CHAPTER 42

Narcissistic Personality Disorder

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AUTHOR NOTE

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WHAT IS NARCISSISTIC PERSONALITY DISORDER?

Narcissistic personality disorder (NPD) is one the group of cluster B disorders that also includes antisocial, histrionic, and borderline. NPD involves three elements: an inflated view of the self, a lack of warmth or empathy in relationships, and the use of a variety of strategies for maintaining the inflated self-views.

The inflated self-views of those with NPD can include the general sense of specialness, uniqueness, self-esteem, and entitlement coupled with specific inflated self-beliefs (e.g., Campbell, Bonacci, Shelton, Exline, & Bushman, 2004; Emmons, 1984). For example, there may be the belief that one is smarter, more attractive, or more creative than others. These inflated views tend to fall in the area of social dominance rather than social warmth. Narcissism is not associated with seeing oneself as more caring and kind than others (Campbell, Rudich, & Sedikides, 2002). Instead they want to be seen as beings with high status and competence.

Consistent with the view that narcissists are less concerned with warmth and intimacy than with other admirable attributes, they exhibit a relative disinterest in caring and selflessness in romantic relationships (e.g., Campbell, Foster, & Finkel, 2002). They score low on self-report measures of agreeableness (Bradlee & Emmons, 1992) and on projective measures of intimacy such as the TAT (Carroll, 1987). The lack of warmth, however, does not mean that those with NPD are not social. Quite the contrary, narcissism is associated with social extraversion (Bradlee & Emmons, 1992). Indeed, more narcissistic individuals tend to be well-liked in initial social meetings (Paulhus, 1998).

Narcissism is associated with the use of a wide range of strategies for maintaining inflated self-views. These strategies can be categorized as either intrapsychic or interpersonal. Intrapsychically, narcissism is associated with fantasies of success and power (Raskin & Novacek, 1991) as well as the self-serving bias (that is, taking credit for success but blaming the situation for failure) (e.g., Campbell, Reeder, Sedikides, & Elliot, 2000). Interpersonally, narcissism is associated with the use of social situations for enhancing status and esteem. Such strategies include bragging and boasting (Buss & Chiodo, 1991), competing (Raskin & Terry, 1988), and striving (often successfully to excel at challenging tasks when others are watching (Wallace & Baumeister, 2002). Narcissism is also associated with indirect strategies for gaining status and esteem, such as acquiring "trophy" romantic partners (Campbell, 1999) and expensive material goods (Vohs & Campbell, 2004).

When faced with the threatening information about the self, such as negative feedback, narcissism can be linked to violence or aggression against those who

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criticize the narcissist (Bushman & Baumeister, 1998) or who socially reject the narcissist (Twenge & Campbell, 2003). Narcissists will also derogate those who are critical of them (Kernis & Sun, 1994). On group tasks, narcissists are quick to blame their coworkers for any failure or poor performance, rather than risk taking blame themselves (Campbell, et al., 2000).

These interpersonal and intrapsychic patterns can be seen as self-regulatory efforts to sustain positive views of self. In that, narcissists are often successful, and narcissism in normal populations is associated with higher self-esteem, and lower depression and anxiety, as compared with other people (Rose & Campbell, in press). There is scant evidence that narcissism is associated with success in any linear way. It is more likely that narcissism is beneficial in some settings (those aided by confidence and extraversion) and harmful in others (those hampered by overconfidence) (e.g., Wallace & Baumeister, 2002; Campbell, Goodie, & Foster, in press).

This model of narcissism—inflated self-views, lack of warmth or empathy, and self-regulation strategies—can be seen in the DSM-IV criteria for NPD (American Psychiatric Association, 1994). According to the DSM-IV, NPD includes:
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 (e.g., 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, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
6. is interpersonally exploitative, i.e., 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 or attitudes

This definition includes the positive views of self (grandiosity, specialness, entitlement), a lack of interpersonal warmth and sensitivity ("lacks empathy", exploitativeness, envy, arrogance), and several self-regulation strategies (fantasies, admiration).

