Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis

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INTRODUCTION

Grandiosity, which may be overt or covert, need for attention and admiration, superficial interpersonal relationships, and a lack of empathy are central features of narcissistic personality disorder (NPD) [1]. Additional features of the disorder have a variable presentation, contributing to disagreement over the disorder's boundaries and diagnostic criteria.

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) focuses on a more aggressive, grandiose subtype of NPD, while an alternative model, which we favor, describes additional subtypes – a healthier, high-functioning type and a vulnerable, introverted type – and places greater emphasis on problems with self-definition, self-esteem regulation, and affective reactivity.

NPD is one of the least studied personality disorders. It appears to be prevalent, highly comorbid with other psychiatric disorders, and associated with significant psychosocial disability. NPD is difficult to treat, and can complicate the treatment of co-occurring disorders.

The epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis of NPD are reviewed here. Treatment of NPD is described separately. The epidemiology, clinical manifestations, assessment, and diagnosis of other personality disorders are also described

separately. (See "Narcissistic personality disorder: Treatment overview" and "Overview of personality disorders" and "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis" and "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)

EPIDEMIOLOGY

The prevalence and sociodemographic features of narcissistic personality disorder (NPD) are poorly defined, in part because of evolving diagnostic criteria.

In studies in the United States and in Europe, the prevalence of NPD in the general population has been estimated as ranging from 0 percent to 6.2 percent [2]. As an example, in a national survey of 35,000 Americans, the lifetime prevalence rate was 6.2 percent; rates were higher in males compared to females (7.7 versus 4.8 percent). In that survey, NPD was significantly more prevalent among Black males and females and Hispanic females, younger adults, and single adults.

In clinical studies of outpatient populations, the rate of NPD has ranged from 1 to 17 percent [3,4]; most studies report higher prevalence among males.

Comorbidities — Co-occurring disorders are common in clinical observations and in epidemiologic surveys of NPD. Among respondents meeting criteria for NPD in the 2004 to 2005 Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions, the disorders with the highest rates of comorbidity were [4]:

- 49.5 percent for mood disorders
  - Major depressive disorder – 20.6 percent
  - Bipolar I disorder – 20.1 percent
- 54.7 percent for anxiety disorders
- 64.2 percent for substance use disorders
- 62.9 percent for other personality disorders
  - Borderline personality disorder – 37.0 percent

NPD also often co-occurs with antisocial, histrionic, schizotypal, and passive-aggressive personality disorders [5]. Patients with more severe NPD are more likely to have a greater number of co-occurring personality disorders [3]. Comorbidity with antisocial personality disorder has the most profoundly negative impact on prognosis [6,7].

Patients with NPD often come to clinical attention seeking treatment for a co-occurring disorder. Comorbidities can complicate diagnosis and treatment decisions; their presence in patients with NPD has been associated with greater functional impairment and elevated suicide risk compared with patients without co-occurring disorders [8].

The presence of comorbid narcissistic pathology in individuals presenting with substance use disorders, mood disorders, or anxiety disorders, can greatly complicate management and is associated with a worse prognosis compared with patients lacking comorbid narcissistic pathology [9].

PATHOGENESIS

The pathogenesis of narcissistic personality disorder (NPD) is not known. Most hypotheses invoke a combination of and interaction among genetic, biologic, and psychosocial causes.

Genetic — As with other personality disorders, studies of heritability for NPD are suggestive but inconsistent. Studies of personality disorders overall demonstrate heritability rates above 60 percent, making a significant genetic influence highly likely [10]. NPD has not been assessed in any family or adoption studies, but twin studies suggest heritability varying from 25 percent to 79 percent. A study using a broad definition of NPD (three or more criteria met) found 45 percent concordance in monozygotic twins and 9 percent in dizygotic twins [8]. A study using the Dimensional Assessment of Personality Pathology reported the heritability of narcissism to be 53 percent [11]. The heritability of specific traits (need for adulation, attention seeking, grandiosity, and need for approval) ranged from 37 percent for grandiosity to 50 percent for need for approval.

Biologic — Research relating to biologic factors and NPD is sparse. Brain imaging studies on the neural correlates of empathy have included studies of NPD as well as those of subjects with narcissistic traits [12]. These studies provide preliminary data on neural correlates of the impaired emotional empathy characteristic of individuals with NPD. As examples:

- A 2011 functional magnetic resonance imaging (fMRI) study found that subjects with high and low scores on the Narcissistic Inventory questionnaire performed differently when processing emotional faces [13]. The group with high narcissistic scores showed differences in the right anterior insula, a region associated with empathy in previous studies.

