

Narcissistic Personality Disorder: Facing DSM-V

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Psychoanalytic theories and clinical case studies of patients with narcissistic character pathology were most influential in outlining the conceptualization and description of the narcissistic personality disorder (NPD) when it was first included as a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition, (DSM-III) in 1980. This was eloquently summarized by Salman Akhtar.¹ Influences from other disciplines, (ie, psychiatric and psychosocial research on epidemiology and prototypical features), as well as academic social psychological inventory and laboratory studies of human behavior, have contributed additional perspectives on pathological narcissism and NPD. More recently, cognitive neuropsychology and studies of infant and child development have also added valuable information to our understanding of the origins of pathological narcissism and specific areas of narcissistic personality functioning. Three recent reviews²⁻⁴ have

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TABLE 1.

Prevalence of NPD

General population	0%-5.3% ⁸⁶⁻⁹⁰
Wave 2, NESARC lifetime prevalence	4.8%-7.7% ¹³
Clinical population	1.3%-17% ^{53,91-94}
Forensic population	6% ⁹⁵
Outpatient private practice	8.5%-20% ^{67,96,97}
Military setting (NPD and NP traits)	20% ^{98, 99}
Medical school, first-year students	17% ¹⁰⁰

summarized available knowledge and suggested new avenues toward improvement in diagnosis and clinical conceptualization of NPD.

Clinical accounts of the narcissistic personality indicate a range of characteristics and behaviors among these patients. Some match the typical expectation of a narcissistic personality (ie, being boastful, assertive, and arrogant). Others can initially appear friendly and tuned in, but gradually become strikingly distant and aloof. Some can be modest and unassuming with an air of grace. Still others present as perpetual failures, while constantly driven by unattainable, grandiose aims. One can be shy and quiet, another charming and talkative, yet another domineering, aggressive, and manipulative. Absence of symptoms and experiences of suffering can be a paradoxical blessing for some people with NPD while others are prone to depression, substance use, mood swings, or eating disorder. Some people effectively hide their narcissistic aims, while others openly and bluntly exhibit their most extreme narcissistic characteristics. Nevertheless, the underlying commonality is that they all struggle with grandiosity, self-esteem fluctuations, limitations in their interpersonal relationships, and intense emotional reactions to threats to their self-experience.

Empirical studies have supported the clinical observations that pathological narcissism can be expressed in temporary traits or in a stable, enduring personality disorder. It can be identified as symp-

tom that to various degrees influence and limit interpersonal and/or vocational functioning, or as context-determined narcissistic reactions.^{5,6} Independently of level of severity, pathological narcissism can either show as overt, striking and obtrusive symptoms and functioning, or it can be internally concealed and unnoticeable.^{1,7} Narcissism can also take malignant forms and co-occur with anti-social behavior or psychopathy.^{8,9}

Currently, there is evidence within four areas of relevance for NPD that can further guide the discussion about the diagnosis of NPD and its delineating criteria. Regulatory patterns in pathological narcissism can be identified within a range of narcissistic features. The range of function, phenotype, changeability, and empathy in NPD will be discussed and integrated into reformulations of characteristics that can represent, describe, and help understand people with disordered narcissism and NPD.

THE FUNCTIONAL RANGE

The variable prevalence rates of NPD in different settings imply a functional range in people given this diagnosis (see Table 1). Several studies have indicated functional impairment and mental disability, especially when co-occurring with major Axis I disorders such as substance use and mood and anxiety disorders.¹⁰⁻¹² A recent study, Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC),¹³ found a lifetime prevalence rate of 6% (7.7% for

men and 4.8% for women) in the general population, with considerable psychosocial disability, especially among men, and co-occurring mood disorders (depression, bipolar I disorder), anxiety disorder, personality disorders, and substance use disorder.

On the other hand, the NPD diagnosis has more often been reported in outpatient private practice and small clinics as compared with the general population and larger psychiatric settings. NPD has also been diagnosed in non-psychiatric professional settings such as the military and medical school, indicating that NPD does not necessarily cause nor is it necessarily accompanied by impairment in ability to work, or in social or daily functioning. In other words, people with NPD, contrary to most other personality disorders, include both those who are high-functioning who can be professionally and socially successful, as well as those with functional impairment, with severely disabling narcissistic traits and character functioning or accompanying Axis I disorders.

