The Narcissistic Personality Disorder: Empirical Studies

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Abbreviations

ANCOVA	Analysis of covariance
ANOVA	Analysis of variance
APA	American Psychiatric Association
BDI	Beck Depression Inventory [Beck-Depressionsinventar]
BPD	Borderline personality disorder
BPS	Borderline-Persönlichkeitsstörung
CI	Confidence interval
CLPS	Collaborative Longitudinal Personality Disorder Study
D	Difference score D-score/D-index representing the IAT-effect
d	Cohen's measure of sample effect size for comparing two sample means
DAPP-BQ	Dimensional Assessment of Personality Pathology – Basic Questionnaire
df	Degrees of freedom
DSM-III	Diagnostical and Statistical Manual of Mental Diseases – Third Version
DSM-III-R	Diagnostical and Statistical Manual of Mental Diseases – Third Version - Revised
DSM-IV	Diagnostical and Statistical Manual of Mental Diseases – Fourth Version
DSM-IV-TR	Diagnostical and Statistical Manual of Mental Diseases – Fourth Version – Text Revision
DSM-5	Diagnostical and Statistical Manual of Mental Diseases – Fifth Version
ESS	Experiential Shame Scale
F	*F* distribution
GSI	General severity index
IAT	Implicit Association Test
ICD-10	International Classification of Diseases – Tenth Version
IRI	Interpersonal Reactivity Index
LPS	Leistungsprüfsystem
LSPD	Longitudinal Study of Personality Disorders
M	Sample mean
M.I.N.I.	Mini International Neuropsychiatric Interview
MANCOVA	Multivariate analysis of covariance
MASC	Movie for the Assessment of Social Cognitions
MET	Multifaceted Empathy Test
MSES	Multidimensional Self-Esteem Scale

n	number of cases in a subsample
N	number of cases
NPD	Narcissistic personality disorder
NPI	Narcissistic Personality Inventory
NPS	Narzisstische Persönlichkeitsstörung
OR	Odds ratio
p	Probability that the observed statistic occurred by chance alone
PD	personality disorder
PNI	Pathological Narcissistic Inventory
PS	Persönlichkeitsstörung
PTBS	Posttraumatische Belastungsstörung
PTSD	Posttraumatic stress disorder
r	Correlation coefficient
RCI	Reliable change index
SCID-I	Structured Clinical Interview for DSM-IV for Axis I Disorders
SCID-II	Structured Clinical Interview for DSM-IV for Axis II - Personality Disorders
SCL-90-R	Symptom-Checklist 90 revised [Symptom-Checkliste 90 revidiert]
SD	Standard deviation
SE	Self-esteem
SKID-I	Strukturiertes Klinisches Interview für DSM-IV für Achse-I-Störungen
SKID-II	Strukturiertes Klinisches Interview für DSM-IV für Achse-II-Persönlichkeits-störungen
SPSS	Statistical Package for Social Siences
STAI	State and Trait Anxiety Inventory
t	Student's/Welch's *t* distribution
TOSCA-3	Test of Self-Conscious Affects – Third Version

α	Cronbach's index of internal consistency
β	Population values of regression coefficients
χ^2	Chi-square distribution
η_p^2	Partial Eta squared - effect size
κ	Cohen's measure of agreement corrected for chance agreement
Λ	Wilk's multivariate test criterion
ρ	Spearmen's correlation coefficient
ω^2	Omega squared - effect size

Abstract

Narcissistic personality disorder (NPD) is discussed due to its inconsistent conceptualization. The aim of this study was to investigate a naturalistic sample of patients with NPD to collect empirical evidence and discuss the validity and clinical relevance of NPD. The survey is based on a multi-methodological conceptualization using structured clinical interviews, self-report questionnaires, and PC-based experiments. Two epidemiological studies are included in this thesis. Study 1 focused on the general mental stress of NPD patients and assesses Axis I and Axis II comorbidities, Study 5 looks at the stability and remission rate of the diagnosis and its diagnostical criteria. Study 1 found that NPD is associated with general mental stress and a high comorbidity rate for affective disorders and substance use disorders, Study 5 found that NPD demonstrates a moderate remission rate of about 53% that indicates a general changeability of the disorder. Further, three studies that focused on intrapsychic and interpsychic processes in NPD were included. In Study 2 and 3, self-related cognitions and emotions were examined. Study 2 investigated explicit and implicit self-esteem. It was determined that NPD is associated with a lower explicit self-esteem and an unaffected implicit self-esteem. Study 3 focused on shame-proneness in NPD that has been assessed on an explicit as well as on an implicit level. Patients with NPD showed significantly higher explicit and implicit shame-proneness. These results indicate that the narcissistic vulnerability characterized by low explicit self-esteem and high explicit and implicit shame-proneness is necessary in inpatients with a NPD. In Study 4, social cognitions and emotions were examined, particularly cognitive and emotional empathy. NPD patients displayed impairment in emotional empathy while cognitive empathy was unaffected.

In summary, the findings are in line with the critique that the diagnostic criteria of the DSM are too narrow to describe the entire manifestation of the disorder. Study 1-3 presented empirical evidence for the narcissistic vulnerability (general mental stress, low explicit self-esteem, high explicit and implicit shame-proneness) that is not represented by the current diagnostic NPD criteria, Study 4 provided empirical evidence for an unaffected cognitive empathy that is contrary to the seventh diagnostic criteria “lack of empathy”, and Study 5 calls the stable pattern of long duration (a basic criterion of personality disorders) into question. Implications for further research and clinical practice are discussed.

