

Narcissistic Personality Disorder

Description/Etiology

Narcissistic personality disorder (NPD) is one of 10 diagnosable personality disorders that appear in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*, all of which are retained from the fourth edition of the manual. NPD is grouped with antisocial personality disorder, borderline personality disorder, and histrionic personality disorder to form the cluster B personality disorders, which share the features of extreme affect, theatricality, and unpredictability. The general criteria for NPD are an exaggerated and unrealistic sense of superiority, a need for admiration, and an inability to understand the feelings of others, starting by early adulthood and present in different areas of functioning.

To diagnose NPD, at least five of the nine specific following criteria must be met: inflated and unjustified self-regard, with expectations that others will concur; an inordinate focus on having success, power, and unrealistic relationships; belief that one is superior and can only be understood by persons or institutions with the same superior standing; a constant demand for attention and extreme praise; belief that one deserves special treatment above and beyond others, and that others should unquestioningly carry out any request; an exploitative view of relationships; failure to acknowledge or understand the feelings or needs of others; belief that others are envious of one, or being envious of others; and exhibiting arrogance in interpersonal interactions. The grandiosity and beliefs of a person with NPD may manifest as either fantasy or actual behavior. Furthermore, such fantasies and beliefs are different from the bizarre delusions associated with psychotic disorders in that the fantasies and beliefs are possible, in principle, no matter how embellished or distorted.

Although they are not included in the *DSM-5*, there are two subtypes of NPD recognized in the clinical setting: grandiose, or overt, and vulnerable, or covert. Individuals with the grandiose subtype of NPD tend more toward overt displays of self-importance, entitlement, fantasies of admiration, denial of weakness, and exploitative behavior, whereas those with the vulnerable subtype tend more toward hypersensitivity to insult; self-criticism; feelings of shame, helplessness, or inadequacy; and social withdrawal. It is theorized that the subtypes develop because of the different approaches of earlier caregiver(s): overly indulgent with extravagant praise versus cold with excessive expectations. Both approaches adversely affect attachment and development of healthy self-esteem.

It is important to note that even though the *DSM-5* retained the *DSM-IV* criteria for personality disorders, the *DSM-5* Section III (which includes potential models for future research) presents an alternative model in which personality disorders are characterized by impairments in personality functioning and pathological personality traits. The proposed diagnostic criteria for NPD in Section III of the *DSM-5* include significant impairments in personality functioning manifested in self functioning in four areas: identity, self-direction, empathy, and relationships. Furthermore, criteria for diagnosis of NPD in Section III of the *DSM-5* include antagonism (i.e., active hostility) characterized by grandiosity (e.g., feeling above others, being condescending) and attention-seeking (e.g., trying an inordinate amount to get the attention of others). Researchers believe that the alternative model provided in Section III of the *DSM-5* represents a significant improvement in diagnostic criteria in comparison with the traditional model in Section II of the *DSM-5* and that it is much more clinically useful (Ronningstam, 2014; Skodol et al., 2014).

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The etiology of NPD is unresolved, with most literature attributing it to an interaction of genetically inherited traits and environmental influences, particularly the impact of early parenting on the ability to self-regulate emotions and other internal controls.

Facts and Figures

The *DSM-5* reports prevalence rates of NPD in community samples in the United States ranging from 0% to 6.2%, with 50% to 75% of individuals with NPD being male (American Psychiatric Association, 2013). Investigators performing analysis of the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (Stinson et al., 2008) found rates of NPD among respondents with bipolar I disorder to be 31.1%; among those with panic disorder with agoraphobia, 23.9%; and among those with drug dependence, 34.9%. Other findings included greater rates of NPD among individuals who were separated, divorced, or widowed, and an inverse relationship between NPD and age, with the greatest decline after age 29 (Stinson et al., 2008). Unfortunately, there is a paucity of further NPD statistics.

Risk Factors

Risk factors include lack of parental empathy during early development or otherwise disrupted development of self-regulation skills. Some studies have found higher rates of NPD among children of individuals with NPD, but there is no conclusive evidence that genetic or environmental factors are the cause.

Signs and Symptoms/Clinical Presentation

Signs and symptoms include grandiosity, fantasies of unlimited power and success, a need for admiration and to be associated with high-standing individuals or institutions, lack of empathy, exploitation of others, sense of entitlement, insecurity, feelings of being a fraud, excessive envy, and displays of arrogance. Individuals with NPD may appear to have fragile self-esteem, be hypersensitive to criticism, have high levels of achievement, have strong feelings of humiliation or shame, and possess a need to be the object of attention. They may appear manipulative, indifferent, inadequate, lonely, self-centered, and self-absorbed.

