Identifying Narcissistic Personality Disorders in Preadolescents

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Objective: To establish whether consensus exists among 3 diagnostic systems that outline criteria for narcissistic personality disorders (NPDs) in children (Kernberg), in adolescents (Bleiberg), and in adults primarily (DSM-IV) and to identify age-related criteria for preadolescents.

Method: A comparative analysis was used to determine the rate of concordance for the 9 DSM-IV criteria for NPD.

Results: There is a high concordance among the 3 systems for DSM criteria, suggesting that NPD can be identified among preadolescents.

Conclusion: Preliminary ways of adapting DSM-IV criteria for NPD in this age group are discussed.

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Key Words: narcissism, narcissistic personality disorder, preadolescent, assessment, diagnostic criteria, DSM-IV

Clinicians are facing increasing difficulty with severely disturbed preadolescents who have treatment-resistant narcissistic disorders (1–4). Because they are self-absorbed, these patients experience difficulties in their interpersonal relationships both at school and at home. They may be seen as oppositional and self-indulgent, demanding of others but giving little in return. Many project the impression that they are entitled to do what they want, appearing reluctant to make any effort to realize their academic potential and controlling others through dramatic tantrums. The narcissistic disorders these adolescents suffer from may represent a risk factor for later disturbances (1); therefore, their early identification and treatment is important.

The criteria for NPDs before adulthood are still debated by clinicians, who remain reluctant to use this diagnostic category in psychiatric assessments. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (5) now recognizes that NPD, one of the cluster B personality disorders, can be diagnosed in children, although the diagnostic criteria used until now have been derived from those applied to adults. Research is needed, therefore, to identify criteria pertinent to preadolescents with these disorders and to develop diagnostic tools that will facilitate their assessment.

The purpose of this paper is to determine whether consensus can be reached on diagnostic criteria for NPD in children and adolescents and to identify some age-related criteria for preadolescents. The comparative analysis in this paper of the diagnostic systems of criteria for NPD developed by Paulina Kernberg, Efrain Bleiberg, and the DSM-IV constitutes a first step towards the adaptation of the DSM-IV criteria for preadolescents.

Personality Disorders in Children and Adolescents

A unifying concept of personality disorder (PD) does exist, despite numerous variations, according to a recent literature review by Hill and Rutter (1). PDs are defined as “pervasive and persistent abnormalities of overall personality functioning that cause social impairment and/or subjective distress” (1). These dysfunctions are not due to any major mental disorder. DSM-IV defines PD as an enduring pattern of inner experience and behaviour affecting cognition, affectivity, interpersonal functioning, and/or impulse control. Similarly, Kernberg (6), one of the key authors in the literature on personality disturbances in children, refers to PD as a set of rigid and long-lasting maladaptive traits. Even from a developmental perspective, these traits appear pathological. For patients with PD, development proceeds, but along pathological lines (6). Since the disturbance is persistent, the disorder

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is not restricted to any particular developmental stage, although it may express itself with some specific age-related facets. As long as age-appropriate criteria are defined, therefore, it is possible to diagnose PD in preadolescents.

Longitudinal studies support the view that PD can be identified and distinguished from other psychiatric disturbances. In their review of adult studies and follow-up of youngsters, Hill and Rutter (1) conclude that PDs are both distinctive from and comorbid with episodic disorders on Axis I. Questions remain, however, regarding the meaning of this comorbidity. Two disorders on Axis I that have been studied most often in their relationship to PDs in adolescents are conduct disorder and mood disorder. Coker and others (7) found that conduct disorder was the most prevalent (21%) Axis I diagnosis among adolescent psychiatric patients with a cluster B personality disorder (n = 26). According to some studies (8,9), conduct disorders in childhood tend to lead to antisocial personality disorders in adulthood. A few studies have reported the co-occurrence of personality disorders and mood disorders in adolescents (10,11).

