental permissiveness. In Paul Wink's (1992b) longitudinal study of narcissism among a sample of Mills College women, he found that his group of "hypersensitive" (or covert) narcissists described their parental relationships as generally lacking warmth and claimed feelings of insecurity toward their mothers. His "willful" (or overt) narcissists reported an attitude of dislike toward their mothers with concurrent pride in their fathers.

Wink's (1992b) findings seem to confirm and even expand some of Block's (1971) observations of his female "dominating narcissists" group. Block followed this group from junior high school through adulthood and found that the familial context common among these women was characterized by parental discord; a dominant, self-indulgent, and extraverted father; and a neurotic, somewhat dysphoric, vulnerable mother. Block suggests that the extremely aggressive, condescending, self-indulgent, undercontrolled dominant narcissist seen in his adult sample was the product of identification with one's detached but impressive father.

Genetic hypotheses related to the development of narcissism have not been articulated. NPD has not been assessed in any family or adoption studies, although there are some initial twin study data relevant to its etiology. Livesley, Jang, Jackson, and Vernon (1993), using the Dimensional Assessment of Personality Pathology (DAPP), reported the heritability of narcissism to be 53%. The heritability of the specific traits of need for adulation, attention seeking, grandiosity, and need for approval ranged from 37% for grandiosity to 50% for need for approval. Torgersen and his colleagues (2000) examined heritability in 92 monozygotic (MZ) and 129 dizygotic (DZ) twin pairs using the SCID-II. They found 45% concordance in MZ twins and 9% in DZ twins using a broad definition of NPD (three or more criteria met). Heritability was 79%; however, this estimate was determined using broad definition diagnoses, best-fitting models did not include shared environmental effects, and interviewers assessed both twins and were not blind to zygosity status. All three of these limitations are known to inflate the estimates of genetic effects.

Two other studies examined the genetic effects of narcissism (Coolidge, Thede, & Jang, 2001, 2004). In these studies, parents were asked to assess their children's personality disorder features using the Coolidge Personality and Neuropsychological Inventory for Children (CPNI; Coolidge, 1998; Coolidge et al., 1990, 1992; Coolidge, Thede, Stewart, & Segal, 2002). In the 2001 study, 112 twin pairs (70 MZ and 42 DZ) were assessed; findings revealed a 66% concordance in MZ twins and a 34% concordance in DZ twins. In addition, these findings yielded a 66% heritability index. The generalizability of these findings is limited by three methodological shortcomings: (1) the effects of environment on development were not estimated, (2) the sample was not recruited representatively, and (3) personality disorder traits were rated by parents. Parents are of course not blind to zygosity, and there is evidence that they tend to overestimate trait concordance in MZ twins (Hoffman, 1991). In their 2004 study, Coolidge and his colleagues

attempted to reduce the influence of preconceived ideas about twin similarity by having parents complete questionnaires on different days. A wholly environmental model specifying shared and nonshared environmental influences provided the most satisfactory fit to the narcissistic personality disorder scales; no heritable influence was detected for narcissistic personality disorder.

Paris (1993) suggested that the etiology of personality disorders is unlikely to be underpinned by simple, linear, monocausal processes; complex interactive processes among variables are likely to be involved in the etiology of personality disorders. A primary difficulty is the absence of a clear definitive phenotype, which is required for the establishment of inheritance. Lack of diagnostic clarity (e.g., misdiagnosis, overlap) inevitably leads to spurious estimates of inheritance (Jang & Vernon, 2001). Given the contradictory findings and limitations of the study designs, it is safe to say that at present the heritability of narcissistic personality disorder is uncertain.

Last, no studies have been conducted to directly identify biological markers for narcissistic personality disorder, although a number of studies have examined biological markers in near neighbor disorders, such as borderline personality disorder and antisocial personality disorder, and some studies have examined markers in vague groups that might have included narcissistic patients (e.g., patients with Cluster B personality disorders or those high in impulsive aggression). However, it is difficult to know if there is a specific effect for NPD.

