

Narcissistic Personality Disorder and the *DSM-V*

Joshua D. Miller
University of Georgia

Thomas A. Widiger
University of Kentucky

W. Keith Campbell
University of Georgia

We address 3 issues relevant to narcissistic personality disorder (NPD) and the *DSM-V*. First, we argue that excluding NPD while retaining other traditional personality disorder constructs (e.g., avoidant) makes little sense given the research literature on NPD and trait narcissism and their association with clinically relevant consequences such as aggression, self-enhancement, distorted self-presentation, failed relationships, cognitive biases, and internalizing and externalizing dysregulation. Second, we argue that the *DSM-V* must include content (in diagnostic form or within a dimensional trait model) that allows for the assessment of both grandiose and vulnerable variants of narcissism. Finally, we suggest that any dimensional classification of personality disorder should recover all of the important component traits of narcissism and be provided with official recognition in the coding system.

Keywords: narcissism, narcissistic personality disorder, *DSM-V*, diagnosis

The American Psychiatric Association's (APA) Personality and Personality Disorders (PPD) Work Group for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* is well into the process of developing its proposed revisions. The Work Group began meeting in 2007, and the final product is anticipated to be published in 2013. The purpose of the current article is to discuss these three fundamental taxonomic issues for the diagnosis of pathological narcissism: (a) whether narcissism should be deleted from the diagnostic manual (as suggested in the proposal put forth by the *DSM-V* PPD Work Group), (b) the need for the *DSM-V* personality disorders (PDs) system to be able to assess different variations of narcissism, and (c) how to best characterize narcissistic traits within an alternative dimensional model of classification. Each of these issues will be discussed in turn, followed by a set of explicit recommendations.

Should Narcissism Be Excluded From the *DSM-V*?

Any discussion of how narcissism should be classified within the *DSM-V* must first address the question of whether any representation of narcissism will be included. The latest meeting of the International Society for the Study of Personality Disorders (ISSPD) included the symposium "Narcissistic Personality Disorder and *DSM-V*." Each paper offered proposed revisions to narcissistic personality disorder (NPD; e.g., Levy, 2009). Donna S. Bender, a member of the *DSM-V* PPD Work Group, indicated in

her role as the discussant to this symposium that the various presentations were all quite interesting but that all of the proposals were potentially moot, because there might not in fact be any such diagnosis in the *DSM-V* (D. S. Bender, personal communication, August 22, 2009).

Skodol (2009), chair of the PPD Work Group, provided his proposal at the ISSPD meeting, a proposal that he indicated was based on the advice and guidance he has received from the Work Group members, the explicit details of which were presented by Skodol and Bender (2009) and a slightly revised version of which was posted on the *DSM-V* website February 10, 2010, as the official proposal of the *DSM-V* PPD Work Group (see www.dsm5.org). One notable aspect of the proposal for *DSM-V* was the deletion of five PD diagnoses, including NPD (along with the dependent, histrionic, paranoid, and schizoid PDs). It might indeed be true that there is little point in discussing how narcissism should appear in the diagnostic manual if it is not going to appear at all. As such, the first question to consider is: Should NPD be included in the *DSM-V*?

The basis for the *DSM-V* PPD Work Group's proposed deletion of NPD is not entirely clear. It is stated on the website that the rationale for reducing the number of diagnoses from 10 to five is to reduce diagnostic co-occurrence. However, removing fully half of the diagnoses would seem to be a rather draconian approach to addressing a problem of diagnostic co-occurrence. Persons are likely to still have dependent, schizoid, paranoid, histrionic, and narcissistic personality traits despite their being excluded from the manual. In addition, diagnostic co-occurrence will still remain for those five that are retained (e.g., borderline and antisocial PDs). Of course, there is no clear rule on how many PD diagnoses are optimal or when there are so many that the classification system becomes inordinately complex (Frances & Widiger, 1986). The members of the PPD Work Group for the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*; APA, 1994)

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Joshua D. Miller and W. Keith Campbell, Department of Psychology, University of Georgia; Thomas A. Widiger, Department of Psychology, University of Kentucky.

Correspondence concerning this article should be addressed to Joshua D. Miller, Department of Psychology, University of Georgia, Athens, GA 30602-3013. E-mail: jdmiller@uga.edu

were reluctant to add additional diagnoses (H. A. Pincus, Frances, Davis, First, & Widiger, 1992), but they also felt that passive-aggressive PD was the only one for which there was adequate justification for its deletion (Millon, 1996).

The *DSM-V* PPD Work Group's rationale for retaining the borderline, antisocial, schizotypal, avoidant, and obsessive-compulsive PDs while excluding the rest is also unclear. It is stated on the *DSM-V* website that the "borderline, antisocial/psychopathic, and schizotypal PDs have the most extensive empirical evidence of validity and clinical utility" (Skodol, n.d.) but no clear rationale is provided for the decision to retain the avoidant and obsessive-compulsive PDs instead of (for instance) NPD. At this time, there are only brief, incomplete statements concerning level of impairment, prevalence, and health care utilization and costs for the avoidant and/or obsessive-compulsive PDs. The information provided is severely limited, and there is no direct comparison of this literature with the findings obtained for the PDs slated for exclusion, such as NPD. For example, with respect to mental health care treatment utilization, only one study is cited, and it did not consider NPD (i.e., Bender et al., 2001). With respect to epidemiology within the community, only one study is cited (in reference to the prevalence of obsessive-compulsive PD; 7.9%; Grant et al., 2004), and researchers from this same program (i.e., National Epidemiologic Survey of Alcohol and Related Conditions) found that NPD was the second most frequent PD (6.2%; i.e., Stinson et al., 2008) of the eight PDs studied.