- A 2013 fMRI study of 17 patients diagnosed with NPD showed structural differences compared with controls in the right anterior insula, the left anterior insula, rostral, and

median cingulate cortex, as well as the dorsolateral and medial parts of the prefrontal cortex [14]. These brain regions have been described as broadly overlapping with the neural circuitry commonly implicated in the representation of empathy.

Psychosocial — The empirical literature on parenting and NPD is inconsistent, but overall provides some support for the proposition that parenting styles can contribute to the development of NPD, and that different facets of narcissism may have different psychosocial etiologies [15]. In the absence of empirical data, models of pathogenesis based on clinical experience with NPD patients and observations of parenting have been developed within psychodynamic, attachment, and social learning frameworks [16-18].

These models relate NPD to problems in the development of a sense of self in early life, and increasingly emphasize the role of the child's genetic predisposition in shaping both the child's responses to the environment as well as in shaping his or her environment (ie, eliciting particular responses from caretakers). It has been hypothesized that disruptions in the caretaker-child relationship, reflecting parental failure to adequately meet the developmental needs of the child in the setting of the child's temperamental predispositions, interfere with normal developmental processes. These deficiencies are compounded over time as a result of repeated, pathogenic interactions with caretakers and the child's resulting expectations and behavior in relation to others.

Theorists have pointed variously to the role of parental over-involvement, overprotectiveness, and overvaluation of the child, often coupled with excessive frustration, parental coldness, aggression, and rejection, as potentially contributory to the development of narcissistic pathology in childhood and NPD later in life.

Though most children who experience trauma do not develop personality disorders, evidence from the National Epidemiologic Survey on Alcohol and Related Conditions [3,4] shows an overall association between NPD (and other personality disorders) and childhood abuse and neglect [19,20]. Other research supports the association between emotional abuse and NPD, specifically with covert narcissistic traits [21].

CLINICAL MANIFESTATIONS

Among the personality disorders, narcissistic personality disorder (NPD) is associated with the most variable presentation and the widest range of severity. There is strong agreement among clinicians and researchers with expertise on the subject that there are different subtypes of NPD.

Core features — Despite the variability among presentations, all individuals with NPD share central clinical features, some of which are and some of which are not emphasized in DSM-5-TR (see 'Diagnosis' below):

In DSM-5-TR:

- Grandiosity, either overt or covert
- Excessive need for admiration
- Superficial and exploitative relationships
- Lack of empathy

Not in DSM-5-TR:

- Identity disturbance
- Difficulty with attachment and dependency
- Chronic feelings of emptiness and boredom
- Vulnerability to life transitions

Grandiosity — Individuals with NPD have an exaggerated sense of self-importance, viewing themselves as superior to others and deserving of special treatment. Feelings of superiority are often overt, but may also be covert, hidden behind feelings of inferiority or deficiency. (See 'Subtypes' below.)

Grandiose attitudes, whether overt or covert, and feelings of being exceptional or special, are often complemented by private fantasies of unlimited success, beauty, brilliance, power, or ideal love.

Excessive need for admiration — Individuals with NPD have an excessive need for admiration. They have a constant need to experience themselves as the center of attention, regardless of the setting, perpetually grabbing the limelight and monopolizing social conversations. When attention is not forthcoming, or others receive the attention they feel they themselves deserve, the individuals with NPD are prone to feeling slighted, mistreated depleted, and enraged.

Superficial and exploitative relationships — NPD is characterized by markedly superficial relationships, based on surface attributes rather than the unique personal qualities of the other. Relationships are valued only to the extent that they are viewed as beneficial, either providing material gain or enhancing self-esteem. As a result, individuals with NPD are often drawn to wealthy, beautiful, or famous people, with the aim of self-enhancement.

Lack of empathy — Individuals with NPD lack the capacity to empathize with the needs of others. Some individuals with NPD may be excessively attuned to the reactions of others, but only if these reactions are perceived as relevant to the self, while others may seem strangely oblivious. In either case, emotional empathy, the ability to "feel with," or care about the emotional needs or experience of others, even one's closest loved ones, is severely limited, and may be totally lacking, in NPD [22,23].