Still, there is disagreement over the nature of NPD. The biggest source of disagreement in NPD involves the psychic underpinnings of the disorder. In one camp, largely psychodynamic in origin, it is argued that narcissism is a defensive response to some inner sense of abandonment, shame or hurt (e.g., Kernberg, 1975). In the other camp, based largely on research in social, cognitive, and personality psychology, narcissism is seen as an offensive rather than defensive condition, and no soft inner core of self-loathing is postulated. Narcissism in this second view is associated with overconfidence, approach orientation, and extraversion. If reality monitoring is lost, it is largely a result of excessive zeal in the quest for status and esteem. Indeed, some have argued that narcissism is in many ways like an addiction (Baumeister & Vohs, 2001), in which the positive experiences of being admired and esteeming oneself can becoming reinforcing.

The disagreement as to whether to conceptualize narcissism as offensive or defensive has not been resolved. Our opinion lies closer to the latter (offensive) view, though like many others we prefer to reserve judgment until more evidence is available. In current empirical studies, narcissism appears largely the result of a desire for status and esteem with little restraint from warm social relationships (see Morf & Rhodewalt, 2001, for review). However, there are arguments to be made on both sides, with some suggesting that there are two forms of narcissism (e.g., Millon & Davis, 1996; Rose, 2002).

A second debate involves the structure of narcissism. Is narcissism a dimensional variable, with NPD representing the top of the continuum or a subset of individuals? Or does NPD represent a discrete type? Millon and Davis (1996) and others (including ourselves) think that narcissism might be best considered a continuous variable rather than a discrete category. Although NPD would fall on the extreme end of the narcissism continuum, the clinical sample of NPD is not representative of this extreme group. Instead, so-called "failed narcissists" are overrepresented in those diagnosed with NPD (Campbell, 2000). Failed narcissists are those in whom the narcissistic self-regulatory strategies are not successful at sustaining the desired high level of self-esteem. For example, failed narcissists may be experiencing depression in the aftermath of a series of career disappointments and unmet goals. From the failed narcissist's perspective, the depression, not the NPD, is the problem. This small group of failed narcissists, then, is different from the majority of narcissists who are largely happy and nondepressed. This skewed sample of those with NPD seen by clinicians may, in part, be responsible for the view of narcissism as a defense against clandestine feelings of worthlessness (described above).

If this dimensional conceptualization of narcissism is correct, this has important implications for research. There is very little research done on individuals diagnosed with NPD. This reflects the low number of individuals with NPD seeking treatment, as well as perhaps funding priorities by the major research grant agencies. The alternative is to conduct research on nonclinical samples. This approach allows access to far more research participants and opens the door for more rapid theoretical progress. Indeed, the majority of research findings presented here are from nonclinical samples.

BASIC FACTS ABOUT NPD

Comorbidity. Comorbidity depends on the current state of the individual with NPD. Those who have experienced a series of failures may present with depression or dysthimia. In contrast, individuals with NPD who are doing well in life may present with hypomania. There also may be some link between NPD and anorexia nervosa as well as drug use. NPD is associated with the other cluster B personality disorders, and even some cluster A disorders such as paranoid personality.

Frequency. According to the DSM-IV, less than 1% of the general population suffers from NPD. Our impression is that there are far more narcissists around than that figure would suggest, but that most of those with NPD are high functioning (at least from their own perspective) and therefore do not request psychological treatment.

Age. NPD should not be diagnosed until early adulthood, because many symptoms of NPD are common (and perhaps developmentally normative) among adolescents. As a rule, the prevalence of narcissism declines with age. There is evidence for this in cross-sectional data from nonclinical samples (Foster, Campbell, & Twenge, 2003).

Gender. According to the DSM-IV, 50–75% of those with NPD are male. This same pattern is found in research on narcissism in normal samples. There is a small association between gender and narcissism, $r = .12$, with males being slightly more narcissistic (Campbell et al., 2003). This finding is similar to gender differences in self-esteem (Kling, Hyde, Showers, & Buswell, 1999).

Racial Differences. NPD is not associated with any racial differences. In normal samples, self-reported narcissism differs slightly across racial and cultural groups, with Asians being on the lower end of a continuum and African Americans on the higher end (Foster, et al., 2003). This parallels the differences found in self-esteem (Twenge & Crocker, 2002). These differences in narcissism are sufficiently small as to be regarded as without practical importance (e.g., r's < .10) and nondiagnostic.

ASSESSMENT

What Should be Ruled Out?

