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Grandiose and Vulnerable Narcissism

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Abstract

Pathological narcissism encompasses prototypical features of grandiose and vulnerable narcissism presentations which are differently associated with personality functioning and trait domain specifiers in males and females. This chapter begins with a historical review of the concept of narcissism and its evolution, from being seen as a myth to being considered an official clinical designation in the psychiatric nomenclature. It then proceeds to review the transition from categorical to dimensional models in conceptualising Narcissistic Personality Disorder (NPD), followed by an illustration of how grandiose and vulnerable expressions in males and females are captured in the new ICD-11 model of personality disorders. This is achieved through the use of preliminary research data (Day et al., in preparation; Green et al., in preparation) and six brief case descriptions, each of which contain relevant treatment considerations for clinical practice.

Keywords: Narcissistic Personality Disorder, ICD-11, pathological narcissism, personality severity, personality traits.

Introduction

Long before narcissism was conceptualised as a diagnostic and clinical entity, it was expressed in Greek myth and poetry through the characters of Narcissus and Echo (Metamorphoses; Ovid, 8AD/2000). Of Narcissus we are told that he possessed an exceptional beauty – but had scorned many suitors with his pride and self-absorption. One such suitor was the nymph Echo, who was inflamed with love for Narcissus but was cursed by the goddess

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Hera to only repeat the words of others and not speak herself. One afternoon, spying Narcissus in a forest, Echo is able to attract him to her by repeating his words from the shadows. Yet when she reaches out in embrace he recoils: “*May I die before what’s mine is yours!*” (She responds, “*what’s mine is yours!*”; lines: 359-401). Heartbroken, Echo retreats to lonely caves to live in shame until her death. Narcissus for his part, bends to quench his thirst in a nearby stream, becomes enamoured with his reflection and here, transfixed, he dies.

Inspired by this ancient myth, narcissism entered the psychological lexicon as a pathological form of self-love, first appearing in the writings of Ellis (1898) and Näcke (1899) who coined the terms “Narcismus” and “narcissus like” to illustrate auto-erotic behaviour. With further development in psychoanalytic theory, Freud (1914/1957) distinguished between a ‘primary’ narcissism of normal infantile psychological development, and a pathological ‘secondary’ narcissism by which “the libido that has been withdrawn from the external world has been directed to the ego” (p. 74). Extending these concepts, the influential theoretical models proposed by Kernberg (1975) and Kohut (1977) provided divergent nosological accounts of narcissism and painted contrasting clinical pictures. Kernberg (1975) denoted narcissism as centred around grandiosity and aggression, a pathological character which he considered to be associated with the borderline personality organisation. According to his theory, the “pathological grandiose self absorbs both real and idealised self-representations and object-representations into an unrealistically idealised concept of self” (Kernberg, 2008, p. 19). Central affects of aggression, envy and hatred dominate, which prevent the sincere investment into loving, mutual, satisfying relationships with others.

On the other hand, Kohut’s (1977) theory of narcissistic pathology reflects themes of vulnerability, shame, and depression. He describes narcissism not as a separate pathological self-structure, but as an arrested stage of normal development. Traumatic empathic failures in infancy result in the failure to internalise the idealised self-object (i.e., the caregiver) and

instead leave the individual empty, attempting to fill their internal absence with their own idealised self-representation. These different aetiological and theoretical accounts also result in different treatment tactics, with Kernberg stressing the need to systematically target the grandiose pathological narcissistic structure through techniques of clarification, confrontation and interpretation, whereas Kohut highlighted the working through of idealising and mirroring transference in the therapeutic context in order to help facilitate the internalisation of a more mature and realistic internalised object.

The extensive conceptual and clinical contributions of Kernberg (1975) and Kohut (1977) led to the narcissism's eventual inclusion in the publication of the DSM-III (American Psychiatric Association, 1980) as a diagnosable personality disorder, while ICD-10 only allowed this pattern to be diagnosed as "Other specific personality disorder" (World Health Organization, 1994). The current categorical criteria for Narcissistic Personality Disorder (NPD; DSM-5; American Psychiatric Association, 2013) state the defining core characteristics as features of grandiosity, including preoccupation with fantasies of grandeur, entitlement to special treatment, lack of empathy, excessive need for admiration and interpersonal exploitativeness. It is noteworthy that the initial versions of NPD criteria (e.g., DSM-III and DSM-III-R) acknowledged vulnerable aspects of narcissism, such as 'inferiority', 'shame' or 'humiliation', however these features were deleted in subsequent editions (Cain et al., 2008). While these changes to diagnostic criteria have been ostensibly made in an attempt to increase the precision and reliability of diagnoses by reducing overlap with other conditions, they have occurred at the expense of the true phenomenological nature of NPD (Day, et al., 2020; Levy et al., 2011).

Consequently, the clinical utility of the NPD diagnosis has been increasingly questioned, citing discrepancies such as the very wide variation in community prevalence rate of (0 – 6.2%, Stinson, et al., 2008), the mismatch between presentation rates and diagnoses

conferred in clinical practice (Karterud et al., 2011), and the inapplicability of the narrow grandiose criteria to actual clinical patients (Pincus et al., 2014). More recently, criticism of the gendered nature of the NPD criteria have also been outlined as ‘hallmark’ grandiose features are heavily weighted towards traditional masculine norms (e.g., authoritarian character style, superiority, assertiveness) which may not be representative of female patients (Green et al., 2021) who instead may be misdiagnosed with alternate ‘feminised’ conditions (e.g., borderline personality disorder; Green et al., 2023). As such, in response to this mounting criticism and growing dissatisfaction with the categorical approach to conceptualising personality disorders, a new dimensional model of classification emerged (Hopwood et al., 2018).

In 2013, the DSM-5 introduced a new dimensional model for assessing and diagnosing personality disorder termed the “Alternative DSM-5 Model for Personality Disorders” (AMPD). In this model, personality disorders are diagnosed according to Criteria A features involving impairments of self (i.e., identity, self-direction) and interpersonal functioning (i.e., empathy, intimacy) indexed according to a dimension of severity (‘No Impairment’ to ‘Extreme Impairment’). Criteria B outlines maladaptive personality traits of the ‘Big Five’ (Antagonism, Negative Affectivity, Detachment, Disinhibition, and Psychoticism). After a decade of implementation, there is a general consensus regarding the validity and reliability of the new dimensional model, as well as its clinical and prognostic utility, the degree to which it can predict psychosocial impairment and its usefulness in informing clinical management (Bach & Tracy, 2022). Regarding the diagnosis of NPD specifically, these new criteria better account for diverse narcissistic expressions with vulnerable presentations being explicitly referenced in Criteria A (e.g., “self-appraisal inflated *or deflated*”, p. 767) and through proposed specifiers referenced in the associated text for Criteria B in the domain of ‘negative affectivity’ (e.g., emotional lability, depressivity), or ‘antagonism’ (e.g., manipulativeness,

deceitfulness) for severe expressions (e.g., ‘malignant’ narcissism). However, while this alternative model is argued to be a more theoretically, clinically, and empirically useful framework (Pincus et al., 2016; Schalkwijk et al., 2021), the main criteria still privilege a narrow overt grandiosity over more vulnerable expressions.

