

Beyond the Diagnostic Traits: A Collaborative Exploratory Diagnostic Process for Dimensions and Underpinnings of Narcissistic Personality Disorder

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Narcissistic personality disorder has been challenging to diagnose in psychiatric and general clinical practice. Several circumstances and personality factors related to the nature of pathological narcissism and NPD contribute. NPD is usually a moderately impairing condition, often accompanied by specific capabilities and high level of functioning. Comorbidity of other urgent and recognizable psychiatric conditions, such as mood and substance use disorders or suicidality, can override even significant narcissistic personality functioning. Patients' limited ability to recognize own contribution to problems or impact on other people, their hypersensitivity and defensive reactivity, and compromised ability for self-disclosure, self-reflection, and emotional empathy can make initial evaluations difficult. The aim of this study is to integrate recent clinical and empirical knowledge on the underpinnings of pathological narcissism and narcissistic personality functioning, and distinguish narcissistic self-regulatory patterns that are affecting diagnostic traits. A more flexible, exploratory, and collaborative diagnostic process is proposed that integrates the patients subjective experiences and interpersonal functioning in terms of self-regulation, agency, and traits in a way that is informative and meaningful for both the patient and the clinician.

Keywords: narcissistic personality disorder, self-regulation, agency, diagnostic traits

Pathological narcissism is characterized by fragility in self-regulation, self-esteem and sense of agency, accompanied by strong self-protective reactivity, emotion dysregulation, and a range of self-enhancing and self-serving behaviors and attitudes. Areas or periods of proactive and healthy narcissism coexist with pathological narcissism. Self-regulatory fluctuations and accompanying shifts in self-esteem are context dependent and affected by situational, that is, interpersonal or event triggered reactivity. The phenotypic presentations of pathological narcissism and NPD range from interpersonal pretentiousness, arrogance, and assertiveness, to insecurity, shyness, and hypersensitivity (Cooper, 1998; Russ et al., 2008). Notable is also that narcissistic individuals' internal experiences may differ significantly from their overt behavior and descriptive accounts. From an attachment perspective narcissistic personality style and pathological narcissism are suggested to be anchored in a detached-dismissing pattern (disliking attachment to others and preferring investment in interpersonal space and own agency), or in an avoidant pattern (defensive self-sufficiency). In addition, sensitive, vulnerable narcissism has been associated with anxious or fearful preoccupied attachment style (aspiring attachment but anticipating disappointment or rejection; Fonagy, 2001; Dickinson & Pincus, 2003).

Self-Esteem, Self-Regulation, and Self-Agency

Grandiosity and accompanying self-enhancing and self-serving incentives and behavior are part of a self-regulatory spectrum of narcissistic personality functioning. Overt as well as covert signs of both grandiosity and vulnerability coexist and affect narcissistic personality functioning in each situation (Pincus & Lukowitsky, 2010). Sense of competence, control, standards, and achievements are crucial for self-evaluation and self-esteem (Zeigler-Hill, Myers, & Clark, 2010).

Self-agency conceptualizes the subjective awareness and ownership of goal setting, and planning, initiating, executing, and controlling one's own thoughts, intentions, actions, and accomplishments (Fonagy, Gergely, Jurist, & Target, 2002; Gallagher, 2006; Knox, 2011). It signifies implicit as well as explicit initiation, mastery, and self-direction, and it is a fundamental part of self-regulation and self-esteem. As such self-agency is a potential base for evaluating self-esteem regulation including grandiosity and inferiority. In social-psychological studies of narcissism, self-agency has been introduced to conceptualize narcissistic interpersonal and self-regulatory strategies, such as attention seeking, competitiveness, and self-esteem-enhancing relationships (Foster & Brennan, 2011).