There are several possible explanations to the high functional ability in people with NPD. One suggests that they can appear stable stoic, rigorous, and organized despite internal dysregulation, hyperreactivity, and fluctuations. Their surface functioning and absence of symptomatology, combined with interpersonal distance and difficulties with self-disclosure, may support their internal control and allow their internal suffering to remain bypassed or hidden. Another suggests that people with NPD cause distress, pain, and suffering in others while they themselves are oblivious and do not experience their own suffering. Those without accompanying Axis I disorder who also can avoid professional or personal failure may not experience psychological stress at all.¹⁰

A third explanation relates to the range of narcissism from healthy and extraordinary to pathological and malignant.¹⁴ Co-exis-

tence of and fluctuations between healthy and pathological aspects and functions of narcissism are common. Narcissistic individuals may have strengths and abilities in certain areas (ie, in their professional or social lives), which can help sustain self-esteem regulation and interpersonal functioning, but still present with severe vulnerabilities and narcissistic patterns in other areas (eg, in their intimate relations, parental roles, or moral and ethical standards or behavior). Working capacity (ie, the ability for sustained- and evidence-based vocational or creative activities maintained over time and during phases of success as well as when facing challenges and setbacks) is a significant indication of sustainable higher functioning in people with NPD. Ability for temporary achievements and a history of occasional or irregular accomplishments, or a one-time top achievement under favorable circumstances, can indicate an actual or potential capability that is hampered by narcissistic fluctuations or vulnerabilities. In others, such fleeting achievements can be the results of temporary self-enhancing and self-serving behavior with little or no accompanying capability or potential. Such differences are noticeable in the following examples.

After graduating from college Ms. A protested against her professionally accomplished and demanding parents by working as a taxi driver. While driving in the city, she observed the architectural construction of several of the new buildings. Increasingly fascinated by envisioning architectural novelties and by the idea of herself as a designer of exceptional interiors and exteriors, she studied architectural design on her own, formed a team of artists and contractors, and implemented her ideas in a few buildings. After a period of successful collaboration and production, her business ran into financial difficulties. In the context of being denied a bank loan, she barely survived a serious suicide attempt.

Mr. P, a very smart, articulate, and laid-back middle-aged man, told one of

his numerous psychotherapists about his outstanding accomplishments. Convincingly outlining his passion from beauty and design, he described a project he had done in a residence owned by the Dutch royal family and another owned by a famous Hollywood film director. Further exploration revealed that at both occasions he had been involved in romantic relationships with partners who were designers and contracted to do these projects, and that Mr. P's role had been to assist with certain tasks while the relationships lasted. When confronted with the discrepancies in his accounts, he resumed to convincingly outline his interest in architectural and artistic beauty by showing photographs of the interiors of exceptionally esthetic and artistically designed buildings he had visited.

THE PHENOTYPIC RANGE

Several clinical accounts and studies have suggested a two-cluster or two-factor structure indicating two phenotypes of NPD. This was initially suggested by Akhtar and Thomson¹⁵ and further discussed and confirmed by several other authors.¹⁶⁻²⁰ Empirical studies have also supported such subtypes.²¹⁻²⁶ Despite their descriptive variations, a phenotypic range within different and opposite sets of narcissistic personality traits is indicated: one arrogant, overt, grandiose, assertive, and aggressive, and another shy, covert, vulnerable, insecure, and shame-ridden. As with the functional range, the individual presentation can include traits and patterns of both phenotypes (ie, the narcissistic individual may fluctuate between assertive grandiosity and vulnerability with shame-driven aggressive reactions).²⁷ In the Psychodynamic Diagnostic Manual (PDM)²⁸ the two subtypes of NPD, P104, are labeled Arrogant/entitled and Depressed/depleted. People with narcissistic withdrawal or negative narcissism as suggested by Green,²⁹ with a state of emptiness, nothingness, or even chronic suicidality, may be included in the latter category.

Outstanding for the Arrogant type is the more striking predominant presentation, with openly featured expressions of self-serving and enhancing behaviors and attitudes in their more active and deliberate interactions with others. This is in contrast to 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, tuned in, and interpersonally awaiting. Nevertheless, under a modest surface, the shy narcissistic individual is equally preoccupied with self-enhancing fantasies and strivings and hyperreactive to oversights or unfulfilled expectations from others. Contrary to the Arrogant type who has more compromised, inconsistent, or fluctuating super-ego ranging from perfectionism to temporary corruption/deceitfulness, the shy type suffers from more strict conscience, harsh self-criticism, and feelings of guilt.

