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# Pathological Narcissism and Narcissistic Personality Disorder

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## Key Words

personality disorders, criterion problem, narcissistic grandiosity, narcissistic vulnerability, diagnosis

## Abstract

We review the literature on pathological narcissism and narcissistic personality disorder (NPD) and describe a significant criterion problem related to four inconsistencies in phenotypic descriptions and taxonomic models across clinical theory, research, and practice; psychiatric diagnosis; and social/personality psychology. This impedes scientific synthesis, weakens narcissism's nomological net, and contributes to a discrepancy between low prevalence rates of NPD and higher rates of practitioner-diagnosed pathological narcissism, along with an enormous clinical literature on narcissistic disturbances. Criterion issues must be resolved, including clarification of the nature of normal and pathological narcissism, incorporation of the two broad phenotypic themes of narcissistic grandiosity and narcissistic vulnerability into revised diagnostic criteria and assessment instruments, elimination of references to overt and covert narcissism that reify these modes of expression as distinct narcissistic types, and determination of the appropriate structure for pathological narcissism. Implications for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* and the science of personality disorders are presented.

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**Narcissism:** ability to regulate self-esteem and manage needs for affirmation, validation, and self-enhancement from the social environment

**NPD:** narcissistic personality disorder

**DSM-V:** *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*

**Criterion problem:** inconsistent construct definition leading to disparate operationalizations, assessment instruments, and research programs that hamper development of a cohesive knowledge base

**INTRODUCTION**

The concept of narcissism can be traced to the Greek myth of Narcissus and its retelling in Homeric hymns. Narcissism has a relatively long history as a psychological construct as well, beginning with Havelock Ellis (1898) and early psychoanalytic theorists (e.g., Freud 1914) through the development of object relations and self psychological theories (Kernberg 1967, Kohut 1968) and later ascribed to Axis II of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III; Am. Psychiatr. Assoc. 1980) as narcissistic personality disorder (NPD). Since the publication of DSM-III Axis II, both clinical interest and psychological research on narcissism have increased. There is now a broad theoretical and empirical literature on narcissism that spans the related fields of clinical psychology, psychiatry, and social/personality psychology. However, this literature is poorly calibrated across the disciplines (Cain et al. 2008, Miller & Campbell

2008), and despite narcissism’s longevity as a construct in psychology and psychiatry, action must be taken to resolve disjunctions and integrate findings in future conceptualizations of pathological narcissism, otherwise continuing disparate efforts will impede progress toward a more sophisticated understanding of this complex clinical construct. When this state of affairs is combined with potentially significant revisions to the personality disorders in the upcoming DSM-V (Clark 2007, Krueger et al. 2008), the current status of pathological narcissism and NPD are truly in flux.

There have been a number of valuable and comprehensive reviews of pathological narcissism and NPD in recent years (Cain et al. 2008; Levy et al. 2007, 2009; Ronningstam 2005a,b, 2009). Taken as a whole and with varying emphases, these reviews document many of the issues giving rise to the difficulties integrating scientific and clinical knowledge on narcissistic disturbances, and they provide excellent summaries of the contemporary clinical and empirical literature. In this article, we hope to avoid simply providing a redundant review and take a number of steps to achieve this aim. First, our initial sections review and delineate problems with construct definition and suggest potential ways to clarify the construct of narcissism amid the phenotypic and taxonomic diversity found in the literature. Second, when we turn to an examination of assessment, we consider the topic with regard to the major phenotypic and taxonomic issues we discuss next.

**PHENOTYPIC AND TAXONOMIC ISSUES**

Reviews of the literature on pathological narcissism and NPD converge in concluding that the clinical phenomenology described across—and even within—disciplines is quite diverse (Ronningstam 2005b, 2009) and that narcissism is inconsistently defined and assessed across clinical psychology, psychiatry, and social/personality psychology (Cain et al. 2008). This leads to a fundamental criterion problem (Austin & Villanova 1992, Wiggins 1973),



one that is particularly vexing for complex constructs such as narcissism and many other mental disorders (Acton 1998). Simply put, there is no gold standard as to the meaning of the construct and thus whether it is clinically described or empirically measured, it can be difficult to synthesize among and across clinical observations and empirical findings. In his general discussion of the criterion problem and related construct validity issues in clinical psychology, McGrath (2005) observed that "The disparity between the diagnostic nomenclature and actual psychiatric phenomena is largely ignored, and extensive research is conducted to understand the psychosocial and treatment implications of the existing diagnostic categories" (p. 114). We can think of no better summary of the state of affairs found in the current clinical and empirical literature on pathological narcissism and particularly NPD. This disparity is also evident when comparing the low prevalence rate (0.0% to 5.7%, median <1.0%) of DSM NPD diagnosis in most epidemiological studies (Mattia & Zimmerman 2001, Zimmerman et al. 2005) with the greater frequency of narcissistic diagnosis found in clinical practice (Doidge et al. 2002, Morey & Ochoa 1989, Ronningstam & Gunderson 1990, Shedler & Westen 2007, Westen 1997, Westen & Arkowitz-Westen 1998). It is notable that the most recent epidemiological study of NPD (Stinson et al. 2008) found a higher lifetime prevalence rate than did many prior studies (men, 7.7%; women, 4.8%). Investigations of epidemiological and practitioner diagnostic rates suggest that, like the diversity of clinical psychology itself, the prevalence of NPD and pathological narcissism likely varies according to clinical setting, type of practice, and theoretical orientation (Levy et al. 2007).

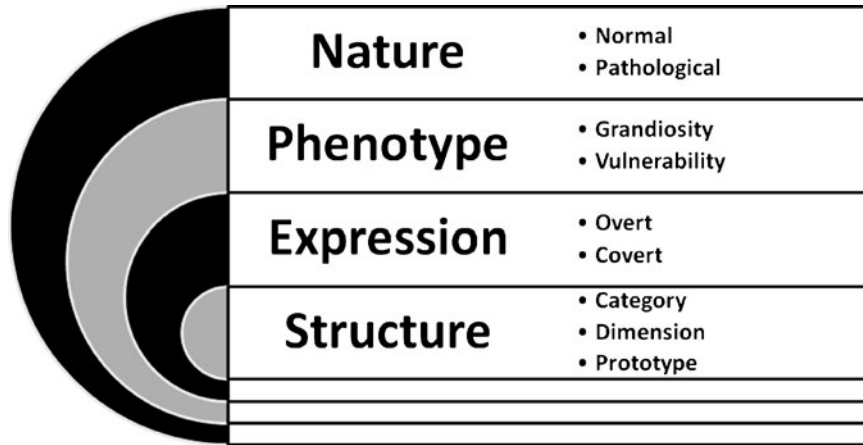
### Organizing the Tower of Babel: Phenotypic and Taxonomic Inconsistencies in Conceptualizations of Narcissism

The diversity of phenotypic description and taxonomic structure across clinical theory,

psychiatric diagnosis, and social/personality psychology raises fundamental questions about the appropriate descriptive characteristics and diagnostic criteria that best exemplify narcissism. This is truly unfortunate because we strongly believe pathological narcissism is an important clinical problem associated with significant functional impairments (Miller et al. 2007, Stinson et al. 2008) and several related areas of maladjustment, including DSM Axis I disorders, psychopathy, interpersonal problems and relational dysfunction, substance use and abuse, aggression and sexual aggression, impulsivity, homicidal ideation, and parasuicidal/suicidal behaviors (Pincus et al. 2009; Ronningstam 2005a,b). We identified four interpenetrating aspects of descriptive phenomenology and taxonomy that are inconsistently addressed in the literature on pathological narcissism and NPD, leading to a poorly coordinated theoretical and empirical base and a patchy nomological net. These inconsistencies involve diversity in conceptualizations of narcissism's Nature (Normal, Pathological), Phenotype (Grandiosity, Vulnerability), Expression (Overt, Covert), and Structure (Category, Dimension, Prototype) (see **Figure 1**).