Psychoanalytic studies noted that the subjective experiences of fluctuating or loss of self-agency are especially consequential for people whose sense of self-worth is fragile and whose ability for interpersonal relatedness is compromised (Knox, 2011). Disturbance in self-agency is an essential part of psychopathology (Spengler, von Cramon, & Brass, 2009; Fonagy et al., 2010). For example, schizotypal traits correlate with deficits in prediction

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which lead to weaker sense of self-agency (Asai & Tanno, 2008; Asai, Sugimori, & Tanno, 2008). Discrepancies between predicted and actual action–effect connection contributed to decreased sense of agency (Sato & Yasuda, 2005; Spengler, von Cramon, & Brass, 2009), and perceived reduced control of events was associated with decreased experience of authorship/instigation (Aarts, Wegner, & Dijksterhuis, 2006).

Case Vignette

A young man, Bob 21 years old, dropped out of college and was hospitalized with a range of problems: At the initial evaluation the clinician noticed general anxiety, obsessive–compulsive preoccupation, racing thoughts, social anxiety, avoidance, and suicidality. Family members and friends portrayed Bob to the case-manager as inconsiderate, demanding, and demeaning, with threatening and verbally aggressive behavior, and involved in poly substance abuse. Bob described himself as struggling with internal agony caused by his inconsistent cognitive intellectual functioning, and feeling overwhelmed by insecurity and internal self-criticism. He often felt frustrated with other people; he found them stupid, unpredictable, and difficult to understand. In addition, he had been isolating and engaged in Internet sex-dating where he felt safer and more in control compared with if he tried to meet somebody at bars and parties.

Bob also described the week before being hospitalized; on Friday he met with his professor and began outlining a project for a paper. He thought the meeting went well as he perceived that his ideas were well understood and appreciated by his professor, and he left feeling motivated and competent. On Sunday he spoke in front of 10,000 people at a big sports event at his college. Apparently he did a good job, both according to his own assessment and based on the others' enthusiastic feedback. With a smile he admitted that he felt he could become a future president of the United States. On Tuesday he found himself unable to speak in front of his class of 8 peer students. It was his turn to present the outline of his project, and just before the class began he experienced sudden anxiety with difficulties holding on to logical thinking and reasoning. When he was about to begin he experienced a total cognitive blockage and had to leave the room. A day later he saw no future for himself and struggled with excruciating self-reproach and intense suicidal ideations and impulses. He admitted that he anticipated critical and "stupid" comments from his peers and feared the anticipation of exposing himself to something he could not control. Most of all, he felt unable to rely upon his own competence and dreaded a sudden loss of his ability to think and speak.

Bob was highly intelligent, with an IQ in the range between 140 and 150. Some even considered him to be a genius, although he himself did not believe that, but he appreciated the admiration and acknowledgment. He was a competitive swimmer and leader of his swim team, and had encountered no problems with either swimming or team leadership. He had overall done well in college, especially on exams, and received high grades despite some inconsistencies. His professional aspirations and plan was to become a lawyer like his grandfather. He met 8 of the 9 Diagnostic and Statistical Manual of Mental Disorders, fourth edition (*DSM-IV*) and fifth edition (*DSM-5*) criteria for NPD (not #6, interpersonal exploitive) according to the Diagnostic Interview for *DSM-IV* Personality Disorders, DIPD-IV (Zanarini, Frankenburg, Sickel, & Young, 1996).

After having presented this rather diverse set of experiences Bob said to the therapist: "I cannot trust my faculties, I do not know from one day to another whether I can rely on my thinking and reasoning, access my knowledge, communicate, and perform. I struggle inside myself with dreadful self-scolding, constantly comparing and criticizing

myself. I am a perfectionist, and I know that I can be very good, even exceptional. I have been considered a genius, but it does not hold up. I can't tolerate closer contact with people. I get so angry and frustrated at them. I can see that I may be unfair, at times . . . , but I just can't stand it. It works much better when I am in charge or if there is a distance to other people, like if I have a large audience. I feel extremely afraid of the future and ashamed of having to be in treatment. Some days I really doubt that anything can change or that I can get help, other days I can feel more optimistic".

