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INTEGRATING TRAIT- AND PROCESS-BASED CONCEPTUALIZATIONS OF PATHOLOGICAL NARCISSISM IN THE DSM-5 ERA

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Abstract

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders contains an innovative alternative model of personality pathology, which includes a substantially revised description of narcissistic personality disorder. Although this novel articulation represents a major advance in the description of pathological narcissism in the diagnostic nomenclature, significant challenges remain in the integration of core processes associated with self and interpersonal impairments with trait-based models of personality pathology. This chapter discusses this tension and the potential for integrating trait- and dynamic process-based approaches for understanding pathological narcissism. Two cases are presented to illustrate the utility of understanding traits as ensembles of dynamic processes. Suggestions for future research are offered.

Keywords: pathological narcissism, DSM-5, personality traits, dynamic processes, narcissistic personality disorder

INTRODUCTION

Recently a major reconceptualization in the description of personality pathology was proposed for the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). At the heart of the proposed revision was a pivot away from the problematic discrete categorical model that has been in place over the past three decades toward a model informed by longstanding clinical theory and basic personality science (Skodol et al., 2011; Krueger, Hopwood, Wright, & Markon, in press). Ultimately, however, this model was not officially adopted, but was instead included as an “alternative model,” in extenso, in Section III (Emerging Models and Measures) of the manual. Along with the proposed revisions to the general conceptualization of personality pathology, the definition of narcissistic personality disorder (NPD) received a dramatic overhaul. In many ways, the revised articulation of NPD addresses established criticisms of the DSM’s representation of pathological narcissism (e.g., though the inclusion of vulnerable content). At the same time, with the new model come several challenges in conceptualization and measurement that warrant thoughtful consideration.
Specifically, more fully integrating personality traits, which are rooted in the basic science of individual differences, with the clinical description of complex dynamic processes, is required. In this chapter, I discuss contemporary perspectives on pathological narcissism, the articulation of NPD in DSM-5, and the potential for a model of pathological narcissism that links basic personality trait processes with clinical theory and observation.

**PATHOLOGICAL NARCISSISM LEADING UP TO DSM-5**

As a construct, narcissism has a long history rooted in the intellectual climate at the turn of the last century (Ellis, 1898; Freud, 1914/1957). However, unlike many psychological notions from that era, narcissism remains a subject of vibrant intellectual and scientific inquiry (Miller, Widiger & Campbell, 2010). Indeed, the DSM-5 revision process arrived at an interesting time in narcissism’s history. In the years leading up to DSM-5, the construct of narcissism, broadly defined, received increased scientific interest, resulting in a rapidly expanding body of theoretical, empirical, and clinical literature (e.g., Cain, Pincus, & Ansell, 2008; Miller, Gaughan, Pryor, Kamen, & Campbell, 2009; Ogrodniczuk, 2013; Pincus & Lukowitsky, 2010; Roche, Pincus, Lukowitsky, Menard, & Conroy, 2013; Ronningstam, 2005a, 2005b, 2009). A consistent theme in the clinical and scientific literature on narcissism in the years prior to DSM-5 was a growing dissatisfaction with the way the diagnostic nomenclature narrowly emphasized overt grandiosity to the exclusion of the frequently observed vulnerability to self-, interpersonal, and affective dysregulation (Hendin & Cheek 1997; Pincus & Lukowitsky, 2010; Pincus, Lukowitsky, Wright, & Eichler, 2009; Ronningstam, 2009; Russ, Shedler, Bradley, & Westen, 2008; Wink, 1991).

In an attempt to improve reliability and discriminant validity across successive revisions of the DSM, NPD was more narrowly defined in terms of grandiose features (e.g., exaggerated sense of self-importance) to the exclusion of
more vulnerable features (e.g., unstable self esteem). This is understandable given that narcissistic vulnerability encompasses the more inferential aspects of the construct (e.g., Kernberg, 1975; Kohut, 1971, 1977). Central to the clinical description of pathological narcissism is a core psychological structure oriented toward satisfying intense needs for validation and admiration (i.e., grandiosity). However, equally important is what happens when individuals fail or struggle to effectively manage these needs. Due to extreme or rigid behavior or impaired regulatory capacities, these failures often result in a number of negative psychological consequences that may be characteristically grandiose or vulnerable in nature (Pincus, 2013; Pincus & Roche, 2011). This is borne out in the quantitative research on NPD. For instance, narcissism has been associated with an array of traits and behaviors that can be understood as manifestations of, or closely related to grandiosity, such as psychopathy, impulsivity, violence, aggression, homicidal ideation, and sexual aggression (Pincus et al., 2009; Ronningstam, 2005a, 2005b). However, narcissism is also associated with more vulnerable forms of dysregulation such as anxiety, depressive disorders (Clemence, Perry, & Plakun, 2009; Stinson et al., 2008), and variable self-esteem (Rhodewalt, Madrian, & Cheney, 1998), as well as functional impairments, interpersonal distress, and even suicidal behavior (e.g., Ansell et al., 2014; Miller, Campbell, & Pilkonis, 2007; Ronningstam, 2005b, 2011).