**Pathological and normal narcissism.** Narcissism can be conceptualized as one's capacity to maintain a relatively positive self-image through a variety of self-, affect-, and field-regulatory processes, and it underlies individuals' needs for validation and affirmation as well as the motivation to overtly and covertly seek out self-enhancement experiences from the social environment (Pincus et al. 2009). Most theorists suggest narcissism has both normal and pathological expressions reflecting adaptive and maladaptive personality organization, psychological needs, and regulatory mechanisms, giving rise to individual differences in managing needs for self-enhancement and validation (Kernberg 1998, Kohut 1977, Morf 2006, Pincus 2005, Ronningstam 2009, Stone 1998). Some suggest that normal and pathological narcissism lie on a single continuum or dimension from healthy to disordered





**Figure 1**  
Phenotypic and taxonomic inconsistencies in conceptualizations of narcissism.

functioning (e.g., Cooper 2005, Paulhus 1998, Ronningstam 2005a, Watson 2005), whereas others suggest adaptive and pathological narcissism may be two distinct personality dimensions (e.g., Ansell 2006, Pincus et al. 2009).

The vast majority of empirical research on normal narcissism has been conducted by social/personality psychologists measuring narcissistic personality traits in nonclinical (often student) samples. This research is dominated by the use of the Narcissistic Personality Inventory (NPI; Raskin & Hall 1979, 1981) as the main self-report measure of narcissism. Although originally developed with reference to the introduction of NPD criteria in DSM-III, factor analytic studies of the NPI have demonstrated an unstable factor structure with two- (Corry et al. 2008), three- (Kubarych et al. 2004), four- (Emmons 1987), and seven- (Raskin & Terry 1988) factor solutions reported. Of these, only Raskin & Terry (1988) felt their seven factors reflected DSM NPD criteria. Unfortunately, no NPI subscales based on these factor solutions exhibit acceptable levels of internal consistency (del Rosario & White 2005), and thus most recent studies employ only the NPI total score or the recent shortened version (NPI-16; Ames et al. 2006).

Consistent with a single continuum viewpoint, some investigators propose the NPI

assesses “subclinical narcissism” (e.g., Paulhus & Williams 2002, Wallace & Baumeister 2002). Using both student and clinical samples, Miller and colleagues (Miller et al. 2009) reported relatively convergent profiles when comparing the patterns of correlations of NPI scores and NPD assessed with the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) with facets of the NEO Personality Inventory-Revised (NEO-PI-R; Costa & McCrae 1992) and the HEXACO-Personality Inventory (HEXACO-PI; Lee & Ashton 2004). Both NPI and NPD profiles emphasized Disagreeableness, whereas NPI profiles reflected greater Extraversion than did NPD profiles. Although Miller et al. (2009) concluded that the NPI assesses general personality traits consistent with NPD and thus is a useful measure for the study of NPD, it is notable that their patient sample scored higher than their student sample on NPD ratings, whereas the student sample scored higher than the patient sample on the NPI. In a related study, Miller & Campbell (2008) compared the five-factor model correlates of the NPI and another clinical measure of narcissism, the Personality Diagnostic Questionnaire (PDQ-4; Hyler 1994), and concluded that the conceptualization of narcissism diverged across clinical psychology and social/personality psychology. They

**NPI:** Narcissistic Personality Inventory  
**SCID-II:** Structured Clinical Interview for DSM-IV Axis II Personality Disorders



found that although both measures were associated with an antagonistic interpersonal style, the NPI assessed an emotionally resilient, extraverted form of narcissism, whereas the PDQ-4 assessed an emotionally unstable, negative-affect-laden, introverted form of narcissism. Other investigators recommend manipulating NPI scoring procedures to distinctly assess “healthy” and “unhealthy” forms of narcissism (e.g., Horton et al. 2006), and still others conclude that the NPI mainly assesses adaptive narcissism (e.g., Ansell 2006, Pincus et al. 2009, Watson et al. 2005–2006).

This ambiguity reflects the diverse empirical associations found with the NPI. The results of both experimental and correlational research describe individuals with high NPI scores as being reactive to unmet expectations, resistant to feedback disconfirming of positive self-views, manipulative, self-enhancing, prone to aggression, and exhibiting a dominant interpersonal style (Bushman & Baumeister 1998, Morf 2006, Morf & Rhodewalt 2001, Paulhus & Williams 2002). Paulhus (1998) reported that the grandiose self-enhancement style associated with high NPI scores leads to hostility and interpersonal rejection over time. However, research also demonstrates that the NPI assesses adaptive characteristics. For example, high NPI scores are negatively associated with trait neuroticism and depression and positively associated with achievement motivation and self-esteem (Brown et al. 2009, Lukowitsky et al. 2007, Rhodewalt & Morf 1995, Watson et al. 1992). Many investigators have attempted to empirically tease apart the consistently positive associations found between the NPI and self-esteem as well as other measures of well-being (e.g., Brown & Zeigler-Hill 2004, Campbell et al. 2007, Sedikides et al. 2004, Zeigler-Hill 2006). Several researchers have pointed out that the content of the NPI total score may reflect a confusing mix of adaptive and maladaptive content (e.g., Emmons 1984, 1987; Watson et al. 1999–2000), with the latter being limited to the traits of entitlement and exploitativeness. However, Brown et al. (2009) recently demonstrated that even these traits are not ideally measured

by the NPI, and Pincus et al. (2009) reported that in a small clinical sample, the NPI correlated positively with self-esteem, correlated negatively with shame, and exhibited small negative relations with aspects of psychotherapy presentation and utilization.

Given that the NPI has been used in only two studies employing clinical samples and, unlike NPD, consistently correlates positively with measures of adjustment and negatively with measures of maladjustment, we are not convinced that patterns of correlations with general models of personality traits that converge with NPD ratings are sufficient evidence to conclude that the NPI assesses pathological narcissism. Although this debate continues, we assert that the NPI does not assess subclinical narcissism reflecting a continuum of functioning, but rather predominantly assesses nondistressed adaptive expressions of the construct. However, we believe that the corpus of social/personality psychology research utilizing the NPI can make important contributions to the study of narcissism by conceptualizing normal narcissism and pathological narcissism as distinct individual differences.