Identity disturbance — Underlying the spectrum of NPD presentations is a disturbance of identity formation. In contrast to the flexible and reality-based self-experience that characterizes normal identity formation, or the fragmented, black and white views of self in relation to others that characterize identity formation in borderline personality disorder, in NPD we see a sense of self that is relatively stable, but highly superficial, extremely rigid, and often fragile – a disturbed self-state in which stability depends on maintaining the view that one is exceptional. This grandiose and rigidly inflexible sense of self is easily threatened, sustained only by receiving constant feedback of superiority from the environment, and collapsing when such feedback in unavailable. To maintain the integrity of their self-state, individuals with NPD must retreat from or deny any realities that might challenge their grandiosity.

Attachment and dependence difficulties — In NPD, self-esteem and self-definition are entirely reliant on feedback from the environment. In this circumstance, relationships are "functional" tools to shore up positive self-states and self-definition. Interactions with others remain superficial and need-fulfilling in orientation. Genuine intimacy is avoided insofar as it confronts narcissistic individuals with the recognition that others have desirable attributes that they themselves lack.

Narcissistic relationships have high measured rates of "vindictive and contemptuous behavior," along with low empathy scores [24]. Results of a study on the effect of narcissistic features in marriages confirm the expected steep decline in marital satisfaction and steep increases in marital problems over time [25].

Chronic emptiness and boredom — Narcissistic patients complain frequently of emptiness, restlessness, and boredom – affective experiences that appear to represent baseline emotional states in NPD. In the setting of narcissistic pathology, emotion regulation mirrors fluctuations in self-states and self-esteem; attention seeking and the admiration of others will lead to positive affect states, but when attention and praise are not available, individuals with NPD quickly become restless and feel depleted, empty, or depressed. The diminished capacity to invest deeply in relationships or in creativity, beyond gratification of narcissistic goals, is a chronic vulnerability to feelings of emptiness and boredom [17,26].

Life transition vulnerabilities — The nature of identity formation in NPD can make it difficult to maintain reality-based personal and professional goals over time. The incremental growth, the deferred gratification, and the compromises required by school, jobs, or relationships can feel intolerable, and patients often withdraw to protect their feelings of specialness. At the same time, narcissistic individuals of any age may convey a sense that time is suspended, as if they exist outside of and are exempt from the passage of years; they may defer careers or relationships in the implicit belief that they are in a perpetual state of youthful potential.

Young adults with pathological narcissism can present with a syndrome of "failure to launch." These stalled transitions occur as students move from high school to college, or from college to postgraduate training or to careers; young adults may stop attending classes, or not complete job applications or fail to attend interviews at the precise moment these failures will be the most damaging. Realistically pursuing a particular career path or academic degree can be felt as "ordinary," or as "settling for less," a perceived limit on the grandiose fantasies by which these individuals have been sustained.

The aging process can be especially challenging for individuals with NPD. Older adult narcissists can become depressed or act out as their function declines in old age and as they feel they are receiving decreased attention from others (often because of their exploitative and superficial relationships); it can be a devastating realization that expectations of uniqueness and specialness have not been met [17].

Subtypes — There is strong empirical and clinical support for two distinct presentations, or subtypes, of NPD, the grandiose or "overt" subtype and the vulnerable or "covert" subtype [27]. The distinction between subtypes depends on whether core narcissistic grandiosity is openly expressed or masked, and whether stability is maintained by outward arrogance and evoked praise, or by hiding grandiose self-states behind feelings of inadequacy and inferiority. There is growing empirical and clinical support for a third, high-functioning subtype of NPD [28,29]. Though with dramatically different presentations and levels of functioning, individuals in all three subtypes suffer from a grandiose and superficial sense of self, poverty of interpersonal relations and intimacy, and deficiencies in empathy described above. (See 'Core features' above.)

High-functioning subtype — The high-functioning, exhibitionistic, autonomous subtype of NPD is relatively adaptive and stable. Individuals in this group may not appear, at first glance, to have a personality disorder at all. They are competitive, arrogant, and have an exaggerated sense of self-importance. While their grandiosity and excessive need for admiration interfere with the ability to obtain sustained gratification from work or personal relationships, they are

otherwise able to use their narcissistic traits to succeed. These individuals may act out sexually to bolster self-esteem and obtain needed stimulation, and often complain of boredom.