Course and Long-Term Outcome

Data on the long-term course and outcome of NPD are sparse. There is little systematic follow-up information on this group. Plakun (1989) compared the long-term (approximately 14-year) outcome of 17 inpatients with NPD with that of 33 inpatients with borderline personality disorder and showed that the outcome of the latter was superior. NPD patients were more likely to have been readmitted and had poorer overall functioning and sexual satisfaction. McGlashan and Heinssen (1989) found that, over time, individuals with NPD show decreases in destructive interpersonal behaviors. However, both McGlashan and Heinssen (1989) and Stone (1989) found no differences over time in global functioning between narcissistic and borderline patients (provided there was no antisocial comorbidity). Ronningstam, Gunderson, and Lyons (1995) examined change in narcissism over a 3-year period in 20 treated patients diagnosed with NPD. They found that the majority of their patients (60%) who initially had NPD showed significant improvement in their levels of pathological narcissism at 3-year follow-up. Although grandiosity had differentiated narcissistic patients from borderline patients in an earlier study (Ronningstam & Gunderson, 1991), it did not predict stability of the disorder over time. Patients who continued to show high levels of narcissistic pathology were significantly more narcissistic in their interpersonal relationships and lacked a commitment to anyone.

Ronningstam and her colleagues (1995) found some evidence that three events might have effected change in the narcissistic pathology: (1) corrective achievements, (2) corrective disillusionments, and (3) corrective relationships. In a 30-month follow-up of depressed outpatients, Ferro, Klein, and Schwartz (1998) also found low stability for NPD, particularly compared to other personality disorders. In fact, narcissistic personality at baseline was more highly correlated with eight other disorders than with itself at follow-up. In contrast, Grilo, Becker, Edell, and McGlashan (2001) found that narcissism assessed dimensionally was stable over a 2-year period. 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; for other patients, NPD was a comorbid disorder (with depression or borderline personality disorder). Only the Grilo et al. (2001) study utilized consecutively admitted patients. The use of nonconsecutive samples complicates the interpretation of the data, because the study groups may be skewed in some undefined way. For example, patients agreeing to participate may be more engaged with their therapists or may be more distressed, both of which factors have been related to better outcome (Clarkin & Levy, 2003). Second, some studies examined treated patients, which is likely to have influenced the outcome.

The most extensive work on the course of narcissism has been carried out in nonclinical samples in the context of examining normal development (Block, 1971; Wink, 1992a, 1992b). In *Lives Through Time*, Block (1971) reported that between ages 18 and 30, women classified as "dominant narcissists" increased in socialization and consideration of others. However, they continued to be egotistically dominating and exploitative. Over a 20-year period, Wink (1992b) examined the relationship between narcissism and midlife development in a sample of Mills College women who graduated between 1958 and 1960. Using the California Q-Set, Wink identified three patterns of narcissism—hypersensitive, willful, and autonomous (or healthy)—that showed quite distinct patterns of personality change during the transition from college to midlife. In their early 40s, hypersensitive narcissists showed a course of steady decline relative to how they had been functioning in their early 20s. Willful narcissists showed little change at age 43 relative to age 21, after showing some growth in their late 20s. Autonomous, or healthy, narcissists, following conflict in their late 20s, experienced a surge of personality development by their early 40s, as indicated by satisfying intimate interpersonal relationships and career satisfaction and successes.

Treatment Research

Recommendations for psychotherapeutic management of patients suffering from NPD are based primarily on clinical experience and theoretical formulations. These clinical case studies illustrate that some patients with NPD can

be treated successfully while others fail to respond to treatment. These patients are believed to be difficult to treat because they are unable to admit weaknesses, appreciate the effect their behavior has on others, or incorporate feedback from others. However, no randomized controlled treatment studies on NPD exist (Groopman & Cooper, 2001; Oldham, 1988). There are a number of psychotherapy studies of patients with a specific personality disorder, a subset of personality disorders, personality disorders in general, or Axis I disorders that have included patients with NPD. However, these controlled studies are difficult to interpret because they focused on mixed personality disorders without specifying narcissistic cohorts. One exception is a naturalistic study by Teusch, Böhme, Finke, and Gastpar (2001), which examined the effects of client-centered psychotherapy (CCT) on personality disorders, alone and in combination with psychopharmacological treatment. They examined the effect of diagnostic subgroup of personality disorder on outcome. For NPD, they found that CCT, as compared to CCT plus medication,[8] led to greater reductions in depression. The authors speculated that the CCT-only group might have experienced more autonomy and self-efficacy. Given the difficulty in medicating personality-disordered patients, it is also possible that the prescribed medication regimens had a negative effect. Callaghan, Summers, and Weidman (2003) presented single-subject data on a patient with histrionic and NPD behaviors who was treated with functional analytic psychotherapy (Kohlenberg & Tsai, 1991). They reported significant changes in NPD behaviors during the psychotherapy sessions. Using lag sequential analysis, they linked 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, Fowler, & Padawer (1998), in a study of early termination in a university-based community clinic, found that NPD patients had the largest percentage of dropout (64%). In addition, the criterion "requires excessive admiration" was one of four DSM-IV criteria that significantly predicted dropout. The follow-up studies of Plakun, McGlashan, Ronningstam, and Stone and their respective colleagues (Plakun, 1989; McGlashan & Heinssen, 1989; Ronningstam et al., 1995; Stone, 1989) were all carried out on treated samples and therefore bear some limited implications for treatment. Generally, these studies show improvement over time in the treated samples. In Ronningstam et al.'s (1995) prospective follow-up study, retrospectively obtained information about treatment experiences suggested that treatment utilization was not differentially distributed among the patients who improved and those who did not. However, the authors acknowledged that the treatment reports were not sufficiently detailed or structured to enable one to draw valid conclusions. Pharmacological treatment of NPD without Axis I comorbidity has not been sufficiently studied. Abramson (1983) presented a series of case reports in which he prescribed the benzodiazepine lorazepam in adjunct to standard individual psychotherapy in the treatment of patients exhibiting what Kohut (1973) referred to as