One might argue that clinical utility should weigh heavily in the decision to include or exclude individual diagnoses. One clear, explicit indicator of clinical utility is clinical interest and attention. If clinical interest is considered, then the decision to delete NPD would not appear to be justified. There is a substantial body of theoretical and clinical literature on narcissism, recently summarized by Levy, Reynoso, Wasserman, and Clarkin (2007); A. L. Pincus and Lukowitsky (2010); Ronningstam (2005); and others. There is no comparable clinical or theoretical literature on the avoidant or obsessive-compulsive PDs (Costa, Samuels, Bagby, Daffin, & Norton, 2005; Tyrer, 2005).

One might hope that a decision to delete NPD would be made on the basis of insufficient empirical support for its retention (Regier, Narrow, Kuhl, & Kupfer, 2009), at least relative to the five PD constructs that would be retained. According to the writing provided by the *DSM-V* PPD Work Group, this was, at least in part, the basis for retaining the borderline, schizotypal, and antisocial PDs. Construct validity support has long been recognized as a primary basis for deciding whether a diagnosis should be included or excluded from the APA diagnostic manual (Blashfield, Sprock, & Fuller, 1990; Frances, Widiger, & Pincus, 1989; Regier et al., 2009; Spitzer, Williams, & Skodol, 1980; Widiger & Clark, 2000). Informative, quality research validating the presence of significant psychological pathology and negative life outcomes and consequences secondary to the presence of the disorder would seem central to determining whether a diagnosis should be retained within the diagnostic manual. It is conceivable that the *DSM-V* PPD Work Group is using a different set of guidelines for making these decisions, such as level of impairment or prevalence, but there is no apparent effort to systematically compare the *DSM-IV* PDs with respect to these other concerns, nor is it clear whether these are in fact the bases for the inclusion/exclusion decisions being made for the *DSM-V*.

If the decision is to be made on the basis of the extent of empirical support for the validity of the diagnosis, then it is again difficult to understand why NPD would be subject to deletion, particularly relative to the avoidant and obsessive-compulsive PDs. Four of the five PD diagnoses proposed to be retained (all but antisocial) are the four that were included within the Collaborative Longitudinal Personality Disorder Study (CLPS). It is plausible that NPD is proposed for deletion in part because it was not part of the CLPS investigation. The CLPS has generated a substantial number of studies concerning the borderline, schizotypal, avoidant, and obsessive-compulsive PDs (Skodol et al., 2005) and perhaps thereby has generated more empirical support and scientific foundation for these PDs than has occurred in the meantime for NPD.

However, there are other highly productive and informative PD research programs besides CLPS that have helped to develop a scientific foundation for the PDs for the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; APA, 2000), including NPD (examples of which will be presented later). It is also worth recognizing that rarely has a CLPS study been concerned specifically with either the avoidant or the obsessive-compulsive PD. For the most part, these two PDs have been simply included along with the other two in any particular CLPS study. As such, the CLPS has not yielded a sizable empirical literature that could be said to concern the specific pathology of either the avoidant or the obsessive-compulsive PD. In contrast, quite a sizable body of such literature has been generated for NPD.

Blashfield and Intoccia (2000) conducted a computer search of a limited segment of the PD literature. They reported that of the PDs they examined, only borderline PD had a rising rate of growth in the literature since 1980. They reported that the antisocial and schizotypal PDs had relatively large literature bases, but works on these PDs were not rising in their rate of publication. They considered the literatures for borderline, antisocial, and schizotypal PDs to be "alive and well" (p. 473), whereas the literatures for avoidant and obsessive-compulsive PDs were either dying (small base that is actually decreasing) or dead (no appreciable literature base).

We conducted a search of PsycINFO for peer-reviewed publications with the phrase *narcissistic personality disorder* in the title, which yielded 123 publications. A search for publications with *avoidant personality disorder* in the title yielded only 90 publications, and *obsessive-compulsive personality disorder* yielded only 52. It is difficult to compare these figures with the findings of Blashfield and Intoccia (2000) because they did not report the specific results for the narcissistic, avoidant, or obsessive-compulsive PDs, but it is at least evident that there are fewer publications concerning the latter two PDs than for NPD.

A significant limitation of our search and that by Blashfield and Intoccia (2000), however, is the confinement to studies that contained the precise title of a respective PD. Such a search will miss a vast amount of literature relevant to some of the *DSM-IV-TR* PDs. For example, it is evident that studies of psychopathy are relevant to an understanding of antisocial PD. Reviews of *DSM-IV-TR* antisocial PD invariably include references to studies of psychopathy (e.g., Cloninger, 2005; Derefinko & Widiger, 2008; Millon et al., 1996; Patrick, 2007; Stoff, Breiling, & Maser, 1997). It is stated explicitly in the *DSM-IV-TR* that this disorder "has also been referred to as psychopathy" (APA, 2000, p. 702), yet none of

the psychopathy research was considered by Blashfield and Intocchia in their search for the empirical support for or scientific interest in antisocial PD. A similar point can be made for studies of “narcissism” being relevant to the validity of and scientific interest in NPD (Miller & Campbell, in press), yet none of these studies would have been identified by Blashfield and Intocchia (2000). It is conceivable that the substantial body of literature on narcissism is being similarly missed by the *DSM-V* PPD Work Group. Miller and Campbell (in press) discussed elsewhere the importance of appreciating the relevance of the social-psychological research on narcissism to an understanding of the clinical disorder of NPD. It would be unfortunate if one consequence of this neglect was the deletion of NPD from the diagnostic manual.