Other research programs also distinguish between adaptive/normal and pathological narcissism. Wink identified three narcissistic prototype scales for the California Q-set (Block 1978), labeled Willfulness, Hypersensitivity, and Autonomy (Wink 1992, 1996; Wink et al. 2005). Autonomy correlated with self-ratings and partner-ratings of creativity, empathy, achievement orientation, and individualism. These prototypes were validated in a series of longitudinal studies predicting a variety of life outcomes that showed the Autonomous prototype was generally associated with positive trajectories, leading Wink (1992) to interpret it as an indicator of healthy narcissism. Similarly, based on Q-factor analysis of NPD patient ratings on the Shedler-Westen Assessment Procedure (SWAP-II; Shedler & Westen 2004, 2007), three NPD subtypes were identified: Grandiose/Malignant, Fragile, and High-Functioning/Exhibitionistic (Russ et al. 2008). Individuals in the final subtype exhibited an

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**SWAP-II:** Shedler-Westen Assessment Procedure-II

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**Narcissistic grandiosity:** dysfunction characterized by an overvalued, entitled self-image; exploitative, exhibitionistic behaviors; absorption in idealized fantasies; and other maladaptive self-enhancement strategies

exaggerated sense of self-importance but were also outgoing, articulate, and energetic. They tended to “show good adaptive functioning and use their narcissism as a motivation to succeed” (Russ et al. 2008, p. 1479).

Normal expressions of narcissism may contribute to self-esteem and well-being by increasing an individual’s sense of personal agency (Oldham & Morris 1995). For example, normal narcissism supports asserting interpersonal dominance (Brown & Zeigler-Hill 2004), fueling approach and achievement motives such as competitive and mastery strivings while lowering avoidance motivation (Foster & Trimm 2008, Lukowitsky et al. 2007, Wallace et al. 2009). Concurrently, normal narcissism is associated with a tendency toward endorsing positive illusions about the self and minimizing information inconsistent with a positive self-image (Farwell & Wohlwend-Lloyd 1998, Morf & Rhodewalt 2001). Such individuals tend to be ambitious, satisfied, and relatively successful (Campbell 2001, Kohut 1977, Ronningstam 2005a, Russ et al. 2008, Stone 1998, Wink 1992, Wink et al. 2005), although this may be at the cost of having disagreeable interpersonal relations (Miller & Campbell 2008, Miller et al. 2009).

All individuals have normal narcissistic needs and motives (Kohut 1977, Stone 1998); however, pathologically narcissistic individuals appear particularly troubled when faced with disappointments and threats to their positive self-image. Since no one is perfect and the world is constantly providing obstacles and challenges to desired outcomes, pathological narcissism involves significant regulatory deficits and maladaptive strategies to cope with disappointments and threats to a positive self image (Horowitz 2009; Kernberg 1998, 2009; Ornstein 2009; Ronningstam 2005b). In clinical and psychiatric research, such pathological expressions of narcissism are typically operationalized (dimensionally or categorically) as reflecting NPD as found in the DSM. In such studies, pathological narcissism is typically assessed via semistructured diagnostic interviews for DSM personality disorders or

self-reported responses to either DSM criteria or omnibus inventories that include personality disorder scales such as the MMPI-2 and MCMI-III (Hilsenroth et al. 1996). Diagnosis of NPD is associated with functional impairments and distress (Miller et al. 2007, Stinson et al. 2008), substantial psychiatric comorbidity (e.g., Clemence et al. 2009), and increased risk for suicide (e.g., Heisel et al. 2007, Ronningstam et al. 2008).

We conclude that there is significant evidence to support the view that the nature of narcissism is reflected in both normal adaptation and pathological personality functioning. It remains unclear whether this distinction is best reflected in a bipolar dimension ranging from normal to pathological narcissism or as two distinct dimensions or types of narcissism. One limitation of the single-dimension approach is the potential confounding of normal narcissism with the absence of pathological narcissism (Hatcher & Rogers 2009, Peterson 2006). Although this foreshadows taxonomic issues regarding the optimal structure of narcissism that we address below, we first discuss issues of phenotypic scope and styles of expression that create significant inconsistency and confusion in the literature.

**Narcissistic grandiosity and narcissistic vulnerability.** To the layperson, the construct of narcissism is most often associated with arrogant, conceited, and domineering attitudes and behaviors (Buss & Chiodo 1991), which may be captured by the term narcissistic grandiosity. Grandiosity is indeed a core component of narcissistic personality, and its clinical description includes intrapsychic processes and behavioral expressions. Intrapsychic processes include repressing negative aspects of self- and other-representations and distorting disconfirming external information, leading to entitled attitudes and an inflated self-image without requisite accomplishments and skills, as well as engaging in regulatory fantasies of unlimited power, superiority, perfection, and adulation. Narcissistic grandiosity is often expressed behaviorally through interpersonally exploitative

acts, lack of empathy, intense envy, aggression, and exhibitionism. This may also be covertly enacted by providing instrumental and emotional support to others but concurrently harboring contempt for the person being helped and secretly experiencing the situation as reflecting one's own specialness, goodness, or superior capabilities (e.g., Nurse 1998, Pincus et al. 2009).

In the past 40 years, the expanding clinical literature on narcissism and narcissistic personality pathology has led to a marked proliferation of labels implying variations in the phenotypic expression of narcissism. Cain et al. (2008) identified more than 50 distinct labels describing variability in the expression of pathological narcissism and asserted, "While each individual conceptualization has unique clinical value, neither future classification systems (e.g., DSM-V), nor intervention models, are likely to sustain such a level of diversity in diagnostic discrimination nor is it clear that such continued parsing would facilitate an integrative understanding of pathological narcissism" (p. 640). They concluded that two broad themes of narcissistic dysfunction, labeled narcissistic grandiosity and narcissistic vulnerability, could be synthesized across the literature with varying degrees of emphasis (see **Table 1**). Clinical theorists have employed themes of grandiosity and vulnerability to describe the core aspects of narcissistic dysfunction through defects in self-structure (Kernberg 1998, Kohut 1977), difficulties in the therapeutic relationship (Gabbard 2009, Kernberg 2007), and maladaptive defensive strategies used in response to stressors, such as shame (e.g., Broucek 1982), trauma (e.g., Hunt 1995, Simon 2002), unfulfilled needs (e.g., Bursten 1973), dependency (e.g., Cooper & Maxwell 1995), or abandonment depression (Masterson 1993).

In recent years, recognition of both grandiose and vulnerable themes of narcissistic dysfunction has increasingly become the norm. Ronningstam (2005a,b) identified subtypes of narcissistic personality based on similarities and differences in self-esteem dysregulation, affect dysregulation, and difficulties in

interpersonal relationships. Grandiose themes are emphasized in descriptions of the arrogant narcissist and the psychopathic narcissist. The former copes with self-esteem dysregulation by creating an exaggerated sense of superiority and uniqueness as well as by engaging in grandiose fantasies. These individuals exhibit entitlement, exploitativeness, and a lack of empathy, and experience intense envy and aggression as a result of their affect dysregulation. The psychopathic narcissist copes with self-esteem dysregulation by engaging in antisocial behaviors to protect or enhance their inflated self-image. Such individuals will commit violent criminal acts in order to gain admiration from others, display extreme rage reactions to criticism, and are interpersonally sadistic without experiencing remorse or empathy. Consistent with Akhtar's (2003) and Dickinson & Pincus's (2003) description of narcissistic vulnerability, Ronningstam's shy narcissists deal with self-esteem dysregulation by engaging in grandiose fantasy while also feeling intense shame regarding their needs and ambition. The dominant affect problem for shy narcissists is shame rather than envy or aggression, and they avoid interpersonal relationships because of hypersensitivity to rejection and criticism.