A third and more outstanding presentation includes narcissistic people within the range of antisocial personality disorder, psychopathy, and malignant narcissism,^{8,30} characterized by aggression and hostility, or by cruel, sadistic, and destructive criminal or violent behavior. Typically, such behavior serves to protect and enhance the narcissistic individual's self-esteem and can be driven by envy, entitlement, vengefulness, or sadism, combined with severely compromised empathic functioning (ie, when empathic ability is connected to exploitive ambitions).

FLUCTUATIONS AND CHANGEABILITY

Fluctuation in narcissistic character functioning, especially grandiosity, and changeability both toward improvement and worsening is the third area of studies with relevance for the diagnosis of NPD. A follow-up study showed overall improvement with less pathological narcissistic traits and diagnosis after 3 years.⁵ It also suggested that grandiosity, the core

trait and the most distinguishing and differentiating characteristic for NPD, is reactive and state-dependent. For instance, it can be influenced by brief depressive reactions or depressive disorder causing a more self-critical and humble attitude, or by moving from late adolescence to adulthood with experiences of more realistic achievements and interpersonal experiences that stabilize self-esteem. Sudden threats to self-esteem or to more favorable self-images can temporarily increase defensive grandiose behavior, such as anger and hostility.^{31,32} Alternatively, such threats can cause a loss of self-esteem with shame and detachment.³³ A continuous search for others' affirmation of the grandiose but vulnerable self is typical, as is the use of interpersonal self-regulatory strategies such as self-enhancing behavior and blaming others for failures. On the other hand, corrective life events, such as achievements, relationships, and manageable disillusionments, can contribute to a more realistic alignment of the self-esteem and of the evaluation of the person's own capacity and potential.⁵ In addition, life events such as losses and narcissistic injuries can also promote disengagement from inhibitions and can lead to meaningful engagements and self-representational change in the context of achieving more realistically anchored ego-ideals.³⁴

Depression and anxiety, not endemic to NPD but resulting from problems, failures, or realizations of their own limitations, may also cause changes in narcissistic individuals' general functioning.¹⁰ Stress associated with external experiences can escalate narcissistic symptoms and functioning, overwhelm the self, and trigger symptoms such as shame, humiliation, and rage. Although underlying vulnerability to such stress can stem from the presence of pathological narcissism or NPD, even relatively healthy people can develop narcissistic symptoms after experiencing more or less severe narcissistic threats or humiliation.⁶

THE RANGE OF EMPATHIC FUNCTIONING

Empathy, usually considered an inborn and naturally occurring ability, is also a complex, multidimensional regulatory process that requires skills, tact, and experience. Empathy is an essential aspect of self-esteem regulation, and it is crucial for the ability to master interpersonal relationships and social interactions. Compromised or fluctuating empathic processing is basic to pathological narcissism and NPD. Recent studies on empathic functioning have implications for identifying, understanding, and treating empathic deficits in narcissistic patients.

Social psychological research has identified empathic regulation in terms of cognitive empathy (perceiving the expression in others and theory of mind) and emotional empathy (affective recognition of the emotions perceived in others). Both empathic accuracy and empathic concern are involved in empathic regulation and both can vary independently³⁵ (ie, an individual can present with empathic accuracy in the absence of empathic concern, and vice versa). Netzelek and colleagues³⁶ suggested that people have dispositional ability to be empathic (ie, to perceive and experience the emotions of others), but situational factors can influence, or even overwhelm the expressions of such abilities. They concluded: "... the capacity to experience empathy in the right contexts can be viewed as a skill or ability rather than an automatic, dispositionally driven process ... Such an ability is likely related to people's ability to regulate their emotions."³⁵

Empathy refers to the ability to perceive the inner psychological state of others and to identify and feel the feelings and needs of other people. Decety and colleagues³⁷ identified four neuropsychological components involved in empathic capability: affect sharing is based on the ability to mimic and the development of shared representations between self and others; self-other awareness requires a sense of self-

agency and separateness from the other; mental flexibility includes the ability for perspective-taking and adopting the other's subjective perspective; and emotional regulation holds emotional resonance and reappraisal. Self-awareness and self-regulation are also central components in empathic functioning. Those require several abilities (ie, to identify and feel one's own emotions and separate oneself from one's own feelings); to recognize the other person as similar to one's self but at the same time as separate and different from one's self; and the ability to regulate and inhibit one's own emotional expressions. Fonagy³⁸ suggested empathy dysfunction can stem from impaired capacity to understand own feelings and disconnected interpersonal affective interpretative function, which are essential in emotional resonance. Low affect tolerance, or strong reactions to the perception of the feelings of others, especially helplessness and shame, tend to impair capacity for empathic concern.³⁹ On the other hand, self-serving and self-enhancing strivings also interfere with empathic capability.⁴⁰ In addition, empathy is modulated by cultural values and personal, developmental experiences.

