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Narcissism and Psychopathological Profiles: Definitions, Clinical Contexts, Neurobiological Aspects and Clinical Treatments

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ABSTRACT

Starting from the general concept of "narcissism", the present work focuses on the essential aspects of personality disorder that define the clinical and diagnostic contexts, laying the foundations for a correct differential diagnosis, without neglecting the neural characteristics developed by the scientific community. A new classification of the narcissistic disorder is presented that better defines the different types, in a more general framework of the "narcissistic spectrum". The discussion ends with the best suggested therapeutic approaches.

KEYWORDS

Narcissism; Personality disorder; Narcissistic disorder

INTRODUCTION

Narcissism: General Profiles and Definitions

In common parlance, the use of the term "Narcissism" essentially takes on a negative meaning, identifying with it an egocentric, selfish, vain, and conceited person, in all its possible uses and socio-cultural contexts. In short, narcissism is the tendency and psychological attitude of those who make of themselves, of their person, of their physical and intellectual qualities, the exclusive and pre-eminent center of their interest and the object of a smug admiration, while remaining more or less indifferent to others, whose value and works they ignore or despise. In technical language, in psychology and psychiatry, on the other hand, the generally accepted meaning has a dual value, depending on the context and other specific indicators; in fact: in psychology, a distinction is made between the functional form (healthy self-love, i.e. normal love for oneself) and the dysfunctional form (the insane egocentricity caused by a disorder of the sense of self that is reflected in relationships with oneself and with others); in psychiatry, on the other hand, it identifies the foundation of the narcissistic personality disorder [1,2].

The origins of the term are Greek and come from the myth of Narcissus. According to the story, Narcissus was a handsome young man who rejected the love of the nymph Echo. As punishment, he was therefore destined to fall in love with his image, reflected in the water. Unable to consummate his love, Narcissus thus turned his gaze into the mirror of water, hour after hour, becoming forever a flower (which bears his name, the narcissus).

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More recently, recalling the Greek concept of "self-love" (hybris), in 1898, Havelock Ellis, an English sexologist, used the term "narcissus-like" about excessive masturbation, whereby the person becomes his sexual object, while Paul Näcke, in 1899, was the first to use the term "narcissism" in a study on sexual perversions, giving it a purely clinical and psychological meaning. A few years later, in 1911, Otto Rank published the first psychoanalytic document specifically concerned with narcissism, linking the latter to vanity and self-admiration, before Sigmund Freud could pave the way with his manuscript on narcissism in 1914, called "Introduction to Narcissism" [3].

At the beginning of the first chapter, freud fully defines narcissism as the "libidinal completion of the egoism of man's drive for self-preservation", therefore not as a perversion but as a character belonging in a different way to all men and never completely overcome. According to the Viennese doctor, the interest in the narcissistic stage resides in the particular form of some psychosis in which the ego of the sick person seems to be the center of the libidinal current: The patient loses all interest in the outside world by turning to himself his object libidinal current, thus giving form to over-investment of the ego which leads, for example, to delusions of grandeur. This according to freud is what happens in paraphrenias (schizophrenia and dementia præcox), despite obsessive neurosis in which the interest towards the outside is confirmed by the fantasies of the patient. Freud also identifies this phase in the behavior of the child when he assumes himself at the center of the world, in his omnipotence of thoughts and the superstitious beliefs of primitive men. In the second chapter, freud deals extensively with the drives of the ego, the object libido, and the libido of the ego, as opposed to Jung's theories that tended to unify these drives into a single psychic energy. Also in this chapter, freud exemplifies narcissistic behavior in cases of human love life, illness, and even hypochondria, when an "excited" organ becomes somehow erogenous and susceptible to libidinal investment. The dangers one encounters during the narcissistic phase are, according to freud, anxiety due to the complex of revascularization and some cases of homosexuality, in which the beloved object still represents an image of oneself. In the last chapter freud, holding firm the distinction between object libido and ego libido questions himself about the destiny of the latter, going so far as to suppose that it goes to support an idea that the ego has of itself. In adulthood, therefore, a part of the narcissistic current is no longer directed to the ego but to its ideal, an ideal to which freud acknowledges the dignity of psychic instance and moral conscience. The existence of this ideal would also be a condition for the removal of drives and thoughts, as well as for dreamlike censorship and the sensation of "feeling observed" reported by neurotics. In the last part of the book, the author follows the genesis of the ideal of the ego, the dynamics of libidinal investments (especially in love life), and underlines the importance of the ideal of the ego in understanding the psychology of the masses. Melanie Klein reinforces the concept of "primary narcissism" (benign, typical of childhood) and "secondary or protracted" (malignant, typical of adolescence and adulthood), where the latter is the term to indicate withdrawal to the ego. Heinz Kohut, the father of the psychology of the self, also dealt with this theme, defining the narcissistic state of the mind as a libidinal investment of the self that has no pathological characteristics but represents an organization that expresses an attempt to deal with those irregular maturing situations that inevitably occur in childhood development, and that tends to idealize or counter-idealize the parental imago. From this operation are born, for Kohut, that love/hate and attraction/repulsion that characterize the ideal of the ego, which has the task of managing the world of drives, until a maturation and balance that brings out a different stage of development and promotes a careful reformulation of attitudes. The

principle of Kouthian mythology is this "idealized object" which contains its idealized images of the self and the objects-self [2].