The *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force 2006) subdivides narcissistic personality disturbance into an Arrogant/Entitled subtype and a Depressed/Depleted subtype. In addition to the High-Functioning/Exhibitionistic subtype identified by their Q-factor analyses of NPD patients' SWAP-II profiles, Russ et al. (2008) described two pathological subtypes convergent with the PDM. The Grandiose/Malignant subtype is characterized by seething anger, manipulativeness, pursuit of interpersonal power and control, lack of remorse, exaggerated self-importance, and feelings of privilege. These individuals tend to be externalizing and have little insight into their behavior. In contrast, the Fragile subtype individuals are unable to consistently maintain a grandiose sense of self such that at times when their defenses fail, narcissistic injury evokes shame,

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**Narcissistic vulnerability:**

dysfunction characterized by a depleted, enfeebled self-image; angry, shameful, and depressed affects; self-criticality and suicidality; interpersonal hypersensitivity and social withdrawal

**PDM:** *Psychodynamic Diagnostic Manual*

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**Table 1 Phenotypic labels for pathological narcissism reflecting grandiosity and vulnerability**

| Source                                 | Grandiose themes                              | Vulnerable themes                          |
|--|---|--|
| Kohut (1971)                           | Horizontal split                              | Vertical split                             |
| Bursten (1973)                         | Manipulative<br>Phallic<br>Paranoid           | Craving                                    |
| Kohut & Wolf (1978)                    | Mirror-hungry<br>Alter-ego                    | Ideal-hungry<br>Contact-shunning           |
| Am. Psychiatr. Assoc. (1980)           | DSM-III NPD                                   |  |
| Akhtar & Thomson (1982), Cooper (1981) | Overt   | Covert                                     |
| Broucek (1982)                         | Egotistical                                   | Dissociative                               |
| Kernberg (1984)                        | Pathological<br>Malignant                     |  |
| Rosenfeld (1987)                       | Thick-skinned                                 | Thin-skinned                               |
| Am. Psychiatr. Assoc. (1987)           | DSM-III-R NPD                                 |  |
| Cooper (1988, 2005)                    |   | Narcissistic-masochistic                   |
| Gabbard (1989, 1998, 2009)             | Oblivious                                     | Hypervigilant                              |
| Gersten (1991)                         | Overtly grandiose                             | Overtly vulnerable                         |
| Wink (1992)                            | Willful                                       | Hypersensitive                             |
| Masterson (1993)                       | Exhibitionistic                               | Closet                                     |
| Fiscalini (1993)                       | Uncivilized spoiled child<br>Special child    | Infantilized spoiled child<br>Shamed child |
| Am. Psychiatr. Assoc. (1994)           | DSM-IV NPD                                    |  |
| Cooper & Maxwell (1995)                | Empowered<br>Manipulative                     | Disempowered                               |
| Hunt (1995)                            | Classical                                     | Diffident                                  |
| Millon (1996)                          | Unprincipled<br>Amorous<br>Elitist<br>Fanatic | Compensatory                               |
| Simon (2002)                           | TANS  |  |
| Akhtar (2003)                          |   | Shy  |
| Dickinson & Pincus (2003)              | Grandiose                                     | Vulnerable                                 |
| Ronningstam (2005b)                    | Arrogant<br>Psychopathic                      | Shy  |
| PDM Task Force (2006)                  | Arrogant/entitled                             | Depressed/depleted                         |
| Russ et al. (2008)                     | Grandiose/malignant                           | Fragile                                    |
| Pincus et al. (2009)                   | Narcissistic grandiosity                      | Narcissistic vulnerability                 |

DSM-IV, *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition*; DSM-III-R, *Diagnostic and Statistical Manual of Mental Disorders-Third Edition, Revised*; NPD, narcissistic personality disorder; PDM, *Psychodynamic Diagnostic Manual*; TANS, trauma-associated narcissistic symptoms.

anxiety, depression, and feelings of inadequacy. Many contemporary clinical experts on narcissistic personality disorder now recognize that grandiose self-states oscillate or

co-occur with vulnerable self-states and affective dysregulation. Ronningstam (2009) noted, “the narcissistic individual may fluctuate between assertive grandiosity and vulnerability”



(p. 113). Similarly, Kernberg (2009) indicated that narcissistic personalities endure “bouts of insecurity disrupting their sense of grandiosity or specialness” (p. 106). Horowitz (2009) suggested that as narcissistic pathology negatively impacts relationships, creativity, and occupational adjustment, grandiosity cannot be maintained, and “he or she is more and more vulnerable to shame, panic, helplessness, or depression as life progresses without support from admiring others” (p. 126).

The clinical themes of grandiosity and vulnerability also converge with research on narcissistic traits in social/personality psychology. Structural evaluations of self-report measures of narcissism that included measures beyond the NPI consistently found evidence for two molar dimensions (Rathvon & Holmstrom 1996; Wink 1991, 1996). Wink (1991) submitted six MMPI-derived narcissism scales to a principal components analysis and found two orthogonal components labeled Vulnerability-Sensitivity (V-S) and Grandiosity-Exhibitionism (GE). V-S and G-E exhibited distinct patterns of self- and informant-rated correlates. Wink & Donahue (1997) found boredom proneness to be related to both forms of narcissism, but in different ways. G-E was related to restlessness and feelings of impatience in response to external constraints on behavior, whereas V-S was related to difficulties in keeping oneself interested and entertained (lack of internal stimulation), feelings of meaninglessness, and the perception that time is passing by slowly. Rathvon & Holmstrom (1996) replicated Wink’s work by submitting the NPI and five MMPI- or MMPI-2-based narcissism measures to a principal components analysis and extracting two orthogonal components, labeled Depletion and Grandiosity. Grandiosity was positively related to exhibitionism and negatively related to depression, anxiety, bodily concerns, and social discomfort. Depletion was positively related with all MMPI-2 clinical scales and supplemental scales assessing maladjustment.

It is also notable that Wink (1992) identified similar grandiose (Willful) and

vulnerable (Hypersensitive) narcissistic prototypes using an entirely different methodological approach (Q-sorts), and these also exhibited a distinct pattern of self- and partner-rated correlates. Unlike Wink’s normal prototype (Autonomous) discussed above, the Hypersensitive prototype was associated with negative life trajectories, and the Willful Prototype was generally associated with flat trajectories, leading to the suggestion that the Hypersensitive prototype is the most pathological form of narcissism (Wink 1992, Wink et al. 2005).

In contrast to prevailing clinical theory and psychological research, revisions of DSM NPD criteria have become increasingly narrow and focused exclusively on grandiosity (Cain et al. 2008). The current DSM-IV-TR criteria for NPD include a grandiose sense of self-importance; a preoccupation with fantasies of unlimited power, success, brilliance, beauty, or ideal love; a belief that he/she is “special” or unique and can only be understood by, and should associate with, other special or high-status people or institutions; a need for excessive admiration; a sense of entitlement; interpersonal exploitativeness, a lack of empathy; often envious of others or believes that others are envious of him/her; and arrogant, haughty behaviors or attitudes (Am. Psychiatr. Assoc. 2000). A confirmatory factor analysis of these NPD criteria supported a one-factor solution (Miller et al. 2008b). The changes to NPD criteria from the DSM-III eliminated many of the characteristics underlying vulnerable themes (e.g., shameful reactivity or humiliation in response to narcissistic injury, alternating states of idealization and devaluation). These are now described in the “Associated Features and Disorders” section, where clinicians are also cautioned that patients may not outwardly exhibit such vulnerable characteristics (APA 2000).