Narcissism in the ICD-11

The new classification of the ICD-11 (World Health Organisation, 2023) similarly employs a mixed severity and trait dimension approach for assessing and diagnosing personality disorder, however in a more radical move this framework has completely dispensed with personality ‘types’ (e.g., narcissistic, paranoid, histrionic, etc) and instead personality dysfunction is conceptualised solely according to severity of personality functioning and trait domains. Similar to in the DSM-5-AMPD, clinicians first specify degree of severity from ‘no personality disorder’, personality ‘difficulty’, up to ‘mild’, ‘moderate’, ‘severe’ personality disorder. Table 1 displays examples of narcissism expressions at varying level of personality severity.

Table 1. Examples of ICD-11 severity of personality functioning for narcissism

Severity Level	
Personality Difficulty	• Similar to Mild severity description, but only intermittently or at low intensity. • Problems are insufficiently severe to cause notable disruption in various relationships. • May be limited to specific relationships or situations (e.g., narcissistic ‘reaction’ to a self-esteem threatening situation such as serious physical injury, relationship breakup or personal failure).
Mild Personality Disorder	• Particularly sensitive towards injuries to self-esteem (i.e., narcissistic injury) and may adopt a pervasive ‘martyr-like’ style. • Ability to set appropriate goals and to work towards them is compromised (e.g., narcissistic procrastination). • Difficulty persisting in face of even minor setbacks (due to underlying entitlement, dismissive devaluation of what cannot be easily achieved to protect the fragile self).

	• Minor interpersonal conflicts stemming from difficulties with authentic and empathic understanding and connection with others, but not so severe that they cause serious and long-standing disruption.
Moderate Personality Disorder	• Has a pervasive and contradictory self-view blending themes of grandiosity (e.g., individual exceptionalism) and/or vulnerability (e.g., moroseness) that is not modified by evidence to the contrary. • May persist unreasonably in pursuit of goals that have no chance of success (e.g., narcissistic vanity and perfectionism). • Exhibit little genuine interest in or efforts toward sustained employment (e.g., overt entitlement, or nihilistic devaluation). • Lack of mutually satisfying relationships because of limited ability to appreciate others' perspectives, resulting in unbalanced relationships in which the individual is highly dominant. • Relationships highly conflictual and antagonistic, and/or persistent avoidance and devaluation of others (always 'disappointed' and 'let down' in relationships by others)
Severe Personality Disorder	• The individual's self-view is very unrealistic and typically highly unstable or contradictory, with polarised extremes self-aggrandisement and/or self-loathing. • Emotional experience is dominated by envy, resentment and hatred. • Serious difficulty with regulation of self-esteem, resulting in exquisite interpersonal sensitivity to slights or unwavering despair • Relationships lack mutuality and are extremely one-sided. • Interpersonal conflict may involve serious violence, either directed towards others or towards the self via self-destructiveness. • Unwilling to sustain regular work due to entitlement (lack of interest or effort, 'parasitism'), fits of temper, and/or insubordination.

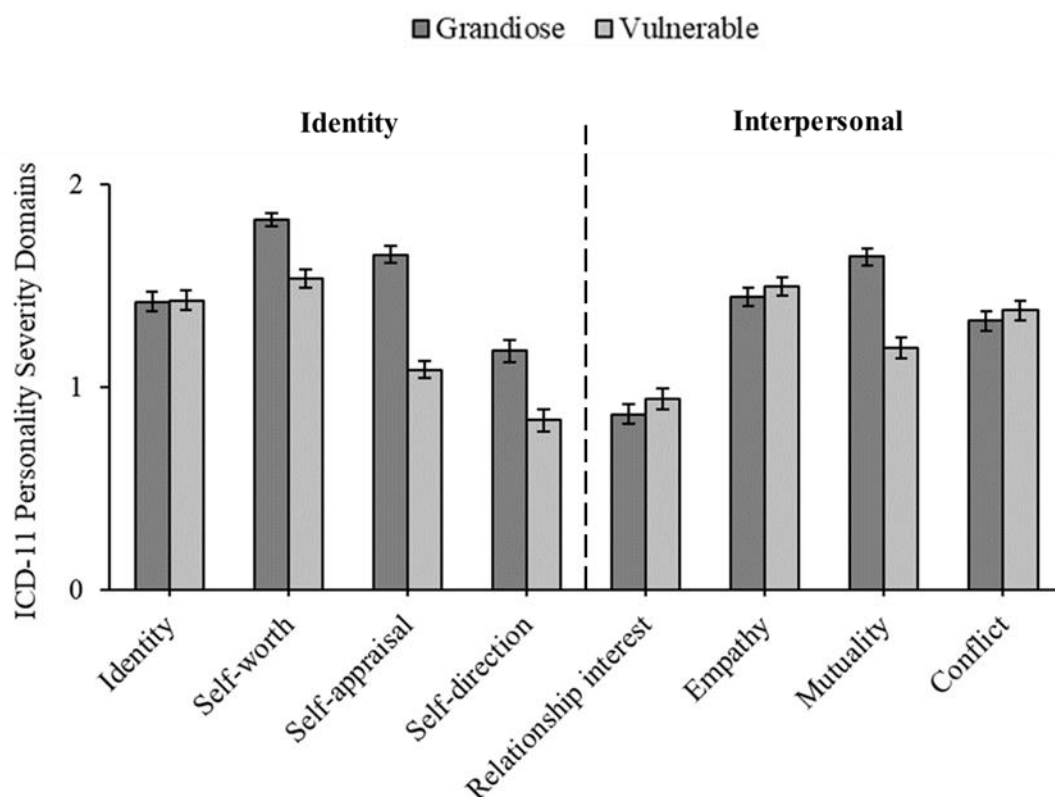
After specifying severity of personality functioning, clinicians then rate personality trait domains: negative affectivity (e.g., emotional lability, negativistic attitudes, low self-esteem, mistrustfulness), detachment (e.g., social withdrawal, emotional avoidance), dissociality (e.g., self-centeredness, lack of empathy), disinhibition (e.g., impulsivity, distractibility, irresponsibility, recklessness), and anankastia (e.g., perfectionism, emotional and behavioural constraint). Further, the ICD-11 allows for a 'borderline pattern' specifier in which individuals who meet DSM-5 BPD categorical criteria can be identified, however this addition is of more pragmatic utility (e.g., facilitating treatment funding) than clinical (Gutierrez et al., 2022).

In the following section we will outline preliminary data investigating clinician perceptions ($N = 180$) rating hypothetical patients of grandiose and vulnerable narcissism presentations through the lens of the ICD-11 (Day et al., in preparation; Green et al., in preparation).

Clinician ratings: Personality functioning

Regarding aspects of personality functioning as outlined in the ICD-11 *Clinical Descriptions and Diagnostic Requirements* guidelines, Figure 1 displays clinician ratings according to indices of ‘Identity’ (identity, self-worth, self-appraisal, and self-direction) and ‘Interpersonal’ functioning (relationship interest, empathy, mutuality and conflict) as measured by the PDS-ICD-11 (Bach et al., 2021).