Empathic Variations in Psychiatric Samples

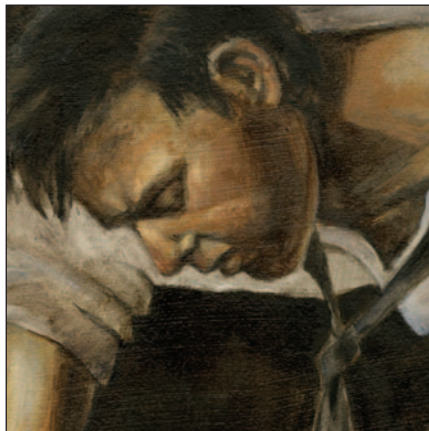
Studies of empathic functioning in psychiatric samples can provide some information relevant to understanding the narcissistic individual's empathic abilities and limitations. People with autism have difficulties with "cognitive empathy" (ie, perceiving the expression in another person's face). They also have problems with empathic accuracy, (ie, to accurately infer or even recognize the existence of others' thoughts and feelings). However, variations in empathic ability, especially empathic accuracy, have been found along the autism spectrum.⁴¹ Patients with schizophrenia have a general empathic deficit manifest across all domains of empathy-related processes.⁴² However, notable variations are related

to the symptoms and source that cause a specific deficit. For instance, patients with schizophrenia with paranoid symptoms are hypersensitive to threats and therefore likely to misinterpret others' facial intentions and expressions. On the other hand, an inability to feel what the others feel (affective blunting) can also lead to a misidentification of others' facial expressions.

Blair and colleagues⁴³ found a high degree of selectivity in empathic functioning in people with psychopathy. They concluded that while these people have an impaired ability to process selective emotional expressions (fear, sadness, disgust), there is no evidence that they have a cognitive or "theory of mind"-related empathic impairment. Similarly, studies of empathic functioning in people with antisocial personality disorder (ASPD) also show that they do not have basic "cognitive or "theory of mind" deficits, or difficulties reading basic or complex emotions from facial expressions. Instead, their problems refer to their ability to make empathic inference about how others feel.⁴⁴ Patients with borderline personality disorder (BPD) have been considered above average in their ability to infer others' thoughts and feelings. However, Flury and Ickes⁴⁵ challenged this assumption in a study of paired BPD–non-BPD dyads whose ability to accurately read thoughts and feelings of each other were measured. They concluded that people with BPD do not have empathic impairment (ie, they are capable of processing the complex borderline-related dysregulatory emotional experiences in themselves and others, but they do not have exceptional or above-average empathic capability).

Conditions related to pathological narcissism have been associated with low levels of cognitive empathy (preoccupation with other things). Gilgun⁴⁶ identified a high degree of self-centeredness in perpetrators of child abuse (ie, "a focus on the self so intense that it precludes

consideration of the feelings and choices of others and which at times causes direct emotional and/or physical harm to others").⁴⁶ Similarly, Wiehe⁴⁷ found an inverse correlation between empathy and need for power, control, and dominance in child abuse perpetrators.



Sudden threats to self-esteem or to more favorable self-images can temporarily increase defensive grandiose behavior, such as anger and hostility.

Implications for Empathic Functioning in Narcissistic Individuals

Compromised empathic functioning causing recurrent interpersonal failures or conflicts can be a source of fluctuating or low self-esteem and underlying insecurity. The narcissistic individual, ready to blame others, may or may not be aware of such a deficit. Several possible factors may impact the narcissistic individual's empathic capability and functional pattern. Those include:

- a) High degree of self-centeredness and focus on self-enhancing and self-serving interpersonal strivings;
- b) Emotional dysregulation (ie, insensitivity or impaired ability to appraise

certain emotions in others, such as despair, sadness, grief, joy, happiness; or difficulties in tolerating, modulating, and processing certain of one's own emotions triggered by the perception of others' experiences or emotions, such as strong negative feelings of contempt, shame, rage or envy);

c) Self-esteem dysregulation, where the perception of others' experiences evoke self-promoting or self-enhancing strivings, or alternatively, feelings of inferiority, powerlessness; and

d) Superego dysregulation, with compromised ability for care and concern, exploitative efforts, disregard for the possessions, and well-being of other people, or deceitfulness.