Mr. A is a 55-year-old married man who presents complaining of marital dissatisfaction. He has a successful academic research career, and is highly competitive inside of work and out; he has an active social life, but he identifies himself in groups as the "alpha" and likes to be the center of attention. Mr. A describes that at the very beginning of his marriage there was a modicum of closeness and an engaged sexual life, but he soon became bored with his wife and lost interest. He has had affairs with a series of women who were not his social and intellectual equals, and whom he supported with housing and funds. He denies that his infidelities have had any impact on his relationship with his wife ("one has nothing to do with the other"), but is chronically troubled by the sense that could he "do better" with someone else.

Grandiose/overt subtype — The grandiose, overt, "thick-skinned" subtype of NPD corresponds closely with description of NPD in the DSM-5-TR. In this group the sense of being exceptional is overt; these individuals appear arrogant, entitled, and demonstrate little observable anxiety. Socially, they are extraverted and attention seeking, and can be superficially charming and socially adept, but struggle with closeness and feelings of dependency. Interpersonally, they are exploitative, lack true empathy, and use their understanding of other's needs for their own self-advancement. Individuals in this group can be aggressive or intimidating, especially when threatened.

Ms. B is a 29-year-old single woman with a history of opiate and marijuana use, currently unemployed. She presented to her local urgent care clinic for back pain not responsive to conventional analgesics and requesting oxycodone ("nothing else works!"). She was flattering and flirtatious with the resident physician who took her history and examined her; when he explained that he would have to speak with her primary care physician before writing a prescription for a narcotic, Ms. B began to insult and bully him. The resident spoke with Ms. B's sister, whose contact information Ms. B provided. The sister explained that the patient was estranged from the family because she had financially exploited her siblings and her parents. Since being fired one year earlier from a remunerative job in residential real estate, she had been unable to find employment meeting her lofty expectations for herself, preferring instead to live off money from her father, and she had secretly opened a credit card in her mother's name and incurred a large debt.

Vulnerable/covert subtype — Individuals presenting with the vulnerable, covert, "thin-skinned" subtype of NPD are openly anxious and in distress, and are often interpersonally and occupationally impoverished. In this group, the grandiosity and sense of being exceptional that characterize NPD are superficially masked, cloaked in overt feelings of deficiency. These

individuals suffer from chronic feelings of inferiority and inadequacy, are preoccupied with evaluating themselves in relation to others, and are extraordinarily self-absorbed. Socially they appear inhibited, shy, withdrawn, and hypersensitive to criticism ("thin-skinned"). This surface presentation masks more commonplace features of narcissism: they are privately absorbed with envying and devaluing others, and frequently withdraw from life's challenges to protect their hidden grandiosity and entitlement. They often harbor fantasies that they will "eventually" triumph, or that they are special, unique, but fragile, and so sequester themselves from a world for which they feel contempt. In adolescents, a common feature of vulnerable narcissism is a "failure to launch."

Mr. C is a 33-year-old single man with a history of Crohn disease who presented to an outpatient mental health clinic for treatment of chronic mild depression and social phobia. Immediately after college he began a career-level job, but quit when he was passed over for advancement. Since that time, he has held a series of low-level jobs that "have not worked out," and he currently works part-time stocking shelves at a local pharmacy. At his assessment at the clinic he describes his mood as "depressed…forever." He has no friends or romantic attachments, no hobbies or passions, and regularly tells his family that he is bored and that "life is not worth living." He avoids his Crohn medication when he gets depressed and eats foods that trigger his symptoms; he has had multiple hospitalizations for bleeding and abdominal pain. He tells his interviewer he feels he is inadequate and a failure, but also that he resents others' advantages and success. He blames his failures on people who don't recognize all he has to offer. He fantasizes that his employer will finally recognize his special talents and promote him to a senior managerial position; at other times, he imagines humiliating his boss with a display of superior knowledge.

Many individuals with NPD fluctuate between grandiose and vulnerable states [30]. Because these individuals are characteristically rigid and adapt poorly, changes in external circumstances can lead to extreme shifts in mood and level of functioning. The grandiose narcissist may feel helpless and victimized, his grandiosity deflated, when served with divorce papers, for example; it would be typical that he reconstitute with the restored conviction that the partner is unworthy, with no sense of his own role in the conflict. A successful venture may induce a brief period of exalted confidence and grandiosity in the vulnerable, withdrawn narcissist, which then may crumble as they are confronted with increased responsibilities and expectations.