Questions have also been raised about the distinctiveness of the different Axis II categories of PDs. There is some support for grouping antisocial, borderline, hysterical, and narcissistic categories together (cluster B), but there is less clinical and empirical evidence about the distinction between them (1,12). The few longitudinal studies carried out with children and adolescents reveal no clear life course for any given PD (13,14). There are some promising findings, however, in studies on familial aggregation (15). Very few studies have addressed issues of comorbidity within specific personality disorders (11,16,17). Kutcher and others (11) found that 15% (n = 20) of a sample of adolescents with bipolar disorder received a diagnosis of NPD. In addition, 15% met criteria for more than one PD, reflecting the overlap between PDs.

This area of research has been hampered by a lack of validated and reliable diagnostic criteria for the different PDs in childhood. Establishing such criteria should be a priority for further research because it would clear the way for the study of comorbidity issues (18) and prediction of adult personality disorders.

Narcissistic Features and NPD

Psychodynamically oriented therapies have generated much information about children with narcissistic conditions. In his pivotal writings on narcissism, Otto Kernberg (19), using a theoretical frame that combines ego psychology and object relations theory, discriminates between normal and pathological narcissism. Normal narcissism refers to well-integrated representations of self and others. Pathological narcissism describes an impaired intrapsychic structure with grandiose self-representation and a severe pathology in object relations. According to Otto Kernberg, pathological narcissism differs from both healthy narcissism of the child and transient regression to infantile narcissism.

Paulina Kernberg (referred to as Kernberg in this text) (20), in turn, defines narcissism in children using Otto Kernberg’s theoretical framework in a developmental perspective. She states that normal infantile narcissism expresses itself in age-appropriate fantasies, demands, and relationships. It results in the constitution of a healthy equilibrium between the internal need to maintain good self-esteem and genuine consideration of others. In contrast, pathological narcissism in children and adolescents reveals itself in excessive demands that cannot be fulfilled by the parents, ongoing denigration of what is received, and disregard of others, despite the transitory overidealization of others while they serve as narcissistic suppliers. Pathological narcissism, therefore, diverges from the development of normal narcissism and can be traced throughout childhood and adolescence (20,21).

Narcissistic stability, however, comes under considerable pressure during adolescence. Bleiberg (22) defines this narcissistic vulnerability as a central feature of both normal and pathological adolescence. Bleiberg’s (21) approach is inspired by Blos’s (23) adaptation of Mahler’s separation-individuation process to adolescents. Normal adolescents can rely on ideals that guide their transition into adulthood, while in narcissistic youngsters the reliance on grandiose self-representations is crystallized. These youngsters refuse to acknowledge their shortcomings and their ongoing demand for public affirmation of their illusory power. This generates an organization of self-experience that is specific to narcissistic disorders. Bleiberg defines this self-experience as a combination of dissociation of vulnerability, omnipotence, and control of others.

According to Otto Kernberg (19,24,25), primitive defence mechanisms shape the self and other representations and interpersonal relations. Along with splitting, primitive idealization, projective identification, and denial, narcissistic patients also frequently use defences of omnipotence and devaluation (25). These defences, he claims, are used by narcissistic children and adolescents as well (25). The narcissistic preadolescent maintains grandiose fantasies and denigrates what he or she is unable to master, including individuals and activities. These defences are observed in the child’s interactions with teachers, parents, and peers; in play and with toys; and with school work.

Otto Kernberg depicts how narcissistic defences may occur within the transference, shaping the therapist’s stance. In the eyes of the patient, the therapist alternates between brilliance, which sustains the patient’s need for overidealization, and humility, which prevents the patient’s envy. Under the strain of the patient’s wishes for omnipotent control, the therapist may feel that he or she exists only to serve the patient’s demands. In addition, the therapist may find it
difficult to discriminate between a transient increase of such narcissistic defences in a nonnarcissistic patient and deeper and longer-lasting defences that characterize a narcissistic disorder. Nevertheless, a predominance of frequent, rigid narcissistic defences often indicates a narcissistic organization (24,25).