Zusammenfassung

Die Narzisstische Persönlichkeitsstörung (NPS) wird aufgrund ihrer inkonsistenten Konzeptualisierung stark diskutiert. Das Ziel der Studie war, eine naturalisitsche Stichprobe von Patienten mit einer NPS zu untersuchen, um mit empirischen Daten die Validität und klinische Relevanz der NPS zu diskutieren. Die Studie beruht auf einem multi-methodischen Konzept, in dem strukturierte klinische Interviews, Selbstbeurteilungsfragebögen und PC-basierte Experimente zur Anwendung kommen. Es wurden zwei epidemiologische Studien durchgeführt. Studie 1 betrachtet die allgemeine psychische Belastung von NPS-Patienten und erfasst Achse-I- und Achse-II-Komorbidiäten, Studie 5 schaut auf die Stabilität und Remissionsrate der Diagnose und der einzelnen diagnostischen Kriterien. Studie 1 fand, dass die NPS mit einer allgemeinen psychischen Belastung und hohen Komorbiditätsraten für affektive Störungen und Störungen durch Substanzkonsum einhergeht, Studie 5 fand, dass die NPS eine moderate Remissionsrate von ca. 53% aufweist, was eine generelle Veränderbarkeit der Störung kennzeichnet. Weiterhin beschäftigen sich drei Studien mit intrapsychischen und interpsychischen Prozessen der NPS. In Studie 2 und 3 wurden selbstbezogene Kognitionen und Emotionen untersucht. Studie 2 erforschte die explizite und implizite Selbstwertschätzung. Dabei zeigte sich, dass die NPS mit einem niedrigen expliziten Selbstwert aber einem unbeeinträchtigten impliziten Selbstwert einhergeht. Studie 3 betrachtete die Schamneigung auf der expliziten und impliziten Ebene bei der NPS. Patienten mit einer NPS zeigten eine signifikant höhere explizite und implizite Schamneigung. Diese Ergebnisse indizieren, dass die narzisstische Vulnerabilität, beschrieben durch einen niedrigen expliziten Selbstwert und einer hohen expliziten und impliziten Schamneigung bei stationären NPS-Patienten eine wichtige Rolle spielt. In Studie 4 wurden soziale Kognitionen und Emotionen untersucht, speziell die Fähigkeit zur kognitiven und emotionalen Empathie. NPS-Patienten zeigten eine Beeinträchtigung in ihrer Fähigkeit zur emotionalen Empathie, wobei die Fähigkeit zur kognitiven Empathie ungestört zu sein scheint.

Zusammenfassend passen die Ergebnisse in die aktuelle Kritik, dass die diagnostischen Kriterien des DSM zu eng sind, um das Störungsbild der NPS adäquat zu beschreiben. Studie 1–3 präsentieren empirische Hinweise für die narzisstische Vulnerabilität (allgemeine psychische Belastung, niedriger expliziter Selbstwert, hohe explizite und implizite Schamneigung), die nicht in den aktuellen diagnostischen NPS-

Kriterien repräsentiert wird, Studie 4 erbrachte empirische Hinweise für eine unbeeinträchtigte kognitive Empathiefähigkeit, was konträr zum siebenten diagnostischen Kriterium „Empathiemangel“ ist, und Studie 5 stellt die Beschreibung der NPS als stabiles Muster von langer Dauer (ein Grundkriterium der Persönlichkeitsstörungen) in Frage. Implikationen für weitere Forschung und für die klinische Praxis werden diskutiert.

1 Theoretical and Empirical Background

Narcissistic Personality Disorder (NPD) is the most strongly criticized personality disorder, but also the disorder with the most proponents. Its critics say that because of its nosological inconsistency, NPD is methodologically untenable (Alarcón & Sarabia, 2012; Karteruda, Øienc, & Pedersena, 2011), while on the other hand, its proponents call for more studies and therapy concepts for NPD because of its clinical relevance (e.g., Ronningstam, 2011; Pincus & Lukowitsky, 2010).

The objective of the present study is to provide empirical studies of the manifestation of NPD as a disorder and to consider issues of its epidemiology and phenomenology so as to obtain empirical data that would permit statements as to the validity of the profile of the disorder. The fact that a naturalistic clinical sample was studied allowed for the focus to remain directed on clinical relevance.

1.1 Narcissism and Narcissistic Personality Disorder

The nomological network surrounding the construct of narcissism is very wide, and there is no universal consensus in the literature with regard to the definition of narcissism and narcissistic psychopathology. Various psychological models attempt to describe the phenomenon. The two most well-known perspectives will be illustrated here briefly[1].

The concepts in use in clinical psychology, psychiatry and personality psychology have historically been based on psychoanalytical characterizations of narcissism. The term *narcissism* was originally introduced into the psychiatric discussion at the turn of the 19th/20th centuries by Ellis (1898) and Näcke (1899) as a neologism to describe an autoerotic disorder. The concept of narcissism was then appropriated up by Freud (1914) in psychoanalysis and was further developed in Kohut's self-psychology (1971, 1977) and in Kernberg's object relations theory (1970, 1975, 1984)[2]. According to Kohut (1977), this leads to development-related narcissism, in which an ideal self-image associated with fantasies of greatness and the need for admiration and idealization of the parents develops. Narcissism as a normal stage of development disappears as the child develops. However, if there is an absence of support from the parents (or primary

[1] The third perspective examines trends in critical social theories that discuss narcissism as a social problem (Lasch, 1979; Twenge & Campbell, 2009).

[2] Narcissism as a concept has been integrated into many other psychodynamic models described elsewhere (e.g., Grenyer, 2013; Bender, 2012).

caregivers), this can result in the child becoming insufficiently reconciled with reality, so that the ideal images of the self and the parents remain in place and express themselves in pathologically narcissistic behavior.

Kernberg (1984) describes how narcissistic behaviors serve as an attempt to compensate for negative self-esteem, positing that negative self-esteem arises from emotional deprivation in the form of devaluation, indifference or latent aggression on the part of the parents, and that it is accompanied by sadness, helplessness, and shame. This leads to the desire for attention becoming separated out (e.g., through rage and anger). In order to compensate for the threat to his self-esteem that has thus arisen, the child focuses on those aspects that are accepted and valued by his parents (e.g., achievements, appearance, talents), which in turn leads to the formation of the grandiose self. Herein Kernberg (1984) emphasizes the coexistence of feelings of inferiority and grandiosity in narcissistic individuals for the first time. These somewhat monocausal models of the development of narcissism can be supplemented by other models of disorders from other schools of therapy, but these will not be described in further detail here[3].

From a clinical psychology/psychiatry perspective, narcissism is understood to be a discrete nosological entity, and was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980; Millon, 1998) for the first time as *Narcissistic Personality Disorder* (NPD) on the basis of psychodynamic theories and clinical case studies. There are thus fundamental overlaps between the conceptions of narcissism of Kohut and Kernberg and the designation as a disorder.