Social Work Assessment

› Client History

- Standard biopsychosocial-spiritual assessment, including risk for suicide. Individuals with NPD are more likely than others to present themselves in a favorable way and to omit or avoid unfavorable feelings or experiences
- Assessment for risk factors, including coexisting mental health conditions
- Observation of functioning and demeanor during interview
- Collateral information from family, friends, and coworkers is especially important because individuals with NPD frequently have limited insight into their own symptoms

› Relevant Diagnostic Assessments and Screening Tools

- Care should be used with self-reporting screening tools due to the client's general lack of insight. Not all of the tools listed are specific to NPD but are used for general measurements of personality dysfunction
- Personality Inventory for DSM-5 (PID-5), a 220-item self-report designed to assess 25 personality traits
- Five-Factor Narcissism Inventory (FFNI), a 148-item self-report of 15 traits related to vulnerable and grandiose narcissism
- Pathological Narcissism Inventory (PNI), a 52-item self-report measuring traits related to vulnerable and grandiose narcissism
- Narcissistic Personality Inventory (NPI), a 40-item forced-choice self-report measure of grandiose narcissism

› Laboratory and Diagnostic Tests of Interest to the Social Worker

- At present there are no laboratory or medical diagnostic tests available
- Tests for the presence of alcohol or other substances at levels indicating abuse may be useful

Social Work Treatment Summary

- › Researchers have found that clients with NPD are at the highest risk of dropping out of psychotherapy compared to clients with other personality disorders (Ellison et al., 2013)
- › Clinicians have to navigate the complexities of NPD, especially with clients who oscillate between grandiosity and vulnerability. The grandiosity may be evident as domineering and vindictive interpersonal behaviors, whereas the vulnerability may display as shame, agitation, and self-criticism (Pincus et al., 2014)
- › Researchers indicate that progress can be made if barriers to treatment are avoided. The three most common barriers are strong and counterproductive feelings of countertransference; clinicians' belief (and covert communication of that belief

to the individual being treated) in the myth of untreatability; and the provision of direct and specific advice on social functioning or personal problems, which usually produces dependence, noncompliance, or resentment. Establishing an appropriate therapeutic alliance with individuals with NPD may be particularly difficult. A first step in treatment of NPD is collaborative goal-setting with regard to treatment. Once collaborative goals are set, it is important for the clinician to give consistent attention to developing and maintaining therapeutic boundaries and have transparency in all interactions, including sharing diagnostic impressions with the client

- › Clinicians can use an approach called transference-focused psychotherapy (TFP) with their clients with NPD. This therapy initially works on limit setting with the client to decrease destructive behaviors and then explores the client’s mind and sense of identity. Clinicians using TFP usually meet with their client 2 times a week (Stern & Yeomans, n.d.)
- › Clinicians should be aware if client is working with a psychiatrist or other medical prescribing professional and what medications have been prescribed. Clinician can review and help monitor medication regimen and assess for any negative side effects
- › Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice
- › Social workers should practice with awareness of and adherence to their countries’ Code of Ethics (e.g., National Association of Social Workers for the United States, British Association of Social Workers for England) core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. They should become knowledgeable of the ethical standards as they apply to clients with narcissistic personality disorder and practice accordingly

Problem	Goal	Intervention
Clinician has difficulty developing and maintaining a therapeutic alliance with client with NPD	Establish a long-term therapeutic alliance	Sharing diagnostic impressions and greater than usual inclusion of client in developing treatment goals, greater than usual attention to importance of tact, timing, and precise use of language. The clinician should be wary of unwittingly compromising boundaries and becoming a source of narcissistic supply for the client via overt, excessive tact
Client’s heightened sensitivity to criticism is negatively affecting his or her ability to participate in treatment	Full engagement in treatment by client	Use of transference-focused psychotherapy (TFP) to accommodate client’s hypersensitivity

Applicable Laws and Regulations

- › Each jurisdiction (e.g., nation, state, province) has its own standards, procedures, and laws for involuntary restraint and detention of persons who may be a danger to themselves or others. Individuals with NPD might be at risk for suicide. Local and professional reporting requirements for neglect and abuse should also be known and observed
- › Each country has its own standards for cultural competence and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly

Available Services and Resources

› National Mental Health Consumers'

Self-Help Clearinghouse, <http://mhselfhelp.squarespace.com/clearinghouse-resources/category/personality-disorders>

Food for Thought

› In contrast to most mental health disorders, some of the personality traits at the core of NPD are viewed as necessary for both intrapersonal and interpersonal functioning. Healthy development and maintenance of some degree of self-regard and belief in one's abilities and accomplishments, as well as validation and affirmation from external sources, are all needed for development of a robust personality

Red Flags

- › Signs and symptoms of NPD are similar to those of other cluster B personality disorders and can be difficult to distinguish for diagnostic purposes
- › The myth that personality disorders are untreatable can be self-reinforcing when repeated among professionals involved in the treatment of NPD
- › Clinicians report that clients with a comorbid diagnosis of NPD and borderline personality disorder can be the most challenging clients to treat because they tend to provoke or alienate the therapist in an effort to devalue the therapeutic relationship and treatment
- › Physical illness and problems resulting from substance use can threaten the image of superiority held by persons with NPD; they may minimize these issues to preserve their sense of superiority

Discharge Planning

- › Review medication regimen and symptoms of adverse effects, if any, and make follow-up appointment with agency issuing prescription
- › Instruct client to seek immediate attention for aggression and **suicide ideation/attempts**
- › Provide education about the nature of NPD and the need for follow-up treatment if symptoms reappear
- › Assess for stability of employment and housing
- › Refer to appropriate treatment modality depending on severity and subtype of NPD
- › Provide referrals for support and education of family members

DSM-5 Codes

› 301.81

Note

› A recent review of the literature has found no updated research evidence on this topic since previous publication on November 13, 2015

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