Suicide — NPD is a significant risk factor for completed suicide, for suicide attempts, and for suicide attempts of high lethality. The vulnerable subtype of NPD appears to be most strongly linked with suicide attempts and with nonsuicidal self-injury [31]. This observation is consistent

with the much stronger association between vulnerable narcissism and psychological distress, negative affect, depression, and anxiety [32].

As examples, research findings of associations between NPD and suicidality include:

- In a study of 25 patients, narcissistic traits were associated with increased risk of parasuicidal behavior and suicide attempts [31].
- In a retrospective analysis of 538 depressed geriatric patients, NPD and narcissistic traits predicted higher rates of suicidal ideation and behavior independent of severity of depression [33].
- A study of 254 suicide attempters with personality disorders and comorbid axis I disorders found that a diagnosis of NPD predicted less impulsive, but higher lethality attempts compared with other personality disorders [9].
- Analysis of data from a 10-year longitudinal study of 431 patients with two or more comorbid personality disorders found that a diagnosis of NPD increased the risk of ever attempting suicide and predicted multiple suicide attempts [34,35].

Clinical features of suicidality in patients with NPD include:

- The grandiosity and hostility of patients with NPD can mask depressed mood and hopelessness. Clinicians should remain vigilant even in the absence of typical warning signs and should have a low threshold for assessing suicidal thoughts, plans, and intents. Life changes or losses may have a greater and more persistent negative impact in narcissistic patients than in patients with other personality disorders.
- Substance use is an independent and additive suicide risk [36]. Since it occurs at high rates in patients with NPD, drug and alcohol use should be monitored and aggressively treated.
- Old age likely increases suicide risk for narcissistic patients [33].
- Comorbid borderline personality disorder can increase impulsivity and compound risk; in these cases, referring patients for appropriate treatment may be an urgent intervention. (See "Borderline personality disorder: Psychotherapy".)

The pattern of multiple suicide attempts and of higher lethality attempts is particularly significant because NPD patients have more fragile attachments, with unstable treatment alliances, high levels of treatment resistance, and high rates of treatment dropout. (See

"Overview of the therapeutic relationship in psychiatric practice" and "Approaches to the therapeutic relationship in patients with personality disorders".)

These features can leave suicidal patients with NPD beyond the reach of personal or professional support or interventions. There are no evidence-based strategies for the management of suicidality specifically in narcissistic patients, and there are no empirical data for the narcissistic features that most associate with suicides and suicide attempts. Management of suicidal patients is discussed separately. (See "Narcissistic personality disorder: Treatment overview" and "Suicidal ideation and behavior in adults".)

COURSE

The paucity of research data makes the course of narcissistic personality disorder (NPD) difficult to assess. Much of the literature and our clinical experience suggest that narcissistic features persist over time; these patients appear to be resistant to treatment and to change. Some research, however, suggests that aspects of NPD may remit:

- A three-year prospective longitudinal study of 20 patients with NPD, each receiving treatment or supportive care, found that approximately half the patients achieved diagnostic remission, with significant decrease in the overall level of pathological narcissism [37]. Of the 33 individual characteristics assessed, superiority and devaluation/contempt had the most significant decrease; invulnerability, entitlement, exploitativeness, and meaninglessness also declined [38].

- A follow-up diagnostic assessment of 40 patients who were diagnosed with NPD two years earlier reported a two-year remission rate for NPD of 52.5 percent [39]. The clinical relevance of symptom-change and “diagnostic remission” is not clear. Patients may drop below the threshold criteria for NPD but still have distress and significant impairment because of remaining personality deficits.

ASSESSMENT

A diagnostic evaluation of a patient with possible narcissistic personality disorder (NPD) requires a thorough symptom picture and assessment of psychological, interpersonal, and vocational functioning. Given the range of NPD phenotypes, the evaluation should include history from family, friends, and from past treatments, along with assessment of:

- Personality functioning

- Quality and stability of relationships
- Capacity for intimacy and for empathy
- Ability to pursue long-term goals
- Stable sense of self

Since narcissistic patients struggle with feelings of dependency and find attachment difficult, the patient's experience of past treatments should be explored as useful diagnostic and prognostic data. NPD has high treatment drop-out rates (above 60 percent in some studies) [40], and a series of failed therapies and poor attachments (grossly devalued or highly idealized) suggests a poor prognosis, especially if accompanied by antisocial traits [7]. Patients should be assessed for comorbid mental disorders that can complicate treatment, and a detailed substance history is essential. (See 'Comorbidities' above.)