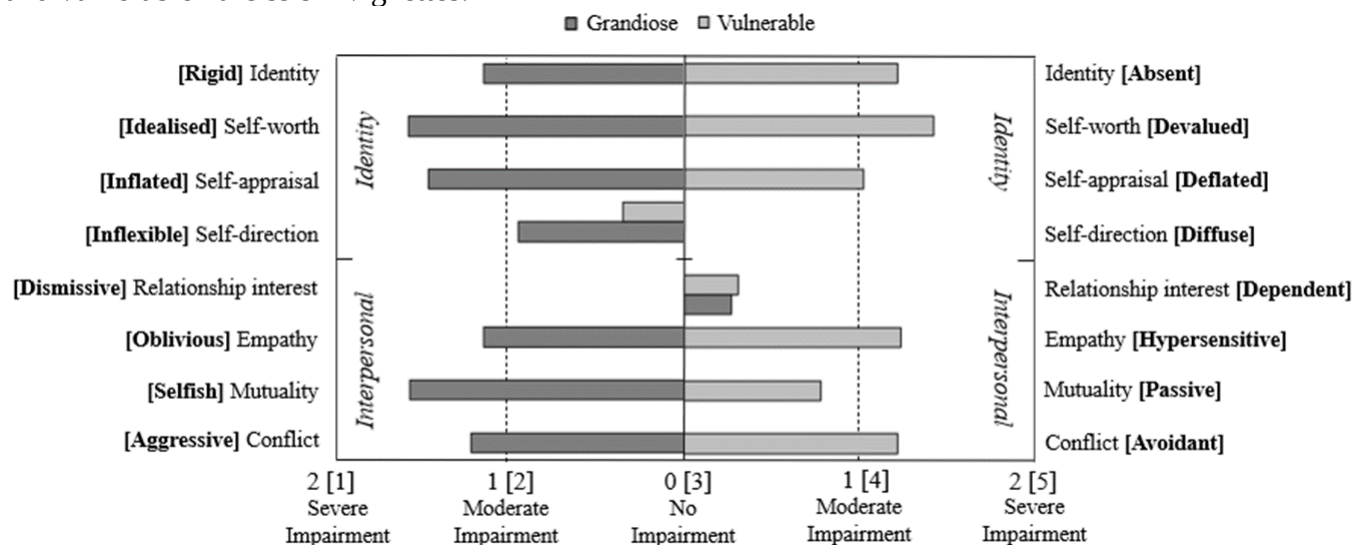
Figure 1. Clinician ratings of grandiose and vulnerable narcissism vignettes according to ICD-11 aspects of personality functioning.



Note. Scale is from 0 (No Impairment) to 2 (Severe Impairment).

While some differences are observed with grandiosity being more severe in a few specific aspects (e.g., self-worth, self-appraisal), overall global impairments in functioning averaged across all personality aspects are roughly equivalent for both grandiose ($M = 2.4$, $SD = 0.3$) and vulnerable ($M = 2.2$, $SD = 0.4$) expressions. Instead, the clearest distinction emerges when the *direction* of impairment in functioning is considered. For instance, the ‘Identity’ personality aspect can be scored as ‘severe’ relating to either: 1. A rigid, fixed, inflexible identity *OR* 2. An unstable, diffuse, contradictory identity. While both are severe manifestations of identity dysfunction, there are significant differences in the way they are expressed. Differential direction of each of these personality aspects between grandiose and vulnerable expression is displayed in Figure 2 and summarised in Table 2.

Figure 2. Divergent clinician rating patterns of personality functioning between grandiose and vulnerable narcissism vignettes.



Note. Title brackets reflect the manifestation of extreme bipolar expression for each aspect. Scale brackets display the re-coded scores used to capture directionality of impairment.

Table 2. Summary of divergent manifestations of narcissistic expression as indexed by ICD-11 personality functioning aspects.

Personality functioning	Grandiose Expression	Vulnerable Expression
<i>Identity</i>	Inflexible, rigid identity in conviction of a grandiose self	Feels empty, lack of identity, oscillating and contradictory view of self

<i>Self-worth</i>	Feels superior, devalues others, haughty, arrogant	Feels worthless, incompetent, humiliated, shamed
<i>Self-appraisal</i>	Believes has no weaknesses, minimises personal failings. Vulnerabilities are projected onto others who are subsequently devalued	Relentlessly self-critical, anticipates others to be similarly critical. Fantasy of ideal, omnipotent self sharply contrasts with actual self
<i>Self-direction</i>	Sets unrealistically high expectations consistent with grandiose expectations, entitled expectation of achieving goals without commensurate effort	Sets unrealistically high expectations that confirm incompetence, uses inability to achieve as justification for entitlement and lack of effort
<i>Relationship interest</i>	Extraverted yet detached, superficial relationships. Acutely devaluing of others yet conflictually dependent for purposes of self-esteem regulation	Needy in relationships yet withdrawn and ambivalent, superficially idealising of others yet chronically devaluing and dismissing
<i>Empathy</i>	Dismissive of thoughts and feelings of others, unwilling to authentically engage with alternative perspectives	Preoccupied with thoughts and opinions of others, but only as relating to the self
<i>Mutuality</i>	Selfish in relationships with others, instrumental in using relationships to bolster self-esteem needs and personal satisfaction	Dependent and passive in relationships, yet resentful and antagonistic of this perceived chronic victimhood
<i>Conflict</i>	Highly conflictual, antagonistic style of relating, regular intense disagreements with others	Avoids direct conflicts with others, chronic passive-aggressive and hostile ways of relating

Clinician ratings: Personality traits

Regarding personality traits, the frequency of endorsed trait domains is displayed in Table 3. Hypothetical patients with prototypical vulnerable features were identified as displaying predominantly Negative Affectivity² (94%) and Detachment (72%) features. Hypothetical patients with prototypical grandiosity were identified as displaying a single dominant feature of Dissociality (91%). While Disinhibition was not particularly high for either expression, it was markedly higher in the grandiose vignette (43%) compared to the vulnerable

² Preliminary data by Green et al. (in preparation) suggest that male clinicians rating female patients are more likely to attribute negative affect to the patient ($M = 1.00$, $SE = .00$) compared to male clinicians rating male patients ($M = .69$, $SE = .06$) with identical symptomatology. It is important for clinicians to be cautious not to over-diagnose or under-diagnose certain trait manifestations in male and female patients due to potential gender stereotypes.

vignette (4%). Interestingly, Anankastia was identified by approximately half of clinicians and roughly equivalent across both expressions (grandiose 58%, vulnerable 53%). Table 2 displays the personality trait domains and sub-facets associated with grandiose and vulnerable narcissistic expressions.

Table 3. Endorsed personality trait domains and facets for hypothetical patients with grandiose and vulnerable narcissistic expressions.