Since 1980, several revisions (DSM-III-R, DSM-IV, DSM-IV-TR, American Psychiatric Association, 1987, 1994, 2000) of the diagnostic criteria for NPD have been made, and NPD was included again in the new DSM-5 (American Psychiatric Association, 2013) after hot debates (Shedler et al., 2010; Pilkonis, Hallquist, Morse, & Stepp, 2011). The diagnostic criteria for DSM-5 were adopted from DSM-IV-TR and contain the basic criteria for personality disorders (e.g., clinical significance and stability), the specific criteria and the additional criteria ("Diagnostic Features" and "Associated Features Supporting Diagnosis"). The specific diagnostic criteria for NPD are as follows:

[3] Further explanations of narcissism are offered in the form of the social learning theory (Millon & Everly, 1985), cognitive-behavioural (Beck & Freeman, 1999; Freeman & Fox., 2013), clarification-oriented (Sachse, Sachse & Fasbender, 2011), schema theory (Young, Klosko & Weishaar, 2005; Behary & Dieckmann, 2013) and interpersonal development and disorder models (Benjamin, 2003).

> "A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
> (1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements),
> (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love,
> (3) believes that he or she is "special" and unique and can only be understood by, or should associated with, other special or high-status people (or institutions),
> (4) requires excessive admiration,
> (5) has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations),
> (6) is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends),
> (7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others,
> (8) is often envious of others or believes that others are envious of him or her, and
> (9) shows arrogant, haughty behaviors or attitudes." (DSM-5, American Psychiatric Association, 2013, pp. 696-670).

Alongside this perspective, which focuses on the nature of the disorder, the personality and social psychology models do not define narcissism as pathological per se, but rather as a dimensional personality trait that can only be described as *pathological narcissism* in its extreme manifestation (Paulhus, 1998, Watson, 2005; Ronningstam, 2005a). Here narcissism refers to a variant of high self-esteem accompanied by positive affects (Morf & Rhodewalt, 2001) and mental well-being (Brown & Bosson, 2001). But when it is highly marked, it is associated with overestimations of the self, especially in terms of one's own attractiveness and intelligence (Gabriel, Critelli, & Ee, 1994; Campbell, Reeder, Sedikides, & Elliot, 2000) and with interpersonal problems that extend to aggression (Bushman & Baumeister, 1998; Campbell, Green, Wood, Tesser, & Holmes, 2008). In addition, it has been shown that a high degree of narcissism is correlated with unstable self-esteem (Zeigler-Hill, Clark, & Pickard, 2008).

The most widespread model was developed by Raskin and Hall (1981) on the basis of the DSM-III criteria and describes narcissism multidimensionally with characteristics such as authority, self-sufficiency, superiority, exhibitionism,

exploitativeness, vanity, and entitlement (Raskin & Hall, 1981; Foster & Campbell, 2007). The authors developed a self-report instrument for this, the Narcissistic Personality Inventory (NPI, Raskin & Terry, 1988), which assesses narcissism as a personality trait. However, the NPI does not permit a psychiatric diagnosis to be derived (NPD) but can only measure *subclinical narcissism* (Paulhus & Williams, 2002; Wallace & Baumeister, 2002; Vater et al., 2012). However, there is no established threshold to classify an individual as either normal or subclinically narcissistic.

The fact that narcissism does not appear to be one-dimensional has already been discussed in various theories and empirical studies. According to these, the construct of narcissism comprises two broad dysfunctional aspects: *narcissistic grandiosity* (overvalued, entitled self-image, exploitative, exhibitionistic behaviors, absorption in idealized fantasies, and other maladaptive self-enhancement strategies) and *narcissistic vulnerability* (depleted, enfeebled self-image, angry, shameful, depressed affects, self-critically, interpersonal hypersensitivity, social withdrawal, suicidal tendencies) (Pincus & Lukowitsky, 2009)[4]. More recent models describing narcissism attempt to take both aspects of grandiosity and vulnerability into account (e.g., the Pathological Narcissism Inventory with the subscales exploitativeness, grandiose fantasy, self-sacrificing self-enhancement, contingent self-esteem, hiding the self, devaluing, and entitlement rage; Pincus et al., 2009), but further research is needed here to ensure the validity.

In summary, *pathological narcissism* as an extreme version of the personality trait is closely associated with *Narcissistic Personality Disorder* as a diagnostic entity, as described in the DSM, but most authors agree that both constructs should be differentiated conceptually (Cain, Pincus, & Ansell, 2008; Pincus et al., 2009; Pincus & Lukowitsky, 2010). The lack of a gold standard for this contributes greatly to the criticism of NPD (Pincus & Lukowitsky, 2010).

1.2 Criticism of NPD

The classification of NPD as a disorder has oft been criticized (Pincus, 2011) as a result of the inconsistencies in conceptualization. The diagnostic criteria for NPD primarily comprise the characteristics of grandiosity (demonstrated by means of factor analysis, Miller, Hoffman, Campbell, & Pilkonis, 2008). However, the apparently paradoxical combination of narcissistic grandiosity and narcissistic vulnerability

[4] The literature also contains a distinction between overt and covert narcissism, which describe the two phenotypes of narcissism (e.g., Akhtar & Thomson, 1982). Other authors assume that these are two forms of expression, narcissistic grandiosity or narcissistic vulnerability (Pincus & Lukowitsky, 2009), and not two different types of narcissism. Other alternative models for differentiating the two aspects are clearly presented by Pincus and Lukowitsky (2009).

described in the literature is not reflected in the specific diagnostic criteria (Dickinson & Pincus, 2003; Pincus & Lukowitsky, 2010; Ronningstam, 2010; Miller, Widiger, & Campbell, 2010) despite the fact that there are often empirical references to these vulnerable aspects in narcissistic patients (Levy, Reynoso, Wasserman, & Clarkin, 2007; Russ, Shedler, Bradley, & Westen, 2008; Cain et al. 2008). This has decisive effects on the practice of treatment (Cain et al., 2008; Ronningstam, 2012).