"narcissistic rage." In all three cases, lorazepam resulted in relief from tensions associated with feeling slighted and angry, with minimal adverse effects. However, although each case was characterized by extremely angry outbursts and rage in response to feelings of being insulted or slighted, 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 (Raulin & Lilienfeld, 1999). Given the absence of controlled trials, lack of data in general, and the limitations of the studies carried out thus far, clinical practice guidelines for the disorder are yet to be formulated.

Narcissistic Personality Disorder and Suicidality

Some have suggested that suicidality in patients with NPD is high because their self-esteem is fragile (Perry, 1990). However, there is little research on suicidality and NPD. Kernberg (1992) posited that these patients are at high risk for suicide despite the absence of depression. Stone (1989) found that patients with comorbid borderline personality disorder and NPD were at higher risk for suicide than borderline patients without NPD. Apter and his colleagues (Apter, King, & Kron, 1993) conducted a postmortem study examining the diagnoses of a group of young men who had committed suicide. They found that over 20% of the young men had been diagnosed with NPD. Although the seminal Stone study is historically important and many findings from it have been confirmed by later research, the lack of blind, structured, and reliable interviews permits only tentative conclusions.

Narcissism and Culture

Although the concept of narcissism and the diagnosis of NPD have been conceptualized in a cultural and sociopolitical context, to date there has been little research on the relationship between culture and narcissism. Lasch (1979) called narcissism the "hallmark" of American culture in which "prevailing social conditions . . . tend to bring out narcissistic traits that are present, in varying degrees, in everyone" (p. 50). He posited that the modernization of Western society, with its focus on rugged individualism, mobility, breakdown of extended family systems, and increased consumerism, has contributed to the development of a pervasive narcissistic personality style.

Rivas (2001) suggested that the exclusion of NPD from the International Classification of Diseases (ICD) may provide some indication of the significantly lower prevalence of NPD in cultures outside the United States. He further suggested that this may be "evidence of its cultural entrenchment" (p. 30). However, just as some cultural styles may be mistaken for narcissistic personality traits, it is just as likely that some cultures may tolerate

narcissistic traits and therefore minimize the disorder. It is certain that the paucity of research studies sufficiently examining any existing cultural differences in the expression, etiology, or prevalence of the disorder renders it difficult to conclude anything about the generalizability of pathological narcissism outside the United States.

In contrast, some have argued that a number of culturally determined interpersonal styles can be misconstrued as narcissistic (Alarcon & Foulks, 1995; Martinez, 1993; Smith, 1990) and that narcissism may be manifested differently in other cultures (Warren & Capponi, 1996). Roland (1991) suggested that Western-centric norms are not reflected in Japanese culture and that narcissism would appear more covert in Japan as opposed to the exhibitionistic form prevalent in America. However, Sato, Sakado, and Sato (1993) found that 18.8% of 96 nonbipolar outpatients with major depression in a Japanese clinic met criteria for DSM-III-R NPD (the overtly exhibitionistic American type). In fact, NPD was the third most common disorder overall, and the most common disorder among younger adult patients (under age 32). In contrast, Smith (1990) found fewer narcissistic traits among Asian-American women compared to Caucasian-American women (using the NPI [Raskin & Terry, 1988]). Recently, Foster, Campbell, and Twenge (2003) employed the Internet in a worldwide study of narcissism using the NPI. They found that self-identified White and Asian participants reported less narcissism than did either Black or Hispanic participants. Respondents from the United States produced the highest levels of narcissism compared to (in descending order) Europe, Canada, Asia, and the Middle East. Consistent with the findings of Foster et al. (2003), Choca, Shanley, Peterson, and Van Denburg (1990) examined the MCMI scores of African-American and Caucasian men hospitalized at a VA hospital and found that African-Americans scored higher on the narcissism scale than the Caucasians. The relative paucity of systematic research on culture highlights the need for increased and more sophisticated work in this area.