The dynamics can change considerably depending on the type and degree of severity of narcissism, but in general, there has been a tendency to replicate internalized behavior as adults as children. It may happen, for example, that a child neglected or mistreated by her father, as an adult, seeks "deviant" companions, while a child ignored or mistreated by her mother once an adult may have controlled, and in the most serious cases, stalking behaviors. Two types of narcissistic parents are generally identified: a) disinterested: since the child does not provide continuous feedback of confirmation and flattery, the narcissistic parent loses interest in him, ignores him, and neglects him, seeking satisfaction elsewhere. However, if the child is successful (e.g. good results at school), this becomes a sort of trophy that the parent exhibits in public; b) controlling: he is obsessed with the child, worries about him and for this reason, monitors him continuously, asking him for continuous feedback on his skills as a parent. He finds it very difficult to respect its boundaries, even emotionally. He cannot accept his child's autonomy and resorts to psychological manipulation if he tries to escape his control, e.g. by provoking a sense of guilt. Both types of narcissistic parents have a low tolerance for failure and can deny their child affection if he or she does not meet their standards of perfection. At the same time, they may compete with the child, who is urged to succeed "but not too much" so as not to overshadow them. Growing up the child can become a very successful person or self-sabotage, or both. The narcissistic parent may have very strong preferences. The preferred child is called "golden child" by psychologists: it is the child with whom the parent identifies and who collects, in his eyes, all his virtues. The golden child is invested with great expectations regarding his fulfillment, which serves to give prestige to the parent. The unwanted child, on the other hand, is called the "scapegoat": He is the child on whom the narcissistic parent projects all his defects, who does not make the right one and who seems predestined to be a total failure. While the golden child is surrounded by attention, on the scapegoat child the narcissistic parent can exercise different forms of psychological or even physical violence. In the most dysfunctional families, the parent can incite the golden child to mistreat the scapegoat child, who assumes the role of "black sheep" of the family. It can also happen that the child rebels against the expectations of the parent and for this reason pass from the status of the golden child to that of the scapegoat. It is no coincidence that a person who has been raised by one or two narcissistic parents typically displays the following characteristics: The habit of self-criticism all the time; chronic fear of being disturbed, difficulty in putting stakes on what others can afford with her, tendency to deny one's own emotional needs; an insecure attachment style, which translates into generalized anxiety, emotional detachment, or an attempt to be accepted by adapting one's personality to the standards required by the parent; may have one or more episodes that specialists call "need-panic" in which suddenly the way one's needs were repressed no longer works, and the person "explodes"; An extreme need for independence, to be understood as a form of avoiding relationships. Other characteristic traits are pervasive anxiety and symptoms of post-traumatic stress disorder, perfectionism, tendency to depression, a poor ability to regulate emotions, possible eating disorders or substance abuse, and above all a poor sense of personal identity [4-7].

In more recent times, however, space has been given to the clear distinction between the various forms of narcissism [2,6,7].

1) The first form (also called “zero form”) is the "healthy and functional" one consisting of self-love and healthy selfishness (that which does not feed on the unhappiness

of others). It is a condition of balance between the person and the surrounding environment where the former is perfectly aware of his means and does not diminish his value due to problems of low self-esteem, guilt, or unjustified shame or character insecurity.

2) The second form (or I form) is the "benign (or apparent) and slightly dysfunctional" one. It consists of the representation of oneself towards the surrounding environment with a slight artifact of one's own identity, where weaknesses and insecurities are masked with attitudes of hyper security, exteriorization of positive elements, and intellectualization. The excess of security that others perceive is an apparent representation of the person who uses his or her resources in a constructive and non-destructive way, being positive for himself or herself and others. In this subject, there are excellent qualities of empathy and is not fed by the suffering or failure of others.