Narcissism can be confused with the related cluster B personality disorders, so it is important to rule those out. Antisocials are typically not as interested as narcissists in gaining admiration, although they are often hypervigilant for disrespect. Narcissism is also associated with greater extraversion than antisocial personality. Likewise, individuals with antisocial personality show greater difficulty with impulse control and are likely to have a childhood history of law breaking or other misconduct. Histrionic individuals are more emotionally buoyant and dramatic than those with NPD. NPD is associated with a "insouciant" affect—basically a detached nonchalance (Millon & Davis, 1996). Last, borderline personality disorder is relatively easy to distinguish from NPD. Borderline personality is more likely than NPD to be associated with self-destructive behavior patterns (e.g., cutting), split object relations (e.g., love or hatred for the same individual across a short period of time), and greater concern with abandonment (DSM-IV).

NPD and some cluster A personality disorders, especially paranoid, can occasionally share similarly grandiose views of the place of the self in the world (Millon & Davis, 1996). Indeed, Freud's original monograph on narcissism linked it potentially with some autistic-like, self-absorbed mental conditions. NPD is different from these other disorders in that it is usually associated with good social skills, even charm and likeability. Those with NPD typically do not appear odd or bizarre.

Grandiose states of mind similar to these in NPD can be found in states of hypomania (or the similar drug-induced states, such as cocaine use). The affective element of these manic states, as well as the nature of their onset, may help rule them out.

The DSM-IV suggests that people who are high in status such as celebrities can have NPD-like symptoms, but celebrity status should not be confused with NPD unless functioning is impaired. We would argue that NPD can be an appropriate diagnosis even when functioning is temporarily high. For example, you can have a CEO of a large company who throws lavish parties and belittles fellow employees but functions adequately in terms of the successful management of his company. If the stock market drops and people start to question the CEO's behavior, however, he or she may start engaging is potentially self-destructive behaviors (e.g., cooking the books, blaming others). We do not think that the NPD emerges when the trouble starts; more likely, it has been there the entire time, but it was not perceived as a problem as long as the profits were good. Indeed, it may be more broadly true that social circumstances dictate when NPD is seen as a pathological disorder and when it is seen as an understandable or merely annoying pattern of self-congratulation in a successful person. Nonetheless, certain circumstances, such as celebrity status,

power, and fame, should be considered risk factors for NPD, because they promote and reinforce self-love to an extent that may seem appropriate during phases of worldly success but then may seem pathological when sustained through less successful periods.

What is Involved in Effective Assessment?

Assessment of NPD usually involves a structured clinical interview, such as the SCID-II (First, Spitzer, Gibbon, & Williams, 1997). This interview is based on the DSM criteria for NPD and can help a clinician make a reasonable diagnosis.

There are self-report measures that are also useful for assessing narcissism. The Millon Clinical Multiaxial Inventory-III (MCMI-III) (Million, Millon, & Davis, 1994) is consistent in large part with the DSM and can be used to diagnose NPD as well as illuminate potential subtypes (e.g., amorous, unprincipled). The narcissistic personality disorder (NPI; Raskin & Hall, 1979) is the most commonly used measure for assessing narcissism in nonclinical samples, primarily for research purposes. It is derived from the DSM-III criteria for NPD, but has no explicit "cut-off" for NPD. The Millon and NPI correlate positively in clinical samples (Prifitera & Ryan, 1984).

There are various other scales used to measure more "covert" aspects of narcissism. These have marginal reliability and tend to not correlate (or they correlate negatively) with the NPI, and we would not recommend their use (Soyer, Rovenpor, Kopelman, Mullins, & Watson, 2001).

What Assessments are Not Helpful?

Projective measures for NPD, such as the TAT or Rorschach, tend to yield mixed responses from those with NPD (Millon & Davis, 1996). This makes these measures marginally helpful. There is no known biological marker.

TREATMENT

What are Effective Therapist Based Treatments?

We know of no solid treatment outcomes studies on NPD. It is difficult to find a large sample of individuals with NPD who actually want to be treated. If you think you are better than other people, have high self-esteem, and are happy, why would you seek psychotherapy? There is certainly a small percentage of individuals with NPD who do have some insight into their problem and do want to change, but this is not the norm. Clearly, the lack of treatment outcome research for NPD is a major problem that needs to be addressed.