Thus, the narrow emphasis on narcissistic grandiosity in the DSM is at odds with clinical and scientific literature that has highlighted the importance of attending to narcissistic vulnerability. This is not without consequences. This narrow focus may partially explain the extremely low prevalence of NPD in community samples (Dhawan, Kunik, Oldham, & Coverdale, 2010), which, in turn, can affect perceptions of the societal impact and importance of narcissistic pathology as a public health concern. In clinical samples, rates of NPD are quite

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1 Alternative reasons may include low endorsement of the highly face valid symptomatology and the brevity of assessments necessitated in epidemiological studies, which may fail to capture covert expressions of narcissism.
variable, but generally fairly high (2.3% to 35.7% as summarized in Dhawan et al., 2010). Yet as Pincus and Lukowitsky (2010) have pointed out, excluding narcissistic vulnerability from the nosology may lead clinicians to fail to appropriately identify, diagnose, and treat pathological narcissism in the clinic. Added to these issues is the ubiquitous problem associated with the poorly articulated constructs in the official nomenclature, namely this leads to the recruitment of inappropriate, heterogeneous, or incomplete samples of patients for costly research on etiology, development, and treatment.

**THE DSM-5 SECTION III PERSONALITY DISORDER MODEL**

Currently, there are two full personality disorder (PD) models printed in the DSM-5. Although this will undoubtedly change in successive iterations of the manual, for now the American Psychiatric Association has decided to maintain full continuity with prior editions of the manual by reprinting the model and criteria presented in *DSM-IV-TR* in *DSM-5* Section II (Diagnostic Criteria and Codes), with only minor textual changes. Accordingly, pathological narcissism is codified in Section II as a categorical disorder, with the same narrow emphasis on the grandiose features of the construct (i.e., the description and criteria are exactly the same). For the time being, all of the existing limitations remain in place.

However, as mentioned above, a considerably different approach to describing and diagnosing PD was included in Section III (Emerging Models and Measures) of the *DSM-5*. This model includes a detailed description of PD-specific impairments (Criterion A) in the form of self- and interpersonal dysfunction that replaces the general definition of PD, as well as a dimensional model of PD features (i.e., pathological traits) intended to map individual

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2 Dhawan et al. (2010) reported a range of 0.0% to 6.2%. However, the 6.2% figure for categorical diagnosis of NPD is a stark outlier and implausible. This statistic came from the Stinson et al. (2008) study, which has been criticized on methodological
differences in PD expression (Criterion B). Remaining criteria reflect the standard requirements for pervasiveness (Criterion C), relative stability (Criterion D), and that the disorders are not better accounted for by other mental disorders, substances, or developmental stage (Criteria E, F, and G).

A major innovation in the Section III model is the expanded general definition of PD that emphasizes core impairments in Self (Identity and Self-Direction) and Interpersonal (Empathy and Intimacy) functioning. Thus, the revised model takes a strong stance by emphasizing the defining features of PD as rooted in social processes, inclusive of both the self-system and how one interacts with others. Furthermore, these are hypothesized to reflect a general domain of severity in personality pathology, cutting across stylistic differences in the manifestation of PD (Bender, Morey, & Skodol, 2011; Morey et al., 2011). Bender and colleagues (2011) drew on a wide body of literature in formulating these domains, which were ultimately operationalized in the Levels of Personality Functioning Scale (LPFS) that is printed in Section III of the manual. Drawing links from the resultant constructs to several existing theoretical models of personality pathology or vulnerability is not difficult (e.g., Berghuis, Kamphuis, & Verheul, 2012; Hopwood, Wright, Ansell, & Pincus, 2013; Kernberg, 1984; Luyten & Blatt, 2013; Parker et al., 2004). The presence of these impairments forms the first, and necessary, criterion for the diagnosis of PD in this framework. Assuming that impairments in self- and interpersonal functioning are deemed present, the second criterion requires the presence or at least moderate elevation of one or more of 25 pathological personality traits that are organized under five higher-order domains. Refinement of this structure was based in part on work with the Personality Inventory for the DSM-5 (PID-5; Krueger, Derringer, Markon, Watson, & Skodol, 2012). This pathological trait model allows for the description of individual differences in the stylistic expression of PD. The five higher-order domains reflect maladaptive variants of the Big 5/Five-Factor Model grounds (Trull et al., 2010). Based on revised estimates from Trull and colleagues
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or the Psychopathy-5 domains (Harkness & McNulty, 1994) and are listed here with their corresponding normal range trait in parentheses: Negative Affectivity (Neuroticism), Antagonism (inverse pole of Agreeableness), Detachment (inverse of Extraversion), Disinhibition (lack of Constraint/Conscientiousness), and Psychoticism (Openness).