	Grandiose (<i>N</i> = 168)	Vulnerable (<i>N</i> = 161)
Negative affectivity	31.5%	94.4%
Emotional lability	27.4%	21.1%
Depressivity	5.4%	88.8%
Anxiousness	7.1%	79.5%
Detachment	32.7%	72.0%
Social withdrawal	6.5%	54.0%
Intimacy avoidance	31.5%	44.1%
Restricted affectivity	16.1%	34.2%
Dissociality	91.1%	12.4%
Manipulativeness	60.1%	3.1%
Grandiosity	89.9%	5.0%
Hostility	64.3%	7.5%
Disinhibition	43.5%	4.3%
Irresponsibility	32.1%	1.2%
Impulsivity	28.0%	3.7%
Distractibility	4.2%	2.5%
Anankastia	58.3%	52.8%
Orderliness	1.8%	4.3%
Rigidity	44.0%	19.3%
Perfectionism	44.6%	49.1%

These findings are consistent with proposals by Bach and First (2018) whereby grandiose narcissism is essentially characterised by Dissociality and vulnerable narcissism is

largely characterised Negative Affectivity, a proposal that has been supported by a review of empirical evidence examining key traits related to traditional personality ‘types’ (Simon et al., 2023). As outlined in the ICD-11, relevant features of Dissociality for narcissism include: a sense of entitlement and automatic assumption of compliance with wishes for favourable treatment, expectation of admiration from others, aggressivity and devaluation of others when admiration and attention is not given, grandiose fantasy and striving. For Negative Affectivity, features may include: envy of others abilities and resentment of others success, ruminating over personal shortcomings/mistakes or over interpersonal threats/slights/insults, and interpersonal hypersensitivity to criticism and setbacks. Anankastia may be differentially associated as features of vanity and perfectionism may be associated with grandiose self-representations, whereas features of self-criticism and shame related to vulnerable states may be in response to setting unrealistically high standards (Fjermestad-Noll et al., 2020). In terms of gender differences in the behavioural expressions of trait domains, the ICD-11 states that elevations on Negative Affectivity are more common in women, and elevations on Dissociality and Disinhibition are more common among men (WHO, 2022, p.15). These patterns converge with longstanding gender differences in narcissistic presentations, where males are significantly more likely to exhibit grandiose narcissism (Dissociality/Antagonism) and females are more likely to endorse vulnerable narcissism (Negative Affectivity; Riegel et al., 2023).

These results provide a snapshot of how the ICD-11 captures prototypical narcissistic subtypes through personality functioning and trait dimensions and demonstrates its ability to robustly capture diverse manifestations of personality. The following section will outline six brief case descriptions which vary in both expression (‘grandiose’ and ‘vulnerable’), severity (‘mild’, ‘moderate’, ‘severe’) and trait domains in male and female patients, highlighting relevant treatment considerations for each case.

Case presentations

Personality Severity: Mild

Case #1

Mrs C, a 38yr old moderately successful artist, enters therapy due to a prolonged depressive episode and creative dry spell. She describes herself as a ‘passionate’ person, with wild mood swings that are unpredictable and frightening, but also make her feel powerful and alive. She typically channels this emotion into her art, but also admits that her moods often cause issues in her relationships. She has been married multiple times, with her current marriage on the rocks. Her pattern in relationships is to fall wildly in love, only to become increasingly disillusioned and bored, until the relationship dissolves. When in the midst of a depressive episode she can completely self-isolate, spending her time obsessively pacing, ruminating about what others think of her and growing increasingly self-critical. Her recent depressive episode followed attending an art exhibition of her younger colleague who has found sudden commercial success. In the session, Mrs C talks about how proud and impressed she is of her colleague in a way that seems “over the top”, with her voice becoming unnaturally high pitched and smiling in a forced way. Other times, she feels that she works harder than others but is an unrecognised talent, yet at the same time derives a sense of superiority and satisfaction from not “selling out” like a lot of her colleagues. In her current creative block, she says she can’t seem to make any progress on her great project ideas because she cannot replicate the perfection of the image she has in her mind. She views the therapist as someone who might be able to help her, but also is worried that they may shamefully expose her as a fraud.

Personality Disorder Severity

	None	Difficulty	Mild	Moderate	Severe
			X		

Personality Trait Domains

	Negative Affectivity	☒	Detachment	☒	Dissociality	☐	Disinhibition	☐	Anankastia	☒
Facets	Emotional lability	☒	Social withdrawal	☒	Manipulativeness	☐	Irresponsibility	☐	Orderliness	☐
	Depressivity	☒	Intimacy avoidance	☐	Grandiosity	☐	Impulsivity	☐	Rigidity	☐
	Anxiousness	☒	Restricted affectivity	☐	Hostility	☐	Distractibility	☐	Perfectionism	☒

Case discussion: There are a number of features that indicate Mrs C to be a relatively high functioning case. She appears sincerely invested into her occupation and to have achieved some success with this, she is able at times to ‘transform’ her intense emotional cascades into productive and creative endeavours, and, despite conflict, she has meaningful and intimate relationships with others. However, she also has an unstable and contradictory sense of her identity and self-worth, swinging between seeming omni-potence and dejection. While she seems to have a clear sense of her goals and life direction, there also appears to be some

elements of self-sabotage in her behaviour. Similarly, her relationships with others appear highly unstable and ambivalent, oscillating between (idealised) passionate love and (devalued) disinterested boredom. In treatment, it may be helpful to focus on the causes of her depressive episodes and relationship ruptures as related to her underlying grandiose fantasies of an idealised perfect love or unlimited power or success. A focus on her emotional experience will also be crucial, as it is likely that she has intense negative feelings towards others (e.g., aggression, envy, rage) which she keeps out of her awareness via relentless perfectionistic self-criticism. Exploring her self-sabotaging behaviours as a way to avoid relinquishing her grandiose ideals and fantasies may also be an important topic to explore. In the therapeutic alliance, Mrs C is likely to heavily idealise the therapist initially as the “expert” however may abruptly become disillusioned and withdrawn over time. Exploring Mrs C’s expectation that the therapist will use their elevated position of power to make her feel bad and humiliate her may be fruitful as a way to explore Mrs C’s own hostile and envious feeling. The therapist being accepting and empathising with of Mrs C’s destructive attitudes and behaviours may help to ‘detoxify’ her normal limitations and weaknesses and allow her to tolerate them without collapsing into self-loathing.

Case #2

Mr E is a 32yr old man who enters therapy on the recommendation from his GP due to his longstanding restlessness and difficulty sleeping. Mr E appears to have a stable sense of superiority and self-confidence, and also strikes the therapist as very friendly and charming, with a scruffy boyishness that is endearing. While Mr E references a very broad friendship circle and lively social life, he isn’t able to describe any particular relationship with depth or meaning. He describes his friendships as constantly shifting, particularly as in the last few years a lot of his longer-term friends have married, bought houses and had children, whereas he has not. Mr E tells the therapist that he is seen as the “shallow” one in his friendship group and that he has been told by many people that he doesn’t listen well or seem interested in their conversations. He also describes many business ventures he is currently working on, but speaks in an overly vague and technical way that prevents the therapist from having a detailed understanding. While on first impression, he implies his businesses are very profitable and successful, after questioning he reveals he has lost the vast amount of profit on gambling, partying and impulsive business ‘pivots’ that have been disastrous. When discussing these failures, Mr E minimises their severity and true impact, and instead presents them as entertaining stories. In general, while the therapist feels that the treatment is “going well” and that there is a good rapport with Mr E, they feel slightly uneasy that there is a lack of meaningful progress being made. On closer inspection, the therapist realises that Mr E routinely diverts the therapy away from emotionally salient content through pithy statements (“that’s just the way it goes”) or by making jokes. His overall attitude appears very unserious and relaxed, instead appearing to spend the sessions attempting to entertain the therapist and treating them like his friend, rather than his treatment provider.