In the clinical interview, focusing on the patient's descriptions of significant others can be particularly helpful in diagnosing NPD. These descriptions are characteristically derogating or, alternatively, colored by idealization. Most striking, however, is the markedly superficial and vague, shadowy quality of the narcissistic individual's experience of others. In contrast, the narcissistic individual's sense of him- or herself may be more intact and nuanced, albeit colored by grandiosity and self-deprecation.

The patient should be assessed for vulnerable as well as grandiose forms of narcissistic pathology. Although grandiose presentations may be more obvious and may seem more overtly pathological, vulnerable forms of NPD are easy to miss and can be equally debilitating and clinically challenging.

Assess carefully for pathology of moral functioning (dishonesty, exploitation) as well as frank antisocial features.

Assessment instruments — Given the variable clinical features that characterize NPD and the sometimes-subtle presentation of higher functioning narcissistic pathology, a systematic interview by an experienced clinician may be the most reliable way to diagnose NPD. There are a variety of structured instruments for assessing NPD. While some have demonstrated reliability and have been used in research [31,41-46], none have been used routinely in clinical care, diagnostically or to track clinical change over time.

DIAGNOSIS

Diagnostic criteria — DSM-5-TR criteria for narcissistic personality disorder (NPD) [47] have been widely criticized for overemphasizing one subtype of NPD, the grandiose/overt type, while

failing to cover other core features and subtypes of the disorder [48,49]. These shortcomings were addressed through the development of an alternative model and diagnostic criteria for NPD, which we favor for clinical use over the DSM-5-TR criteria. (See 'DSM-5-TR' below and 'Alternative-model diagnostic criteria' below.)

DSM-5-TR — DSM-5-TR diagnostic criteria for the disorder include [50]:

- A. A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
  - 1. Has a grandiose sense of self-importance (eg, exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
  - 2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
  - 3. Believes that he or she is "special" and unique and can only be understood by or should associate with, other special or high-status people (or institutions).
  - 4. Requires excessive admiration.
  - 5. Has a sense of entitlement (ie, unreasonable expectation of especially favorable treatment or automatic compliance with his or her expectations).
  - 6. Is interpersonally exploitative (ie, takes advantage of others to achieve his or her own ends).
  - 7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
  - 8. Is often envious of others or believes that others are envious of him or her.
  - 9. Shows arrogant, haughty behaviors and attitudes.

DSM-5-TR criteria for NPD [50] have been widely criticized for overemphasizing aggression, grandiosity, entitlement, exploitation of others, and need for admiration (characteristics of a subset of narcissistic individuals), while failing to cover other core psychological features of the disorder, including vulnerable self-esteem, feelings of inferiority, emptiness and boredom, and affective reactivity and distress [48,49]. In this view, the DSM-5-TR criteria describe a highly disturbed and aggressive subset of the NPD population, corresponding quite closely to the

grandiose subtype, while failing to cover vulnerable and high-functioning NPD subtypes. (See 'Grandiose/overt subtype' above.)

Alternative-model diagnostic criteria — In the American Psychiatric Association's development of DSM-5, the work group responsible for the personality disorders proposed the alternative-model diagnostic criteria for NPD. These criteria added problems with self-functioning (ie, identity and self-direction) and interpersonal functioning (ie, empathy and intimacy) to pathological traits highly characteristic of the disorder.

The alternative-model diagnostic criteria for NPD include:

- A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:
  - 1. Identity – Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal inflated or deflated, or vacillating between extremes; emotional regulation mirrors fluctuations in self-esteem.
  - 2. Self-direction – Goal setting based on gaining approval from others; personal standards unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.
  - 3. Empathy – Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimate of own effect on others.
  - 4. Intimacy – Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain.
- B. Both of the following pathological personality traits:
  - 1. Grandiosity (an aspect of antagonism) – Feelings of entitlement, either overt or covert; self-centeredness; firmly holding to the belief that one is better than others; condescension toward others.
  - 2. Attention seeking (an aspect of antagonism) – Excessive attempts to attract and be the focus of the attention of others; admiration seeking.