Comment to Case Vignette

Bob presented with areas and moments of real potentials, consistent competence, and proactive interpersonal functioning, that is, as a swimmer and team leader, and in individual academic performance and interactions with his supervisors. On the exceptional side was his ability to speak in front of large audiences. He had both unrealistic grandiose fantasies as well as real age-appropriate professional aspirations. He came across as confident and self-promoting, alternating between bragging and a disdainful attitude. However, internally he struggled with extreme self-criticism, self-doubt (the reverse side of perfectionism), and interpersonal insecurity when facing close and intimate or collaborative interactions with peers, as if they tend to become critical enemies. However, this most consequential vulnerability was not triggered in his physical sport activities, only in his intellectual academic activities. In terms of self-agency, Bob was unable to integrate and regulate perceptions of challenges, failures, and interpersonal limitations with his actual competence and real abilities. From a self-regulatory perspective he used perfectionism and avoidance as well as substances to enhance self-esteem, and sense of control and to modulate self-criticism, fear, and anxiety. Apparently he had reached a point where he faced a rapid and extreme downhill spiral. High ambitions, perfectionism, and intermittent experiences of competence and even exceptional abilities under certain circumstances, turned into escalating interpersonal intolerance and fear, insecurity, distancing and avoidance, self-criticism and self-scolding, with substance usage and suicidality.

Diagnosing NPD

Although grandiosity is a diagnostic hallmark for NPD, and an indication of the pathological grandiose self (Kernberg, 1975), its complexity and changeability suggest that the diagnosis of NPD should not depend heavily on overt indications of grandiosity (Ronningstam, Gunderson, & Lyons, 1995). State-dependent signs or temporary reactive increase of grandiosity can alter or coexist with more persistent overt or covert grandiose self-experience, as well as with more proactive or authentic functioning. Given narcissistic patients' identity diffusion and difficulties knowing who they are, identifying and differentiating their real competence, assets, and accomplishments from exaggerated or nonexistent achievement and wished for talents are important. Equally important is the differentiation of their age appropriate ambitions and proactive aspiration from high-flying or unrealistic fantasies. It is not uncommon that patients with NPD struggle with uncertainty, shame, excessive self-criticism, and insecurity related to their actual talents, value and competence, parallel with an enhanced self-presentation, especially if they are young. Like in the case of Bob, it is also important to acknowledge areas of actual individual

uniqueness and special talents or potentials as part of the overall self-regulatory functioning. In addition, encouraging patients' own narrative, especially describing moments when they experience incompetence, inferiority, and fragility, is also a most essential part of the diagnostic process. The shifts in self-esteem from grandeur to inferior or vice versa with accompanying self-regulatory change in self-enhancement and self-devaluation are most informative. The subjective experiences of those interpersonal or situational conditions that cause such shifts are diagnostic hallmark for pathological narcissism and NPD (Ronningstam, 2012a, 2013).

Diagnostic evaluation and treatment tend to mobilize self-protection and control in people with narcissistic personality functioning. Some can be extremely and effectively defensive, focusing on details or seemingly relevant issues while avoiding more urgent or deeper and challenging problems. Others can mobilize plasticity and adjustment, agreeing and following along, and still others can get argumentative, aggressive, and critical. Although on the surface intelligent and articulated, even with moments of perspective-taking and reflection, these people also present with a significant resistance or inability to deeply connect, attach, and change. Doubts, shame and insecurity, confused self-identity, and self-criticism, combined with a range of self-enhancing strategies, contribute to their sometimes drastic self-regulatory interpersonal stands.

A conditional and limited alliance is unfolding, that can seem collaborative and interactive with common language, and even with processing of challenging inquiries and complex interpretations. However, the patients' motive for seeking help and experience of facing treatment may be totally separated from acknowledging their problems and work toward changes or modifications of problematic areas functioning. Their reputation of being difficult to treat, or even untreatable, stems from a particularly complex and constricting mental functioning. Clinical observation and empirical findings indicate compromised functioning and impaired abilities behind the NPD diagnostic traits that indeed underpin pathological narcissism and contribute to the specific internal and interpersonal regulatory patterns. Awareness and integration of these factors in the diagnostic process is crucial for gaining a meaningful identification of the narcissistic patient.