Both the core interpersonal impairments and the pathological personality traits are intended to be understood as dimensional constructs and used as such in conceptualizing patients and describing them clinically. However, in addition to these dimensions, six of the diagnostic categories that have been retained are defined in terms of specific manifestations of self- and interpersonal impairments and combinations of pathological personality traits. As such, this model has been described as a hybrid, due to the fact that it seeks to blend categorical diagnoses with dimensional constructs. The retained categories include Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal. A full summary of the rationale and reasons these six were retained is beyond the scope of this chapter (see Skodol et al., 2011) and several good retrospective overviews of the process now exist (e.g., Krueger, 2013; Skodol et al., 2013; Skodol, Bender, & Morey, in press). When the specific pattern of pathological traits does not match one of the named PDs, it can be referred to as PD Trait Specified (PD-TS).

At first blush, this model may seem to be highly complex and clinically unwieldy. However, if a clinician were to ascertain the presence of significant self- and interpersonal impairments (Criterion A), rate the individual patient’s trait profile (Criterion B), and then determine, based on the patterning of each of these, whether a categorical diagnostic label is appropriate (otherwise PD-TS), it would seem to be quite straightforward. Further, given that the Section III dimensions of core personality functioning and the traits together number much fewer than the criteria in Section II, it may actually be much less cumbersome.

(2010), the range for NPD would be 0.0% to 1.0% across studies.
than a PD assessment based on past versions of the DSM.

The descriptive features of NPD in the Section III model can be found in Table 1. Several aspects of this new articulation are notable and worthy of discussion. First, the features associated with Criterion A are particular manifestations of self- and interpersonal impairment that are hypothesized to be specifically related to narcissistic pathology. Although not explicitly stated in the DSM-5, these features clearly draw from both longstanding and contemporary clinical theories of pathological narcissism (e.g., Kernberg, 2009; Kohut, 1971, 1977; Pincus et al., 2009; Ronningstam, 2011). Second, consistent with clinical theory and a growing body of scientific literature, the general description of the construct and the material in Criterion A contain references to a core vulnerability reflected in a contingent and variable self-esteem, affective dysregulation, and shifting self-concept.

The included language goes beyond descriptive vulnerability to suggest that the grandiose features are largely driven by efforts to regulate an unstable and tenuous self-image and fragile self-esteem. Although there is evidence from the basic personality literature to support these notions to some degree (e.g., see Morf & Rhodewalt, 2001; Rhodewalt et al., 1998), more clinical research is needed. Third, it is noteworthy that all of the vulnerability is officially contained in Criterion A and that Criterion B is circumscribed in its focus on grandiosity. However, the text of the manual draws the clinician’s attention to the fact that the traits of Grandiosity and Attention-Seeking can be augmented with additional traits from the Antagonism domain (e.g., Callousness, Manipulativeness) when warranted (e.g., malignant narcissism), or additional traits from the Negative Affectivity (e.g., Affective Lability) or Detachment (e.g., Withdrawal) domains if indicated. Finally, it is noteworthy that the Criterion B traits are described in what are generally static terms; whereas the Criterion A material is often cast in terms of dynamic processes that suppose a functional purpose to the behavior. I return to this issue and discuss it in more detail below.
### TABLE 1

**SUMMARY OF DSM-5 SECTION III NARCISSISTIC PERSONALITY DISORDER**

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<thead>
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<th>DSM-5 Section III Narcissistic Personality Disorder Criteria</th>
<th>General</th>
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<td>Typical features of narcissistic personality disorder include variable and vulnerable self-esteem, with self-esteem regulation through exhibitionism and seeking out approval, and grandiosity that is either overt or covert. Characteristic impairments include problems with identity, self-direction, empathy and/or intimacy, along with maladaptive traits from the Antagonism domain.</td>
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| Criterion A | Identity | Self-definition and self-esteem regulation based on others to an excessive degree; self-appraisal is exaggerated and overvalued, undervalued, or vacillates between these extremes; emotional regulation shifts with self-esteem. | 
| --- | --- | 
| Self-Direction | Sets personal goals based on gaining approval from others; standards for oneself are disproportionately high in order to support exceptional view of self, or deficient due to a sense of entitlement; lacks awareness of personal motivations. | 

| Empathy | Limited ability to recognize or identify with feelings and needs of others; social attunement is excessive, but only when relevant to self; over- or underestimates effects of behavior on others. | 

| Intimacy | Superficial relationships that are maintained largely to serve self-esteem regulation; relationships lack reciprocity due to a lack of genuine interest in others’ experiences and needs for personal gain. | 

| Criterion B | Grandiosity | Overt or covert feelings of entitlement; self-absorbed; sure of one’s own superiority; condescension toward others. | 
| --- | --- | 
| Attention-Seeking | Unreasonable efforts to attract and be the focus of others’ attention; exhibitionistic; recognition seeking. | 