The DSM classification system integrates part of the psychoanalytic findings and translates them into observable features. This process has led to the inclusion of a category for NPDs and to its present formulation in the DSM-IV. Commenting on grandiosity, the DSM-IV states that the narcissistic patient’s self-esteem is enhanced by the idealized value the subject assigns to the people he or she associates with. Its description of disturbances in relationships emphasizes aspects of entitlement and disdain. It does not, however, stress the dynamics of controlling others, which are part of the child and adolescent picture.

<table>
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<tr>
<th>COMPARISON OF DIAGNOSTIC SYSTEMS</th>
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<td><strong>DSM-IV Criteria</strong></td>
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<td><strong>HE</strong></td>
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<td>1. Grandiose sense of self-importance</td>
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<td>2. Fantasies of power, success, beauty</td>
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<td>3. Uniqueness</td>
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<td>5. Entitlement</td>
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<td>6. Exploitativeness</td>
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<td>7. Lack of empathy</td>
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<td>8. Envy</td>
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<td>9. Haughty behaviours</td>
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### Specifications of Previous Criteria

A. Gaze aversion |
B. Compulsive need to look in the mirror or fascination for mirror self-image |
C. Learning impediments despite normal or superior intelligence |
D. Impaired peer relations |

### Possible New Criteria

E. Hypersensitivity to criticism |
F. Hypersensitivity to defeat |
G. Inhibition in fantasy play |
H. Quick boredom with toys |
I. Appreciation of others as friends if they are echoes or clones of themselves |
J. Inability to depend on others |

### ASSOCIATED FEATURES

K. Separation anxiety syndrome |
L. Depressive feelings |
M. Hypomanic mood associated with grandiosity |
N. Suspiciousness |
O. Lying to justify personal defeat or irresponsible behaviours |
P. Somatic complaints |
Q. Self-inflicted pain |
R. Anorectic behaviours |

### POSSIBLE EXTERNAL CRITERIA

S. Sadistic enjoyment in play therapy |
T. Repetitive twin fantasy in therapy |
U. Reaction to the therapist’s interventions by increased disdain or coldness |
V. Parental narcissistic investment of the child |

Comparison of Diagnostic Systems

This paper investigates whether or not the syndrome identified in DSM-IV is shared by other available systems for diagnosing narcissistic disorders in children and adolescents. Its secondary goal is to outline ways to adapt adult DSM-IV criteria to preadolescents as a preliminary step towards validating these criteria for that age group.

One way to seek consensus about a diagnostic label is to look for the concordance of the diagnostic criteria among different diagnostic systems. This method was applied to the concept of borderline personality by Perry and Klerman (26). The same approach was used for NPD in adults by Ronningstam (27). She regrouped 3 diagnostic systems: the DSM-III, Otto Kernberg’s descriptions (24), and Akhtar and Thomson’s review (28). These 3 systems postulated that NPD is a specific entity distinguishable from normal narcissism. Ronningstam rated the concordance for 78 criteria spread over the 3 systems. Akhtar and Thomson’s system was already an overview taking into account the other 2 systems. Ronningstam found a low (6%) overall concordance for criteria among the 3 systems, but a higher concordance (40%) between clusters. This study revealed the uncertainty surrounding the basic components of the disorder, especially interpersonal disturbances, although the criteria are not detailed and operationalized the same way in each system. The thematic clusters found across the 3 diagnostic systems include grandiose self-experience, devaluation of others, exploitativeness, exhibitionism, reactiveness, interpersonal instability and several affective characteristics such as lack of empathy for or commitment to others.

For the purpose of the present comparison, 3 diagnostic systems that provide criteria which are easily operationalized for children and adolescents have been selected: the DSM-IV, Kernberg’s descriptions (6,20), and Bleiberg’s typology (22) (Table I). The DSM-IV’s definition of NPD is part of a comprehensive diagnostic system based on empirical studies and reviews by an expert committee. Consequently, it comes under periodic revision (29). According to DSM-IV, personality disorder diagnoses may be applied to children when the maladaptive traits are not limited to a particular developmental stage or to an episode of an Axis I disorder and have been present for at least one year.