Further critique concerns quality criteria such as the reliability and validity of the NPD (Zimmerman, 1994; Blais et al., 2001). If the diagnostic criteria are systematically assessed, then moderate to very good reliability values (.68 to .90) can be found for NPD (Blais, Hilsenroth, & Castlebury, 1997; Blais & Norman, 1997; Maffei et al., 1997; Blais, Benedict, & Norman, 1998; Grilo et al., 2001).

The diagnostic criteria for NPD have been studied in various validity studies. Blais and colleagues (1997) confirm the content validity of NPD, but they only studied the DSM-IV criteria for NPD. However, other studies have shown that the DSM criteria for NPD are too narrow to capture the characteristics of the disorder's manifestation in their entirety, particularly because they do not adequately consider the vulnerable aspects of the disorder (Russ et al., 2008).

Contradictory findings are also reported with regard to construct validity. Some studies prove the discriminant validity (Holdwick, Hilsenroth, Castlebury, & Blais, 1998; Fossati, Beauchaine, Grazioli, Carretta, Cortionovis, & Maffei, 2005), while others have shown large overlaps between the criteria for NPD and other personality disorders, especially antisocial, borderline, histrionic, and passive-aggressive personality disorders (Morey, 1988; Gunderson, Ronningstam, & Smith, 1995; Blais & Norman, 1997; Blais et al., 1998; Levy et al., 2007). Additionally, the high rates of comorbidity with Axis I disorders (e.g., Yates, Sieleni, Reich, & Brass, 1989; Taylor, 2005; Garno et al., 2005) and with other Axis II disorders (e.g., Westen, Shedler, & Bradley, 2006) indicate a low discriminant validity.

The construct problems and the fact that until now, NPD has only rarely been studied (Boschen & Warner, 2009; Alarcon & Sarabia, 2012; Morey & Stagner, 2012) call the clinical benefits of the description of the disorder into question (Krueger, 2010), and they were crucial to the initial lack of intention to include the diagnosis of NPD in DSM-5 (American Psychiatric Association, 2013). When this decision was made public, this led to great controversy (Shedler et al., 2010; Pilkonis et al., 2011), which demonstrated that NPD has many supporters who emphasize its clinical relevance (e.g., Pincus & Lukowitsky, 2010). Even if the NPD tends to be found quite rarely in samples of the general population (0-6%; Mattia & Zimmerman, 2001; Stinson, et al., 2008; Torgersen,

2009; Pincus & Lukowitzki, 2010; Trull, Jahng, Tomko, Wood, & Sher, 2010), its clinical relevance is apparent through the high prevalence rates of up to 37.5% in clinical settings (Zimmerman, Rothchild, & Chelminski, 2005; Garno et al., 2005; Stinson et al., 2008; Clemence, Perry, & Plakun, 2009).

Other studies have highlighted the clinical relevance of NPD to mental health services. NPD is thus associated with substantial impairments in the intrapsychic and interpsychic processes (Maccoby, 2000; Miller, Campbell, & Pilkonis, 2007; Cain et al., 2008; Volkan & Fowler, 2009; Ronningstam, 2011), a high rate of comorbidity with affective disorders and substance use disorders (Stinson et al., 2008), and an increased rate of suicidal behavior (Bronisch, Götze, Schmidtke, & Woltersdorf, 2002; Ronningstam Wienberg, & Maltsberger, 2008; Blasco-Fontecilla et al., 2009). But there is a dearth of empirical studies on the matter. Most of the studies are based on samples of non-clinical subjects or general psychiatric patients, and not all of the subjects suffered from NPD.

The present thesis aims to help address this gap in the literature and contribute to the research on NPD in terms of its psychopathological phenomenology. Empirical data will be presented for a more precise description of the disorder so as to justify the validity of the construct. In addition, by examining a naturalistic sample of NPD, the thesis will also focus on the general clinical relevance of the disorder. The study as a whole and its sub-projects are presented below.

1.3 Research Agenda

The five studies presented in this thesis are the result of a very broad-based study on the subject of “Narcissism and Narcissistic Personality Disorder”, which was a cooperation project between the Humboldt-Universität zu Berlin (Institute of Psychology), the Charité-Universitätsmedizin (Campus Benjamin Franklin, Department of Psychiatry), cooperating hospitals, and outpatient settings[5]. The objective was to study patients with NPD diagnosed in accordance with DSM-IV-TR in connection to epidemiological and phenomenological questions. Figure 1.1 is a schematic diagram of the multi-method conceptualization of the research project.

[5] The cooperating hospitals were the Asklepios Klinik Nord – Ochsenzoll, Hamburg; Kliniken im Theodor-Wenzel-Werk e.V. Berlin, Institut für Verhaltenstherapie Berlin GmbH and two psychiatry/psychotherapy practices in Berlin.