*Note.* Exact wording paraphrased due to copyright (American Psychiatric Association, 2013).
Evidence for the general *DSM-5* framework has been rapidly accruing. To briefly summarize, it appears that Criterion A can be rated reliably even with very modest training (Few et al., 2013; Zimmermann et al., 2014). Also, clinician ratings of moderate or higher scores on the LPFS are both sensitive and specific to the presence of any Section II PD (Morey, Bender, & Skodol, 2013). Early work has shown that the Criterion B trait structure replicates across samples and cultures (De Fruyt et al., 2013; Fossati, Krueger, Markon, Borroni, & Maffei, in press; Krueger et al., 2012; Wright, Thomas, et al., 2012) and this extends to clinician ratings (Morey, Krueger, & Skodol, 2013). The Section III traits can account for the majority of the variance in Section II PD constructs, whether assessed via self-report (Fossati et al., in press; Hopwood, Thomas, Markon, Wright & Krueger, 2012) or interview (Few et al., 2013). Additionally, the *DSM-5* traits align with existing inventories of normal and pathological range personality traits in expectable ways (De Fruyt et al., 2013; Gore & Widiger, 2013; Thomas et al., 2013; Wright & Simms, 2014) and studies of content validity are encouraging (Anderson et al., 2013; Ashton, Lee, de Vries, Hendrickse, & Born, 2012; Fossati et al., in press; Hopwood, Schade, Krueger, Wright, & Markon, 2013; Quilty et al., 2013; Strickland, Drislane, Lucy, Krueger, & Patrick, 2013; Watson, Stasik, Ro, & Clark, 2013; Wright, Pincus, et al., 2012).

There is some initial evidence for the *DSM-5*’s approach toward narcissism, mostly in the form of survey studies mapping correlations between a variety of narcissism scales and the *DSM-5* traits. In one study, Miller, Gentile, Wilson, and Campbell (2013) examined the pattern of correlations between the PID-5 scales and latent factors of grandiosity and vulnerability, and the residual correlations controlling for PID-5 Grandiosity and Vulnerability (i.e., the *DSM-5* NPD traits). The grandiosity factor in this study drew from a variety of popular measures; whereas the vulnerability factor was mostly comprised of item parcels from Henden and Cheek’s (1997) Hypersensitive Narcissism Scale. This study found modest to moderate associations between the Grandiosity factor and most
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PID-5 scales, with the strongest relationships found among the Antagonism scales, Grandiosity, and Attention-Seeking. Virtually all of these associations were reduced to non-significance when the researchers controlled for the NPD-specific traits. In contrast, the Vulnerability factor evinced moderate to strong correlations with most PID-5 scales, with the strongest related to Negative Affectivity. Many of these associations retained their significance after researchers controlled for the NPD-specific traits.

In a separate but similar study, Wright and colleagues (2013) tested the associations between the PID-5 scales and measures with distinct conceptualizations of narcissism: the Narcissistic Personality Inventory-16 (NPI-16; Ames, Rose, & Anderson, 2006), the Personality Disorder Questionnaire NPD scale (PDQ-NPD; Hyler, 1994), and the Pathological Narcissism Inventory (PNI; Pincus et al., 2009). Both the NPI-16 and the PDQ-NPD were constructed to capture DSM conceptions of narcissism; whereas the PNI was developed to measure narcissism as defined in clinical theory and by how it typically manifests in treatment settings. The PNI has been shown to have a two-factor structure with scales for narcissistic grandiosity and vulnerability (Wright, Lukowitsky, Pincus, & Conroy, 2010). The NPI-16 and PDQ-NPD demonstrated their strongest associations with PID-5 Antagonism scales, and these remained significant and substantial at the domain level after controlling for all other domains. PNI Grandiosity similarly demonstrated its strongest associations with Antagonism scales, and the association remained significant and moderate at the domain level after controlling for all other domains. Moderate to strong relationships were observed between PNI Vulnerability and most of the PID-5 scales, with the strongest relationship being that between PNI Vulnerability and Negative Affectivity. When controlling for all other domains, the relationship to Negative Affectivity remained significant and strong; whereas Antagonism maintained a modest association with PNI Vulnerability.

Taken together, the results from these two studies actually inform the
entire *DSM-5* Section III NPD model, even though each was limited to a measure of Criterion B without Criterion A. For instance, scales that measure traditional conceptions of narcissistic grandiosity show circumscribed associations with the Antagonism domain, including strong associations with the PID-5 Grandiosity and Attention-Seeking scales. Thus, the Criterion B portion of Section III NPD seems to account for the legacy content from prior editions of the nosology (cf. Hopwood et al., 2012). Yet as noted above, the Criterion A portion of Section III NPD contains all of the content related to narcissistic vulnerability. Miller and colleagues’ (2013) Vulnerability factor and the PNI Vulnerability scale demonstrated very general associations with most scales across domains, consistent with the interpretation that these reflect manifestations of a core personality impairment. Therefore, it would seem that early analyses support the model as articulated in *DSM-5* Section III.

