



DSM-V SCIENTIFIC FORUM

[COMMENTARY]

HOW TO ELIMINATE NARCISSISM OVERNIGHT: *DSM-V* and the Death of Narcissistic Personality Disorder

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ABSTRACT

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* appears likely to eliminate the diagnosis of narcissistic personality disorder. There are significant problems with the discriminant validity of the current narcissistic personality disorder criteria set; furthermore, the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*'s narrow focus on "grandiosity" probably contributes to the wide disparity between low narcissistic personality disorder prevalence rates in epidemiological studies and high rates of narcissistic personality disorder in clinical practice. Nevertheless, the best course of action may be to refine the narcissistic personality disorder criteria, followed by careful field

testing and a search for biomarkers, rather than wholesale elimination of the narcissistic personality disorder category. The construct of "malignant narcissism" is also worthy of more intense empirical investigation.

"So distinguished was my name, and I possessed such advantages of youth and comeliness, that no matter what woman I might favor with my love, I dreaded rejection of none."—Peter Abelard, from *The Story of My Misfortunes*

INTRODUCTION

Thirty years ago, in his book, *The Culture of Narcissism*, Christopher Lasch argued that our society was becoming increasingly self-preoccupied and narcissistic.¹ But Lasch's claims were mainly

impressionistic. Now, however, a number of researchers and mental health professionals point to studies showing that narcissistic self-absorption is indeed on the increase.² Ironically, it is in just this societal context that the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) Personality Disorder Work Group* has decided to eliminate narcissistic personality disorder (NPD)—along with paranoid, schizoid, histrionic, and dependent personality disorders.³ “Survivors” from the current (*DSM-IV*) schema include antisocial/psychopathic, avoidant, borderline, obsessive compulsive, and schizotypal personality disorders. The proposed DSM-V

and W. Keith Campbell, PhD, provide ample evidence for what they term, “the relentless rise of narcissism in our culture.”⁴ Twenge and Campbell⁴ identify several social trends that have contributed to this problem, including what they term “the movement toward self-esteem” that began in the late 1960s; and the movement away from “community-oriented thinking” that began in the 1970s. But the root causes go far deeper. For example, in a chapter entitled, “Raising Royalty,” Twenge and Campbell point to “...the new parenting culture that has fueled the narcissism epidemic.” In effect, the authors argue, there has been a shift away from limit-setting toward

someone’s idea of “assertiveness” involves cutting off another driver on the freeway, assertiveness has arguably crossed the line into pathological narcissism.

Twenge and Campbell take pains to knock down the notion that all narcissists are basically insecure individuals with very low self esteem. Their research suggests that, on the contrary, most narcissists are rather well endowed with self esteem—as the renowned medieval philosopher, Peter Abelard, demonstrates in the epigram quoted at the beginning of this article. Indeed, Abelard might well fit the category of individuals Twenge and Campbell call the “socially savvy narcissists who have the most influence on the culture.”⁴ These high-fliers may be the sort one of my colleagues had in mind when he defined a narcissist as, “somebody who, at the moment of peak sexual bliss, cries out his own name!”

These celebrity narcissists are not, for the most part, the kind of individuals I used to see in my own psychiatric practice. My patients tended to fall into the group Twenge and Campbell call “vulnerable narcissists.” These unfortunate souls seem to cloak themselves in a mantle of gold, while feeling on the inside that they are nothing but rags. They suffer, to be sure—but they also induce suffering in others by acting out their insecurities in a thousand provocative ways. And, like some of their celebrity counterparts, these vulnerable narcissists are prone to outbursts of anger, verbal abuse, or obnoxious behavior—usually when they feel rejected, thwarted, or frustrated. They remind one of philosopher Eric Hoffer’s observation that, “Rudeness is the weak man’s imitation of strength.”

But narcissism as a personality trait is one thing; NPD, as now defined in *DSM-IV* (Table 1), is quite another. How useful is our present construct of NPD, and how well-supported is it, based on empirical studies?

...the criteria set for a particular disorder ought to have a high degree of “discriminant validity”—essentially, the degree to which the criteria can identify one construct without showing a high correlation with an unrelated construct. So, for example, we would like our present criteria for NPD to identify “narcissism” but not to correlate with high scores on measures of, say, schizoid traits.

approach uses “prototype” descriptions of these five personality disorders, and then introduces a new twist: a trait-based system built around six “dimensions” of personality. These include negative emotionality, introversion, antagonism, disinhibition, compulsivity, and schizotypy.