Emotion Regulation

The first set of such factors concerns the ability to access, process, and identify emotions. Studies have shown that both defensive and compromised emotional functioning influence self-regulation in people with pathological narcissism or NPD (Model, 1975; Krystal, 1998). Avoidance of emotions, especially fear of failure and humiliation, is considered a motivating, self-regulatory strategy (Bélanger et al., 2012). Vigilance, sensitivity, and reactivity to negative events and anticipation of humiliation (Besser & Zeigler-Hill, 2010) can coexist with emotion intolerance and difficulties processing feelings, in particular fear and shame. Fear, recognized in both psychoanalytic and empirical studies as essential in pathological narcissism, is also underlying several management and avoidance strategies typical for narcissistic personality functioning, such as competitiveness, perfectionism, risk-taking, and procrastination (Ronningstam & Baskin-Sommers, 2013). Shame also plays a significant role, especially in narcissistic interpersonal relating, and can motivate avoidance as well as defen-

sive, retaliatory anger to regain agency and control (Tangney, 1995; Trumbull, 2003).

Compromised emotion recognition, that is, impaired accuracy in recognizing facial emotional expressions in others, especially fear and disgust (Marissen, Deen, & Franken, 2012), weaken the narcissistic patient's ability for interpersonal guidance and information processing. Similarly, *alexithymia*, that is, the inability to feel and identify own feelings, either because of unawareness or incapacity to distinguish physical and affect states or because of lacking words for emotions (Krystal, 1998) can also impede on the ability to recognize emotions in others (Fan et al., 2011).

Studies of empathic deficits, another outstanding feature of NPD, have raised the question whether motivation/self-regulation or actual deficits, or both, contribute to compromised empathic ability. Impairment in emotional empathic ability was found in patients diagnosed with NPD (Ritter et al., 2011). Although their cognitive empathic ability was intact and influenced by motivation, their emotional empathic functioning was affected by compromised ability for mirroring and responsiveness to the emotional states of others. On the other hand, NPD patients' failure to accurately recognize emotions in others combined with overestimation of their own empathic ability indicates a more general empathic deficit (Marissen, Deen, & Franken, 2012). Emotion intolerance may also play a role in empathic ability as the person may be able to notice feelings in others, as mentioned above, but the perception of others' feeling states can evoke overwhelming powerlessness, disgust, shame or loss of internal control, and hence trigger strong aggressive reactions or emotional or physical withdrawal (Ronningstam, 2009). In addition, noticeable fluctuations in narcissistic patients' empathic ability may be influenced by self-regulation, with increased ability to empathize when feeling confident and in control, and decreased ability when feeling exposed, inferior or threatened.

Compromised or Dysfunctional Interpersonal Relatedness

The specific attachment pattern associated with pathological narcissism and NPD, as mentioned above, contributes to a second set of factors involving significant difficulties relating and connecting, especially in ways that can promote change (Kernberg, 2007). NPD patients often do not know who they are on a deeper level, and their identity is influenced by more profound and persistent self-enhancing efforts. Difficulties with dependency and mutuality and strong tendencies for avoidance and control are also, like in the case of Bob's choice of intimacy via Internet, typical indicators of compromised interpersonal functioning (Kernberg, 1998). Perfectionism is such an effort because it involves both exceptionally high or inflexible (although inconsistent) ideals and standards of self or others, with strong reactions, including aggression, harsh self-criticism, shame, fear, or deceitfulness when self or others fail to measure up (Hewitt et al., 2008; Ronningstam, 2010). In interpersonal and social situations perfectionism can be self-promoting to enhance certain qualities, but it can also be self-protective and serve to hide something nonperfect. On the other hand, self prescribed perfectionism can contribute to extremely unyielding self-criticism, like in the case of Bob, with hypervigilance and automatic cognitive appraisal of interpersonal situations as overly provocative or threatening. Especially, it con-

tributes to reluctance to acknowledge and being seen as imperfect, and hence, to seek help for own distress and to integrate and benefit from treatment interventions.