Subtypes — Trait "specifiers" are used to identify NPD subtypes:

- High functioning (see 'High-functioning subtype' above)

- Grandiose, overt (see 'Grandiose/overt subtype' above)
- Vulnerable/covert (see 'Vulnerable/covert subtype' above)

The alternative criteria were not ultimately adopted for the DSM-5 [51], which retained the NPD criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV); however, they were included in section III of the DSM-5, "Emerging Measures and Models" [47,52].

In our opinion, the alternative criteria for NPD have several advantages over the DSM-5-TR criteria: coverage of all of the identified subtypes, inclusion of the many patients diagnosed with NPD in clinical practice who do not meet DSM-5-TR criteria, and inclusion of the individual's psychological experience and functioning in characterizing the disorder, in contrast to the DSM-5-TR's dominant focus on observable clinical features and patterns of behavior.

ICD-11 — With the transition from the World Health Organization Classification of Diseases, 10th Revision (ICD-10) to the 11th Revision (ICD-11), the ICD has abandoned all categorical definitions of personality disorders, focusing instead on global and shared features that apply to **all** personality disorders. In the ICD-11, personality disorder diagnosis is based on evaluation of:

- Degree and pervasiveness of disturbances in functioning of the self
- Degree and pervasiveness of interpersonal dysfunction
- Pervasiveness, chronicity and severity of cognitive, emotional, and behavioral manifestations of dysfunction
- The extent to which dysfunction is associated with psychosocial impairment and distress

Degree of dysfunction is characterized as mild (mild personality disorder), moderate (moderate personality disorder) or severe (severe personality disorder). Trait domain specifiers may be added to describe specific features of a patient's clinical presentation. The emphasis on self and interpersonal functioning in ICD-11 is similar to the approach adopted in the Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders (SCID-5-AMPD). In contrast to the SCID-5-AMPD, ICD-11 does not provide specific diagnostic criteria for any personality disorder, including NPD [53].

Differential diagnosis — While the diagnosis of NPD can be difficult to distinguish from other psychiatric illnesses, a careful assessment of personality functioning across time, coupled with careful evaluation of patients' sense of self and their interpersonal functioning, can often make the diagnosis clear. The differential diagnosis for NPD includes mood disorders, substance use and substance-induced disorders, as well as other personality disorders.

- **Bipolar disorder** – The aggression and grandiosity of narcissistic patients can mimic hypomanic or manic states, but typically manic patients do not urgently seek out the admiration of others, or systematically devalue them. Bipolar disorder is cyclic illness, and mania and hypomania occur in discrete episodes that, by definition, feel distinctly different from nonmanic states to the patient and to others; the rigid grandiosity of NPD is typically more a chronic, stable psychopathology. (See "Bipolar disorder in adults: Assessment and diagnosis".)

- **Major depressive disorder, persistent depressive disorder** – The mood and behavior of the covert, withdrawn, envious narcissist can mimic the classic symptoms of major depressive disorder but are primarily characterologic; in clinical experience, treatment refractory depression can often be NPD that has been overlooked. The lack of empathy and superficiality of relationships in NPD are not typically features of major depressive disorder or other mood disorders, and their presence helps clarify diagnosis and direct treatment. (See "Unipolar depression in adults: Assessment and diagnosis".)

- **Generalized anxiety disorder** – Anxiety is a pervasive experience underlying all personality disorders, though the grandiosity of NPD can mask it. A careful inventory of anxiety features, history, and treatment response, as well as longitudinal character assessment in professional and personal life, can help distinguish generalized anxiety disorder from the disturbed, anxious, states of personality disorders. (See "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

- **Substance use disorder, substance-induced disorders** – Chronic intoxication can transiently mimic narcissistic grandiosity and indifference, though it is typically more erratic and unstable. More commonly, the pressure of substance dependence can drive patients to a pattern of "functional," exploitative interpersonal relationships in which they become self-focused and lack empathy; they can on brief assessment appear narcissistic or even antisocial. A thorough substance history can usually differentiate between the exploitative substance user and the grandiose indifference of the narcissist. As always, it is necessary to make definitive diagnoses during stable sobriety. (See "Substance use disorders: Clinical assessment".)

- **Personality disorders** – Histrionic, borderline, and antisocial are the most common personality disorders in the differential diagnosis for NPD. Generally the pervasive grandiosity and need for admiration in narcissistic patients are the most distinguishing features. (See "Overview of personality disorders".)