The lack of sufficient vulnerable DSM-IV NPD criteria is now a common criticism in the recent literature (Cain et al. 2008, Gabbard 2009, Levy et al. 2007, Pincus et al. 2009, Ronningstam 2009). This narrow focus on grandiosity in DSM NPD likely contributes to its discrepant low-prevalence rate relative

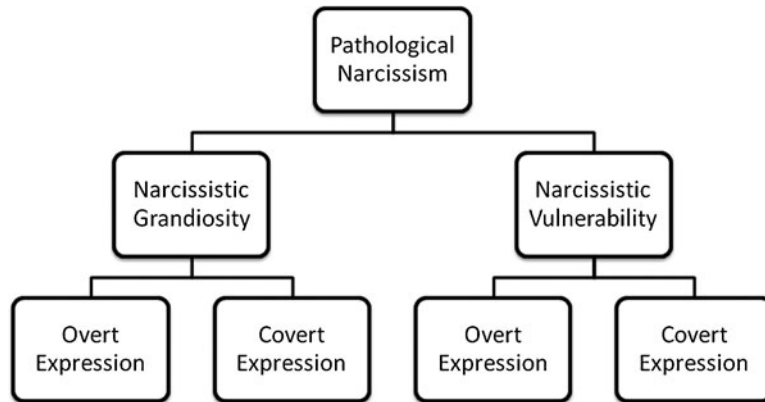
to reports of the diagnosis in clinical practice noted above as well as low temporal stability (e.g., Ball et al. 2001, Lenzenweger et al. 2004, Ronningstam et al. 1995). In a recent study of pathological narcissism and psychotherapy (Pincus et al. 2009), grandiose characteristics most often reduced treatment utilization, whereas vulnerable characteristics most often promoted treatment utilization. Thus, therapists and diagnosticians may be more likely to see narcissistic patients when they are in a vulnerable self-state. Relying solely on DSM-IV NPD diagnostic criteria may impede clinical recognition of pathological narcissism. This becomes a significant issue when combined with results linking pathological narcissism with homicidal ideation, parasuicidal behavior, and suicide attempts. The current DSM NPD diagnosis is thus not sufficient for its original purpose, i.e., to facilitate the accurate diagnosis of patients with pathological forms of narcissism.

The identification of two broad themes of grandiosity and vulnerability in pathological narcissism has implications for clinical theory, social/personality psychology, and psychiatric diagnosis. We recommend that clinical theory and psychotherapy literature end the proliferation of labels for narcissistic pathology and begin to generate a cumulative and more integrated literature on conceptualization and treatment of pathological narcissism organized around grandiosity and vulnerability. To supplement social/personality psychological research on grandiose narcissistic traits, we suggest that recently developed measures assessing vulnerable narcissistic traits (e.g., Bachar et al. 2005, Hendin & Cheek 1997, Pincus et al. 2009, Wink 1992) can complement the NPI, and we recommend that they be regularly included in research focusing on narcissistic personality even in nonclinical contexts and particularly in research investigating negative consequences of trait narcissism. Finally, we recommend that revisions of personality disorder criteria in DSM-V reflect sufficient content to permit diagnosis of NPD when either narcissistic grandiosity or narcissistic vulnerability is predominantly observed in patient presentation.

**Overt narcissism and covert narcissism.** A second distinction found in the phenotypic description of pathological narcissism refers to its overt and covert expressions (Akhtar & Thomson 1982, Cooper 1981). This distinction was further promoted by Wink (1992), who equated his Willful prototype with overt narcissism and his Hypersensitive prototype with covert narcissism. The distinction continued when Hendin & Cheek (1997) also equated their Hypersensitive Narcissism Scale with covert narcissism. Although narcissistic grandiosity and narcissistic vulnerability are far more prominent in clinical theory and research, distinguishing covert and overt narcissism is more common in the social/personality literature (e.g., Besser & Priel 2009, Otway & Vignoles 2006). We believe that this distinction is inaccurate, and any perpetuation of overt and covert narcissism as distinct types or phenotypes simply adds to the criterion problem plaguing pathological narcissism.

Our view is that this distinction is simply about different modes of the *expression* of narcissistic grandiosity and narcissistic vulnerability. DSM NPD criteria, items on various self-reports, interviews, and rating instruments assessing pathological narcissism, and most certainly clinical conceptualizations of all forms of personality pathology include a mix of overt elements (behaviors, expressed attitudes and emotions) and covert experiences (cognitions, private feelings, motives, needs) (e.g., McGlashan et al. 2005). Our clinical experience with narcissistic patients indicates they virtually always exhibit both covert and overt grandiosity *and* covert and overt vulnerability. Prior assertions linking vulnerable hypersensitivity with covert narcissism are clinically inaccurate. In **Figure 2**, we present a model to clarify the overt and covert expressions of narcissistic grandiosity and narcissistic vulnerability. The distinction between overt and covert expressions of narcissism is secondary to phenotypic variation in grandiosity and vulnerability, and there is no empirical evidence that distinct overt and covert types of narcissism exist. What distinguishes actual narcissistic patients is their





**Figure 2**

The hierarchical organization of pathological narcissism.

relative levels of grandiosity and vulnerability and the relative prominence of their overt and covert expressions of the entire range of pathological narcissism. We believe that Wink (1992) and Hendin & Cheek (1997) were correct in describing their measures as assessing hypersensitivity (i.e., vulnerability). The subsequent linking of narcissistic hypersensitivity with covert narcissism was a retrofitting of constructs that contributed to phenotypic and taxonomic confusion.

#### Categories, dimensions, and prototypes.

The structure of pathological narcissism, like that of all personality disorders, has been represented as a diagnostic category, as a set of prototypes, and as a hierarchically organized set of dimensions. Analyses of the strengths and weaknesses of these approaches for classifying personality pathology are widespread and beyond the scope of the current review (e.g., Huprich & Bornstein 2007, Trull & Durrett 2005, Widiger & Mullins-Sweat 2005). Only two taxometric analyses of narcissism have been reported in the literature. Taxometric evaluation of the NPI in student samples indicated narcissistic traits were best represented dimensionally, and no evidence of taxonicity was found (Foster & Campbell 2007). In contrast, taxometric analyses of the DSM-IV criteria in a large patient sample favored a latent taxon (Fossati et al. 2005).

Further taxometric analyses would be welcome, given that current research is limited to the NPI and DSM NPD. What is clear is that the field is now moving beyond debates over categories and dimensions as integrative models are evolving (De Clercq et al. 2009, Krueger et al. 2008, Livesley 2007, Paris 2007). Given increasing support for dimensional models of personality pathology (Clark 2007, Widiger & Trull 2007) and evidence that the current DSM category of NPD is insufficient in scope, we support conceptualizing pathological narcissism from a dimensional perspective that may be further incorporated into evolving integrative models.

**Implications.** The heterogeneity of phenotypic and taxonomic description of narcissism found in the literature clearly impedes the effective synthesis of the empirical and clinical knowledge base. However, with such inconsistencies kept in mind, the literature on assessment of narcissism (and other domains not covered in this review, e.g., comorbidity, etiology, neurobiology, treatment) can be more precisely and effectively evaluated. This is demonstrated in the following sections.