Kernberg’s descriptions are deeply grounded in psychoanalytic theory and clinical experience with preadolescents. Bleiberg (22) describes 3 subtypes of narcissistic disorders occurring in adolescence: histrionic–exhibitionistic, ruthless–psychopathic, and self-victimizing–masochistic. Each subtype is grounded in an organization of self-experience that combines dissociation of vulnerability, omnipotence, and control of others. In addition to these common features, each subtype has some specific characteristics.

If the comparison of diagnostic systems takes into account Bleiberg’s 3 subtypes as separate categories, then a low (11%) concordance is found among the systems, since a total of 5 sets are compared. Only criterion 2 (fantasy of power, success, or beauty) is found in each of the 5 sets. If, however, Bleiberg’s 3 subtypes are collapsed into one category and a comparison is then made between criteria of the DSM and those of the 2 other systems, a high concordance is obtained, since 8 out of 9 DSM criteria are found across all 3 classification systems. Criterion 8, envy, is not specifically mentioned by Bleiberg among the diagnostic features.

This high concordance acknowledges efforts made by psychoanalytically oriented authors to provide clinicians with better-defined criteria applicable to situations other than psychodynamic therapy. Incidentally, it also confirms that consensus can be reached using a reorganization of DSM criteria. The high concordance, however, should not overshadow other findings related to NPD. Aside from the common picture shared by the 3 examined systems, several additional traits are also related, some appearing in Kernberg as well as in Bleiberg. These additional criteria have been listed under the headings of specifications of previous criteria, possible new criteria, associated features, and possible external criteria (see Table I).

Comparison of Criteria across the 3 Systems

The first group of criteria (criteria 1–3, grandiosity) is present in Kernberg’s and Bleiberg’s systems. Grandiosity, however, is described differently in each of Bleiberg’s 3 subtypes. In the histrionic–exhibitionistic subtype, grandiosity will appear in an exhibitionistic manner, while in the 2 other subtypes it will be restricted to fantasies that are more or less concealed. This could be compared to Masterson’s (30) division of NPDs into exhibitionistic and closet narcissistic disorders. The patient with an exhibitionistic narcissistic disorder displays his or her grandiosity, while the individual with a closet disorder hides it.

In fact, Bleiberg’s subtyping depicts 3 divergent modalities of self-experience that lead to 3 formulations of criterion 2 (fantasies of power). The self-experience of the histrionic–exhibitionistic narcissistic adolescent is grounded in fantasies of beauty. In the ruthless–psychopathic individuals, fantasies of invulnerability are the core self-experience. These adolescents are particularly prone to avoid any feeling and are reluctant to recall or acknowledge vulnerability. In the self-victimizing–masochistic subtype, hidden convictions of power and control sustain the masochistic attitudes, and grandiosity is more likely to take the form of apparent helplessness and dependency.

Criterion 4 (need for admiration) is a key component in Kernberg’s depiction, whereas it is present only in Bleiberg’s histrionic–exhibitionistic subtype. Kernberg stresses the lack
of fulfilment of this pervasive need for admiration, which reveals itself in such behaviours as gaze aversion (criterion A) and the urge to look in the mirror (criterion B). According to my clinical experience, the gaze aversion criterion is met only if the behaviour is clearly related to an unwillingness to be confronted by others’ judgements. This distinction allows the symptom to be differentiated from gaze diversion, which is present in hyperactive children and pertains to distractibility. Gaze aversion and a fascination for the mirrored self-image protect the child from a distressing contrast between a grandiose fantasy life and discrepant feedback from others.

Present only in the exhibitionistic subtype within Bleiberg’s classification, criterion 4 is formulated as a craving for admiration that nourishes the self-experience organized around personal talents and beauty. This criterion, however, raises the issue of whether NPD can be differentiated from histrionic personality disorder, since a pattern of attention-seeking behaviour (criteria 1 and 4) is also described in the DSM-IV definition of histrionic personality disorder. In order to improve its validity as a criterion for NPD, criterion 4 must be more precisely delineated. In this respect, Kernberg’s specifications for this criterion are a very valuable contribution.