Personality disorder severity					
	None	Difficulty	Mild	Moderate	Severe
			X		

	Personality Trait Domains									
	Negative Affectivity	☐	Detachment	☒	Dissociality	☒	Disinhibition	☒	Anankastia	☐
Facets	Emotional lability	☐	Social withdrawal	☐	Manipulativeness	☐	Irresponsibility	☒	Orderliness	☐
	Depressivity	☐	Intimacy avoidance	☒	Grandiosity	☒	Impulsivity	☐	Rigidity	☐
	Anxiousness	☐	Restricted affectivity	☐	Hostility	☐	Distractibility	☒	Perfectionism	☐

Case discussion: In Mr E's case it may be quite difficult to gain an accurate, objective picture of his functioning due to his habitual dismissive and avoidant style that defends against exploring any topic that may threaten his fragile grandiosity. While he may seem to have a robust, healthy identity, self-esteem, occupation and social life at a surface level, closer examination reveals it to be superficial and contradictory. The therapist's task is to take notice of moments when they feel confused, if they feel their questions aren't being answered or if they feel like they are being 'maneuvered' away from probing deeper into certain topics. With patients like Mr E, it will be helpful to focus on tangible, objective elements (e.g., his physical symptoms) as a 'way in' to talking about his emotional life. Similarly, it will be crucial to come to an agreement with Mr E about some explicit, concrete goals and topics he would like to focus on that have an objectively negative impact on his life in order to structure the treatment (e.g., his financial irresponsibility). It is a good sign that Mr E is aware of his impact on others and the way they perceive him, however it will be important to explore with him how he feels about being seen as 'shallow' by others and to ascertain his willingness and desire to change these behaviours. Managing countertransference with Mr E will be a challenging balancing act for the therapist. On the one hand they may be 'seduced' into colluding with his denial and

minimisation of issues in his life and instead prolong a friendly, if aimless, treatment. On the other hand, they may become suddenly irritated by his constant diversion and have an impulse to adopt a strict, authoritarian attitude to ‘wake him up’ to his problems. Despite his style of presentation, the therapist needs to hold in their mind that he is likely exquisitely interpersonally and emotionally sensitive and so in the initial stages they should tolerate the parameters of the therapy as Mr E has constructed it (i.e., as ‘friends’). Over time the therapist can introduce a more realistic and appropriate treatment frame.

Personality Severity: Moderate

Case #3

Ms P, a 47yr old business executive, presents for treatment at the request of her HR department due to a recent incident at work where she destroyed a colleague’s property in a fit of rage. She speaks in a clipped, matter of fact way with the therapist, and states that she only agreed to attend the treatment after thoroughly investigating their credentials and was surprised by the therapist's impressive status. When speaking about her work, she speaks in a generally devaluing and dismissive way towards her subordinates, but becomes particularly enraged when talking about her immediate superiors. She states that having to take orders from those who are so clearly incompetent makes her feel “physically violated”. In contrast, she talks about the CEO in an extremely magnanimous way, suddenly appearing quite coy and simpering. She describes no social life beyond obligatory work functions, and has had only one or two short lived romantic relationships. In the treatment she is punctual and seemingly actively participates in the content of the sessions, however the therapist suspects she is simmering with underlying resentment. She tells the therapist she is looking for a “quick fix”, that she won’t tolerate anything but the best, and that the therapist's “reputation is on the line” if they are dissatisfied with the treatment or outcome. In the treatment the therapist often feels unable to gain control of the sessions, feels intimidated and is sometimes tempted to highlight their own achievements in order to gain admiration and respect from Ms P. At other times the therapist is disturbed by their fantasy to point out harshly to Ms P all the areas in her life that she is failing, in order to forcefully assert their status as the professional and her status as the patient.

Personality Disorder Severity

	None	Difficulty	Mild	Moderate	Severe
				X	

Personality Trait Domains

	Negative Affectivity	☐	Detachment	☒	Dissociality	☒	Disinhibition	☐	Anankastia	☒
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Facets	Emotional lability	☐	Social withdrawal	☒	Manipulativeness	☐	Irresponsibility	☐	Orderliness	☒
	Depressivity	☐	Intimacy avoidance	☒	Grandiosity	☒	Impulsivity	☐	Rigidity	☒

	Anxiousness	☐	Restricted affectivity	☐	Hostility	☒	Distractibility	☐	Perfectionism	☒
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Case discussion: In terms of key areas of functioning, Ms P's identity appears unnuanced, rigid and grandiose. Similarly, her relationships with others appear either completely absent, unrealistically polarised or highly conflictual. While Ms P does appear to have quite a successful, high-status job that she is authentically invested in, her recent behaviour appears to be now putting this at risk. While the threat of her losing her job may be sufficient to motivate her to attend treatment, the fact that she has been coerced into attending will surely impact her motivation for exploring and engaging in behaviour change. While supportive interventions (e.g., empathising, comforting, sympathising) may be a therapist's typical tactic to boost motivation and foster the therapeutic alliance, for patients like Ms P such interventions may be seen as humiliating, patronising and even as evidence of the therapist's own pathetic 'softness'. Instead, a direct matter of fact approach may be more useful, however the therapist may similarly need to be careful to avoid evoking a power struggle for dominance in this instance. In the initial stages of the treatment the focus should be on identifying the *presence* of dysfunction (i.e., conflict with others, uncontrolled rage) and its consequences, rather than its cause, as Ms P likely has strong externalised explanations that the therapist is best to avoid confronting directly at the outset. While Ms P heavily idealises the therapist through commenting on their expertise and qualifications, the therapist should beware of colluding with this idealisation by putting on airs and attempting to be a 'perfect professional' (an impossible task). Instead, this idealisation should be recognised as her attempt to tolerate the humiliation of having to attend the sessions, and her effort to deny her underlying rage and resentment. Instead, the therapist should be intentionally normal, human, naïvely curious, and demonstrate a complete willingness to explore the resultant hostile and devaluing reactions when the therapist fails to meet Ms P's grandiose expectations. The therapist will need to be strong

enough in their own professional identity to ‘metabolise’ these intense negative projections without either dismissing or succumbing to them, and in doing so will demonstrate to Ms P an ability to acknowledge imperfection and personal limitations without being overwhelmed and destroyed by them (a capacity that Ms P herself lacks).