#### ASSESSMENT

Although reliable and valid assessment of all personality disorders has historically been challenging, the phenotypic and taxonomic

inconsistencies in conceptualizations of narcissism we have noted (i.e., the criterion problem) result in limited psychometric convergence across the large number of measures and instruments to assess narcissism (Chatham et al. 1993, Hilsenroth et al. 1996, Samuel & Widiger 2008). Efforts to integrate clinical science and practice and to develop a cumulative base of knowledge are difficult when the nature, phenotypic range, modes of expression, and structure of narcissistic constructs vary widely across instruments.

### Narcissistic Personality Disorder

A number of semistructured interviews, observer ratings, and self-reports for DSM personality disorders assess NPD. Although substantial differences between the instruments exist, and validity data for many instruments' specific diagnoses are sparse, all are based on the DSM; thus, in one way or another, all NPD measures assess aspects of narcissistic grandiosity. However, as noted above, relying solely on the narrow DSM NPD conception and diagnostic criteria may impede clinical recognition of pathological narcissism.

Diagnostic interviews for NPD include the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl et al. 1997), the SCID-II (First et al. 1995), the International Personality Disorder Examination (IPDE; Loranger 1999), the Personality Disorder Interview-IV (PDI-IV; Widiger et al. 1995), and the Diagnostic Interview for Personality Disorders (DIPD; Zanarini et al. 1987). Observer-based measures that allow for the assessment of NPD include the Personality Assessment Form (PAF; Shea et al. 1990) and the Shedler-Westen Assessment Procedure-II (SWAP-II; Westen & Shedler 2007, Westen et al. 2006). Finally, self-report inventories containing scales to assess NPD include the Millon Clinical Multiaxial Inventory (MCMI-III; Millon et al. 1997), the Wisconsin Personality Disorders Inventory (WISPI-IV; Klein et al. 1993), the Assessment of DSM-IV Personality Disorders (ADP-IV; Schotte & De Doncker 1996), the Minnesota

Multiphasic Personality Inventory (MMPI-2) Personality Disorder Scales (Hicklin & Widiger 2000, Somwaru & Ben-Porath 1995), the Schedule for Nonadaptive and Adaptive Personality (SNAP) Personality Disorder Scales (Clark 1993), the OMNI Personality Inventory (OMNI; Loranger 2001), and the Personality Diagnostic Questionnaire-4 (PDQ-4; Hyler 1994).

The PDQ-4 is purported to be the self-report measure most directly related to DSM-IV criteria (Widiger & Coker 2002). Despite this, Miller & Campbell (2008) found that the PDQ-4 NPD scale assesses an emotionally unstable, negative-affect-laden, and introverted form of narcissism. In another study, Miller and colleagues (Miller et al. 2008a) also found that specific PDQ-4 items did not converge on the DSM NPD criteria they were supposed to assess when compared to consensus ratings determined by the Longitudinal, Expert, All Data procedure (LEAD; Pilkonis et al. 1991). Although intended to assess DSM NPD, the corresponding PDQ-4 scale seems to assess some of the more vulnerable aspects of pathological narcissism. However, Miller et al. (2008a) cautioned against using the scale as a stand-alone indicator of narcissistic vulnerability.

### Pathological Narcissism

Several omnibus self-report measures of pathological personality traits contain scales that assess narcissism. These include the Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP; Livesley 2006) and the SNAP (Simms & Clark 2006). The Personality Assessment Inventory (PAI; Morey 1991) does not include specific narcissism scales, although diagnostic algorithms for assessing narcissism have been proposed (Morey 1996). As with many of the individual measures of NPD derived from omnibus inventories, there is little published validity data on individual SNAP and DAPP narcissism scales or the PAI narcissism algorithm, and the extent of their grandiose and vulnerable content is not yet established.

A number of unidimensional self-report measures have also been created specifically to assess either narcissistic grandiosity or narcissistic vulnerability. Campbell et al. (2004) developed the Psychological Entitlement Scale (PES) to improve upon its NPI counterpart and to assess the negative consequences associated with this core narcissistic trait. However, recent analyses suggested that the PES does not fully converge with the Entitlement subscale of the NPI (Pryor et al. 2008) and possibly assesses a related but distinct personality trait (Brown et al. 2009). In order to capture aspects of narcissistic vulnerability, Hendin & Cheek (1997) developed the Hypersensitive Narcissism Scale (HSNS). The HSNS is uncorrelated with the NPI and moderately correlated with MMPI measures that load on Wink's (1991) V-S component. Validity evidence for the HSNS is accumulating, including predicted associations with dating violence (Ryan et al. 2008), sensitivity to criticism (Atlas & Them 2008), insecure attachment (Smolewska & Dion 2005), and recollcted parenting (Otway & Vignoles 2006). Although frequently associated with covert narcissism in the empirical literature, we assert that studies examining the HSNS relative to overt narcissism (typically the NPI) can be better understood as contrasting narcissistic vulnerability with narcissistic grandiosity.

Multidimensional measures of pathological narcissism typically contain scales assessing both narcissistic grandiosity and narcissistic vulnerability. An early multidimensional measure was the Superiority and Goal Instability Scales (SGIS; Robbins 1989, Robbins & Patton 1985) based on Kohut's theory of narcissism. The Superiority Scale was designed to measure the grandiose and exhibitionistic aspects of the self, whereas the Goal Instability Scale was designed to measure identity issues about the self and may reflect vulnerable aspects of pathological narcissism. The Goal Instability Scale has been used extensively in vocational and career counseling (e.g., Casillas et al. 2006), but the SGIS has not been used frequently in clinical research on pathological narcissism. Bachar et al. (2005) developed the Narcissistic Vulnerability

Scale (NVS) to assess narcissistic vulnerability to trauma. The NVS assesses three narcissistic traits: Grandiosity, Exploitativeness, and Poor Self-Esteem Regulation. The first two scales correlated positively with the NPI, whereas the third scale was unrelated to the NPI and may tap aspects of narcissistic vulnerability.

Most recently, Pincus and colleagues developed the Pathological Narcissism Inventory (PNI; Pincus et al. 2009), a 52-item multidimensional self-report measure of pathological narcissism that assesses seven characteristics spanning grandiose and vulnerable affect and self states as described in the clinical, psychiatric, and social/personality psychology literature (Cain et al. 2008). Confirmatory factor analyses (Wright et al. 2008) provided additional evidence for a higher-order two-factor structure that captures the themes of narcissistic grandiosity (Exploitativeness, Grandiose Fantasy, Self-Sacrificing Self-Enhancement) and narcissistic vulnerability (Contingent Self-Esteem, Entitlement Rage, Devaluing, Hiding the Self). The measure was validated in a normal sample and in a small clinical sample where the scales exhibited significant associations with parasuicidal behavior, suicide attempts, and homicidal ideation. The PNI was also shown to be associated with a range of interpersonal problems in theoretically meaningful ways, correlated negatively with self-esteem and empathy, and correlated positively with shame, interpersonal distress, aggression, and borderline personality organization. High scores on the PNI also predicted self-reported stalking behaviors in a large college student sample (Marino et al. 2009, Ménard & Pincus 2009). The PNI thus appears to be appropriate for both clinical and nonclinical populations and is currently the only multifaceted measure assessing clinically identified characteristics spanning the full phenotypic range of pathological narcissism.