However, there remains a potentially arbitrary distinction between Criteria A and B in terms of where vulnerability and grandiosity are housed, and this can be problematic given that different parts of the model have different external correlates. This very issue has been brought up in the context of the broader nomological net of grandiosity and vulnerability (Miller et al., 2011). Namely, how does one integrate both aspects of the model given the fundamentally distinct trait profiles? The additional noteworthy distinction, previously mentioned, is that Criterion A is comprised of several contextualized processes that ascribe functional roles to observable behavior; whereas the Criterion B traits are described in decontextualized and static terms. This creates somewhat of a discontinuity across parts of the model, but is representative of two important tensions. First, it reflects the tension between the official psychiatric nosology that has prioritized reliability and discriminant validity over construct validity and the clinical description of pathological narcissism. Second, it captures the distinction between empirically derived trait-based models that have primarily focused on structural concerns and clinical models that emphasize dynamic processes.
Resolving these tensions in an empirically supported, but clinically meaningful way may provide the key to creating a model for NPD that reflects a coherent whole.

**Pathological Processes in a Trait Framework**

One promising way of resolving the issues brought up in the previous section is to formally integrate dynamic processes within a structural framework with a strong empirical base. Few findings in the behavioral sciences are as strong as the structure of individual differences in personality traits (i.e., the Big 5 and its maladaptive variants). Furthermore, strong evidence supports the extension of this structure to personality pathology (e.g., Markon, Krueger, & Watson, 2005; O’Connor, 2005). As such, to disregard this would leave models of personality pathology unmoored from the basic behavioral science that should serve as their anchor. However, traditional conceptualizations of personality traits have emphasized stability and cross-situational generality and thus research has prioritized studying the structure of between-person differences (Fleeson, 2012). In contrast, theories of personality pathology and pathological narcissism, in particular, which have emerged from careful clinical observation, describe the dysfunction in terms of dynamic within-person processes (Beck, Freeman, & Davis, 2004; Kernberg, 1984; Kohut, 1977; Pincus, 2005; Ronningstam, 2011). The dynamic processes that form the focus of clinical description and intervention generally involve an interaction between the afflicted individuals and the situational contexts within which their symptoms emerge (Pincus et al., 2009). As described by the material in Criterion A, the cardinal features of NPD reflect a rigid pursuit of self-enhancement goals irrespective of context (i.e., even when it would be unwise to do so), failures in self-regulation in the face of real or imagined threats to the self in the environment coupled with the use of maladaptive or counterproductive regulatory strategies, a failure to correctly
perceive interpersonal cues, and a disregard for mutual relationships.

In the past, bridging the gap between the empirically derived dimensional personality traits and the more clinically salient processes reflected in the DSM’s PD criteria would have been difficult (Benjamin, 1993). However, advances in the study of within-person fluctuation of personality states have ushered in an empirically tractable way of studying personality traits as ensembles of processes (Fleeson, 2001; Fleeson & Ghallager, 2009; Fleeson & Noftle, 2008). Investigations into the structure of personality have rigorously mapped the important orienting dimensions for the empirical study of processes. These advances, coupled with increased interest in person-situation integration (e.g., Donnellan, Lucas, & Fleeson, 2009; Fournier, Moskowitz, & Zuroff, 2008), have laid the groundwork for the pursuit of a dynamic, process-based understanding of PD that is rooted in the basic science of personality.

Several alternative theories exist that are grounded in basic personality science, while also providing articulated dynamic processes of the type that manifest in PD (e.g., Structural Analysis of Social Behavior; Benjamin, 1996; Contemporary Integrative Interpersonal Theory; Pincus, 2005). However, much of the tension in the debate over whether to adopt a dimensional trait perspective for PD has involved the trait structure of the Big Five/Five Factor Model. Factor analyses of Section II criteria appear similar to the Big Five/Five Factor Model and, therefore, this structure should provide the underlying scaffolding for the model.

Fleeson’s (2012) Whole Trait Theory does exactly that, and views the descriptive framework of personality traits as emerging from explanatory mechanisms that lead to the momentary up or down regulation of trait-relevant behavior. In this approach, personality traits reflect an ensemble of processes, which can be broken down into a series of units, including the input, intermediaries, and output. A modified version of Fleeson’s model is presented in Figure 1, to illustrate the basic approach. Inputs include external (e.g., someone
approaches on the street and begins speaking) and internal (e.g., experience of shame at the recollection of a painful memory) stimuli that provide the starting point for the process. These evoke intermediaries that include, very generally, cognitive (e.g., interpretations of stimuli), motivational (e.g., activation of goals), and self-regulatory mechanisms. Finally, as a result of these mechanisms, the output of the chain may variously be some form of external (i.e., overt behavior) or internal (e.g., covert state shift) outcome. Individual differences likely are distributed throughout the system, but the key location from a process-based perspective is in the links (i.e., large arrows in Figure 1) between inputs, intermediaries, and outputs. In other words, personality differences emerge primarily from differences in the patterning of the links in these chains. It is assumed that any chain of the type depicted here is but a part of a continuous stream of behavior and experience, and, as such, the output of one change may be the input for the next. Or, the output may evoke a response from the environment that serves as a new input, thereby creating the potential for self-fulfilling prophecies and vicious cycles (Carson, 1991).
**Figure 1. Conceptual Diagram of Basic Flow of Personality Processes Generally and Hypothetical Narcissism-Specific Examples**