Case #4

Mr L, a 24yr old male, was referred by their previous therapist who, after a lengthy treatment which appeared to have no impact, suspects that there may be complicating ‘personality factors’. Often referring to himself as a “loser”, all of Mr L’s self-descriptions are persistently negative, harsh and self-critical. When reflecting on his difficulties, he often references his younger years as a time that was “golden” or “perfect”. Mr L graduated high school at the top of his class and demonstrated a lot of promise when he first attended university, however as maintaining his high grades became less and less “easy” for him and required his effort and investment, he stagnated, has deferred his classes, and is now considering dropping out altogether. It is during this time that Mr L began seeking psychotherapy to try and find a “reason” for his difficulty. Over the years he has gathered multiple diagnoses including Attention Deficit Hyperactivity Disorder, Major Depressive Disorder (now Persistent Depressive Disorder) and Generalised Anxiety Disorder. Currently, Mr L also suspects he has an underlying Autism Spectrum Disorder. Mr L describes his parents as extremely controlling and critical, who praised him for his initial achievements but are now open about their profound disappointment in his lack of academic achievement. During sessions, Mr L often discusses how resentful he feels about his peers, expressing indignation that “everyone else has it easy” whereas he has to struggle in everything he does. The therapist is often irritated by Mr L’s constant whining, and finds it difficult to extend an authentic sense of empathy towards him. Despite claiming to be doing everything he can to regain his wellbeing, Mr L’s day-to-day appears to consist mainly of playing video games and smoking marijuana in complete isolation from others. In the treatment, Mr L extensively idealises the therapist verbally however the therapist feels he does not actually pay attention to much of what they say, with every week Mr L saying he “can’t remember” the content of the previous week’s session. Mr L often states that he will simply kill himself if he is still feeling this way by his 25th birthday, the therapist often feels that they are letting Mr L down and that he needs a more specialised care than they have to offer.

Personality Disorder Severity

	None	Difficulty	Mild	Moderate	Severe
				X	

Personality Trait Domains

Negative Affectivity	☒	Detachment	☒	Dissociality	☐	Disinhibition	☒	Anankastia	☐
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Facets	Emotional lability	☐	Social withdrawal	☒	Manipulativeness	☐	Irresponsibility	☒	Orderliness	☐
	Depressivity	☒	Intimacy avoidance	☐	Grandiosity	☐	Impulsivity	☐	Rigidity	☐
	Anxiousness	☒	Restricted affectivity	☐	Hostility	☐	Distractibility	☒	Perfectionism	☐

Case discussion: Mr L suffers significant impairment in virtually all areas of functioning. His identity, self-esteem and self-perception is un-nuanced, unwaveringly negative and manifestly self-critical (yet conceals an underlying grandiose entitlement). He appears to be perpetually withdrawn and isolated with no meaningful relationships, and he seems to have no meaningful direction or ambition for his life. However, Mr L's current level of functioning also appears particularly at odds with what seems like a quite high intellectual capacity. While Mr L certainly has a persecutory internal monologue, supportive interventions from the therapist may not disarm his persistent self-criticism (as it might with a patient with a different personality configuration), instead expressions of concern and sympathy may simply be passively absorbed into a meta-narrative of personal victimhood, entitlement and grandiosity. Similarly, teaching skills, techniques and engaging in activities to improve functioning (e.g., behavioural activation) may simply provide endless opportunities for Mr L to demonstrate his failure to improve and to confirm his 'brokenness' (and need for special treatment). As such, the initial focus when working with Mr L should be exploring the 'secondary gain' of his illness by which he is caught between two opposing forces: 1. his objective suffering and feelings of worthlessness, and 2. the benefits conferred by his 'sick' role and that sap his motivation for change. The diagnostic confusion should be reconciled, with Mr L being provided with a primary diagnosis of 'personality disorder' and shifting away from the myriad of alternate diagnostic labels. Explicit and careful contracting should be conducted with Mr L about the goals of the treatment and gaining his explicit agreement regarding *his role* in therapy. However, in doing so the therapist needs to be wary of enacting the harsh, critical and demanding object that Mr L reports his parents to be (and that Mr L seems to have internalised) and to maintain a sense of compassion and empathy for his plight and suffering. The suicide threat should also be discussed and explored, as therapist may want to privately reflect on their own anxiety and corresponding pressure they may feel to 'do something' to help Mr L in

response to this threat (which is contrasted with Mr L's seemingly laissez-faire and resigned attitude towards it).

Personality Severity: Severe

Case #5

Mr W, 32yrs old, enters therapy following an ultimatum by his girlfriend that if he doesn't get help to manage his aggression she will leave him. This is following a recent argument where he smashed up a whole room and threw objects at her trying to get her to admit that she has been unfaithful to him. Despite this, Mr W openly admits to his own infidelity, and appears unconcerned and dismissive when the therapist raises this contradiction, stating that he feels he should be "free to do whatever he wants". He does admit that he easily loses his temper and appears to be regularly in some kind of physical fight – he currently has a broken nose from his last altercation and becomes particularly animated when describing the violence of his last fight. Mr W states that he can "read people like a book" and when he suspects that someone is out to get him he will always throw the first punch. While Mr W is vague about his job and income, it is clear that he is engaged in some light to moderate criminal behaviour. When the therapist raises concern over being paid with money gained illegally Mr W laughs dismissively and attempts to soothe the therapist by saying the treatment is being paid for by his girlfriend, as she pays for all of his expenses such as rent, groceries and the like. It eventually becomes clear to the therapist that Mr W has no intention of actually engaging in meaningful psychotherapy, and instead views it as a sort of interesting 'game' whereby he can placate his girlfriend, as well as a means to make some easy money – as he further inquires about the possibility of receiving financial benefits for his mental illness. When the therapist raises their concerns and the threat this poses to treatment Mr W is utterly perplexed why they would want to ruin this "win-win" situation. The therapist feels 'dirty' and corrupted by being roped into this exploitation and states to Mr W that they will not participate in this ruse, at this point Mr W becomes extremely cold and tells the therapist they will deeply regret it if they do not continue to offer appointments. The therapist feels very afraid of Mr W and his unpredictability.

Personality Disorder Severity

	None	Difficulty	Mild	Moderate	Severe
					X

Personality Trait Domains

Negative Affectivity	☒	Detachment	☒	Dissociality	☒	Disinhibition	☒	Anankastia	☐
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Facets	Emotional lability	☒	Social withdrawal	☐	Manipulativeness	☒	Irresponsibility	☒	Orderliness	☐
	Depressivity	☐	Intimacy avoidance	☒	Grandiosity	☐	Impulsivity	☒	Rigidity	☐
	Anxiousness	☐	Restricted affectivity	☒	Hostility	☒	Distractibility	☐	Perfectionism	☐