3) The third form (or II form) is "oriented (or hidden) and moderately dysfunctional". The person presents a psychopathological picture already interesting from a clinical point of view, showing one or more typical features of narcissistic functioning: an evident concentration on oneself in interpersonal exchanges; a lack of awareness and recognition of one's psychological traits (significant egosyntony); difficulties with empathy; problems in distinguishing oneself from others; vulnerability to shame or guilt; haughty body language; flattery towards people who admire and strengthen it; hating those who do not admire it; using other people without considering the price of doing so; pretending to be more important than they are; bragging (subtly but insistently) about their achievements and exaggerating them; claiming to be an "expert" in many things; inability to see the world from others; denial of remorse and gratitude. The excess of security and egocentricity that others perceive is the product of the hypertrophic ego, where the person destructively uses his resources (concerning the environment), resulting in both positive and negative for others. In this subject, there are scarce qualities of empathy and is fed by the failure of others.

4) The fourth form (or III form) is the "dysfunctional (or marked) and pathological" one, inserted in the DSM-V manual of psychopathological disorders under the heading "narcissistic personality disorder". It does not have a genetic but environmental (and therefore family) matrix, able to affect the personality structure of the person from the early stages of growth (starting from the so-called "narcissistic wound", generally associated with a sense of shame). Typically, children who later become narcissistic life in a family where their feelings and interests are ignored, humiliated or repressed, unless they can perform some "performance" capable of filling the parent with pride; they become "hungry" for recognition and praise, begin to conceive human relationships essentially as based on power and control, and can begin to use seductive and manipulative techniques. The hypothesis of the fundamental role in the development of the narcissism of resentment seems to emerge more and more strongly, that is, that feeling of having suffered injustice and not being able to rebel against it. If the child feels that he or she has experienced strong injustices, he or she can develop resentment as a defense system, and thus reach adulthood with certain expectations of what he or she is entitled to as compensation. In turn, the fourth form has four levels of severity (mild, moderate, severe, and very severe) and two organizational types (covert/overt).

In emotional and sentimental relationships, especially the narcissist described in the third and fourth form, easily establishes a "toxic relationship", creating a relational dependence necessary to feed his need for admiration: In the first phase we find the classic attitude of "love bombing", where the person is studded with messages and filled with love and attention, then we move on to the colder and more sterile phase of "gaslighting" and finally

abandonment. Only at this moment, the victim of these behaviors becomes even more attached to the person, becoming emotionally dependent. It must be said, however, that the "dependent" person always presents a series of traits or a real personality disorder (tendentially narcissistic, borderline, or dependent) [1,7].

Narcissistic Personality Disorder and Clinical Contexts

As already mentioned above, the fourth form represents the most serious clinical hypothesis: Narcissistic personality disorder. By definition, it is a personality disorder whose main symptoms are pathological egocentricity, a deficit in the ability to feel empathy towards other individuals, and the need to perceive admiration, which begins in early adulthood and is present in various contexts [2]. The notion of narcissistic personality disorder was formulated by Heinz Kohut in 1971 and introduced at his suggestion in the diagnostic and statistical manual of mental disorders (DSM). The clinical picture it describes is a particular form of narcissistic disorder. What distinguishes these patients, i.e. the psychological structure hypothesized by Kohut, and for which he coined the term "grandiose self", is a sort of so-called "false self" or "false self", which preserves some of the primitive characteristics of the infantile self, an overly idealized and "omnipotent" inner image that the individual perceives as the true "I". Patients with narcissistic personality disorder overestimate their abilities and exaggerate their successes. They think they are superior, unique, or special. Their overestimation of their value and achievements often implies an underestimation of the value and achievements of others. These patients are preoccupied with fantasies of great success, of being admired for their overwhelming intelligence or beauty, of having prestige and influence, or of feeling great love. They feel that they should only socialize with other people as special and talented as themselves, not with ordinary people. This association with extraordinary people is used to support and improve their self-esteem. Because patients with narcissistic disorders need to be admired, their self-esteem depends on the positive consideration of others and is therefore usually very fragile. People with this disorder often look to see what others think of them and assess how well they are doing. They are sensitive and annoyed by other people's criticism and failure, which makes them feel humiliated and defeated. They may respond with anger or contempt, or they may brutally fight back. Or they can withdraw or accept the situation externally, in an attempt to protect their sense of self-importance (grandiosity). They can avoid situations in which they may fail. The traits and manifestations that describe this disorder are multiple and give rise to a complex casuistry of personalities, with variable characteristics, located in a very broad spectrum of type and severity. When subjected to criticism, individuals with narcissism can generally react with anger, outrage, or insolence. This can sometimes lead to a form of social withdrawal that can hide a sense of grandiosity. Interpersonal relationships are typically short-lived and short-lived due to the inability of the narcissist to perceive the emotions of the person in front of them and thus offend the sensibilities of others. This pattern of behavior can also lead to high results, thanks to insensitivity to criticism and security, but intolerance to criticism and the constant need to feel admired can lead to failure. This can be associated with the development of a depressed mood, social withdrawal, and persistent dysthymia, or major depressive disorder. Conversely, long periods of grandiose feelings can be associated with hypomaniacal mood development [8,9].