Adapted from Fleeson (2012).
The general flexibility of this model is its strength and this flexibility makes it easily applicable to the description of pathological personality processes as well. To illustrate, when individuals high in grandiose entitlement are approached by a significant other asking for a favor (i.e., input), they may interpret this as burdensome and impinging on them (i.e., intermediary), which might result in an angry outburst (i.e., symptom expression), which might lead to a fight. Alternatively, the very same input, for a different individual (or the same individual in a different state) may be interpreted as an opportunity to self-enhance by demonstrating competence (i.e., intermediary) and, in such a case, the person will agree to do the favor and will be gratified by having the other rely on him or her (i.e., symptom expression). In this sense, between- and within-person differences in PD symptoms can be rearticulated using these input–intermediary–output chains. Several plausible examples related to narcissism are presented in Figure 1.

More broadly, maladaptive aspects of functioning can be infused throughout the model to achieve a very general description of pathological processes that need not be tied to specific symptoms described in the DSM, but can be flexibly adapted to individual patients. These might include functionally equating broad classes of inputs through narrow interpretive lenses (intermediary), general misconstrual of others’ behaviors (intermediary), overvalued goals (intermediary), impaired self-regulatory capacity (intermediary), limited behavioral repertoires (output), selection of behaviors mismatched to situation (output), and so on. Inputs might also be candidates for inclusion (e.g., fantasy, shameful rumination), although, in general, the hallmark of a PD is to respond in exaggerated, ineffective, or generally maladaptive ways to internal and external events that others typically can effectively manage.

The importance of context cannot be ignored, because it explains why seemingly discordant trait profiles can be integrated, while also highlighting the fact that a single trait profile is likely incapable of capturing the breadth of the
phenomenon. For instance, consider the suggestion that individuals with high levels of narcissism are “disagreeable extraverts” (Paulhus, 1998). While this may capture the zero-order relationships between grandiosity and normative traits, it suggests the integration of behaviors that put someone at odds with others with behaviors of seeking out others. What is needed is a contextualization of the behaviors, as well as recognition that under some circumstances an individual will seek to self-enhance by seeking attention and actually may be quite agreeable in those circumstances. However, over time, the individual may lose interest and fail to sustain this behavior, coming off as quite disagreeable (Paulhus, 1998). Or, should the individual’s needs for attention not be met, he or she may respond with retaliatory or punitive antagonistic behavior. However, in other situations, these individuals may respond with avoidance, if there are concerns that they may not receive the attention they desire.

Furthermore, it is very challenging for a general trait profile to capture the fact that two individuals with the same trait may behave quite differently unless one considers contextual factors. So, to stick with examples from the DSM’s constructs, the trait profile for the vulnerability in NPD may look very similar to the profile for Borderline Personality Disorder (BPD), but each may be attuned to distinct cues in the environment that evoke intense negative affect. In the case of BPD, it may be perceived withdrawal of significant others and, in the case of NPD, it might be the loss of status. Regardless of the specifics, the consideration of context allows for the integration of diverse trait profiles, as well as the distinction between similar profiles.

**TWO ILLUSTRATIVE CASE EXAMPLES**

In order to bring the complexity of narcissistic pathology to life and demonstrate the utility of Whole Trait Theory, I describe two cases that highlight the duality of experience associated with the condition. Each of these patients
vacillated between grandiose states at some times and paralyzing vulnerability at others. Although each of these cases is real, the names and some descriptive features have been changed to ensure anonymity. (For additional examples, see Pincus, Cain, & Wright, in press.)

**Mr. J**

Mr. J was a 21-year-old, undergraduate student living alone in an apartment and pursuing a degree in computer design. He presented for treatment requesting help for his “narcissistic personality.” Within the past year, he had been arrested for selling drugs and, as part of his plea bargain, he had seen a therapist who suggested that he might be narcissistic. During the time he was dealing drugs, he had adopted the persona of a colorful, but eccentric celebrity of some repute, acting as the person had been depicted in film and using a pseudonym based on the celebrity’s name. He had also gotten in considerable trouble with the university after being accused of impropriety with a female peer. As he described it, “All I did was pick her up over my shoulder and throw her on the bed. I wasn’t going to do anything else.”

An amateur bodybuilder, he would spend hours a day crafting his physique, and then post naked images of himself flexing on websites, in order to elicit comments from others about his figure. He once brought in digital prints of his artwork to show to his therapist, after which stated he would like the therapist to keep them. When the therapist agreed, Mr. J was very pleased and produced a Sharpie marker and signed the images before handing them over to the therapist. At times, his perceptions of others’ behavior and intentions appeared to be quite discrepant. For instance, he described being tortured by an attractive woman in his class who was “playing games” and “trying to mess” with him because she was interested in him. He offered as irrefutable proof the fact that she never talked to him in class and would not even say hi and, when she passed him in the hall, she did not acknowledge him.
Thus, on the one hand, many of Mr. J’s behaviors and perceptions were based on a grandiose and entitled self-view and, in the past, had landed him in considerable trouble with the authorities. On the other hand, Mr. J demonstrated several characteristics of narcissistic vulnerability as well. As part of his program of study, he described having to regularly publicly demonstrate new computer designs at the front of the classroom. He described this as intolerable, especially when he perceived his work as inferior to that of others. As he stated, “It is so shameful to have to put your work up there for everyone to look at and compare to the better projects.”