Further Research and Recommendations for DSM-V

Although research on NPD has generally been insufficient, there has been significant progress in the empirical research describing NPD. These data are based largely on systematic assessments of patient groups using structured clinical interviews to assess all Axis II disorders. The existing data suggest that NPD occurs frequently enough that DSM-V should continue to include it in some fashion. Nevertheless, there are a number of limitations in the existing data that should be addressed by DSM-V. First, most research on NPD has not examined the concordance between DSM-IV criteria and the essential features of the disorder as seen in clinical practice. Recent research by Westen and his colleagues (Westen & Shedler, 1999) has begun looking at this process; if it is replicated, this research will suggest that DSM-V broaden the criteria set to include controlling behaviors, tendency to engage in power struggles, and competitiveness. A second issue concerns the fact that patients who meet criteria for NPD rarely do not 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 Shedler (1999) has shown that broadening the NPD criteria set significantly reduces the overlap with other Axis II disorders. In addition to these two issues, there is a desperate need for validation studies to determine if a NPD diagnosis predicts etiology, course, and/or treatment response. Ultimately, the value of the diagnosis will rest on whether or not it is useful for predicting adult outcomes and treatment response.

Conclusions

The concept of narcissistic character, disorder, and/or organization was first articulated in 1925 by Waelder and further expanded by Nemiah, Kernberg, Kohut, and Millon. NPD was introduced into the official diagnostic system in 1980 (APA), and its criteria are based heavily upon the writings of Kernberg, Kohut, and Millon.

Although there is general agreement on the trait and behavior descriptions of narcissism—focusing on the feelings of exaggerated self-importance, privilege, grandiosity, and expectation of special treatment—there is little consensus on the etiology, prevalence, assessment, and dynamics of the disorder. Despite the official recognition of the disorder in 1980, there has been disappointingly little empirical study of its course, treatment, and outcome. Data on the naturalistic course and outcome of the disorder are sparse, with information typically based upon small or selected samples of patients followed for relatively short periods of time. 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.

There are no randomized, controlled treatment studies of patients with NPD. Consistent with clinical experience, the limited data available suggest that patients with significant narcissistic traits are prone to early dropout but show some improvement in response to treatment. Given the clinical interests and documented impairment of patients with the disorder, more research on its treatment and prevention is sorely needed.

Notes

1. Narcissus is a flower whose name derives is derived from the Greek word *narke* (where we get *narcotic*) by virtue of its power to alleviate pain and suffering.

2. In the course of his writings, Freud used the term "narcissism" to describe (1) a stage of normal infant development, (2) a normal aspect of self-interest and self-esteem, (3) a way of conducting interpersonal relationships, especially by choosing a partner based on his or her similarity to the self (overinvestment of self) rather than his or her real aspects, and (4) a way of relating to the environment characterized by a relative lack of interpersonal relations. These multiple uses of the term have resulted in significant confusion about the concept, which persists even today.

3. Kernberg discussed countertransference as one of the three main channels a therapist uses to understand a patient's experience. Additionally, Kohlenberg and Tsai (1994) discussed the similarities between a functional analytic approach and a psychoanalytic approach.

4. Murray (1938), building on earlier theorists, such as Freud, developed a measure that assessed both the grandiose self-centered aspect of narcissism and the tendency of these individuals to present this way to mask a fragile, vulnerable, hypersensitive self.

5. Passive-aggressive personality disorder is no longer included in DSM-IV, but studies of the comorbidity of DSM-III-R NPD have found it most often comorbid with passive-aggressive personality disorder (Oldham et al., 1992).

6. Hendin and Cheek (1997) found that the NPI correlated positively with extraversion and openness to experience and that hypersensitivity correlated negatively with extraversion, agreeableness, and openness to experience but positively with neuroticism. Exploitativeness-entitlement correlated negatively with agreeableness and positively with neuroticism.

7. Of the 29 cases presented as exemplary of narcissistic personality disorder in the three major works on narcissism (Kernberg's [1975a] *Borderline Conditions and Pathological Narcissism* and Kohut's [1971, 1977] *Analysis of the Self* and *Restoration of the Self*), only five of the cases are of women.

8. Thirty-seven of the 46 patients in this condition received antidepressants and a benzodiazepine, and nine patients received low-dose neuroleptics along with either benzodiazepines or beta blockers.

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