Narcissistic people may be able to appropriately empathize when feeling in control or when their self-esteem is unchallenged or promoted. Some can empathize more with others' positive feelings and success-related experiences than with others' negative feelings or defeats and vice versa. Those influenced by envy can be unable to tolerate others' positive events and feelings, while those who tend to mirror themselves in the light of others may perceive others' success as an opportunity for self-enhancement. Similarly, those who readily feel contempt can find others' defeats and losses despicable and secure their own superiority or perfectionism in the comparison between self and the other. Others are able to empathize under certain circumstances (ie, when asked for advice by a friend who has marital problems, but unable to relate to their own marital problems as pointed out by the spouse). A guide for evaluation of the narcissistic patient's specific individual empathic deficits and functional patterns is outlined in the Sidebar (see page 116).

Empathic dysfunction and compromised ability for empathic processing can disable the narcissistic patient from accurately perceiving and experiencing empathy from another person. This has

SIDEBAR.

Narcissistic Empathic Functioning: Deficits and Phenotypic Range

Developmental, Emotional, and Cognitive Deficits

- Lack of motivation, curiosity, interest, or other-orientation/narcissistic withdrawal (negative narcissism)
- Underdeveloped, self-other distinction
- Self-centeredness
- Emotional dysregulation, low-affect tolerance
- Superego deficits

Phenotypic Range

Detached Empathic Functioning

- Inattentive
- Obviously insensitive
- Withdrawn
- Silent due to internal reactions: emotional flooding (aggression, shame); confusion; internal paralysis or numbness

Self-enhancing Empathic Functioning

- Tuned in, seemingly empathic
- Friendly, actively helpful, seemingly altruistic
- Multiple-intellectual, perspective taking, seemingly reflective
- Ambitiously intrusive, domineering, or controlling, seemingly concerned, involved, and protecting
- Perfectionist attitude
- Moral superiority or condemnation
- Taking emotional or social advantage of others' feelings and experience

Aggressive Empathic Functioning

- Belittling, ridiculing
- Irritable
- Resentful, rejecting
- Critical, contemptuous
- Retaliating, revengeful
- Hostile dismissive reactions

Malignant Reactions to the Perception of Others' Feelings and Experiences

- Manipulative deceitfulness
- Exploitive usage of empathic competence for self-serving, perverse, sadistic, cruel, or antisocial aims
- Violent impulses or behavior

significant consequences in treatment of the narcissistic individual, who easily can misinterpret the clinician's genuine efforts to help. Glasser⁴⁸ noted that: "Sometimes the patient can actually experience empathy as a danger, since he feels the analyst is getting inside his mind and reading his thoughts, and that the danger of being "brainwashed" is imminent."⁴⁸

IDENTIFYING REGULATORY PATTERNS IN PATHOLOGICAL NARCISSISM

The self-regulatory approach to pathological narcissism focuses on the self-esteem (ie, its range from assertiveness and grandiosity to inferiority or insecurity) and on the various self-enhancing and self-serving interpersonal strategies that aim at protecting and heightening self-esteem and grandiosity. Emotional dysregulation is evident in the predominance of aggression and shame, the intense reactions to threats to the self-esteem, and the individual's efforts to maintain internal and external control.

O. Kernberg^{49,50} suggested a motivational function in aggression as an effect, because it links self-object representations with internalized object relations associated with frustrating experiences. More or less primitive aggression, expressed either overtly toward others or internally, is the self-regulatory process that contributes to a sense of superiority. Kohut^{50,51} considered self-cohesiveness to be central for narcissistic functioning. Several authors have recently recognized the narcissistic patient's preoccupation with control, both internal and interpersonal.⁵²⁻⁵⁴ Internal control, a psychological function that promotes a sense of mastery, cohesiveness, power, separateness, and self-sufficiency, includes both the efforts to maintain a sense of control and an underlying fear of loss of control. Fear of loss of control can be triggered by internal as well as external experiences, especially related to sustaining meaning and self-sufficiency, and to avoiding emotional flooding and shaming. Interpersonal

control is a major obstacle in treatment of the narcissistic patient⁵⁵⁻⁵⁷ and is expressed in a range of attitudes and behavior — from self-assertive independence and self-protection to dominance and power and to critical, aggressive, sadistic intrusiveness.