Although he attributed his living alone to the terms of his probation, the fact of the matter was that he had few friends and none that were close enough to agree to live with him. He would frequently become tearful in session as he described how lonely he was and how he could not understand why nobody wanted to be his friend. Nevertheless, he would frequently become anxious about the possibility of starting new relationships and would withdraw from others rather than risk their rejection. For example, after exchanging phone numbers with a woman and agreeing that they would hang out the next weekend, he “forgot” to turn his phone on during the whole time they could have hung out. Upon probing, he admitted he could not stand the thought that she would not call him or that she would not answer his call, and not turning on his phone seemed like a convenient excuse.

Ms. M

Ms. M was a 50-year-old, single obese female, who lived alone and was on disability support. She was intelligent and had earned a Master’s degree. However, she was underemployed and worked part-time as a video store clerk, as well as taking care of her elderly father. When Ms. M presented for therapy, she reported that she had begun compulsive binge eating around the age of 18. Before her first bariatric surgery, she had weighed over 400 pounds. Since then, she had
regained her weight, but had managed to convince a physician to give her a second bariatric surgery. She had also had other notable surgeries with physical consequences. When therapy began, she reported continuing to binge eat and thinking about food constantly. She also felt disgusted by her body and expressed chronic feelings of worthlessness. She reported being involved with a boyfriend for 2 years, but indicated he had never seen her naked and that she would never eat in front of him. She also expressed envy that the therapist (who was of normal weight) could eat anything he wanted. Overall, her initial presentation reflected intense anxiety, chronic worry, and binge eating. Ms. M also reported prior treatments for anxiety, depression, and binge eating.

However, over the course of psychotherapy, several other features of Ms. M’s thoughts, feelings, and behaviors emerged that reflected considerable narcissistic grandiosity. She often exhibited an inflated self-image, but seemed essentially unaware of it. For example, Ms. M asked for a pen and paper, indicating she would like to take notes during her sessions. Remarkably, the therapist noticed that Ms. M was only writing down what she herself said in the session, but was not recording anything that the therapist said. In another instance, despite requesting therapy for her binge-eating symptoms, she rejected the recommended manualized treatment because the manual was “not written about me specifically.” In spite of having primary caretaking responsibilities for her 90-year-old father, Ms. M had to take him to the emergency room due to life-threatening symptoms that were otherwise easily controlled by medication, because administering his pills was “too inconvenient.” In therapy she fantasized about going on the Oprah Winfrey Show to show her that “my life was worse than any of the wretched people she’s had on her show.”

Ms. M described her boyfriend as looking like a movie star, but had nothing else good to say about him. In terms of her view of the relationship, she asserted that the possibility that other women might be jealous of her was “more reinforcing than actually dating the man.” Most importantly, although Ms. M
exhibited notable eating pathology, the dysregulation that often emerges as anxiety and binging occurred in the context of her significant narcissistic personality pathology. As she put it, “I deserve to eat just as much as everyone else does. Everyone else gets to eat whatever they want, so should I.”

Ms. M and Mr. J could not only be described as having high trait levels of narcissistic grandiosity and vulnerability, but moreover they also vacillated between grandiose and vulnerable states depending on context. One could hypothesize about the contextual features and Mr. J’s and Ms. M’s internal appraisal of them, the emotions they elicited, the types of motivational structures they activated, and how these resulted in their characteristically grandiose or vulnerable behavior. A further step would be to take these patterns and ascribe functional purpose to these processes, either as self-protective or self-regulatory mechanisms. Arguably, this step is necessary for identifying targets for successful intervention and treatment.

Starting with Mr. J., he could be understood as having many classic features of narcissistic grandiosity manifested in attention-seeking, exhibitionism, haughty behavior, and an inability to take the perspective of others, along with disregard for their feelings. At the same time, he experienced considerable lack of stability in his self-esteem, which was highly contingent on the responses of others, and his affect vacillated in concert with his self-esteem. Ascribing a trait profile to Mr. J is challenging because he frequently would describe polar opposite behavior (e.g., attention-seeking, withdrawal) in session. However, if one considers traits as consistencies in dynamic processes that are necessarily contextualized, then the profile is much easier to generate. For instance, when Mr. J feels self-assured (input), he is motivated to seek attention (intermediary), and may do so in dramatic ways (e.g., posting nude photographs of himself; output). When Mr. J feels unsure and is presented with a situation in which he will be judged (e.g., in class or with a new woman; input), he is motivated to protect himself (intermediary), and he avoids the situation (e.g., “forgets” his assignment
or to turn on his phone; output). When presented with feedback that is discrepant from his wishes (e.g., a woman he likes ignores him; input), he interprets in a self-serving manner (e.g., she is “messing” with me; intermediary), and seeks confirmation (e.g., brags to therapist; output).