In summary, the psychological characteristics of individuals with narcissistic personality disorder are [2]:

a) "Vision of themselves": They consider themselves to be defective, vulnerable to abuse, betrayal, neglect. "I'm bad", "I don't know who I am", "I'm weak and I feel overwhelmed", "I can't help myself";

b) "Vision of others": They can see others as warm and loving but still consider them unreliable because "they

are strong and could be supportive, but after a while change to hurt or abandon me";
c) "Intermediate and deep beliefs": "I have to ask for what I need", "I have to answer when I feel attacked", "I have to do it because I have to feel better", "if I am alone, I won't be able to face the situation", "if I trust someone, they will sooner or later abandon me or abuse me and I will feel bad", "if my feelings are ignored or neglected, I will lose control";
d) "Coping strategies": Submitting, alternating inhibition with dramatic protest, punishing others, expelling tension with self-harm.

The clinical diagnosis according to the DSM-V requires that there should be a persistent pattern of grandiosity, need for flattery and lack of empathy, with the presence of five or more of the following elements: An exaggerated, unfounded sense of one's importance and talents (grandiosity), concern with fantasies of unlimited success, influence, power, intelligence, beauty, or perfect love; a belief that one is special and unique and should only associate with people of the highest level; a need to be unconditionally admired; a feeling of privilege; exploitation of others to achieve one's goals; lack of empathy; envy of others and belief that others envy them; arrogance and pride. The more elements are present, the more serious will be the pervasiveness of the psychopathological condition [2,8].

The pathological (or malignant) narcissist, however, can have two different ways to represent himself: the "covert" form and the "overt" form. The covert narcissist is inhibited, vulnerable, hypersensitive to criticism, afraid of rejection, often feels shame and embarrassment, and always feels a huge distance between himself and others. But, unlike what can be seen on a superficial observation, the covert narcissist is not a sweet, affectionate, and defended feline but a sleeping lion. He shares with his overt counterpoint the attitude of exploitation and manipulation towards others, the absence of empathy, a certain amount of aggressiveness (although generally lower than the narcissist overt) and the presence of grandiose fantasies (although these, unlike what happens for the narcissist overt, are hidden and less aware). The fear of failing and not realizing their fantasies of greatness often determines in these people the tendency to avoid situations in which they may be the center of attention. Covert narcissists often feel shame and anger, a sense of failure and defeat, rejection, expulsion. The overt narcissist instead appears superior, self-sufficient, dominant, euphoric, triumphant (or cold and detached). He feels he does not belong to the rest of humanity or a superior elite [9].

For this reason, it seems more correct to speak of the "narcissistic spectrum" and not of simple narcissism. A continuum that goes from healthy to malignant narcissism, passing through covert and overt forms, depending on the degree of grandiosity, loss of contact with reality, lack of feelings and contact with one's own needs, body sensations and emotions. And narcissists place themselves at a point on this continuum [2].

The pathological (or malignant) narcissist (fourth form or “III form”), anyway, essentially depends on "level of insight" concerning the external (reality and environment) and internal (the relationship between the deep instances) plan and consequently also the psychological treatment will have to adapt to the clinical form suffered. Normally, this form is distinguished in four levels of severity (mild, moderate, severe, and very severe) and two organizational types (covert/overt); the writer, however, prefers to use a new classification, more functional and structured [10].

Overt Model

Excellent level of insight

Narcissistic patients of this level define themselves as "oriented" because they meet the criteria proposed by DSM-V, within a framework of a persistent and

pervasive model of grandeur, need for flattery, and lack of empathy, but in a strictly essential way (5 criteria out of 9, mainly related to the envy of others and the belief that others envy him, lack of empathy, a feeling of privilege, concerns related to fantasies of success or perfection and need for admiration), still managing to fit well into the environmental, family and work context, building a network contacts able to allow him an excellent adaptation with the outside.

Good level of insight

Narcissistic patients of this level define themselves as "precarious" because they meet the criteria proposed by DSM-V, within a framework of a persistent and pervasive model of grandeur, need for flattery, and lack of empathy, but in a strictly essential way (6 criteria out of 9, mainly related to the envy of others and the belief that others envy him, lack of empathy, a feeling of privilege, concerns related to fantasies of success or perfection, need for admiration and feeling of privilege), managing to fit into the environmental, family and work context, but building a fragile and insecure network of contacts, which tends to disintegrate following the aforementioned behaviors.