One of the more frequently used measures of narcissism is the Narcissistic Personality Inventory (NPI; Raskin & Terry, 1988), whose items were written to assess the NPD construct for the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III*; APA, 1980). The NPI has scales to assess narcissistic symptoms such as exploitativeness, entitlement, superiority, exhibitionism, and vanity. It has been demonstrated that the NPI correlates as highly (if not higher) with measures of NPD as any two measures of NPD correlate with one another (e.g., Miller, Gaughan, Pryor, Kamen, & Campbell, 2009; Samuel & Widiger, 2008a). Although some are critical of the construct of narcissism as assessed by the NPI and diagnosed by the *DSM-IV* (e.g., Cain, Pincus, & Ansell, 2008), it is apparent that the NPI is providing an assessment of narcissism that is quite close to the construct as defined within the APA diagnostic manual. As indicated by Cain et al. (2008), “since 1985, the NPI was used as the main or only measure of narcissistic traits in approximately 77% of social/personality research on narcissism” (pp. 642–643). A search of PsycINFO for peer-reviewed articles that have used the NPI as a measure of narcissism returned 175 publications, much of which would have been missed by Blashfield and Intocchia (2000) and perhaps is also not being considered by the *DSM-V* PPD Work Group. Of course, it goes without stating that the quality of the research is more important than simply its quantity. Specific examples of this research will be provided later, but for the moment it is important to appreciate that no comparable quantity is available for understanding the pathology or social, clinical consequences of avoidant or obsessive-compulsive personality traits. Ultimately, adding studies that have used the NPI to study narcissism to the literature on NPD results in a sizable empirical literature on the topic, much of which is theoretically driven and has provided a rich empirical support for the construct validity of NPD.

As expressed by Ronningstam (2005), “despite that research with the NPI was [usually] conducted on nonclinical samples, the results, especially in regard to self-esteem and affect regulation, have proved increasingly relevant and applicable to pathological narcissism” (p. 289). As she noted, this research resulted in a rather compelling self-regulatory processing model for narcissistic functioning by Morf and Rhodewalt (2001). In what follows, we review the empirical literature taken from studies of both NPD and trait narcissism with regard to a wide variety of issues and consequences, with a particular focus on interpersonal consequences, pathology, and other clinical implications. As one considers this literature, it is worth contemplating whether there is a comparable literature for the avoidant and obsessive-compulsive PDs.

Consequences of Narcissism

Aggression. One of the more frequently studied social behaviors predicted by narcissism is aggression. This considerable body of research has demonstrated that narcissism is associated with a wide variety of aggressive responses to criticism and other threats to self-esteem, ranging from disdain and contempt to argumentativeness, anger, and more or less controlled aggressive and violent behavior (Ronningstam, 2005). Much of this research has employed laboratory aggression paradigms, in which participants receive bogus feedback from a fictional “other participant” and then are given the opportunity to behave aggressively (e.g., provide electrical shocks, noise blasts) toward this individual. Across studies, narcissism is related to aggressive responding in both nonprovoked and provoked interactions (e.g., ego threat). For instance, narcissism predicts the administration of a louder noise blast toward an opponent following feedback that threatens the inflated sense of self (Bushman & Baumeister, 1998).

Self-enhancement and cognitive distortion. Both clinical and social-personality conceptualizations of narcissism include an aspect of self-esteem maintenance or self-enhancement. This can be seen in the *self-serving bias*, or the tendency to take personal credit for success but to blame the situation or other individuals for failure. In laboratory studies, narcissism predicts the self-serving bias (Campbell, Reeder, Sedikides, & Elliot, 2000; Rhodewalt & Morf, 1998). Narcissism even predicts the self-serving bias in intimate personal relationships. That is, narcissistic individuals will steal credit from those close to them (Campbell et al., 2000). Narcissism also predicts the *better than average effect*, or the belief that one is better than the average individual on a given attribute (e.g., intelligence, attractiveness). Furthermore, narcissism predicts the better than average effect primarily on agentic traits such as intelligence and assertiveness (Campbell, Bosson, Goheen, Lakey, & Kernis, 2007; Campbell, Rudich, & Sedikides, 2002).

The social-personality literature also presents evidence that narcissism is related to other types of cognitive distortions as well. Individuals high in narcissism are notably overconfident. They overestimate their knowledge and fail to learn from critical feedback (Campbell, Goodie, & Foster, 2004). This self-confidence even spills over into the creation of false beliefs known as *overclaiming*. This refers to claiming knowledge of a fact that is false (Paulhus, Harms, Bruce, & Lysy, 2003).