Next, we consider Ms. M. She initially presented as quite distressed with considerable eating pathology and seeking aid for her life-threatening symptomatology. Only through several sessions did her more characteristically grandiose features emerge. Eventually, even her eating pathology could be understood as a manifestation of her pathological narcissism. Of the dynamic processes that emerged in treatment, Ms. M described that she would often feel deprived (internal input), which would lead to an intense desire for gratification (e.g., craving for food) along with the cognition that she was deserving of gratification (intermediaries), which resulted in out-of-control eating behavior (symptom output). Like everyone, Ms. M would receive feedback that suggested she should change her behavior (e.g., reading a treatment manual; input), which, in turn, would lead her to feel threatened (e.g., output), and ultimately lead her to devalue the source of information (e.g., “this manual wasn’t written for me,” output). At other times, threatening information would be dealt with by engaging in fantasy (output).

These are but a subset of Mr. J’s and Ms. M’s actual behaviors, but hopefully the picture emerges that although there is some variability in behavior expected across situations, over the course of many scenarios, a clear signal will emerge indicative of trait narcissism. These patterns, in turn, generalize, making for behavior that is often exhibitionistic, self-serving, but also quite vulnerable at times, depending on the specific features of the environment. The intensity of behavior will vary as well, giving rise to distributions of behaviors over time (Fleeson & Noftle, 2008).

**Necessary Research**
There is a general need for more clinical research on pathological narcissism. Although there has been a great deal of interest in narcissism in the basic personality/social psychology research (Cain et al., 2008), research that is clearly relevant to the clinical constructs (Miller et al., 2011), more research is needed in clinical populations. One potential benefit of the *DSM-5* Section III model is that it may orient individuals toward studying pathological narcissism as a dimensional construct in clinical populations. It is not necessary to find limited samples of individuals who all meet the threshold for a categorical diagnosis. Rather, selecting individuals with relative elevations of narcissistic pathology or sampling across the spectrum of narcissistic pathology would be preferable.

More specifically, there is a need for research that can get at dynamic processes in an ecologically valid manner. Many of the clinical models of narcissism, including the *DSM-5* Section III model, make strong assumptions about the patterning and function of narcissistic behavior. With few exceptions, these assumptions have not been tested directly. There is a need for research designs that will get at these dynamic processes in a temporally sensitive fashion (Collins, 2006). The framework proposed here, Whole Trait Theory, was developed based on a program of research in basic personality that has done precisely this, sampling behavior from individuals intensively and repeatedly in their natural environment (Fleeson, 2001; Fleeson & Ghallager, 2009; McCabe & Fleeson, 2012). The use of daily-diary and ambulatory-assessment methodology holds incredible promise for elucidating the dynamic processes of psychopathology (Trull & Ebner-Priemer, 2013). Personality disorder researchers have adopted this general approach, although their work in this area has mostly focused on borderline symptomatology (e.g., Ebner-Priemer et al., 2007; Russell, Moskowitz, Zuroff, Sookman, & Paris, 2007; Sadikaj, Moskowitz, Russell, Zuroff, & Paris, 2013; Sadikaj, Russell, Moskowitz, & Paris, 2010; Trull et al., 2008). There have been a few investigations specifically targeting narcissistic pathology (e.g., Rhodewalt et al., 1998; Roche, Pincus, Conroy, Hyde, & Ram,
2013), but these have primarily involved student samples in which some of the most extreme behavior may be censored.

Interesting methodological questions arise when considering the types of behavior to sample from individuals at the daily or momentary levels. On the one hand, it might be most advantageous to sample normative range behavior that all individuals are likely to exhibit to some degree each day (e.g., basic emotions, interpersonal behaviors, etc.). This allows for generalizability and incorporating findings with basic personality science. In addition, given that many narcissism-specific behaviors are hypothesized to occur outside of awareness or may make individuals reluctant to endorse them, these challenges are bypassed by staying with normal range stimuli. On the other hand, some of the quintessentially narcissistic behaviors may provide important information and designs that can capture them would be advantageous. Finally, current studies of psychopathology in everyday life have relied on traditional cross-sectional assessments to select individuals. This makes good sense given the state of the field. However, given the problems with the existing diagnostic categories, future work should consider the potential for bottom-up delineation of groups or classes of individuals derived from intensive repeated measures.

**CONCLUSION**

There has been a great deal of change in the conception of the psychopathology of narcissism in the recent past and there is great potential for even more dramatic change moving forward. Specifically, increased recognition of the clinical importance of narcissistic vulnerability lead to loud calls for a shift in the diagnostic nomenclature. A proposal was offered that is generating considerable controversy, but also novel and innovative research. Although the proposed shifts address many concerns, new ones have arisen around how best to create a coherent model of pathological narcissism that integrates the empirical
structure of basic personality and the functional processes of clinical constructs. I have argued that contemporary trait theories, informed by an accumulating body of research, are indeed equal to this task. However, much research is needed to move this beyond speculation to reality.


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