Mediocre level of insight

Narcissistic patients of this level define themselves as "sensitive" because they meet the criteria proposed by DSM-V, within a framework of a persistent and pervasive model of grandeur, need for flattery, and lack of empathy, but in a strictly essential way (7 out of 9 criteria, mainly related to the envy of others and the belief that others envy him, lack of empathy, a feeling of privilege, concerns related to fantasies of success or perfection, need for admiration, feeling of privilege, arrogance, and presumption), managing to barely fit into the environmental, family and work context and building a fragmented and disorganized network of contacts, which tends to distance them as soon as behavioral manifestations become pressing and embarrassing. In some cases there are also paranoid and/or dissociative thoughts of a minor or temporary nature.

Low level of insight

Narcissistic patients of this level define themselves as "vulnerable" because they meet the criteria proposed by DSM-V, within a marked of a persistent and pervasive model of grandeur, need for flattery, and lack of empathy, but in a strictly essential way (8 criteria out of 9, mainly related to the envy of others and the belief that others envy him, lack of empathy, a lack of privilege, concerns related to fantasies of success or perfection, need for admiration, feeling of privilege, arrogance and presumption, and beliefs of being special, unique or very high profile), failing to fit into the environmental, family and work context, failing to build a network of contacts stable over time, if not with occasional, sporadic and superficial relationships. In some cases there are also paranoid and/or dissociative thoughts of moderate entity or in any case temporary.

Bad level of insight

Narcissistic patients of this level define themselves as "critical" because they meet the criteria proposed by DSM-V, within extremely marked of a persistent and pervasive model of grandeur, need for flattery, and lack of empathy, but in a strictly essential way (9 out of 9 criteria, mainly related to the envy of others and the belief that others envy him, lack of empathy, a lack of privilege, concerns related to fantasies of success or perfection, need for admiration, feeling of privilege, arrogance and presumption, and beliefs of being special, unique or of the highest-profile, excessive grandiosity and the need to exploit others to achieve their goals and objectives), failing to fit into the environmental, family and work context and failing to build a network of contacts, even essential or minimal.

Covert Model

Excellent level of insight

Narcissistic patients of this level define themselves as "oriented" because their typology is not clearly defined in the criteria of the DSM-V, but is nevertheless part of a persistent and pervasive model of personalities in a general picture of lack of empathy, selfishness, need to draw attention to their suffering and needs, presenting the following characteristics: deresponsibility with attribution of blame or not to others, operational overcontrol, irrational fixations/beliefs/obsessive episodes, an exaggerated and unfounded underestimation of one's skills and qualities, although aware of the results or objective findings and need to draw attention to one's own needs and requirements, even with the use of complaining and/or guilt. Still managing to fit well into the environmental, family and work context, building a network contacts able to allow him an excellent adaptation with the outside.

Good level of insight

Narcissistic patients of this level define themselves as "oriented" because their typology is not clearly defined in the criteria of the DSM-V, but is nevertheless part of a persistent and pervasive model of personalities in a general picture of lack of empathy, selfishness, need to draw attention to their suffering and needs, presenting the following characteristics: deresponsibility with attribution of blame or not to others, operational overcontrol, irrational fixations/beliefs/obsessive episodes, an exaggerated and unfounded underestimation of one's skills and qualities, although aware of the results or objective findings and need to draw attention to one's own needs and requirements, even with the use of complaining and/or guilt and psychosomatic illnesses of mild to medium magnitude. He manages to fit into the environmental, family and work context, but builds a fragile and insecure network of contacts, which tends to disintegrate as a result of the above behaviors.

Mediocre level of insight

Narcissistic patients of this level define themselves as "oriented" because their typology is not clearly defined in the criteria of the DSM-V, but is nevertheless part of a persistent and pervasive model of personalities in a general picture of lack of empathy, selfishness, need to draw attention to their suffering and needs, presenting the following characteristics: deresponsibility with attribution of blame or not to others, operational overcontrol, irrational fixations/beliefs/obsessive episodes, an exaggerated and unfounded underestimation of one's skills and qualities, although aware of the results or objective findings and need to draw attention to one's own needs and requirements, even with the use of complaining and/or guilt, psychosomatic illnesses of mild to medium magnitude and episodes of generalized or social anxiety, which become involuntary simulations of panic attacks or hysterical crises. He manages to barely fit into the environmental, family, and work context and building a fragmented and disorganized network of contacts, which tends to distance them as soon as behavioral manifestations become pressing and embarrassing. In some cases there are also paranoid and/or dissociative thoughts of a minor or temporary nature.