Impaired relationships. The effects of narcissism are most substantial in relation to interpersonal functioning. In general, trait narcissism is associated with behaving in such a way that one is perceived as more likable in initial encounters with strangers—but this likability diminishes with time and increased exposure to the narcissistic individual (Paulhus, 1998). In fact, several studies have demonstrated that individuals (e.g., strangers) view narcissistic individuals in a positive light on the basis of brief glimpses of their personalities (e.g., Friedman, Oltmanns, Gleason, & Turkheimer, 2006; Oltmanns, Friedman, Fiedler, & Turkheimer, 2004). The empirical research on narcissism and interpersonal relationships has focused primarily on romantic relationships (i.e., dating and marriage). Over the course of time, narcissism has a negative impact on relationships because it is linked to game playing, infidelity, and high levels of unrestricted sociosexuality (e.g., Campbell et al., 2002). As in their meeting with strangers, narciss-

sistic individuals are initially seen as attractive romantic partners because they can present themselves as both exciting and charming. This early attraction, of course, leads to longer term conflict and problems. Oltmanns and Turkheimer (2009) suggested that this may be part of the problem: “Narcissistic behaviors may be perpetuated by the way in which they attract others, at least temporarily. These traits may not become interpersonally disruptive until relationships become more intimate” (p. 33).

These findings relating trait narcissism to potential impairment in the social domain are consistent with evidence from clinical research on NPD. For instance, Miller, Campbell, and Pilkonis (2007) reported that NPD was substantially ($mean\ r = .46$) and uniquely related (i.e., when controlling for the other three Cluster B PDs) to causing distress to significant others. It is not difficult to understand how NPD traits cause substantial social impairment for the individual with these traits and distress for individuals who associate with them. Ogrodniczuk, Piper, Joyce, Steinberg, and Duggal (2009) reported that NPD scores were significantly associated with domineering, vindictive, and intrusive interpersonal behaviors in a sample of psychiatric outpatients.

Externalizing behaviors. Directly relevant to many clinical issues, trait narcissism is related to a variety of maladaptive externalizing behaviors including pathological gambling, alcohol use, compulsive spending, and antisocial behavior (Lakey, Rose, Campbell, & Goodie, 2008; Luhtanen & Crocker, 2005; Miller et al., in press). These behaviors are linked to both a basic appetitive or reward-seeking disposition and a callous lack of concern for the needs of other (Miller et al., 2009). The link between narcissism/NPD and externalizing behaviors should be expected given the significant overlap between these constructs and psychopathy (e.g., Hildebrand & de Ruiter, 2004; Paulhus & Williams, 2002) and interpersonal antagonism (Miller & Campbell, 2008; Miller, Gaughan, et al., 2009), both of which are among the strongest and most reliable personality correlates of externalizing behavior (e.g., Hare, 2003; Miller & Lynam, 2001).

Internalizing behaviors and symptoms. The link between narcissism/NPD and internalizing symptoms is difficult to summarize because the relation depends, in part, on which narcissism variant is being discussed (see the NPD: Addressing the Need to Cover Different Narcissism Variants section for more information on these variants). Nonetheless, there is some research to suggest that narcissism/NPD is linked prospectively to depression and anxiety and that this relation is mediated by functional impairment (Miller et al., 2007). That is, over time narcissistic individuals may experience failure in a wide array of domains—work, romance, social functioning—that leads to psychological distress. There also appears to be a relation between narcissism and suicidal behavior (e.g., suicide completion: Overholser, Stockmeier, Dilley, & Freiheit, 2002; suicide attempts: Pincus et al., 2009) and nonsuicidal self-injury (A. L. Pincus et al., 2009).

Deficits in insight. Individuals with PDs have long been characterized in the clinical literature as lacking insight into their own personalities. In a meta-analytic review, Klonsky, Oltmanns, and Turkheimer (2002) found limited rates of agreement between self- and informant ratings for PD symptoms, although informants tended to agree with one another. These authors reported that NPD manifested the smallest degree of self-informant agreement ($median\ r = .29$) of the 10 *DSM-IV* PDs. Miller, Pilkonis, and Clifton (2005) examined the correlations between expert ratings of

DSM-IV PDs with self- and informant ratings on a measure of the five-factor model (FFM). These authors then correlated the resultant FFM trait profiles (one profile generated by correlating self-reported FFM traits with *DSM-IV* PD ratings, the other profile generated by correlating informant-reported FFM traits with *DSM-IV* PD ratings) to examine the similarity of the trait profiles across raters for each PD. In general, the self and informant trait personality profiles generated by the PDs were quite similar ($median\ r = .75$), with one exception: NPD. The correlation between self- and informant ratings for the FFM’s NPD profiles was .29. Although NPD was negatively associated with FFM Agreeableness as reported by both self and informants, the two trait profiles diverged substantially with regard to the domains of Neuroticism and Extraversion. NPD ratings were unrelated with self-ratings of neuroticism and positively related to self-ratings of extraversion (e.g., assertiveness, excitement seeking). Alternatively, NPD ratings were positively correlated with informant ratings of neuroticism (e.g., anger, self-consciousness) and unrelated to informant ratings of extraversion. Interestingly, there is some evidence to suggest that this lack of insight affects narcissistic individuals’ abilities to rate others’ personalities accurately as well (Friedman, Oltmanns, & Turkheimer, 2007).

In sum, although the body of research literature on NPD may be smaller than that for the borderline, schizotypal, and antisocial PDs, it is evident that there is a substantial body of scientific interest in and research on narcissism and that it is considerably larger than that for the avoidant and obsessive–compulsive PDs. We believe this literature is relevant to an understanding of the pathology of NPD and that the total research literature (e.g., on narcissism and NPD) is suggestive of an active and strong scientific foundation for and a wide-ranging interest in the topic. This research has been concerned with aggression, self-enhancement, self-presentation, interpersonal relationships, cognitive biases, and internalizing and externalizing dysregulation. We believe that this is an important and rich body of literature that suggests that narcissism/NPD warrants recognition in the *DSM-V*.