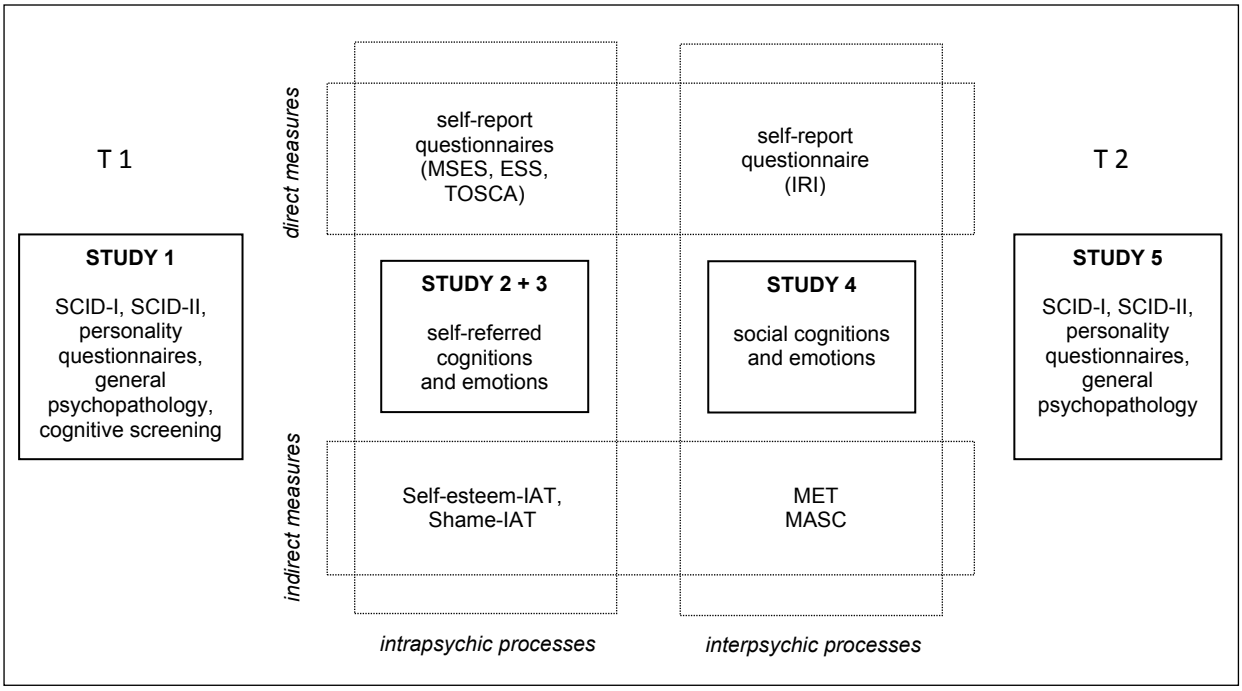

Figure 1.1. Conceptualization of the research project

Note. T1 = baseline measurement, T2 = 2-year follow-up, SCID-I = Structured Clinical Interview for DSM-IV – Axis I Disorders, SCID-II = Structured Clinical Interview for DSM-IV – Axis II Personality Disorders, MSES = Multidimensional Self-Esteem Scale, ESS = Experience of Shame Scale, TOSCA = Test of Self-Conscious Affects, IAT = Implicit Association Test, IRI = Interpersonal Reactivity Index, MET = Multifaceted Empathy Test, MASC = Movie for the Assessment of Social Cognitions

The context is provided by two epidemiological studies: a *cross-sectional study* of the comorbidities and the general mental stress of patients with NPD (Study 1: Ritter et al., 2010) and a *longitudinal study* of the prevalence and stability of the criteria and remission of the diagnosis of NPD (Study 5: Vater & Ritter et al., under re-review). The project is structured around three studies examining the specific personality psychopathology of the NPD. On the one hand, these involved *intrapsychic processes*, mainly comprising the self-referential cognitions and self-referential emotions of self-esteem (Study 2: Vater et al., 2013) and shame-proneness (Study 3: Ritter et al., under re-review). On the other hand, *interpsychic processes,* which primarily involve social cognitions and social emotions, were studied, namely the capacity for cognitive and emotional empathy (Study 4: Ritter et al., 2011). Thus personality differences in the emotional-cognitive area (Studies 2 and 3) and in the social area (Study 4) were examined with particular attention.

Thanks to its multi-method approach and the fact that it poses questions of differential psychology, this project contributes to the research in the central area of application of clinical psychology and psychiatry. All of the procedures were scrutinised

and approved by the ethics committee of the Charité-Universitätsmedizin Berlin[6]. All of the participants in the study provided their written informed consent following a comprehensive explanatory discussion with the leader of the study (the author)[7]. Three samples were included in the study: one group of NPD patients and one non-clinical control group. To investigate whether our findings are specific to NPD or reflect general psychopathology, we included a clinical control group of individuals with a borderline personality disorder (BPD) diagnosed in accordance with DSM-IV-TR. Figure 1.2 illustrates the composition of these groups.

[6] Application number EA4/128/05 scrutinised by ethics committee 4 at the Campus Benjamin Franklin on 15.11.2005 and 25.09.2007.

[7] The declarations of consent and the anonymised original data are archived at the Charité-Universitätsmedizin Berlin, Campus Benjamin Franklin, Klinik für Psychiatrie, Eschenallee 3, 14050 Berlin.