Low level of insight

Narcissistic patients of this level define themselves as "oriented" because their typology is not clearly defined in the criteria of the DSM-V, but is nevertheless part of a persistent and pervasive model of personalities in a general picture of lack of empathy, selfishness, need to draw attention to their suffering and needs, presenting the following characteristics: Deresponsibility with attribution of blame or not to others, operational overcontrol, irrational fixations/beliefs/obsessive episodes, an exaggerated and unfounded underestimation of one's own skills and qualities, although aware of the results or objective findings and need to draw attention to one's own needs and requirements, even with the use of complaining and/or guilt, psychosomatic illnesses of mild

to medium magnitude, episodes of generalized or social anxiety, which become involuntary simulations of panic attacks or hysterical crises and lack of empathy or repressed or dysfunctional affectivity. He is unable to fit into the environmental, family, and work context, failing to build a stable network of contacts over time, except with occasional, sporadic and superficial relationships. In some cases there are also paranoid and/or dissociative thoughts of moderate or temporary entity.

Bad level of insight

Narcissistic patients of this level define themselves as "oriented" because their typology is not clearly defined in the criteria of the DSM-V, but is nevertheless part of a persistent and pervasive model of personalities in a general picture of lack of empathy, selfishness, need to draw attention to their suffering and needs, presenting the following characteristics: deresponsibility with attribution of blame or not to others, operational overcontrol, irrational fixations/beliefs/obsessive episodes, an exaggerated and unfounded underestimation of one's own skills and qualities, although aware of the results or objective findings and need to draw attention to one's own needs and requirements, even with the use of complaining and/or guilt, psychosomatic illnesses of mild to medium magnitude, episodes of generalized or social anxiety, which become involuntary simulations of panic attacks or hysterical crises, lack of empathy that can go as far as anaffectiveness and/or insensitivity to the suffering of others, with exploitation of others to obtain attention and visibility with respect to one's own needs. He fails to fit into the environmental, family, and work environment and fails to build or maintain a network of contacts, even essential or minimal ones.

Narcissistic personality disorder is often also associated with forms of eating disorders such as anorexia nervosa or substance use disorders. Histrionic personality disorder, borderline, antisocial, and paranoid disorders can also be associated with this disorder. In the diagnosis of comorbidity, particular attention should be paid to a potential substance use disorder, which may develop in the association, and to a diagnosis of maniacally or hypomaniacally: These episodes may present peaks of grandiosity and self-esteem similar to those present in a narcissistic disorder. It should be clearly distinguished from: a) “bipolar disorder”, as patients with narcissistic personality disorder often present with depression and, due to their grandiosity, may be misdiagnosed as bipolar. Such patients may suffer from depression, but their persistent need to rise above others distinguishes them from those with bipolar disorder. Moreover, in narcissistic personality disorder, mood changes are triggered by insults to self-esteem; b) “antisocial personality disorder”, as the exploitation of others to promote themselves is characteristic of both personality disorders but the reasons are different. Patients with antisocial personality disorder exploit others for material gain; those with narcissistic personality disorder exploit others to maintain their self-esteem; c) “histrionic personality disorder”, because the pursuit of attention by others is characteristic of both personality disorders, but patients with narcissistic personality disorder, unlike those with histrionic personality disorder, act in contempt of anything nice and silly to attract attention; they want to be admired [11-26].

Epistemological Data, Etiological Causes and Neurobiological Basis of the Psychopathological Disorder

According to recent data, a narcissistic personality disorder can be diagnosed in about 1% - 4% of the adult population, while in hospitalized patients it can be as high as 15% - 20%. The spread of this pathology does not seem ubiquitous, but strongly influenced by cultural contexts: It seems to be more widespread almost exclusively in capitalist and western countries. The disorder seems to have a sexual or gender component so that the spread is not equal between the two sexes: Males affected are more numerous than females, by a share

between 50% and 75%. While females tend to be more affected by borderline personality disorders, which share some characteristics similar to narcissistic ones, such as a substantially unstable mode of relationship. Some narcissistic traits then appear during the development of the individual and to a certain degree are normal. These character traits are very common among adolescents, without necessarily resulting in a pathological personality in adulthood [11].