In its ultimate form, narcissistic self-regulation with self-directed aggression and efforts to control, can also be expressed in suicidal ideations and acts, representing a "my way or no way" or "death before dishonor" attitude. Studies have proved pathological narcissism to be connected to suicide.⁵⁸⁻⁶⁰

Suicidal ideations and behavior can serve to protect against threats or defeats, represent an illusion of mastery, control, or indestructibility, or they can serve as a means to attack or destroy imperfect aspects of the self. Narcissistic individuals can have suicidal thoughts and impulses in the absence of depression, and they can also balance suicide-related self-esteem-preserving grandiose ideas on the one hand and the actual suicidal behavior and its real self-destructive or lethal consequences on the other.^{61,62} Intolerable effects, caused by threats to self-esteem, or loss of essential support or ideals, can be denied and split off.^{30,33,63} These regulatory functions may make narcissistic individuals reluctant (or even unable) to convey their suicidal intentions to a clinician. For some, suicidal ideations may even function as a way to control and process unbearable feelings and help the individual preserve connections to life.⁶⁴ However, if acted upon in a state of rage or despair, they may also cause instant suicide in relatively well-functioning individuals without other major mental illness.^{58,65,66}

FACING DSM-V

The general limitations of DSM-Axis II have been pointed out (ie, failing to capture the range of personality pathology and identify patients whom clinicians consider having personality disorders is particularly consequential for NPD).^{53,67,68} People with traits of patho-

logical narcissism that range beyond the DSM-IV-text revision⁶⁹ criteria set, or people who have less severe or less overt narcissistic pathology and for various reasons do not meet any combination of five required criteria, will consequently not be correctly identified.

The current NPD criterion set has repeatedly been criticized for its low specificity with high diagnostic overlap and comorbidity. The fact that the diagnosis is heavily relying on overt and one-sided determinants of grandiosity and on context-dependent external symptoms or patterns of reactions and interpersonal interactions has contributed to this problem. In addition, the narcissistic individual's experiences of the complex interplay between self-esteem fluctuations and emotional dysregulation within the interpersonal context are not adequately captured. Consequently, there is reluctance among clinicians to use the diagnosis, and patients tend to strongly oppose to being "labeled" NPD, conceiving it as more prejudicial than informative and helpful.

An integrative diagnostic approach for pathological narcissism and NPD with alternative formulations is much called for, one that focuses more on basic indicators for the range of narcissistic personality functioning and less on symptomatic features or phenotypic categories (see Table 2, page 118). Such a diagnostic approach should evaluate basic characteristics of narcissistic functioning, and differentiate temporary fluctuating or externally triggered shifts in narcissistic functioning from enduring indications of pathological narcissism. Regulation of self-esteem, a central part of self-regulation, is identified as the motivating force in narcissistic functioning, and its vulnerability and fluctuations are indicated by reactions to threats and challenges to the self-esteem (ie, the most significant trait of NPD; compare vulnerability and reactions with abandonment as a central marker for borderline personality disorder). A broader definition of grandiosity captures not only a sense of superiority

and success fantasies, but is also expressed in terms of perfectionism and high ideals and is sustained through self-enhancing and self-serving interpersonal behavior. These reformulations serve to expand the spectrum of grandiosity-promoting strivings and activities, capture its fluctuations, and attend to the narcissistic individual's internal experiences and motivation.

Independently of whether the future DSM will remain categorical or move toward a dimensional perspective, the conceptualization of NPD in terms of a range of narcissistic dysregulatory functioning aims at improving clinical utility, promoting awareness, and understanding, and motivating and guiding treatment for both clinicians and patients.

ALTERNATIVE FORMULATIONS

1. Grandiosity

Grandiosity is by now an evidence-based criterion, and the most distinguishing and discriminating for NPD.^{25,70,71} However, it is also limited by the few external features assigned to it. The differentiation between enhanced compared with unrealistic sense of superiority, and the inclusion of value, capability, and fantasies of unfulfilled achievements serve to capture a broader functional range of narcissism and to make the diagnosis applicable to both those with NPD who are vocationally higher functioning and those who are disabled. For the purpose of clinical utility, it is useful to evaluate grandiosity not only in terms of its surface expressions but also in the context of its functional base (ie, to differentiate unrealistic and defensive aspects of grandiosity and grandiose fantasies), from potentially realistic competence and hidden or potential capability for factual or even successful abilities.