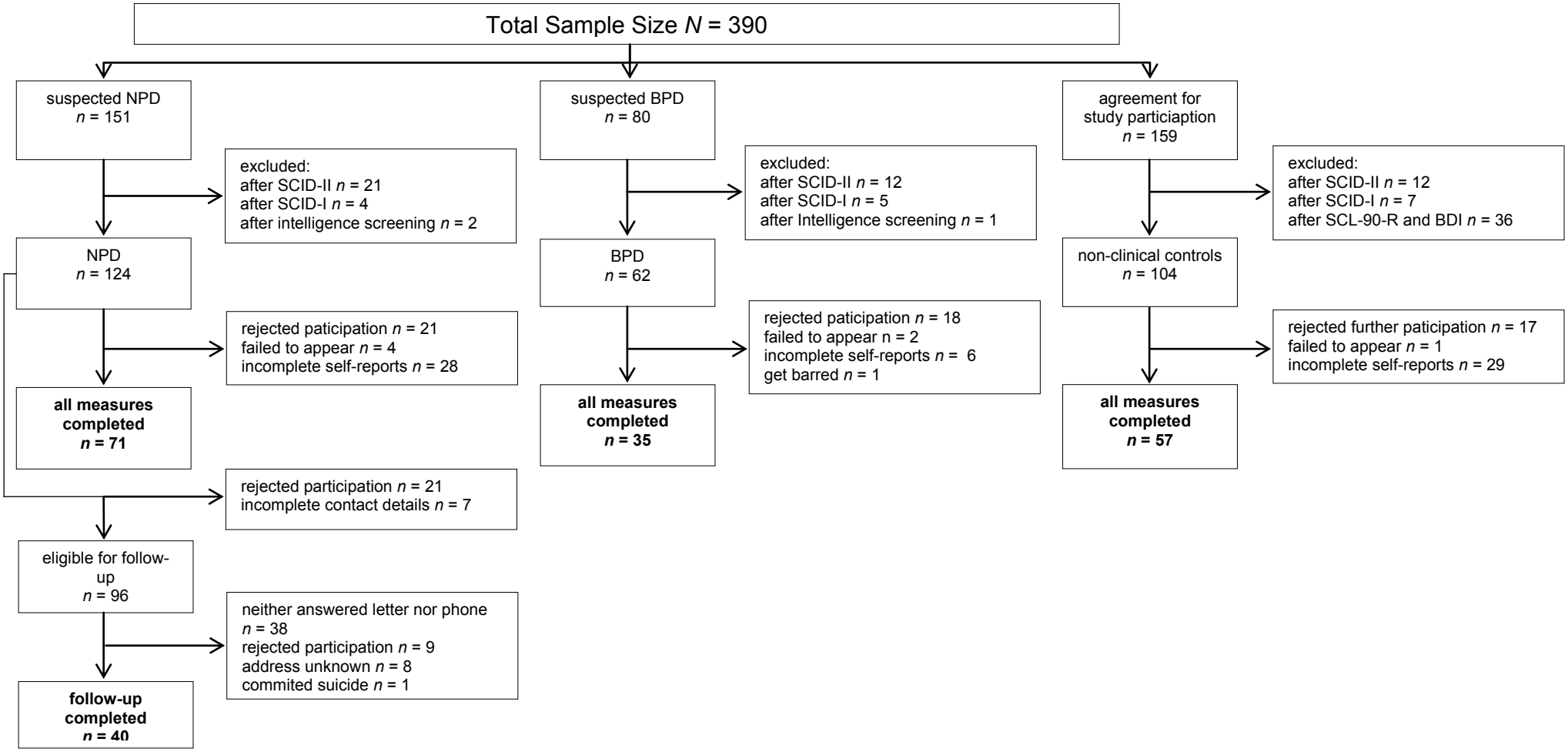

Figure 1.2 Flow of Participants in the Study

Note. NPD = narcissistic personality disorder, BPD = borderline personality disorder, NNC = non-clinical controls, n = number of participants, SCID-I = Structured Clinical Interview for DSM-IV – Axis I Disorders, SCID-II = Structured Clinical Interview for DSM-IV – Axis II Personality Disorders, SCL-90-R = Symptom-Check-List-90-Revised, BDI = Beck-Depression-Inventory.

The studies will now be introduced briefly.

Study 1: Comorbidities

The first study relates to an epidemiological question. The aim of the study was to examine what form the mental stress of patients with NPD takes and which comorbid disorders lead them to seek treatment. To answer this open question, patients with NPD were compared to patients with BPD with respect to the comorbid Axis I and Axis II disorders. Due to the high rate of comorbidity of NPD with BPD, a third group was also studied, consisting of patients with both diagnoses. Structured clinical interviews were held. Self-report questionnaires were used to establish the general mental stress.

Study 2: Self-esteem

The second study dealt with intrapsychic processes in NPD. The aim of the study was to examine self-referential dispositions, especially self-esteem, of NPD patients and to scrutinize hypotheses relating to the vulnerability of NPD patients. There has been a predominant assumption in the literature for some time that patients with NPD actually have low implicit self-esteem, which is compensated by exaggerated explicit self-esteem or grandiosity. The study assessed explicit self-esteem by means of questionnaires and implicit self-esteem by means of the Implicit Association Test (Greenwald & Farnham, 2000; Greenwald, McGhee, & Schwartz, 1998). In order to make statements on differential diagnoses, the results were compared with one clinical and one non-clinical group. A second aim of the study was to examine the extent to which discrepancies occur between explicit and implicit self-esteem, and whether these might explain the narcissistic psychopathology. This study relates to the first specific diagnostic criterion of the disorder (grandiosity).

Study 3: Shame

The third study primarily examined the vulnerable element in NPD patients. The nine diagnostic criteria do not contain any explicit mentions of vulnerability, but the additional information in DSM-IV does. Here experiencing shame is highlighted as an example. The aim of the study was to examine shame on an explicit level, as measured by self-report questionnaires, and on an implicit level, as measured by the Implicit Association Test. Study 3 assumed that NPD patients will exhibit higher values for experiencing explicit and implicit shame-proneness as compared to non-clinical control subjects. In order make specific statements, the results were compared with one clinical and one non-clinical control group. This study relates to an additional criterion for NPD.

Study 4: Empathy

In addition to the intrapsychic processes (self-referential cognitions and emotions in Study 2 and Study 3), the aim of Study 4 was to examine the interpsychic processes (social cognitions and emotions) of NPD patients. Empathy is understood as an essential requirement for people to function interpersonally. Since NPD is described as a disorder that is accompanied by major interpersonal conflicts, the aim of Study 4 was to create an empirical basis for the criterion of lack of empathy. To do this, the capacity for cognitive and emotional empathy was measured by a traditional questionnaire (Interpersonal Reactivity Index, Davis, 1983; German version: Paulus, 2006) and by two new experimental procedures (Multifaceted Empathy Test, Dziobek et al. 2008; Movie for the Assessment of Social Cognitions, Dziobek et al., 2006). The study comprised patients with NPD as well as one clinical and one non-clinical control group. It was assumed that the patients with NPD would demonstrate greater impairments of their capacity for cognitive and emotional empathy than would the control groups. Study 4 also aimed to examine the construct validity (especially the convergent validity) of “lack of empathy”. The study thus relates to the seventh specific diagnostic criterion of the disorder.

Study 5: Stability

Study 5 examines the stability of the diagnosis. Personality disorders are defined as long-lasting (DSM-IV-TR, APA, 2000; ICD-10, Dilling, Mombour, & Schmidt, 2000), like NPD. The literature already contains several examples of empirical evidence that the rates of change of personality disorders are quite high. The aim of the study was therefore to examine the prevalence and remission rates of the individual diagnostic criteria in patients with NPD. For this, 96 baseline patients and, two years later, 40 follow-up patients were questioned by means of standardized diagnostic procedures (interviews and questionnaires). This study relates to a basic criterion of personality disorders (stability).

2 Studie 1: Komorbiditäten

Komorbiditäten bei Patienten mit einer Narzisstischen Persönlichkeitsstörung im Vergleich zu Patienten mit einer Borderline-Persönlichkeitsstörung

Referenz:
Ritter, K., Roepke, S., Merkl, A., Heuser, I., Fydrich, T. & Lammers, C.-H. (2010). Comorbidity in patients with narcissistic personality disorder in comparison to patients with borderline personality disorder [Komorbiditäten bei Patienten mit einer Narzisstischen Persönlichkeitsstörung im Vergleich zu Patienten mit einer Borderline-Persönlichkeitsstörung]. *Psychotherapie, Psychosomatik, medizinische Psychologie, 60*, 14-24.