Case discussion: Mr W is a severe case, with profound impairments in both self and interpersonal functioning. His relationships appear to be dominated by themes of entitlement,

hatred and violence, whereby he seeks to dominate and control (devalued) others for personal gain. For Mr W *all* relationships are parasitic and exploitative, and even with the therapist he assumes that a stable arrangement is one of mutual exploitation (the ‘win-win’ scenario) and appears unable to conceive the therapist’s objection to utilising the treatment in this way. As such, prognosis for Mr W is very guarded. If the therapist were willing to attempt to engage in psychotherapy with Mr W, there would have to be an extensive and detailed contracting phase where they establish appropriate conditions. This would involve things such as practical threats to the treatment (e.g., Mr W’s criminal activity that may land him in prison, thus making treatment impossible), interpersonal elements (e.g., the therapist cannot possibly help Mr W while simultaneously being coerced and threatened by him), the therapists’ ethical obligations (e.g., if he becomes aware of a legitimate risk of harm to someone else he may be required to contact authorities), and outlining that the treatment cannot be in the service of continued pathology (e.g., his desire to use his mental illness for purposes of financial exploitation). There is no guarantee that Mr W would be interested to pursue a treatment within such parameters, however there are some elements that indicate he may be willing to try. The fact that he attended the treatment as the behest of his girlfriend who threatened to break up with him indicates that this may be a real-life consequence that may foster motivation. Similarly, while he clearly gains some sadistic satisfaction in his violent encounters with others, he may also tire of the associated perpetual paranoia (e.g., his belief that his girlfriend is unfaithful, or his needing to be on edge that others are “out to get him”). In the treatment, the therapist will need to have an attitude of incorruptibility, uncompromising honesty, and seek to be a consistent non-punitive, non-exploitable object. They should attempt to avoid appearing emotionally invested in Mr W’s change, as this may provoke a destructive self-sabotage in order for Mr W to demonstrate the therapist’s impotence. Motivation for treatment should focus on practical

consequences (e.g., prison, safety, relationships), rather than empathy-based or moralist motivations which are likely to be dismissed.

Case #6

Mrs Y is a widowed, 52-year-old woman with a history of insulin-dependent diabetes. She often “forgets” to administer her insulin, which has resulted in multiple hospitalisations and related health complications. Mrs Y’s behaviour on the ward often vacillates wildly between rageful shouting, throwing things at staff and claiming it is their fault that she is unwell, or becoming extremely sullen, morose and threatening to kill herself when she is discharged. During these dysphoric states Mrs Y will become tearful and laments her lost life where she claims to have been an internationally recognised and bestselling author. She claims that she has her next book ready to publish once she is discharged, which she believes will have a “bigger cultural impact on the world than the bible”. She similarly grieves the passing of her husband who she describes as an “angel” but whom she also frequently discloses his historical abuse of her. Mrs Y also claims to have been neglected and intentionally mistreated by staff at a different hospital and expresses her belief that the current hospital staff are colluding to have her transferred to the other hospital for further mistreatment. As a result, most staff avoid dealing with her whenever possible. One exception to this is her endocrinologist Dr T, a male physician at the hospital, whom Mrs Y always requests to have consults with when she is an inpatient. She will often proclaim loudly what a “beautiful man” he is to other staff members and patients. Mrs Y often appears very girlish and coy in Dr T’s presence and makes inappropriate remarks such as that she will manage her insulin properly if he will just “give her a kiss”. Dr T often feels profoundly uncomfortable when attending to Mrs Y, and on one occasion suspects her of intentionally indecently exposing herself to him. Mrs Y has multiple open wounds exacerbated by her illness that require treating by staff to prevent infection, and at times the staff suspect that she gains some gratification in seeing them visibly recoil at her chronic self-neglect. While Mrs Y often talks about her suicidal ideation, sometimes she will also add that her fantasy is to kill everyone in the hospital first before killing herself, stated with apparent glee.

Personality Disorder Severity

	None	Difficulty	Mild	Moderate	Severe
					X

Personality Trait Domains

Negative Affectivity	☒	Detachment	☐	Dissociality	☒	Disinhibition	☒	Anankastia	☐
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Facets	Emotional lability	☒	Social withdrawal	☐	Manipulativeness	☒	Irresponsibility	☒	Orderliness	☐
	Depressivity	☒	Intimacy avoidance	☐	Grandiosity	☒	Impulsivity	☐	Rigidity	☐
	Anxiousness	☒	Restricted affectivity	☐	Hostility	☒	Distractibility	☐	Perfectionism	☐

Case discussion: Mrs Y is severely unwell, with both intersecting and complicating personality and physical ailments. Her identity appears highly diffuse, chaotic, contradictory and her relationships with others are dominated by either rageful antagonism, fearful paranoia, or

idealisation (eroticised, in the case of Dr T). While Mrs Y may at times require medical interventions due to her diabetes, admissions to hospital should be short, focused on her medical needs, with longer inpatient stays avoided as this would likely result in her further psychological decompensation. As an inpatient, Mrs Y appears able to freely indulge in her grandiose fantasy of being the world-renowned author (who has unlimited success just around the corner), however this likely contrasts severely and painfully with her actual experience in the real world. As such, her ambivalent, fearful dependency on the hospital service likely parallels her relationship with her late husband (who was both “angel” and abuser). Her related paranoid conviction of the service’s persecutory behaviour towards her (and her resultant antagonistic hostile reactions) demonstrate how her relationships with others are infused with both fear and rage. As such, Mrs Y appears trapped in sadistic-masochistic cycles whereby she is able to use her own self-destruction as a means to counter-attack (and perhaps ‘triumph’) over the clinicians who are attempting to help her, while also facilitating a retreat into grandiosity. As such, supporting the staffing team’s wellbeing is critical in cases like this, with the crucial need to provide regular opportunities for debriefing and supervision to avoid acting out negative transference reactions. Staff may need to work hard to maintain compassion, set appropriate limits on inappropriate behaviour, and strive to deliver consistent, non-discriminatory treatment. Otherwise, they are likely to be pulled into enacting being the exploitative, abusive object that Mrs Y claims of the other hospital staff (also her late husband). Every effort should be made to link Mrs Y with a therapist in the community who will be more able and equipped to help explore her difficulties and support her wellbeing. Any such therapist should actively collaborate with both the hospital health staff and Mrs Y herself in order to form a unified contract and treatment plan that addresses these repeated hospital presentations and understand and explore their underlying motivations. If successful, the therapist will be able to work with Mrs Y to foster greater self-reflection, develop a more realistic and integrated

sense of self, and promote agency for positive behaviour change. Through their work together Mrs Y will hopefully be able to gain insight into her experiences and impulses, and with effort regulate them (as opposed to acting them out within the hospital system/staff).