Perhaps narcissists may now insist, with some justice, that they are not being shown sufficient respect. In any case, it’s an opportune time to re-examine some controversial aspects of NPD, and to ask whether DSM-V’s “double-header” approach to personality disorders is a wise strategy.

NARCISSISM AS A CHARACTER TRAIT

In their book, *The Narcissism Epidemic: Living in the Age of Entitlement*, Jean M. Twenge, PhD,

letting the child get whatever he or she wants.

Twenge et al⁵ have empirical data to back up their claims. For example, in a paper published in the August 2008 *Journal of Personality*, the authors report on 85 samples of American college students studied between 1979 and 2006.⁵ The subjects were evaluated using an instrument called the Narcissistic Personality Inventory (NPI). Compared with their peers in the 1979 to 1985 period, college students in 2006 showed a 30-percent increase in their NPI score. That’s the bad news. If there is some good news, it might be this: Twenge et al point to a rise in several “positive traits” correlated with narcissism, such as self esteem, extraversion, and assertiveness. Of course, a cynic might reply that these traits are “positive” only up to a point: when

DOES NPD HOLD TOGETHER AS A DISORDER?

How do we decide that a putative “disease” or disorder is actually just that, rather than merely a collection of unrelated signs and symptoms? There is no simple answer, but in general, as pathologist L. S. King observed over 50 years ago, “A [disease] pattern has reasonable stability only when its criteria are sharp, its elements cohere, and its utility in clarifying experience remains high.”⁶

More specifically, the criteria set for a particular disorder ought to have a high degree of “discriminant validity,” which is essentially the degree to which the criteria can identify one construct without showing a high correlation with an unrelated construct. So, for example, we would like our present criteria for NPD to identify “narcissism” but not to correlate with high scores on measures of, say, schizoid traits. Another aspect of “stability” is the persistence of a condition over long periods of time. If we agree that a personality disorder (PD) is a life-long pattern of maladaptive behavior, we do not want to see our PD diagnosis evaporate into thin air, five or 10 years after we evaluate the patient.

So, how do our present *DSM* criteria for NPD fare in these respects? The evidence is mixed, but overall, there is reason for considerable skepticism. For example, in a comprehensive review, Cain et al⁷ found that the *DSM-IV* construct of NPD showed poor discriminant validity and only modest levels of temporal stability. Pincus and Lukowitsky⁸ hypothesized that these problems may be due, in part, to an overemphasis on overt grandiosity in the current NPD criteria and a concomitant underemphasis on narcissistic vulnerability (i.e., the tendency to avoid interpersonal relationships “because of hypersensitivity to rejection and criticism”).⁸ These authors believe that the *DSM*’s narrow focus on grandiosity likely contributes to the

Table 1. Essential features of narcissistic personality disorder (modified from DSM-IV)

- Having an exaggerated sense of self-importance
- Being preoccupied with fantasies about success, power or beauty
- Believing that you are special and can associate only with equally special people
- Requiring constant admiration
- Having a sense of entitlement
- Taking advantage of others
- Having an inability to recognize needs and feelings of others
- Being envious of others
- Behaving in an arrogant or haughty manner

MayoClinic.com. Narcissistic personality disorder. <http://www.mayoclinic.com/health/narcissistic-personality-disorder/DS00652/DSECTION=tests-and-diagnosis>. Accessed February 7, 2011.

wide disparity between low NPD prevalence rates in epidemiological studies and high rates of NPD in clinical practice.

To make matters worse, a very large (N=34,653) epidemiologic survey of adults in the United States⁹ found that NPD was inversely related to age, with the greatest decline occurring after age 29. This seems rather odd for a condition that is supposed to represent a life-long pattern of maladaptive behavior! The authors hypothesized that “...NPD may be more prevalent among young adults due to developmental challenges in the transition from adolescence to adulthood.”⁸ Put a bit more coarsely: a bragging, swaggering 19-year-old man who becomes angry and aggressive after being “jilted” by his girlfriend may not meet NPD criteria at age 39. Rather, he may simply be acting out the age-old struggle of becoming an adult.

Even more worrisome, this same epidemiologic study⁹ found that, when comorbidity was controlled for, NPD was associated with mental disability among men but not women. (“Mental disability” was determined using the Short Form-12 Health survey, version 2, which examines social functioning, role impairment, and overall mental health). The authors suggested that among women comorbidity with other psychiatric disorders accounts for much of the disability associated with NPD; in contrast, men may express a more severe form of NPD.