Although some studies mention the importance of genetic influence on the development of this disorder (especially about the search for attention, the need to be flattered and grandiosity), all the other studies suggest that, in the development of narcissistic personality disorder, the interaction that develops between the parent and the child occupies a place of primary importance; in particular, subjects presenting this disorder seem to have developed, starting from the relationship with their parents, relationships characterized mainly by a representation of themselves as in need of care and by a representation of other people as unwilling to provide it, therefore by the expectation of being rejected. This condition generates in the subject a tendency to organize one's existence without the love of others and not requiring their support, relying only on oneself and aiming at absolute self-sufficiency, not recognizing and not expressing one's needs, assuming attitudes of detachment and superiority. From these premises, intimacy becomes a threatening territory in terms of rejection, so that the individual soon learns to renounce it by devaluing it. At the same time, since the figure of attachment is perceived as distant and inaccessible, not manifesting the need for it appears as the best way to be able to gain a certain amount of closeness to it; together with this, the subject develops, on the one hand, the tendency to dissociate aspects of himself perceived as negative (desires and fragility) as they expose him to the further risk of being rejected, on the other hand, the tendency to assume attitudes that make him as lovable as possible in the eyes of the figure of attachment itself. At this point, the subject elaborates the conviction that proximity to the other must be imposed or extorted through a tight control, thus aiming at possessing the other, rather than being with him, in the certainty that the latter would never accept him, being able to choose him. Parallel to this, within a relationship in which the subject has the impression that the other is not there (either because he is absent, distant, disinterested or because he is physically present, but unable to listen to his needs), he gets used to considering his world of meanings as the only one existing; in this sense, also the invalidations coming from outside are filtered and not taken into consideration so that the subject develops the tendency to a grandiose representation of himself, the expectation of having to receive by right special treatments, the disposition to aggressive attitudes towards an environment that does not meet his expectations. The observations on early child-parent interactions also suggest the presence of a style of care in which the child is considered by the parent as a "means" through which to develop and enhance self-esteem, without ever being appreciated for his or her abilities and merits. Although the family environment of the subject with a narcissistic personality disorder may appear welcoming towards the latter the parental figures are generally devoid of empathy, emotionally cold and detached, profoundly incapable of satisfying their child's needs; in this sense, it frequently occurs that they attribute roles or functions to their children that are inappropriate compared to their normal evolutionary processes. In such circumstances, emotional deprivation on the part of parental figures seems to be at the basis of the angry attitude that most often individuals with narcissistic personality disorder tend to assume in the relational sphere. It also seems relevant to come from a family considered by most of the community as different based on ethnic, racial, geographical or economic status reasons. In such situations, the concept of self is characterized by feelings of inadequacy and inferiority,

envy, refuge in idealized fantasies, or attachment to people of prestige. The families of narcissists are frequently isolated from a social point of view, so the future narcissist, not developing the ability to recognize commonality and belonging to the group, solves the threat to self-esteem by clinging to the sense of superiority and believing to be "excluded because envied" [7,11,26].

The American doctor Alexander Lowen, founder of the school known as bioenergetics but of psychoanalytic school, is the best known among the first authors to dedicate monographic studies to pathological narcissism. He proposes a typing of the narcissistic personality disorder according to a scale, identifying some degrees, considered as having increasing gravity: the "phallic-narcissistic character", defined by Lowen as the least serious degree, followed by the "narcissistic character", then by what Lowen calls the borderline personality, the "psychopathic personality" and finally the "paranoid personality". This scale would correspond to an increase in the areas in which the personality is dysfunctional, a progressive loss of realism and increasing forms of grandeur, a progressive deficit in the ability to feel empathy for others as well as to perceive the authenticity of one's feelings [27].

From a cognitivist point of view, the heart of psychopathology lies in the processing of information that is altered due to dysfunctional beliefs, and thus leads to specific behavioral and emotional experiences; these structures, called "patterns", are like lenses through which we read what happens to us and get ideas about ourselves, others and the world. Patterns, according to Beck, develop during childhood through the interaction between predisposing biological factors and relationships with significant figures. When the child's primary needs are frustrated, specific "early maladaptive patterns" are configured, which in the case of narcissistic disorder concern emotional deprivation (feeling that one's emotional needs will never be satisfied in the relationship with others), sense of inadequacy and shame (the belief that one is wrong, inferior, and cannot be loved if the other discovers these weaknesses) and pretensions (tendency to feel superior to others, to compete for dominance and to think that one deserves special rights or privileges). The family context within which these patterns are formed would be characterized by loneliness and isolation, lack of rules and excessive permissiveness, exploitation or manipulation (for example, the child has been a tool to meet the needs of the parents) and conditional approval, i.e. the possibility of feeling special and loved only when the parents' standards are met. A particular attention to thought processes also characterizes the interpersonal metacognitive approach, which, although in line with the cognitive-behavioral model, adds to it significant aspects that we could define as over-ordered. In this model, the architecture of personality disorder is more complex and identifies as a central factor the compromise of metacognitive functions, i.e. the set of abilities that allow us to access our internal states and to grasp those of others. This set of functions is essential for the development of the Self and the construction of healthy interpersonal relationships, and it is for this reason that these aspects are strongly compromised in personality disorders [28].