DOI: 10.1055/s-0028-1102943

3 Study 2: Self-esteem

When Grandiosity and Vulnerability Collide: Implicit and Explicit Self-Esteem in Patients with Narcissistic Personality Disorder

Reference:
Vater, A., Ritter, K., Schröder-Abé, M., Schütz, A., Lammers, C. H., Bosson, J., et al. (2013). When grandiosity and vulnerability collide: Implicit and explicit self-esteem in patients with narcissistic personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry 44,* 37-47.

DOI: 10.1016/j.jbtep.2012.07.001

4 Study 3: Shame

Shame in Patients with Narcissistic Personality Disorder

Reference:
Ritter, K., Vater, A., Rüsch, N., Schröder-Abé, M., Schütz, A., Fydrich, T., Lammers, C.-H., & Roepke, S. (under re-review). Shame in patients with narcissistic personality disorder. *Psychiatry Research*

DOI: 10.1016/j.psychres.2013.11.019

5 Study 4: Empathy

Lack of Empathy in Patients with Narcissistic Personality Disorder

Reference:
Ritter, K., Dziobek, I., Preißler, S., Rüter, A., Vater, A., Fydrich, T., Lammers, C.-H., Heekeren, H.R., & Roepke, S. (2011). Lack of empathy in patients with narcissistic personality disorder. *Psychiatry Research, 187*, 241-247.

DOI: 10.1016/j.psychres.2010.09.013

6 Study 5: Stability

Stability of Narcissistic Personality Disorder:
Tracking the Categorical and Dimensional Rating Systems across Two Years

Reference:
Vater, A., Ritter, K., Renneberg, B., Strunz, S., Ronningstam, E., & Roepke, S. (under re-review). Stability of narcissistic personality disorder: Tracking the categorical and dimensional rating systems across two years. *Personality Disorders: Theory, Research, and Treatment*

DOI: 10.1037/per0000058

7 General Discussion

The aim of the present studies was to examine the manifestation of the narcissistic personality disorder (NPD) in a clinical naturalistic sample with respect to intra- and interpsychic processes, and to make statements about epidemiological questions. In this way, the study aimed to gain information about the narcissistic psychopathology, especially the general mental stress and narcissistic vulnerability, as well as additional information that would reinforce the validity of NPD. The intention was for the findings to provide empirical indicators of the clinical relevance of the NPD. The findings of the five studies are summarized below, and will be discussed with respect to their implications for further research and treatment practice. Reflection on the strengths and limits of the studies will comprise the conclusion of the paper.

7.1 Integration of the results

Study 1: Comorbidities

The first study determined the comorbidities and the general mental stress of patients with NPD. The results indicate a high prevalence of affective disorders and substance use disorders in NPD patients, and indicate similarly high rates of prevalence to those of patients with BPD or patients with diagnoses of both NPD/BPD.

In comparison to the clinical comparison groups, NPD patients seemed to suffer less stress than the comparison subjects (lower number of comorbid Axis I and Axis II disorders, lower depressivity and lower general symptomatic stress). However, taking the results of Studies 2 and 4 into account, NPD patients showed a significant higher general mental stress than did the non-clinical control subjects.

The findings are limited to patients admitted for inpatient treatment. Future comparative studies are needed to examine whether the comorbidity rates are similarly high in patients with NPD in an outpatient setting or individuals fulfilling DSM-IV-TR or DSM-5 NPD criteria patients who are not undergoing psychiatric treatment or psychotherapy.

A problem to be noted here is the fact that the comorbidity problem so strongly criticized in the literature (Fydrich, 2008; Livesley, Schroeder, Jackson, & Lang, 1994) is also reflected in this study. This is not merely a problem immanent to the system, because according to DSM-IV-TR (and the same applies for ICD-10) precisely as many psychiatric diagnoses need to be encoded as are necessary to describe the clinical

picture as a whole – and this gives rise to high comorbidity rates (Alarcón & Sarabia, 2012; Skodol, 2012; Karteruda et al., 2011).

Research implications arise through the question of how NPD is associated with the comorbid disorders. The joint occurrence of affective disorders or substance use disorders together with NPD might provide indicators of a shared etiology or pathogenesis. It could be supposed in principle that one disorder represents the prerequisite for the development of a second disorder (Gaebel & Zielasek, 2008). However this can only be understood as a hypothesis, because when applying the comorbidity principle, the aim is not to characterize primary and derivative disorders in terms of contemporaneousness or pathogenesis, so the relationship between the disorders remains unclear. Long-term studies and/or family studies would be useful for examining these associations.

Another implication of the research is that the motives for therapy should be examined in more detail. Generally it is the ego-dystonic symptomatic disorder and less often the personality disorder—here the strongly ego-syntonic NPD—that determines the motivation to seek therapy and represents the cause of the therapy (Fydrich, 2001). In light of this, one might hypothesize that life events (Brown & Harris, 1989) involving great stress might have had corrosive effects and accordingly triggered psychopathological symptoms such as low explicit self-esteem (Study 2), so-called temporary or recurrent narcissistic crises (Henseler, 2000).

One therapeutic implication that may be derived from Study 1 is that when treating NPD patients, the motivation for therapy and the treatment task must first be clarified. The “Motivorientierte Indikations- und Interventionsmodell für die kognitive Verhaltenstherapie bei Persönlichkeitsstörungen [Motivation-oriented model for indication and intervention in cognitive-behavioral treatment of patients with personality disorders]” (MIIM; Fydrich, 2001) could prove helpful in this task. When NPD is experienced strongly ego-syntonically, the therapist should focus on treating the index disorder, because when experienced ego-syntonically, the narcissistic elements of personality are not accessible to metacommunication (Fiedler, 2007) due to biased self-presentation (Lanyon, 2004), self-deception (Paulhus, 1984), or lack of self-insight (Robins & John, 1997). In this case, the therapist should take the NPD into account when structuring the therapy in order to encourage compliance and prevent the therapy from being broken off prematurely. If the narcissistic personality traits are experienced ego-dystonically, the focus of the therapy should be to treat both the NPD and the comorbid disorder. Therapeutic strategies for the treatment of NPD have been suggested by various schools of therapy, such as transference-focused psychotherapy (Stern,

Yeomans, Diamond, & Kernberg, 2013), cognitive-behavioural therapy (Beck & Freeman, 1999; Freeman & Fox, 2013), clarification-oriented psychotherapy (Sachse, Sachse, & Fasbender, 2011), and schema therapy (Dieckmann, 2011; Behary & Dieckmann, 2013).