Impaired ability for self-disclosure, self-silencing, selective or non-communicativeness, and inability to share feelings and thoughts (Model, 1980; Besser, Flett, & Davis, 2003) are all aspects of narcissistic pathology that contribute to diagnostic challenges. Similarly, reversible perspective taking (Etchegoyen, 1999), the tendency to smoothly adopt the therapist's comments and interpretations and seemingly internalize those given perspective without changing one's own, and without incorporating the therapeutic process to generate change in own personality functioning, is yet another complicating defensive feature.

Narcissistic Trauma

A third set of factors relates to the specific psychological aspects of trauma that can reinforce pathological narcissistic functioning. A narcissistic trauma is caused by a subjective experience of loss of supportive or sustaining external life conditions, such as changes in marriage/family, work and career, or financial situation, or loss of connection to a good, supportive idealized other person, leading to a loss or distortion of internal ideals and meaning. Sudden loss of a sense of control and competence, like in the case of Bob, can also be traumatizing for people whose self-esteem is strongly connected with performance and achievement. Such losses cause an acute internal state that threatens the continuity, coherence, stability, and wellbeing of the self (Maldonado, 2006). Narcissistic self-protection aimed at organizing and understanding the traumatic experience fail, and the sense of loss, rejection, and abandonment, along with feelings of shame, fear, and worthlessness become overwhelming (Gerzi, 2005). A narcissistic trauma is more subjective and self-esteem related, and involving exposure and humiliation. Sometimes such trauma can even be entirely emotional and internal, accompanied by compromised hope, sense of value, control, meaning, and affiliation. This contrasts to more external obvious traumatic experiences, such as physical attacks, abuse, accidents, and so forth. Narcissistic trauma, like in Trauma Associated Narcissistic Symptoms, TANS (Simon, 2002) can be intrinsic to the characterological vulnerability to disruption of self-regulation, and loss of agency and self-esteem in NPD. On the other hand, narcissistic traumas, experienced in young age, can also be deeply internalized and subjectively organized in a narcissistic patient's mind, contributing to an armor-like, seemingly impenetrable narcissistic character functioning, with denial, omnipotence, and organizing and protecting narcissistic fantasies, covering split off shame and fear. These types of traumatic experiences may easily be either misdiagnosed or bypassed in a diagnostic evaluation as they often differ from standard psychiatric definitions of trauma involving abuse, neglect, catastrophes, and so forth (Ronningstam, 2012b; Simon, 2002; Krystal, 1998) and can remain effectively shielded. Facing the impact of external life events might actually help some patients to begin to access and process such subjectively internalized experiences.

Conclusions

This study has focused on identifying underpinnings and self-regulatory patterns behind the diagnostic traits for NPD. A

flexible, exploratory, and collaborative diagnostic process is recommended that attends to the patients' internal experiences and motivations as well as to their external and interpersonal functioning. The patients' limitations and compromised abilities, as well as their interpersonally provocative, although sometimes quite elaborative self-regulatory and enhancing strategies should be attended to in ways that are informative and meaningful for both the patient and clinician. Identifying and differentiating healthy or protective aspects of narcissistic patterns from those that are pathological and perpetuating is important. Clarifying the threatening, injuring, or traumatic experiences and situations that escalate narcissistic reactivity is equally essential. Clinicians' observations of the narcissistic patients' functioning often do not concur with the patients' own experiences of themselves or formulations of their problems. More detailed exploration of a recent event that caused fluctuations in the patient's self-esteem and agency can be a useful start. Such exploration can provide the opportunity to clarify the patient's internal subjective perspective, needs, and motives for self-enhancement, experiences of vulnerability and deflation, and the organizing and protective role of narcissistic functioning, both internally in relation to self and in relationship to others. A focus on these areas of functioning is in line with the Workgroups proposal for personality functioning in DSM-5 Section III, which includes identity (regulation of self and emotions), self-direction (self-agency), empathy and intimacy (interpersonal relatedness). With regard to the diagnosis of NPD, these changes represent significant improvement compared with the entirely trait-based diagnosis. Encouraging self-assessment and the patients' own narratives of their performance, anticipations, aspirations, and shifts in states, self-esteem, and emotions can begin to bridge the different perspectives of the patient and the clinician, and help reaching a diagnostic agreement and understanding of the patient's functioning.

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