Conclusion

The presentation of narcissistic grandiosity and vulnerability (or a fluctuation between the two) in males and females can greatly influence the therapeutic situation, regarding assessment, countertransference, and treatment tactics. This chapter has offered an insight into the applicability of the new ICD-11 model, in terms of its ability to effectively capture diverse manifestations of narcissism through personality functioning and trait dimensions. It is hoped that the clinical case descriptions and proposed treatment approaches will aid the assessment and treatment of pathological narcissism in clinical practice.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*: DSM-5.
- Bach, B., Brown, T. A., Mulder, R. T., Newton-Howes, G., Simonsen, E., & Sellbom, M. (2021). Development and initial evaluation of the ICD-11 personality disorder severity scale: PDS-ICD-11. *Personal Ment Health*, 15(3), 223-236. <https://doi.org/10.1002/pmh.1510>
- Bach, B., & First, M. B. (2018). Application of the ICD-11 classification of personality disorders. *BMC Psychiatry*, 18(1), 351. <https://doi.org/10.1186/s12888-018-1908-3>
- Bach, B., Kramer, U., Doering, S., di Giacomo, E., Hutsebaut, J., Kaera, A., De Panfilis, C., Schmahl, C., Swales, M., Taubner, S., & Renneberg, B. (2022). The ICD-11 classification of personality disorders: a European perspective on challenges and opportunities. *Borderline Personality Disorder and Emotion Dysregulation*, 9(1), 12. <https://doi.org/10.1186/s40479-022-00182-0>
- Bach, B., & Tracy, M. (2022). Clinical utility of the alternative model of personality disorders: A 10th year anniversary review. *Personal Disord*, 13(4), 369-379. <https://doi.org/10.1037/per0000527>
- Cain, N. M., Pincus, A. L., & Ansell, E. B. (2008). Narcissism at the crossroads: phenotypic description of pathological narcissism across clinical theory, social/personality psychology, and psychiatric diagnosis. *Clinical Psychology Review*, 28(4), 638-656. <https://doi.org/10.1016/j.cpr.2007.09.006>.
- Fjermestad-Noll J, Ronningstam E, Bach B, Rosenbaum B, Simonsen E. (2020). Perfectionism, shame, and aggression in depressive patients with narcissistic personality disorder. *Journal of Personality Disorders*. 34, 25–41. <https://doi.org/10.1521/pedi.2020.34.suppl.25>
- Freud, S. (1914/1957). On narcissism: An introduction. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 67–104). Hogarth Press.
- Day, N. J. S., Townsend, M. L., & Grenyer, B. F. S. (2020). Living with pathological narcissism: A qualitative study. *Borderline Personality Disorder and Emotion Dysregulation*, 1-14. <https://doi.org/10.1186/s40479-020-00132-8>
- Day, N.J.S., Green, A., Grenyer, B.F., & Bach, B. (in preparation). Grandiose and Vulnerable Narcissism in the ICD-11 model of personality disorders.
- Ellis, H. (1898). Auto-erotism: A psychological study. *Alienist and Neurologist*, 19, 260-299.
- Green, A., MacLean, R., & Charles, K. (2021). Female Narcissism: Assessment, Aetiology, and Behavioural Manifestations. *Psychol Rep*, 332941211027322. <https://doi.org/10.1177/00332941211027322>

Green, A., MacLean, R. & Charles, K. (2023). Clinician perception of pathological narcissism in females: a vignette-based study. *Frontiers in Psychology*, 14, 1090746. <https://doi.org/10.3389/fpsyg.2023.1090746>

Green, A., Day, N.J.S., Hart, C.M., Grenyer, B.F., & Bach, B. (in preparation). Gender differences in narcissism in the ICD-11 model of personality disorders.

Gutierrez, F., Aluja, A., Ruiz Rodriguez, J., Peri, J. M., Garriz, M., Garcia, L. F., Sorrel, M. A., Sureda, B., Vall, G., Ferrer, M., & Calvo, N. (2022). Borderline, where are you? A psychometric approach to the personality domains in the International Classification of Diseases, 11th Revision (ICD-11). *Personality Disorders: Theory, Research, and Treatment*, 14(3), 355-359. <https://doi.org/10.1037/per0000592>

Hopwood, C. J., Kotov, R., Krueger, R. F., Watson, D., Widiger, T. A., Althoff, R. R., Ansell, E. B., Bach, B., Michael Bagby, R., Blais, M. A., Bornovalova, M. A., Chmielewski, M., Cicero, D. C., Conway, C., De Clercq, B., De Fruyt, F., Docherty, A. R., Eaton, N. R., Edens, J. F., Forbes, M. K., Forbush, K. T., Hengartner, M. P., Ivanova, M. Y., Leising, D., John Livesley, W., Lukowitsky, M. R., Lynam, D. R., Markon, K. E., Miller, J. D., Morey, L. C., Mullins-Sweatt, S. N., Hans Ormel, J., Patrick, C. J., Pincus, A. L., Ruggero, C., Samuel, D. B., Sellbom, M., Slade, T., Tackett, J. L., Thomas, K. M., Trull, T. J., Vachon, D. D., Waldman, I. D., Waszczuk, M. A., Waugh, M. H., Wright, A. G. C., Yalch, M. M., Zald, D. H., & Zimmermann, J. (2018). The time has come for dimensional personality disorder diagnosis. *Personal Ment Health*, 12(1), 82-86. <https://doi.org/10.1002/pmh.1408>

Karterud, S., Oien, M., & Pedersen, G. (2011). Validity aspects of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, narcissistic personality disorder construct. *Compr Psychiatry*, 52(5), 517-526. <https://doi.org/10.1016/j.comppsy.2010.11.001>

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. Jason Aronson.

Kohut, H. (1977). *The restoration of the self*. International Universities Press.

Levy, K. N. (2012). Subtypes, dimensions, levels, and mental states in narcissism and narcissistic personality disorder. *Journal of Clinical Psychology: In Session*, 68(8), 886-897. <https://doi.org/10.1002/jclp.21893>

Näcke, P. (1899). Die sexuellen perversitäten in der irrenanstalt. *Psychiatrie en Neurologische Bladen*, 3, 122-149.

Pincus, A. L., Dowgwillo, E. A., & Greenberg, L. S. (2016). Three cases of narcissistic personality disorder through the lens of the DSM-5 alternative model for personality disorders. *Practice Innovations*, 1(3), 164-177. <https://doi.org/10.1037/pri0000025>

Riegel, K.D., Schlosserova, L., & Zboenik, T.S. (2022). Self-reported narcissistic traits in patients with addiction through the lens of the ICD-11 model for personality disorders. *Frontiers in Psychiatry*, 13. <https://doi.org/10.3389/fpsy.2022.1041480>

Simon, J., Lambrecht, B., & Bach, B. (2023). Cross-walking personality disorder types to ICD-11 trait domains: An overview of current findings. *Front Psychiatry*, 14, 1175425. <https://doi.org/10.3389/fpsy.2023.1175425>

Stinson, F., S., Dawson, D., A., Goldstien, R., B., Chou, S., P., Huang, B., Smith, S., M., Ruan, W., J., Pulay, A., J., Saha, T., D., Pickering, R., P., & Grant, B., F. (2008). Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Narcissistic Personality Disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 69(7), 1033-1045. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669224/>

Schalkwijk, F., Luyten, P., Ingenhoven, T., & Dekker, J. (2021). Narcissistic Personality Disorder: Are Psychodynamic Theories and the Alternative DSM-5 Model for Personality Disorders Finally Going to Meet? *Frontiers in Psychology*. 12, 676733. <https://doi.org/10.3389/fpsyg.2021.676733>

Ovid. (8AD/1717). *Metamorphoses (Book 3)*. Translated by Sir Samuel Garth and John Dryden, 1717. <http://classics.mit.edu/Ovid/metam.3.third.html>

World Health Organization. (2019). *The ICD-11 classification of mental, behavioural or neurodevelopmental disorders* (11th ed.). Author. <https://icd.who.int/browse11/l-m/en>

World Health Organization. (1994). *The ICD-10 classification of mental and behavioural disorders* (10th ed.). Author.