NPD: Addressing the Need to Cover Different Narcissism Variants

If NPD is retained, an additional issue that must be resolved is whether the taxonomy can address the substantial heterogeneity that exists in the conceptualization and assessment of NPD. Multiple studies have documented the existence of two or more narcissism subtypes, which are typically referred to as grandiose versus vulnerable narcissism (Dickinson & Pincus, 2003; Fossati et al., 2005; Miller & Campbell, 2008; Russ, Shedler, Bradley, & Westen, 2008; Wink, 1991).¹ Grandiose narcissism primarily reflects traits related to grandiosity, aggression, and dominance; this conceptualization is consistent with Freud’s (1931/1964) conceptualization of this personality (“libidinal”) type. Cain et al. (2008)

¹ It is important to note that some narcissistic individuals may not fit well into either narcissism variant in the long term but rather fluctuate between grandiose and vulnerable presentations. For instance, a grandiosely narcissistic individual may eventually present more vulnerably narcissistic traits as he or she experiences more failure and impairment across the life span (see A. L. Pincus & Lukowitsky, 2010, and Ronningstam, 2009, for a more detailed discussion of this idea).

identified a host of “phenotypical labels” (p. 641) used by various PD theorists associated with grandiose narcissism—labels such as *overt, malignant, oblivious, elitist, arrogant, and psychopathic*, to name just a few.

Vulnerable narcissism reflects a defensive and fragile grandiosity in which the grandiosity serves as a facade that obscures feelings of inadequacy, incompetence, and negative affect; this conceptualization is more consistent with Kernberg’s (1984) notion of narcissism. Ronningstam (2009) contrasts individuals with grandiose forms of narcissism with the

inhibited, shame-ridden, and hypersensitive shy type, whose low tolerance for attention from others and hypervigilant readiness for criticism or failure makes him/her more socially passive . . . nevertheless, under a modest surface, the shy narcissistic individual is equally preoccupied with self-enhancing fantasies and strivings and hyperreactive to oversights and unfulfilled expectations from others. (p. 113)

Cain et al. (2008) identified a number of phenotypical labels that correspond with this vulnerable narcissism dimension, including *closet, shy, thin-skinned, and compensatory*. Factor analyses of the *DSM-IV* NPD symptoms suggest that the *DSM-IV* NPD criterion set is either entirely (Miller, Hoffman, Campbell, & Pilkonis, 2008) or primarily (i.e., six of nine symptoms; Fossati et al., 2005) consistent with the grandiose variant.

It is worth noting that this is not a new issue or concern for this diagnosis. The authors of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.; *DSM-III-R*; APA, 1987; Widiger, Frances, Spitzer, & Williams, 1988) and the *DSM-IV* (APA, 1994; Gunderson, Ronningstam, & Smith, 1991) criterion sets also struggled with the problem that narcissism is associated with a tendency to respond to criticism, defeat, or rebuke with either disdainful indifference or shameful embarrassment. The authors of the *DSM-IV* placed an emphasis within the criterion set on the confident, assured, and grandiose variant but did also acknowledge in the text that “vulnerability in self-esteem makes individuals with Narcissistic Personality Disorder very sensitive to ‘injury’ from criticism or defeat. Although they may not show it outwardly, criticism may haunt these individuals and may leave them feeling humiliated, degraded, hollow, and empty” (APA, 2000, p. 715). What is new to this debate is the presence now of a considerable body of empirical literature on both variants of narcissism, particularly if one goes beyond studies confined to the *DSM* criterion sets (A. L. Pincus & Lukowitsky, 2010).

It is our opinion that the comingling of these two forms of narcissism has serious consequences for the field because a great deal of unreliability is introduced into our communications, assessments, and conceptualizations. An example of this can be seen in a recent study by Samuel and Widiger (2008a) in which they compared five self-report assessments of NPD and narcissism. The correlations between the five scales ranged from .29 to .64, with a median correlation of .45. More interesting are the correlations each generated with an FFM instrument, the Revised NEO Personality Inventory (NEO PI-R; Costa & McCrae, 1992). The degree of similarity across the trait profiles generated by the five narcissism/NPD scales (i.e., correlations between each NPD scale and the 30 facets of the NEO PI-R), as assessed via double-entry intraclass correlations (see McCrae, 2008, for a review), ranged from $-.10$ to $.92$, with a median of $.45$. The authors noted that the

five measures primarily share a negative correlation with FFM Agreeableness but diverge with relation to the direction and size of the effect sizes found for Extraversion (r s ranged from $-.15$ to $.48$) and Neuroticism (r s ranged from $-.40$ to $.13$). The findings from this study are not unique; the same pattern of discrepancy is found in a meta-analysis of the FFM correlates of NPD (Saulsman & Page, 2004). For example, Saulsman and Page (2004) reported a mean correlation of $.03$ between NPD and FFM Neuroticism. Yet a review of the individual effect sizes revealed that roughly one third of the relations were significantly negative, one third were significantly positive, and one third were nonsignificant. A similar pattern was found for Extraversion; despite a significant mean effect size ($r = .24$), the majority of findings (i.e., 61%) were nonsignificant. Ultimately, the only constructs shared by measures of NPD are related to interpersonal antagonism.