Two other instruments assessing pathological narcissism should be mentioned. First, the Diagnostic Interview for Narcissism (DIN; Gunderson et al. 1990) represents the lone diagnostic interview designed specifically to

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**HSNS:**  
Hypersensitive  
Narcissism Scale

**PNI:** Pathological  
Narcissism Inventory

**DIN:** Diagnostic  
Interview for  
Narcissism

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assess pathological narcissism based on the authors' phenomenological studies (e.g., Ronningstam & Gunderson 1988, 1990, 1991). This interview has recently been extended to a parent report for assessment of narcissism in youth (Bardenstein 2009, Guilé et al. 2004). The DIN is associated with DSM NPD, but examination of the interview questions suggested to us that it likely assesses aspects of narcissistic grandiosity and narcissistic vulnerability. Empirical examination of the phenotypic scope of the DIN would be a useful start as there is currently no validated interview to assess narcissistic vulnerability. Finally, Wink's (1992) measure of narcissism based on the California Q-set allows for the assessment of both grandiose (Willful) and vulnerable (Hypersensitive) prototypes.

### Narcissism and the Five-Factor Model of Personality

Theorists have also suggested that the Five-Factor Model (FFM) of personality can be used to both conceptualize and assess NPD (Corbitt 2002). With regard to narcissism, the most consistent findings are that there is a strong positive correlation between NPD and extraversion, a strong negative correlation between NPD and agreeableness, and a modest negative correlation between NPD and conscientiousness (Saulsman & Page 2004). As would be expected given phenotypic inconsistencies, the findings regarding the correlation between NPD and neuroticism are inconsistent and depend upon the measure of narcissism being employed (e.g., Trull 1992). The Personality Psychopathology Five (PSY-5) (Harkness & McNulty 1994) was developed based on scales from the MMPI-2 in order to more fully capture personality pathology based on a five-factor structural model. In a recent study comparing the PSY-5 and the NEO-PI-R, Bagby et al. (2008) found that the combined PSY-5 domains were better than the combined NEO-PI-R domains at predicting narcissistic personality disorder symptom counts when using the SCID-II-PQ as a criterion. Zero-order correlations between NPD

symptom counts and the PSY-5 scales suggested that NPD was strongly and positively correlated with aggressiveness and psychoticism, moderately and positively correlated with negative emotionality/neuroticism and disconstraint, and not significantly correlated with introversion/low positive emotionality.

Samuel & Widiger (2008) recently used the NEO-PI-R to compare five different measures of narcissism: the MMPI-2, MCMI-III, PDQ-4, NPI, and SNAP. Consistent with previous reports (e.g., Hilsenroth et al. 1996), there was a substantial degree of variability in convergence across the measures of narcissism. Results also suggested an inconsistent pattern of correlations between the narcissism measures and the domains of the FFM. For example, the MCMI-III and MMPI-2 narcissism scales consisted of low neuroticism, high extraversion, and marginal antagonism, whereas the PDQ-4 and the SNAP consisted of little to no extraversion or neuroticism but high antagonism. The NPI fell between the other measures and consisted of high extraversion and antagonism. The authors concluded that all five measures of narcissism share a conceptualization that includes narcissistic grandiosity but that none of them seem to reflect aspects of narcissistic vulnerability.

### Limitations of Self-Reports, Interviews, and Observer-Based Measures

Although interview, self-report, and observer-based measures all represent important methods for assessing pathological narcissism, they also have some important limitations. For example, both observer-based assessments and interviews require that the assessor make a judgment about personality traits that have typically been observed for only a short period of time. Interview-based measures also suffer from some of the same limitations that affect self-reports in that they may be subject to biased, distorted, or otherwise misleading information, particularly if assessing socially undesirable traits (Bernstein et al. 1997). Thus, investiga-

tions based on these methods of assessment alone are unlikely to provide a complete understanding of personality pathology (Oltmanns & Turkheimer 2006, 2009). Hilsenroth et al. (1996) argued for a multimethod assessment that includes self-reports, semistructured interviews, and projective measures. Although projective tests including the Rorschach may be quite capable of detecting narcissistic defenses in less overt presentations of the disorder, research using the Rorschach has largely been limited to its ability to predict DSM NPD criteria and its relationship to MMPI-2 NPD scales (Handler & Hilsenroth 2006).

### Informant Ratings

A number of researchers have also argued for the importance of obtaining informant ratings when assessing adult psychopathology (e.g., Achenbach et al. 2005, Klonsky et al. 2002, Westen & Shedler 1999). Investigations that have included self- and other ratings have demonstrated that both sources provide relatively independent and incremental information that can be used to make more informed diagnoses and predictions (e.g., Fiedler et al. 2004, Klein 2003, Miller et al. 2005, Oltmanns et al. 2002). Given the diminished level of self-reflection attributed to individuals with personality disorders and NPD in particular (Dimaggio et al. 2007; Oltmanns et al. 2005), the inclusion of multiple sources of assessment is particularly important. Indeed, a review of self-other concordance for personality disorders suggested that, at best, there is only a modest relationship between the way individuals with personality disorders view themselves and the way they are viewed by others, with NPD being particularly prone to self-other discrepancies (Klonsky et al. 2002).

Recently, several studies have used self- and other ratings to investigate systematic differences in the way individuals with NPD view themselves in comparison with the way they are viewed by others. Miller et al. (2005) found that in contrast to most personality disorders, NPD was associated with low correspondence

between self- and other reports on the FFM at both the facet and domain level and that, in general, informants' ratings indicated significantly higher levels of NPD than did the patients' ratings. A series of studies on interpersonal perception of personality disorders (Clifton et al. 2004, 2005, 2007; Oltmanns et al. 2004, 1998; Thomas et al. 2003) found little cross-source convergence for narcissism but significant consensus among peers. In addition, studies found that narcissism, more than any other PD, reflected a greater distortion in interpersonal perception that was characterized by individuals putting a positive and self-enhancing spin on their personality while being described by peers as domineering, vindictive, and intrusive. Consistent with these studies, Lukowitsky & Pincus (2009) found low self-other agreement for pathological narcissism assessed with the PNI. However, individuals identified as high in pathological narcissism agreed with others about their level of interpersonal problems, suggesting that although these individuals may have a narcissistic blind spot, they do have some awareness of their interpersonal distress.

### RECOMMENDATIONS AND FUTURE DIRECTIONS

Clinical conceptualizations of pathological narcissism and NPD are at a crossroads. There is a significant criterion problem that must be resolved in order to synthesize current research and clinical practice and develop a more cohesive nomological net. In our view, the current situation is similar to issues in the relationship between psychopathy and antisocial personality disorder (Hare & Neuman 2008). Like psychopathy, pathological narcissism is a broader construct that is strongly related to its narrower DSM Axis II counterpart. It may be that the broader constructs are the appropriate targets for future development.

In terms of the four phenotypic and taxonomic inconsistencies we noted, future research will ultimately provide the most robust solutions. For now, our recommendations are as follows. First, the nature of pathological and



normal narcissism should be clarified. We do not believe it is possible to define normal and pathological narcissism as opposite poles of a single continuum because the absence of pathological narcissism is not equivalent to the presence of normal narcissism. Evidence to date suggests that measures of narcissistic traits like the NPI are often unrelated to (rather than negatively correlated with) measures of pathological narcissism. Although normal and pathological narcissism may share similar relationships with general models of personality, they tend to exhibit opposite patterns of correlations with measures of well-being and maladjustment. Consistent with clinical theory, normal narcissism may actually support adaptive functioning, achievement motivation, and ambition, whereas pathological narcissism is associated with significant impairments.