2. Vulnerable and Fluctuating Self-esteem

Vulnerable and fluctuating self-esteem relate to changeability in grandios-

ity. Several accounts support the shifts in self-esteem-related internal experiences and overt expressions of grandiosity.^{5,31} Vulnerability and insecurity have usually been assigned to the range of NPD that includes the shy, covert, shame-ridden phenotype. However, such shifts in the arrogant aggressive phenotypic range may be easily bypassed or covered up, and only overtly occur in the context of ultimatums or when feeling trapped with no way out, and then expressed in rage attacks, retaliation, or suicidal behavior.

3. Strong Reactions to Perceived Challenges or Threats to Self-esteem

Strong reactions in response to criticism from others was included in DSM-III⁷² and DSM III-revision but excluded in DSM IV⁷³ because of its low discriminatory power and overlap with other personality disorders. Morey⁵³ has convincingly argued for its reinstatement. This alternative formulation, strong reactions to perceived challenges, or threats to self-esteem attest to the narcissistic individual's specific self-esteem vulnerability and to the threats or challenges that are perceived as especially narcissistically threatening. It also captures a pattern of emotional dysregulation. Mood variations as a sign of narcissistic vulnerability and reactivity reflect shifting levels in self-esteem¹⁸ and are important in differentiating Axis I mood disorders. The concept "threatened egotism"³² suggests that such vulnerability and reactivity could make narcissistic individuals prone to more distress, such as depression, substance use, self-defeating or violent behavior, or suicidality.

4. Self-enhancing Interpersonal Behavior

The alternative formulation self-enhancing interpersonal behavior integrates 3.5 of the DSM-IV-TR criteria. It aims at diminishing the previously heavy focus on grandiosity-related features by highlighting its self-esteem regulatory and motiva-

TABLE 2.

Diagnostic Criteria for NPD: DSM-IV-TR⁶⁹ and Alternative Formulations

DSM-IV-TR NPD: Construct and Criteria	Alternative Formulations: Construct and Criteria
A pervasive pattern of grandiosity (in fantasy and behavior), need for admiration, and lack of empathy, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:	A pervasive pattern of fluctuating and vulnerable self-esteem ranging from grandiosity and assertiveness to inferiority or insecurity, with self-enhancing and self-serving interpersonal behavior, and intense reactions to perceived threats, beginning in early adulthood and present in a variety of contexts as indicated by five (or more) of the following:
DSM 1. Has a grandiose sense of self-importance (eg, exaggerates achievement and talents, expects to be recognized as superior without commensurate achievements). DSM 2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love. DSM 3. Believes that he or she is "special" and unique and can only be understood by, or should be associated with, other special or high-status people (or institutions).	1. Grandiosity: enhanced or unrealistic sense of superiority, uniqueness, value or capability, expressed either overtly in unwarranted expectations, exceptionally high aspirations, and self-centeredness, or covertly in inner convictions, fantasies of unfulfilled ambitions or unlimited success, power, brilliance, beauty, or ideal relationships.
	2. Fluctuating and vulnerable self esteem, alternating between feeling overly confident or assured, and feeling inferior or insecure.
DSM 8. Is often envious of others or believes that others are envious of them.	3. Strong reactions to perceived challenges or threats to self-esteem (humiliation, defeats, criticism, or envy from others), including overtly expressed or covertly hidden intense feelings (aggression, envy or shame) or mood variations (irritability, depression or elation).
DSM 3. Believes that he or she is "special" and unique and can only be understood by, or should be associated with, other special or high-status people (or institutions). DSM 4. Requires excessive admiration.	4. Self-enhancing interpersonal behavior (ie, admiring attention seeking, self-promoting, boastful, or competitive behavior).
DSM 5. Has a sense of entitlement (ie, unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations). DSM 6. Is interpersonally exploitive (ie, takes advantage of others to achieve his or her own ends).	5. Self-serving interpersonal behavior (ie, expecting unreasonable and unwarranted rights and services and unreciprocated favors from others, or taking emotional, intellectual and social advantage of others).
DSM 9. Shows arrogant, haughty behaviors or attitudes.	6. Interpersonally aggressive (ie, arrogant, critically argumentative, resentful, hostile, or passive-aggressive).
	7. Interpersonally controlling (ie, domineering, distant or uncommitted interpersonal behavior that serves to avoid intolerable affects or threats to self-esteem).
DSM 7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.	8. Fluctuating or impaired empathic ability, compromised by self-centeredness, self-serving interests, or emotional dysregulation (low affect tolerance or intense reactions, ie, shame, envy, inferiority, powerlessness, anger).
	9. Exceptionally high or perfectionist (although inconsistent) personal ideals and standards, with strong reactions, including aggression, harsh self-criticism, shame, or deceitfulness when failing to measure up.

tional functions, and broadening the range of behavior that the individual can use for self-enhancing purposes.