It is clear that measures of NPD diverge with relation to the contribution of negative affectivity (i.e., weighting of vulnerability) versus positive affectivity and dominance (weighting of grandiosity). We believe this inconsistency of the trait correlates of NPD reflects this comingling of grandiose and vulnerable narcissism. Measures of NPD (or raters) that associate NPD with the more grandiose conceptualization typically result in a profile comprising low neuroticism and agreeableness and high extraversion. Alternatively, measures of NPD (or raters) that associate NPD with the more vulnerable forms of narcissism typically result in a trait profile comprising low extraversion and agreeableness and high neuroticism (e.g., Miller & Campbell, 2008; Miller, Dir, et al., in press).

These forms of narcissism are also differentially related to environmental etiological factors such as emotional, physical, and sexual abuse and poor parenting practices (Horton, Bleau, & Drwecki, 2006; Miller & Campbell, 2008; Miller, Dir, et al., in press; Otway & Vignoles, 2006). For example, grandiose narcissism typically manifests no relations with childhood abuse (Miller, Dir, et al., in press) and negative parenting practices, with the exception of a small negative correlation with parental supervision (Horton et al., 2006; Miller & Campbell, 2008; Miller, Dir, et al., in press) and a small positive correlation with parental overvaluation (Otway & Vignoles, 2006). Alternatively, vulnerable narcissism is significantly related to reports of childhood sexual, physical, verbal, and emotional abuse (Miller, Dir, et al., in press) and to reports of parenting described as psychologically intrusive, controlling, and cold, as well as a lesser degree of parental supervision (Miller & Campbell, 2008; Miller, Dir, et al., in press; Otway & Vignoles, 2006).

Interpersonally, individuals with vulnerable and grandiose narcissism are viewed differently by important others; spouses describe individuals with either form of narcissism as “bossy, intolerant, cruel, argumentative, dishonest, opportunistic, conceited, arrogant, and demanding” (Wink, 1991, p. 595). Spouses of individuals high on grandiose narcissism, however, are also rated as being “aggressive, hardheaded, immodest, outspoken, assertive, and determined,” whereas spouses of individuals high on vulnerable narcissism are seen as “worrying, emotional, defensive, anxious, bitter, tense, and complaining” (Wink, 1991, p. 595).

It is likely that these forms of narcissism are differentially associated with important clinical outcomes. Given the much stronger relation between vulnerable narcissism and psychological distress, negative affect, and Axis I psychopathology (e.g., depres-

sion, anxiety; Miller & Campbell, 2008; Miller et al., 2007; Miller, Dir, et al., in press; A. L. Pincus et al., 2009), it is not surprising to find that vulnerable narcissism is more strongly linked with nonsuicidal self-injury and suicide attempts (Miller, Dir, et al., in press; A. L. Pincus et al., 2009). In addition, these forms of narcissism may present differently in therapeutic settings in terms of treatment utilization. In a small clinical sample, A. L. Pincus et al. (2009, p. 376) found that “grandiose [narcissism] characteristics most often reduced treatment utilization (e.g., more cancellations and no-shows, less medication use, less contact with partial hospitalizations and inpatient admissions,” whereas “vulnerable [narcissism] characteristics most often promoted treatment utilization (e.g., more contact with crisis services and partial hospitalizations, fewer therapy no-shows).” Others have found that DSM-IV NPD is associated with failure to complete treatment; Ogrodniczuk and colleagues (2009) found that 63% of their high NPD group dropped out of treatment, compared with 28% and 36% in their moderate and low NPD groups, respectively. These narcissism variants may also have a differential impact on therapeutic rapport. Gabbard (2009, p. 132) suggested that individuals with the grandiose narcissism variant will use “the therapist as a sounding board, a listening ear that exists primarily to enhance the patient’s self-esteem.” Gabbard argued that these individuals pay little attention to cues (verbal and nonverbal) from the therapist and demonstrate a failure to connect with the therapist in a meaningful manner that is representative of their failure to connect with others outside the therapeutic setting. With regard to vulnerable narcissism, Gabbard suggested that these individuals may be acutely sensitive and feel “wounded, ignored, or rejected by the therapist” (p. 133) and thus move to devalue the clinician. These patients may also be suspicious of the therapist and “perceive in the therapist’s eyes a wish to hurt, humiliate, and deride the patient” (Gabbard, 2009, p. 134).

The various behaviors associated with these forms of narcissism will certainly affect the therapist’s view of and attitude toward the patient. Betan, Heim, Conklin, and Westen (2005) presented the clinician ratings that were most and least descriptive of clients with NPD, which included items such as “I feel annoyed in sessions with him/her” and “I feel used by him/her” (the two most descriptive statements) and “I look forward to my sessions with him/her” and “S/he is one of my favorite patients” (the two least descriptive statements). Unfortunately, it is not clear from this work whether these reactions are germane to both narcissism variants. It certainly seems plausible, however, that clinicians might react differently to these variants, perhaps empathizing more with the vulnerable form due to the more obvious presence of psychological distress.