Second, future conceptions of pathological narcissism must include both grandiosity and vulnerability in the description and assessment of phenotypic characteristics. Continued narrow operationalization of narcissistic grandiosity greatly limits the clinical utility of the construct by contraindicating a diagnosis of pathological narcissism if a patient presents with low self-esteem, complains of subjective distress, or exhibits shameful affects. However, these aspects of narcissistic vulnerability are often what promote pathologically narcissistic individuals to seek treatment. The core feature of pathological narcissism is not grandiosity, but rather defective self-regulation leading to grandiose and vulnerable self and affect states.

Third, the field should recognize that narcissistic grandiosity and narcissistic vulnerability are expressed in overt and covert forms within the same individual. In narcissistic patients, for every act of overt grandiosity, there is likely an underlying state of covert vulnerability, and for every act of overt vulnerability, there is likely a strong link to an underlying aspect of covert grandiosity. Continued phenotypic distinctions between overt and covert narcissism, be they typological or dimensional, are not supported by empirical evidence or clinical presentation. Most of the recent research

merely and inaccurately equates the term covert narcissism with measures of narcissistic vulnerability. In addition, concurrent overt and covert characteristics are common to all forms of psychopathology, where diverse symptoms are described as constellations of overt and covert behaviors, cognitions, affects, etc. Finally, we view the term covert narcissism as risking inaccurate communication. At times, grandiosity or vulnerability may be expressed covertly, but pathological narcissism itself is quite detectable with appropriate training.

Fourth, we support representing the structure of pathological narcissism using hierarchically organized dimensions (see **Figure 2**). Narcissistic grandiosity and narcissistic vulnerability are facets of pathological narcissism, much like facet-level traits associated with the FFM structure. A dimensional approach to pathological narcissism can also be incorporated into evolving models of personality pathology that integrate categories and dimensions (e.g., Krueger et al. 2008). In addition, given diagnostic rules for DSM personality disorders, dimensional conceptualization is also more consistent with an emerging literature on narcissistic disturbances in children and adolescents (e.g., Bardenstein 2009; Beren 1998; Freeman 2007; Kernberg 1989; Thomaes et al. 2008a,b; Vizard 2008).

Others may disagree with our recommendations, and the imminent arrival of DSM-V certainly requires further discussion of the future of NPD. Ronningstam (2009) has proposed alternative formulations for revising the DSM NPD construct and criteria that broaden the indicators of pathological narcissistic personality functioning, highlighting oscillation between grandiose and vulnerable states. She proposes NPD be characterized as “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” (Ronningstam 2009, p. 118). Ronningstam’s explicit criteria indeed incorporate fluctuating and vulnerable self-esteem, fluctuating empathic ability, overt and covert expressions of grandiosity and vulnerability, and other characteristics not currently included in DSM NPD, such as perfectionistic tendencies. Incorporation of characteristics highlighting variability into a revised DSM NPD conceptualization and criterion set would certainly shift NPD from its current narrow focus on chronic grandiosity.

## CONCLUSION

Conceptions of personality disorders are currently in flux, and the clinical and empirical literatures on pathological narcissism and NPD suffer from significant phenotypic and taxonomic inconsistencies. Our review suggests that the field is now clearly aware of the criterion problem and is beginning to address it on multiple fronts. Acknowledging the problem is the first step, and we hope the current review

helps heighten awareness across disciplines investigating and treating narcissism. Advances in personality science (e.g., Eaton et al. 2009) should provide additional integrative frameworks and methodologies to help resolve the criterion problem and propel research forward. This is an important step for both classification and treatment, as we view pathological narcissism as a significant clinical problem that is likely underdetected using the current nosology. Improved conceptualization and diagnosis will benefit patients, therapists, theorists, and investigators alike and will promote more accurate research and more effective treatments. This is certainly preferable to seeing the construct dropped from the nosology of personality pathology, done in by poorly calibrated conceptualizations across disciplines and a weak nomenclological net. At the risk of sounding grandiose, we believe clinical science and practice can indeed overcome these problems and that empirically rigorous and clinically useful conceptualizations of pathological narcissism are certainly on the horizon.

## SUMMARY POINTS

1. Narcissism is inconsistently defined and assessed across clinical psychology, psychiatry, and social/personality psychology. This leads to a fundamental “criterion problem” where there is no gold standard as to the meaning of the construct; thus, whether it is clinically described or empirically measured, it can be difficult to synthesize among and across clinical observations and empirical findings.
2. Narcissism is reflected in both normal adaptation and pathological personality functioning. The most widely used measure of normal narcissistic personality traits is the Narcissistic Personality Inventory (NPI). The NPI does not assess pathological narcissism.
3. The clinical and empirical literatures recognize that pathological narcissism includes two broad themes of dysfunction—narcissistic grandiosity and narcissistic vulnerability. In contrast, with each DSM revision, NPD criteria have become increasingly narrow in their focus on narcissistic grandiosity. This leads to the lowest prevalence rate among DSM Axis II personality disorders, limited psychotherapy research, and a significant disconnect with the much more common use of pathological narcissism as a diagnosis in clinical practice. Revisions of NPD in DSM-V should include sufficient criteria to permit diagnosis of NPD when either narcissistic grandiosity or narcissistic vulnerability is predominantly observed in patient presentation.



4. Distinguishing overt and covert narcissism as distinct types or phenotypes of narcissism is clinically inaccurate. This distinction is simply about different modes of the expression of narcissistic grandiosity and narcissistic vulnerability. DSM NPD criteria; items on various self-reports, interviews, and rating instruments assessing pathological narcissism; and most certainly clinical conceptualizations of all forms of personality pathology include a mix of overt elements (behaviors, expressed attitudes and emotions) and covert experiences (cognitions, private feelings, motives, needs). Narcissistic patients virtually always exhibit both covert and overt grandiosity and covert and overt vulnerability.
5. Future research should employ new assessment measures of pathological narcissism that include grandiose and vulnerable characteristics. In addition, research indicates that for the assessment of pathological narcissism, it is critical to go beyond self-reports and employ peer ratings whenever possible.
6. The relationship between pathological narcissism and DSM NPD parallels the relationship between psychopathy and DSM antisocial personality disorder. Like psychopathy, pathological narcissism is a broader construct that is strongly related to its narrower DSM Axis II counterpart. It may be that the broader constructs are the appropriate targets for future development.

## DISCLOSURE STATEMENT

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Interdisciplinary review  
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Reviews research on agreement of self- and informant reports of personality disorders demonstrating low convergence for NPD ratings.

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Review of narcissistic personality disorder (NPD).

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Currently the only multidimensional measure assessing clinically identified characteristics spanning the full phenotypic range of pathological narcissism.

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Review of narcissistic personality disorder (NPD).

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Proposes revisions to NPD for DSM-V.

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Q-factor analyses of the SWAP-II validating narcissistic grandiosity and narcissistic vulnerability.

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Correlates five narcissism measures with the NEO-Personality Inventory and demonstrates marked variability of five-factor model profiles across instruments.

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Summarizes the author's important factor-analytic and Q-sort research validating narcissistic grandiosity and narcissistic vulnerability.

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