5. Self-serving Interpersonal Behavior

Self-serving interpersonal behavior is an integrative formulation capturing types of behavior previously referred to as entitlement and exploitation. With its normal developmental and social/political connotation, entitlement can be misleading as a diagnostic criterion. To be non-entitled or score low on entitlement does not necessarily indicate a healthy narcissistic functioning, and strikingly entitled behavior may stem from an underlying sense of being undeserving, with restricted entitlement or even feeling nonentitled.⁷⁴ Where normal or exceptional rights and expectations end and unrealistic expectations take over with exaggerated and overbearing interpersonal demand, intense reactions can vary with individual contexts and cultures. Exploitative behavior failed to differentiate NPD in previous studies.^{71,75-77} Narcissistic exploitative behavior is distinguished by a more passive, manipulative, entitled, and emotionally focused quality that serves to support and enhance self-esteem.

6. Interpersonal Aggression

Depending upon the narcissistic individual's ability for emotional regulation and interpersonal skills, interpersonal aggression can range from subtle arrogance, argumentativeness, or resentment to various expressions of passive-aggression to more strikingly hostile, enraged behavior, or outbursts. Such outbursts can also stem from underlying feelings of shame, envy, inferiority, diffuse guilt, or fear.

7. Interpersonal Control

Interpersonal control refers to domineering, distant, or uncommitted interpersonal behavior that serves to avoid potentially intolerable affects or threats to self-esteem evoked in closeness to others. Several accounts have supported its differ-

ent components; (ie, uncommitted,⁷¹ controlling/hostile,⁵³ dominance to manage hostility and protect self-esteem;⁷⁸ controlling/competitive^{54,79,80}). Attention to these underlying regulatory mechanisms of emotions and self-esteem serve to differentiate pathological narcissism and NPD from more psychopathic and malignant interpersonal behavior.

8. Fluctuating or Impaired Empathic Ability

Fluctuating or impaired empathic ability, influenced by emotional dysregulation (low affect tolerance or intense reactions) and/or self-centeredness or self-serving interest, is a reformulation of the seventh of the NPD criteria in DSM, based on the review of research on empathy presented. The differentiation between actual and impaired capability and between temporarily interfering and persistently dysregulatory characteristics are specifically important for choice of treatment approach and modality, and for prognosis.

9. Exceptionally High or Perfectionist Personal Ideals and Standards

A complex interrelation between ego-ideals, self-esteem regulation, self-criticism, and deceitfulness can be found in narcissistic individuals. Some can be found among those who openly take pride in their superior and perfectionist standards and ideals.⁸¹⁻⁸³ Such perfectionism can coexist with incompatible, inconsistent, and contradictory moral standards. For example, a married, middle-age man who took pride in being monogamous was bothered by what he considered to be his wife's imperfect physical appearance. Feeling compelled and justified to approach perfect-looking young women to meet his standards for ideal ecstatic intimacy and full satisfaction, he struggled with an obvious dilemma: as a perfect husband he should be satisfied within his marriage, but a perfect-looking woman was necessary for him to experience perfect excitement, and such standards were

unreachable to him within his marriage. Playing with infidelity and dishonesty, he struggled with underlying self-critical attacks for being an imperfect, dishonest husband, which tended to escalate his desire for more ecstatically perfect erotic adventures. The narcissistic individual's internal underlying self-shaming⁸⁴ and harsh or punitive self-criticism is often bypassed or externalized during evaluation and treatment because it may be expressed as self-deprivation or excessive entitlement.⁸⁵

SUMMARY

Facing the process of outlining and deciding the new DSM-V, there are a few major incentives with regards to the future NPD diagnosis. The first concerns the self-regulatory nature of narcissistic functioning and its focus on self-esteem and interpersonal control. The second relates to the clinical range of pathological narcissism, including both the enhanced, seemingly inviolate grandiosity, as well as the fluctuating and vulnerable nature of self-esteem with its opposites — inferiority and insecurity. The third is the underlying reactivity and sensitivity to threats (ie, potential defeats or depreciation of self-esteem), and various self-serving and self-enhancing strivings to protect or heighten the internal and external value of the self. The fourth refers to reevaluation of the empathic functioning and the variable, context-dependent deficits in empathic ability. This review has aimed at summarizing, reformulating, and outlining a proposal for a diagnosis and set of descriptive criteria for NPD accordingly.

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