It is clear that the DSM-V should make efforts to ensure that both of these narcissism variants can be captured. Given the uncertainty surrounding the manner in which personality pathology will be addressed in the DSM-V, we present ideas for addressing these two narcissism variants in two alternative situations: In Situation 1, the DSM-V includes NPD as one of the official diagnostic constructs, and in Situation 2, the DSM-V includes NPD only to the extent that it can be captured by the dimensional trait model. Here we address only the first proposal, because the dimensional trait model is covered in the final section of this article: NPD and Dimensional Trait Models of PD. In this latter section we also address our own recommendations as to which of the two aforementioned models should be used.

If the DSM-V PPD Work Group decides to retain NPD as an official diagnosis, an outcome we fear is unlikely, it should officially recognize both narcissism variants. The DSM-V would not be the first diagnostic manual to recognize these two forms of narcissism. The *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006) recognizes two narcissistic personality disorders, which are labeled *Arrogant/Entitled* and *Depressed/Depleted*. Including both forms of narcissism would encourage research into the potentially divergent etiologies, outcomes, and effective treatments for these two forms of narcissism, which seem to share only a core of interpersonal antagonism. It is clear that, should NPD remain an official DSM-V diagnosis, more vulnerable diagnostic criteria must be included. A. L. Pincus and Lukowitsky (2010) argued that “relying solely on the DSM-IV NPD diagnostic criteria may impede clinical recognition of pathological narcissism” (p. 430). In fact, these authors contended that the extreme dearth of empirical work on vulnerable narcissism is a significant limitation of the extant empirical base and suggested that measures of vulnerable narcissism “be regularly included in research focusing on narcissistic personality, even in nonclinical contexts, and particularly in research investigating negative consequences of trait narcissism” (p. 430). Low prevalence rates that have at times been obtained for NPD are probably due in part to having an overly narrow conceptualization of the disorder. Ronningstam (2009, p. 118) also recently put forth a number of “alternative formulations” of the DSM-IV NPD criteria, some of which should prove more successful at capturing the vulnerable form (e.g., “fluctuating and vulnerable self-esteem”).

NPD and Dimensional Trait Models of PD

Although the diagnosis of NPD has been proposed for deletion, the chair of the DSM-V PPD Work Group has also suggested supplementing the five PD diagnoses that would be retained with a set of ancillary dimensions, consisting of *negative emotionality*, *introversion*, *antagonism*, *disinhibition*, *compulsivity*, and *schizotypy* (see www.dsm5.org), from which the diagnosis of narcissistic personality traits might still be derived (D. S. Bender, personal communication, August 22, 2009). The authors of this article have long argued for a shift to a dimensional classification of PD and would certainly prefer that narcissistic personality traits be understood from this perspective (Miller & Campbell, 2008; Widiger & Simonsen, 2005). However, it is important to recognize that whatever the ancillary dimensions or traits that are included within the DSM-V, they will not provide an officially recognized PD diagnosis. It appears that these trait scales are not being provided with code numbers in the DSM-V and will then not have any clear, specific, or official recognition within a clinician’s diagnostic record for a respective patient. The clinician will have to rely upon the already catchall, nonspecific, wastebasket diagnosis of “Not Otherwise Specified” to record the presence of any narcissistic personality traits included within the supplementary trait dimensions (Verheul & Widiger, 2004). The likelihood that the ancillary trait ratings will even be used by most clinicians, let alone have any actual impact in health care, will be substantially handicapped by the absence of any official coding system or record.

Even if the dimensional model were provided with official recognition, it remains unclear whether the traits of both variants of narcissism could in fact be recovered from the collection of

traits proposed by the *DSM-V* PPD Work Group. The dimensional trait proposal consists of six broad domains, each defined by more specific facets. Negative emotionality includes the specific traits of emotional lability, anxiousness, suspiciousness, submissiveness, self-harm, pessimism, depressivity, guilt/shame, self-esteem, and separation insecurity. Introversion includes the traits social withdrawal, social detachment, restricted affectivity, anhedonia, and intimacy avoidance. Antagonism includes the traits narcissism, callousness, manipulateness, histrionism, hostility, aggression, oppositionality, and deceitfulness. Disinhibition includes the traits impulsivity, distractibility, recklessness, and irresponsibility. Compulsivity includes the traits perfectionism, perseveration, rigidity, risk aversion, and orderliness. Finally, the schizotypy dimension includes the traits unusual perceptions, unusual beliefs, eccentricity, cognitive dysregulation, and dissociation proneness.

There is a substantial body of empirical literature on alternative dimensional models of PD (Clark, 2007; Livesley, 2005; Widiger & Simonson, 2005). It is worth noting that the six-dimensional model proposed for inclusion in the *DSM-V* is not equivalent to any previously proposed dimensional model. For example, distinct from all other dimensional models of PD, the proposal for the *DSM-V* splits constraint (otherwise known as conscientiousness) into two separate, independent dimensions: disinhibition (low constraint or conscientiousness) and compulsivity (high constraint or conscientiousness). The proposal for the *DSM-V* also fails to include maladaptive extraversion (the opposite of introversion), maladaptive agreeableness (the opposite of antagonism), and maladaptively low levels of neuroticism, included within the five-factor model of PD (Widiger & Mullins-Sweatt, 2009). These failures contribute to the potential misalignment of some traits, such as histrionism, which includes behaving in a manner to attract attention, flamboyance, admiration seeking, and sexualization of interpersonal relations (Skodol & Bender, 2009). There is a considerable body of research to indicate that these traits more comfortably belong within a domain of extraversion than within antagonism (Samuel & Widiger, 2008b). Similarly, submissiveness is clearly a manner of interpersonal relatedness, yet it is included within a domain of negative affectivity due in part to the absence of the domain of agreeableness (Lowe, Edmundson, & Widiger, 2009).