Perhaps so—but if our present NPD criteria do not predict mental disability in half the population, it is hard to see how the *DSM-IV* construct identifies a true mental disorder.

On the other hand, it is possible that certain subtypes of NPD may represent severe mental dysfunction. For example, so-called “malignant narcissism” (MN)—first described by Otto Kernberg¹⁰—appears to be associated with significant intrapsychic and interpersonal impairment. As Goldner-Vukov and Moore observe, “People with MN give the appearance of being self-sufficient and successful. Covertly, however, they are fragile, vulnerable to shame, and sensitive to criticism. Failure to succeed in grandiose efforts results in prominent mood swings with irritability, rage, and feelings of emptiness...When not involved in narcissistic pursuits, they are cold, unempathetic, exploitative, and indifferent toward others. Disturbing feelings of inferiority, self-doubt, boredom, alienation, emptiness, and aimlessness underlie their persona.”¹¹

Unfortunately, there has been little empirical research on MN, and it is not clear if it represents a discrete disorder or a pastiche of narcissistic, antisocial, “borderline,” and paranoid traits.

THE WORLD’S SHORTEST TREATISE ON NEUROBIOLOGY

As Stinson et al⁹ observed, “Among the 10 personality disorders

(PDs) defined in the [DSM-IV], NPD has received the least empirical attention.” It is extraordinary that, in the more than 16 years since DSM-IV appeared, virtually no neurobiological research has been done on NPD (L. Siever MD, personal communication, 12/22/10). This is in contrast, for example, to numerous biological investigations of borderline and antisocial personality disorders, which may be associated with excessive amygdala reactivity, reduced prefrontal inhibition, and diminished serotonergic facilitation of prefrontal controls.^{12,13}

To my knowledge, virtually the only study looking at biogenetic factors in NPD is the twin study by Torgersen et al,¹⁴ which involved 92 monozygotic and 129 dizygotic twin pairs. The study found that the overall heritability for Cluster B personality disorders was 0.60, with the largest effect in NPD (narcissistic personality=0.79; borderline personality disorder=0.69; histrionic personality disorder=0.67). On its face, this finding is intriguing and might point to a biogenetic basis for NPD. This, in turn, might suggest a variety of neurochemical or neurocircuitry abnormalities in NPD—but, alas, the research cupboard is bare. Furthermore, the best evidence to date suggests that genetic factors do not reflect the specific DSM-IV personality disorder clusters, but, rather, more general qualities, such as impulsivity, agreeableness, and introversion.¹⁵ This tends to support the “trait-oriented” approach taken by the DSM-V PD Work Group. But even if the science warrants such an approach, is it clinically useful? There is reason to doubt this.

THEORY VERSUS PRACTICE; RESEARCH VERSUS UTILITY

In a commentary piece penned by a virtual “Who’s Who” of personality disorder specialists and senior clinicians, the DSM-V proposals took quite a beating. Shedler et al¹⁶ raised two main objections to the DSM-V approach: first, that the five

personality disorder prototypes may not be sufficient “...to encompass the spectrum of personality pathology seen in the community...”; and second, that “...mental health professionals think in terms of syndromes or patterns...not in terms of deconstructed subcomponents or...trait dimensions.” These authors note, specifically, that NPD may have received less empirical research attention not because it does not exist, but because “...samples are hard to obtain outside of clinical practice settings...” They pointedly commented that “absence of evidence is not evidence of absence.” I suspect that Shedler et al¹⁶ are right on the issue of how clinicians would “take” to the proposed, trait-based system. In my view, few clinicians, other than a cadre of academic specialists, would take the time and effort to rate patients on six complex trait dimensions. As for primary care doctors with 15 minutes to see a patient—don’t even ask.

CONCLUSION

No question about it: there are serious problems with our current construct of NPD. It is probably too heavy on the “grandiosity” dimension and too light on “vulnerability.” Furthermore, the present NPD criteria seem to be associated with mental disability among men but not among women—a major problem. The current criteria may also over-identify subjects going through the turmoil of adolescence, rather than those with an enduring or life-long characterological disposition. But none of these problems necessarily means that NPD should be tossed on the scrap-heap of outmoded diagnoses. A more prudent approach would be to refine our NPD criteria so as to address these deficiencies, and then field-test the revised NPD criteria in clinical settings. Then we need to begin careful genetic and neurobiological studies of NPD subjects, searching

for biomarkers and endophenotypes. After all, would not our narcissistic patients demand the very best from us—and, like all our patients, don’t they deserve it?

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