Knowledge about the neurobiological functioning of the narcissist's mind is very limited, despite the high clinical relevance of the disorder and the tendency to underestimate its prevalence. In recent years, however, there has been an increase in contributions that deepen the black-biological functioning of the narcissist brain, intending to also give a neurobiological explanation of the cognitive, emotional, and behavioral aspects that characterize the functioning of these patients. In a pilot study in 2015, some authors analyzed the gray and white matter of six male patients with narcissistic personality disorder (NPD), comparing them with a control group of subjects without personality disorder. The results show

that patients with NPD show alterations in gray matter including anterior cingulate cortex, right prefrontal cortex, and bilateral medial prefrontal cortex. The evidence found in the frontal lobes provides a basis for hypothesizing an alteration in the structural connection of the prefrontal and subcortical areas. The latter include the cluster below the right lateral prefrontal cortex, such as the right anterior thalamic peduncle, the front-thalamic tract connecting the medial thalamic nuclei with the medial and lateral prefrontal cortex. This suggests that alterations in the white matter may contribute to structural cortical deficits. The results need to be replicated due to the small sample size, but a potential malfunction in the frontothalamic or front-limbic systems in patients with NDP could be hypothesized, as it has been found in other B-cluster disorders. A recent functional MRI study supports the hypothesis of the presence of a right lateral prefrontal anomaly associated with narcissism; in a non-clinical sample of subjects with the prevalence of narcissistic traits, there is a decrease in the activation of the right anterior insula and right dorsolateral prefrontal cortex. Given the scarcity of this type of research on NPD, the data of this study serve as a starting point for the development of a neurobiological model of the disorder that can take into account its different phenomenological manifestations. It can now be said that it is plausible that this structural prefrontal deficit may contribute to emotional dysregulation, cognitive deficits related to the attribution of responsibility, or coping strategies, which are some central aspects of the psychopathology of the disorder [10,11].

Clinical Treatments

The general treatment of narcissistic personality disorder is the same as for all personality disorders. Psychodynamic psychotherapy, which focuses on the underlying conflicts but can be scarcely effective if the form is particularly severe, as there is little scope for focused transference analysis and mentalization techniques. Cognitive-behavioral therapy can be beneficial to these patients, as the therapist can leverage the personality characteristics of the subject and model their behavior, as long as the patient is collaborative. After a first series of evaluation meetings, the therapist returns the case showing the patient the personal mental functioning (thoughts, emotions, behaviors) and therefore the thoughts and behaviors that generate suffering. The aim, first of all, is to replace such negative automatic thoughts with more adaptive and realistic ones using the technique of cognitive restructuring. A typical work is that on "all or nothing thinking" which consists in the tendency of narcissists to consider themselves either wonderfully superior or completely worthless. The restructuring of this form of thought does not question the value of narcissism but helps it to limit the excessive expectations it has about itself and others and to replace them with more realistic alternative beliefs such as: "One can be human, like everyone else, and still be unique"; "I can be happy to be like others, rather than always having to be the exception"; "Common things can be very pleasant". The same process of identification and substitution applies to dysfunctional behaviors, such as possible acting out of anger, characteristic of the disorder. To the purely cognitive therapy, it is necessary, afterward, to combine behavioral techniques and specific strategies to improve social skills such as the ability to manage anger, to enter into intimacy with the other, the expression of one's own needs without the need to use manipulation and empathy and therefore the ability to recognize the value and importance of the needs and feelings of others. Also the Schema Therapy, or more precisely Schema-Focused Therapy, as an integrated approach that combines aspects of cognitive-behavioral, experiential, interpersonal and psychoanalytic therapy in a single model of intervention, is very useful, to unravel toxic patterns or traps. Evidence in favor of drug therapy for the treatment of narcissistic personality disorder is rather scarce, except in cases where it is used for the

treatment of states of social anxiety, hypochondria, depression, states of angry impotence that most often motivate the request for help. Pharmacological therapy does not intervene on personality characteristics, but it can still be very useful for the treatment of possible secondary consequences. In particular, the drugs that can effectively act on the psychopathological phenomena frequently associated with narcissistic personality disorder are selective serotonin reuptake inhibitors (SSRIs), anticonvulsant drugs, and mood stabilizers [22,26,28].

CONCLUSION

Narcissistic personality disorder, together with borderline disorder and the large family of cluster A disorders are probably the most difficult therapeutic challenges to overcome, both because of the patient's lack of complete cooperation and their pervasiveness. If, on the one hand, genetics offers food for thought on trends towards grandiosity and the need for gratification, on the other hand, the socio-environmental and family condition plays a fundamental role in the genesis of this disorder, which certainly appears not as a unitary one but in the form of a "narcissistic spectrum", with a precise gradation and scale. From the healthy form of narcissism (zero form), we move on to the more dysfunctional and complex forms: Type I (benign), type II (oriented), type III (pathological, in its two forms "covert" and "overt"), further distinguishing five other forms by type. The best approach is undoubtedly the integrated one (psychotherapy and psychopharmacology), where patient awareness plays a fundamental role between cognitive-behavioral, strategic and dynamic techniques and strategies.

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