The last group of criteria (lack of empathy, criteria 5 through 9) includes symptoms of overconcern in one’s own needs and disregard of others’ needs. As opposed to earlier findings (31), recent cognitive studies report that a pathology of empathy can be detected within the first 2 years of life (32). Zahn-Waxler and Radke-Yarrow (33), in a review of studies on the development of empathy in children, state that as early as 2 years of age, children are equipped with the cognitive and emotional capacity to understand the psychological state of others.

Lack of empathy is a key component in narcissistic disorders, although it is found primarily in Bleiberg’s ruthless–psychopathic subtype. According to Bleiberg, criteria 5 to 9 reflect the core self-experience organized around the need to maintain a sense of invulnerability. Lack of empathy is associated with a particular type of object relations and an immaturity of empathy, both of which are displayed in the realms of play, learning, and peer relations. In my clinical experience, a lack of empathy is associated with oppositional symptoms at school. These could take the form of refusals to comply with adults’ requests because of entitlement and grandiosity. In cases of parental narcissistic investment of a skilled child, however, academic achievements are highly valued. Hence, performance in elementary school is usually very good, whereas it begins to decline in high school.

According to Kernberg and Bleiberg, exploitativeness (criterion 6) and lack of empathy (criterion 7) are expressed in poor peer attachments and lack of reciprocity. Kernberg emphasizes impairments in peer relations (criterion D), which result from entitlement, exploitativeness, lack of empathy, and envy. In Ronningstam’s (34) recent study based on a follow-up of NPD in adults using a semistructured interview (the Diagnostic Interview for Narcissism [DIN]), impairments in the area of interpersonal relations also emerged as an important diagnostic indicator.

In childhood, envy (criterion 8) is expressed in temper outbursts and excessive, recurrent, and unsatisfiable demands imposed on parents. Clinical experience indicates that envy is a very important feature in children. Bleiberg, however, does not specifically name envy as a criterion. This symptom appears to be covert in adolescence, and it is not usually assessed during the clinical interview.

Possible New Criteria

Criterion E (hypersensitivity to criticism) is cited in Bleiberg and Kernberg’s systems. This criterion appears to be relevant for several authors (6,22,29) and in my clinical practice as well. Hypersensitivity to criticism was deleted from the list of DSM-IV criteria due to the lack of specificity of its DSM-III-R formulation. It was later placed in the associated features section of DSM-IV. Gunderson, Ronningstam, and Smith (29) proposed a more specific formulation: “reacts to criticism, defeat, or rejection with sustained feelings of disdain, shame or humiliation (even if not expressed).”

To illustrate this, one finds in psychotherapy that narcissistic youngsters tend to perceive the therapist’s interventions as criticism and to react with increased disdain or coldness (external criterion U) (see Table I). Gunderson’s formulation, therefore, would make it possible to include criterion E as part of the diagnostic criteria.

As an associated feature, DSM-IV mentions hypersensitivity to defeat (criterion F), whereas Kernberg describes intense reactions to defeat in structured games. Narcissistic children change rules repeatedly in order to win the game or quit if they cannot win. They may also have temper tantrums expressing inner rage. Bleiberg mentions feelings of rage in the ruthless–psychopathic subtype. Hypersensitivity to defeat is an illustration of Kohut’s (35) description of narcissistic rage. According to Kohut, rage emerges when the environment (including others) fails to comply with one’s expectations. The response helps the person to avoid devastating feelings of loss of control.

Kernberg (6,20) stresses the particularities of narcissistic children’s play: inhibition, especially in fantasy play (criterion G) and even with new toys or games (criterion H). This
inhibition takes the form of a reluctance to let go and to trust the process of play therapy, which is different from anxious inhibition. It is as if therapy elicits expectations that the child knows will not be satisfied, so therapy will inevitably lead to an experience of frustration.