Currently, the PDs are organized into three clusters that have failed to be supported empirically (Sheets & Craighead, 2007) and have been difficult to understand conceptually. For instance, passive-aggressive personality was never well understood as being an anxious-fearful PD, nor is antisocial PD well understood as a dramatic-emotional PD (APA, 2000). It would be unfortunate for a hierarchical dimensional classification to continue to be problematic conceptually and empirically, particularly when there is a considerable body of research to help guide the organization of the traits.

The omission of some of the aforementioned traits may also contribute to a failure to capture traits that are important in describing and understanding some of the existing PDs. For example, low anxiousness and fearlessness are excluded (due to the absence of a dimension pertaining to low negative affectivity), which may be central to an understanding of psychopathy (Lynam & Widiger, 2007). A similar argument can be made with respect to the inclusion of traits necessary to adequately describe narcissism. Despite the inclusion of a trait titled "narcissism," we believe the trait

model proposed by the *DSM-V* PPD Work Group will be incapable of capturing traits related to maladaptively high levels of extraversion such as dominance, excitement seeking, and behavioral activation/approach. The failure of this model to assess these traits suggests that the model will be unable to assess fully the grandiose narcissism construct. Multiple studies have demonstrated a strong link between grandiose narcissism and extraversion-related traits such as assertiveness (e.g., Miller & Campbell, 2008: $r_s = .61$ and $.55$; Miller, Gaughan, et al., 2009: $r_s = .49$ and $.51$), excitement seeking (e.g., Miller & Campbell, 2008: $r_s = .28$ and $.28$; Miller, Gaughan, et al., 2009: $r_s = .48$ and $.48$), and behavioral activation/approach (Foster & Trimm, 2008: r_s ranged from $.34$ to $.57$). Importantly, in several of these studies (e.g., Foster & Trimm, 2008; Miller, Campbell, et al., 2009) the extraversion-related traits mediated the relations between narcissism and several behavioral problems (e.g., aggression, risk taking).

It is also unclear what traits (e.g., which narcissism variants) will be assessed by the *DSM-V* PPD Work Group's narcissism scale. This scale was not included in the original version of this proposal provided by Skodol and Bender (2009) but appears to have replaced the trait grandiosity that was originally proposed. One possibility is that a trait scale for narcissism was ultimately included in the *DSM-V* proposal because it exists within the Dimensional Assessment of Personality Pathology (DAPP) created by Livesley (2006), a member of the *DSM-V* PPD Work Group. If this is the case, it is interesting that the narcissism scale measured by the DAPP appears to be a better measure of the vulnerable narcissism variant because this scale typically loads more strongly with the DAPP Emotional Dysregulation factor rather than the Dissocial Behavior factor (e.g., Bage & Trull, 2003; Livesley, Jang, & Vernon, 1998; Maruta, Yamate, Iimori, Kato, & Livesley, 2006). Given these results, the content validity of the *DSM-V*'s trait model remains unclear, at least as it pertains to the assessment of narcissism.

Recommendations

Removal of half of the PDs section (i.e., the paranoid, schizoid, histrionic, dependent, and narcissistic PDs) represents a substantial gutting of this section of the diagnostic manual. One of the repeated criticisms of the APA's PDs section has been its lack of adequate coverage (Clark, Watson, & Reynolds, 1995; Trull, 2005; Verheul, 2005; Verheul & Widiger, 2004; Westen & Arkowitz-Westen, 1998). The *DSM-V* as proposed by the PPD Work Group will grossly exacerbate this problem. We focused in particular on narcissistic personality traits because there is a considerable body of clinical literature and empirical research on narcissism that would support its retention, particularly relative to the avoidant and obsessive-compulsive PDs.

The decision of which diagnoses should be removed should be based primarily on the extent of documented clinical interest and the quality of construct validity research (Frances et al., 1989). NPD is much stronger in both regards than is either the avoidant or the obsessive-compulsive PD, both of which are PDs that have been proposed for retention in the *DSM-V*. If any PDs are to be retained, we propose that NPD should not only be retained but be expanded to include both the grandiose and vulnerable subtypes.

Nevertheless, the authors of this article have argued elsewhere for replacing the diagnostic categories with a dimensional model (e.g., Widiger & Mullins-Sweatt, 2009), and we continue to favor this approach. However, if a dimensional classification is to replace the categorical classification of certain PD diagnoses, then it must have a status equal to the diagnostic categories that are retained. A dimensional classification lacking any official coding recognition is unlikely to be used on any regular, systematic basis. Those traits removed from the official list of diagnoses and relegated to a set of ancillary dimensions are being effectively deleted from the diagnostic manual.

If categorical diagnoses are to be replaced by a dimensional classification of maladaptive personality trait scales, then the structure of the latter should be governed by the empirical research, with a documented ability to recover all of the important maladaptive personality traits currently covered by the existing diagnostic categories, and should be given official recognition, including being part of the official coding system that clinicians must use. We do not support what we perceive to be a middling step forward in which some traditional diagnostic PD constructs are retained whereas some are deleted on the basis of relatively arbitrary and unspecified decision rules. One is then left with a crippled set of diagnostic categories, taking only a half step away from the diagnostic categories and only a half step toward a dimensional model.

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