- **Histrionic personality disorder (HPD)** – HPD and NPD are both characterized by seeking the approval of others and the need to be the center of attention. In contrast to NPD, HPD is associated with a greater capacity for interpersonal relationships and dependence, a greater capacity for emotional expression, and less devaluation of others. NPD is associated with a greater tendency to exaggerate successes and to take excessive pride in achievements than is characteristic of HPD.

- **Borderline personality disorder (BPD)** – BPD and NPD share common features, including superficiality in the experience of others in relationships colored by idealization and devaluation. However, the sense of self in NPD is relatively stable and well elaborated, in contrast to the markedly unstable, fragmented, and contradictory self-image characteristic of BPD.

  The differential between the relatively specific self-description and markedly vague description of significant others that is characteristic of individuals with NPD, can help differentiate NPD from borderline personality disorder. In borderline personality disorder, descriptions of both self and significant others tend to be comparably distorted – black and white, poorly differentiated, intense, and chaotic.

  The impulsivity, self-injury, and fears of abandonment central to the BPD diagnosis are not typically associated with NPD. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)

- **Antisocial personality disorder (ASPD)** – ASPD and NPD are both characterized by superficial, exploitative relationships, and a marked lack of empathy. ASPD can be differentiated from even the most extreme version of narcissism (“malignant narcissism”) by the total lack of moral functioning or of loyalty that might transcend personal need or gain. NPD is typically not associated with childhood conduct disorder, a frequent prodrome of ASPD [6,7]. (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)

  Because antisocial traits are common in NPD, especially as pathology becomes more severe, in any patient for whom NPD is in the differential diagnosis, assess carefully for pathology of moral functioning (dishonesty, exploitation) as well as frank antisocial features.

All of the above diagnoses can also be comorbid with NPD, complicating diagnosis, and worsening prognosis; in addition, patients with other personality disorders, as well as those with affective illness, chronic psychotic illness, substance-related disorders and anxiety disorders may present with narcissistic traits in the absence of NPD.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Personality disorders".)

SUMMARY AND RECOMMENDATIONS

- Among the personality disorders, narcissistic personality disorder (NPD) has the most variable presentation and the widest range of severity, contributing to disagreement over the disorder's boundaries and diagnostic criteria. (See 'Introduction' above and 'Diagnosis' above.)

- The prevalence and sociodemographic features of NPD are poorly defined, in part because of evolving criteria for diagnosis. The prevalence of NPD in the United States and Europe has been estimated in the general population as ranging from 0 to 6.2 percent. (See 'Epidemiology' above.)

- Patients with NPD often come to clinical attention seeking treatment for a co-occurring disorder. Co-occurring mood, anxiety, substance-use, and personality disorders are all common in NPD, complicating diagnosis and treatment. The presence of comorbid disorders in patients with NPD has been associated with greater functional impairment and elevated suicide risk compared with patients without co-occurring disorders. (See 'Comorbidities' above.)

- All individuals with NPD share central clinical features: grandiosity excessive need for admiration, superficial and exploitative relationships, and lack of empathy as well as identity disturbance, difficulty with attachment and dependency, chronic feelings of emptiness and boredom, and vulnerability to life transitions. (See 'Core features' above and 'Diagnosis' above.)

- Evaluation of a patient who may have NPD requires an assessment of psychological, interpersonal, and vocational functioning to obtain a thorough symptom picture, make a differential diagnosis, and establish the presence of the disorder, especially in patients who present with substance use disorder, affective illness, anxiety, and/or interpersonal or work related problems. (See 'Assessment' above.)

- The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria for NPD have been widely

criticized for overemphasizing aggression, grandiosity, entitlement, exploitation of others, and need for admiration, characteristics of a subset of narcissistic individuals, while failing to cover other presentations of the disorder. Alternative diagnostic criteria for NPD, which we favor, account for additional core features, including vulnerable self-esteem, feelings of inferiority, emptiness and boredom, and affective reactivity and distress. (See 'DSM-5-TR' above and 'Alternative-model diagnostic criteria' above.)

- There is strong agreement among clinicians and researchers with expertise on the subject that there are different subtypes of NPD including the grandiose/overt type as well as the high functioning type, and the vulnerable/covert type. (See 'Subtypes' above.)

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