In the area of peer relations, Kernberg specifies that the child makes friends with others only when they are echoes or clones of the child (criterion I). Acknowledgement of difference is denied in an effort to avoid feelings of envy. Narcissistic youngsters tend not to perceive peers as autonomous but as complementary parts of themselves or as an alter ego. This interpersonal difficulty reflects an inability to depend on others (criterion J), also mentioned by Kernberg. In my experience as well, it takes the form of an unwillingness to recognize dependency on others in everyday life.

**Associated Features**

All 3 diagnostic systems describe associated features (see Table I). Kernberg (20) highlights the underlying separation anxiety syndrome (criterion K), which could be either overtly present or masked by heightened and devaluation of pleasurable activities requiring separation. Kernberg’s emphasis on the separation anxiety syndrome supports the perspective of other authors (36,37).

Depressive feelings (criterion L) are mentioned as associated features in the 3 diagnostic systems, whereas hypomanic mood (criterion M) is mentioned in DSM-IV only. Depressive episodes have already been described in the course of NPD (4,37) and are even viewed as a good prognostic indicator. The association between mood states and such core symptoms as grandiosity stresses the importance of assessing the concurrent mood status while evaluating the presence of NPD. Based on the course of grandiosity at follow-up among adults, Ronningstam and others (34) also emphasize the need to distinguish state-dependent symptoms from more stable signs of grandiose self-experience.

Suspiciousness (criterion N) can also be present if the expectation of being humiliated or attacked is as prominent as it is in Bleiberg’s ruthless–psychopathic subtype. Several other features that currently lack a precise definition or specificity have also been described (criteria O to R).

Criteria S to U (see Table I) are observable only within a therapeutic setting. If these features are displayed in play therapy, they may confirm the presence of NPD. These criteria may, therefore, serve as external criteria for a validation study since the need for etiological or treatment criteria has been advocated (38).

**Conclusion**

The comparative analysis of the 3 diagnostic systems presented in this paper converges with Ronningstam’s (27) findings with adults. Of the 7 clusters obtained by Ronningstam, we found that 4 were explicitly present in all 3 systems we compared, while the remaining ones were partially present.

Thus we obtain a portrait of narcissistic preadolescents with 3 dimensions reported in the DSM-IV (grandiosity, need for admiration, lack of empathy) and some other possible criteria. Their grandiose self-experience is organized around overestimation of their achievements, fantasies of invulnerability, success, and beauty, or a feeling of uniqueness. Their need for admiration appears unfulfillable and could result in gaze aversion and a compulsive need to look in the mirror. Their lack of empathy and feelings of envy or entitlement result in impairments in the areas of peer relations, adjustment in school, and play. They appreciate others as friends only if they are echoes or clones of themselves. Narcissistic preadolescents appear exploitative and haughty and they are hypersensitive to criticism and defeat.

This comparison reveals a high concordance across the 3 systems for DSM criteria (8 out of 9), suggesting that a consensus among the available diagnostic systems can be reached. It may be possible, therefore, to identify NPD in preadolescents. This paper offers suggestions for adapting the DSM-IV criteria for NPD with a view to developing a scale that may be used to assess this disorder in preadolescents.

**Clinical Implications**

- Early identification of narcissistic personality disorder (NPD).
- Integration of behavioral and psychodynamic components in the definition of NPD.

**Limitations**

- Weak operationalization of diagnostic criteria.

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**References**

Résumé

Objectif : Établir si le consensus existe entre 3 systèmes diagnostiques qui décrivent les critères de troubles de la personnalité narcissique (TPN) chez les enfants (Kernberg), chez les adolescents (Bleiberg) et principalement chez les adultes (DSM-IV) et déterminer les critères liés à l’âge chez les préadolescents.

Méthode : Une analyse comparative a servi à déterminer le taux de concordance des 9 critères de TPN du DSM-IV.

Résultats : Il y a une concordance élevée entre les 3 systèmes quant aux critères de TPN du DSM-IV, ce qui dénote que les TPN peuvent être diagnostiqués chez les préadolescents.

Conclusion : Les moyens préliminaires d’adapter les critères du DSM-IV à ce groupe d’âge font l’objet d’une discussion.