Despite the lack of treatment outcome research on NPD, there is a wealth of clinical treatment reports. These reports share two common similarities: (1) narcissism is difficult to treat and the treatments are not often effective, and (2) one key in treatment is to form a strong alliance with the client. This alliance is crucial to encouraging the client to remain in therapy. Beyond these basics, there are three overarching therapeutic approaches: a psychodynamic approach, an interpersonal approach, and a cognitive-behavioral approach, each broadly defined (Millon, 1999).

The historically oldest of the approaches is psychodynamic. These treatments are based largely on the work of Kernberg (1975) and Kohut (1977). The two had similar views on the appearance of narcissism, but they differed in terms of etiology, with Kernberg looking toward childhood abandonment issues as a source, and Kohut emphasizing a lack of mirroring in childhood. More recently, psychiatrists such as James Masterson have focused their practices on personality disorders. These efforts have produced well-written accounts both of therapy and of the

disorder (e.g., Masterson, 1988; 1999). The commonality in these approaches is that they focus on negative childhood experience as crucial to the etiology of NPD, and they also use classic dynamic techniques in therapy (e.g., analysis of transference and countertransference, interpretation). It is also important to note that this view of the etiology of narcissism differs markedly from the learning model of narcissism proposed by Millon (e.g., Millon & Davis, 1996). Millon hypothesizes that narcissism is learned from parents who overestimate their offspring.

Interpersonal approaches are derived from the tradition of Sullivan. Interpersonal approaches focus on the structure of social relationships, both past and present, in therapy. In particular, the individual's representations of those relationships are investigated. The interpersonal approach has shown some promise in treating disorders such as NPD that have strong interpersonal components (Benjamin, 1993). (We should also note that group therapy is not generally recommended for NPD [Millon, 1999]).

More recent cognitive-behavioral approaches focus on the current manifestations of narcissism and the cognitions that accompany them. These are grandiose self-views, lack of empathy, and reactance to negative feedback. The goal of the therapy is to moderate these beliefs. Such techniques can range from the strictly cognitive (e.g., Beck & Freeman, 1990) to others that include a focus on the past more typical of psychodynamic therapies. For example, schema therapy (Young, Klosko, & Weishar, 2003) focuses on the development of early cognitive schemas or mental representation of self and other.

As noted, these different approaches to therapy have been used effectively with NPD, but there are no large scale treatment outcome studies. Given this lack of data, two other treatment approaches deserve consideration. First, there is a potential treatment for NPD that involves strengthening the narcissism rather than minimizing it. This approach, for example, may be advantageous in elderly populations (Jacobowitz & Newton, 1999). Simply reinforcing the client's narcissism should remove certain symptoms, especially those involving depression. Second, several forms of therapy based on the traditional meditation technique of "mindfulness" have been employed for a range of mental disorders (e.g., Baer, 2003; Roemer & Orsillo, 2002). Of particular note, mindfulness techniques have been used effectively as part of a broader dialectical behavior therapy (DBT) for individuals with borderline personality disorder (Linehan, 1993). Mindfulness practice has been used in the East for millennia to combat egotism, and it is plausible that these techniques might well prove useful in minimizing narcissism.

What are Effective Self-Help Treatments?

There are no known effective self-help treatments for NPD.

Useful websites There are few useful websites on NPD that we could find. Much of the information on the web is highly suspect. There are many discussion groups on NPD, but these are primarily aimed at those who have been victimized by narcissists, not at the narcissists themselves. There are also many sites on NPD that are not run by professionals. However, we could find few websites that were research based. Dr. Theodore Millon has a website on personality disorders at that is probably the best of these: http://www.millon.net.

What is Effective Medical Treatment?

Medical treatment may be effective for some of the symptoms reported by those with NPD, such as depression, but there is no known medical treatment for NPD.

How Does One Select Among Treatments?

Because treatment outcomes are so uncertain, treatment should be based on other factors, such as cost and therapist expertise. At present, our preference is for cognitive-behavioral techniques that focus on the current situation rather than those that focus on childhood etiology of the disorder. We make this recommendation because: (a) there are no good data on the etiology of narcissism, and (b) there is reason to believe that ongoing situational factors can lead to the development of narcissism (Baumeister & Vohs, 2001).

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