Study 2: Self-esteem

The second study showed that patients with NPD exhibited lower explicit self-esteem as compared to non-clinical subjects, but did not differ from the non-clinical subjects with regard to implicit self-esteem. It was not confirmed whether the trait of grandiosity in NPD involves partly unconscious low self-esteem as described in the mask model (Kernberg, 1975). However, the low explicit self-esteem might be an indicator of the vulnerable side of NPD (Dickinson & Pincus, 2003; Pincus et al., 2009) that is currently only described in the additional diagnostic criteria for the NPD ("Diagnostic Features" and "Associated Features Supporting Diagnosis", DSM-5, American Psychiatric Association, 2013) but is not capable with a structured clinical interview (e.g., SCID-II, First et al., 1997; Fydrich et al., 1997). Diagnostical instruments that assess the narcissistic vulnerability are thus needed.

In addition, discrepancies between explicit and implicit self-esteem, especially the combination of high implicit and low explicit self-esteem, are accompanied by an increased severity of narcissism. The study thus replicated previous findings that showed that discrepancies in self-esteem are accompanied by poorer psychological health and can lead to dysfunctional behavior (Schröder-Abé, Rudolph & Schütz, 2007; Franck et al., 2007a; Vater et al., 2010; Rudolph et al., 2010).

The findings of the study allow for the hypothesis that fluctuations between grandiosity and vulnerability may occur in NPD patients. These could be triggered by mental crises (Ronningstam, 2009; Kernberg, 2009; Horowitz, 2009), and the associated low explicit self-esteem (correlated with dysfunctional cognitions and negative affectivity) might have been crucial for the patient to seek psychiatric treatment/psychotherapy (Cain et al., 2007; Pincus et al., 2009). This assumption could be checked by measuring the changes in self-esteem at different times. Short-term fluctuations in self-esteem as reactions to specific situations have already been postulated by different authors (Kernberg, 1975; Kohut, 1988; Morf & Rhodewalt, 1995). A long-term measurement providing evidence for changes in the grandiosity criterion and thus in self-esteem can be found in Study 5.

Study 3: Shame-proneness

The third study examined the explicit and implicit shame-proneness of NPD patients. Here two important findings are to be noted. Firstly, patients with NPD reported higher explicit shame and shame-proneness than did non-clinical subjects, confirming previous theoretical assumptions (Martens, 2005; Ronningstam et al., 2010; Pincus & Lukowitsky, 2010). Secondly, NPD patients also displayed significantly higher implicit shame-proneness than did healthy subjects.

The study provided empirical evidence that both the grandiose aspects of NPD and also the vulnerable aspects described in the literature can be of clinical relevance. There is ambiguity as to what extent the grandiose traits that constitute the narcissistic picture in DSM-IV-TR (and also in the current DSM-5) should be regarded as compensation strategies that no longer exert a stabilizing function for the patients studied, and thus might have led to the inpatient stay. Indications that vulnerable features most often promoted treatment utilization may be found in the literature (Cain et al., 2007; Pincus et al., 2009).

With regard to the findings from Study 2 (low explicit self-esteem but unaffected implicit self-esteem) and the findings from Study 3 (high explicit and implicit shame-proneness) the question arises as to what is the relationship between the constructs of self-esteem and shame-proneness. The connection between self-esteem and shame has already been examined in earlier studies by means of questionnaires, and moderate negative correlations were found (r = -.42) (Tangney & Dearing, 2002). However, this connection does not appear to be absolute, but it seems that it could be influenced by a wide variety of factors, such as coping skills (Tangney & Dearing, 2002). Thus it could be assumed that over time, for example, particular abilities, skills, and academic or professional success have led to positive implicit self-esteem (Schröder-Abé et al., 2007). Repeatedly being judged negatively by other people (as applicable through parental socialization) or experiencing negative life events might have led to increased shame-proneness. The explicit negative self-esteem and the explicit increased shame-proneness might be explained by feeling hurt (e.g., through criticism) or so-called narcissistic crises (in term of the damaged self-esteem, Schröder-Abé et al., 2007; Henseler, 2000). To understand the dynamic between self-esteem and shame-proneness long-term studies that also investigate subjects suffering from NPD not currently receiving inpatient psychiatric treatment/psychotherapy are required. Theories on the fluctuations in self-esteem (between grandiosity and vulnerability) have already been described in the literature (Ronningstam, 2009; Kernberg, 2009; Horowitz, 2009). On the basis of the correlative connection between self-esteem and shame, we could

also suppose that fluctuations exist in the way shame is experienced, but this assumption needs to be studied empirically.

Study 4: Empathy

The fourth study demonstrated that NPD patients are cognitively capable of empathy but exhibit emotional impairment. The study thus provides the first empirical indicators that a “lack of empathy”, as described by the seventh diagnostic criterion of DSM-IV-TR (and now also of DSM-5), exists in NPD patients. But the need for differentiated consideration also becomes apparent, since this criterion alone does not distinguish between cognitive and emotional aspects of empathy. A recent study has shown that NPD patients not only display impairments in terms of their emotional empathy, but that they are also limited in their emotion detection abilities, which points towards a limited capacity for cognitive empathy (Marissen, Deen, & Franken, 2012). The differences between the two studies may be due to the different instruments used to measure empathy and the different characteristics of the samples. Thus in Study 4, the MET and MASC were used, which also presented further information (background information, language, gestures) in addition to facial expressions. The test subjects thus had to process far more information than was the case in the facial recognition task used by Marissen and colleagues (2012). Another study examined the neurobiological bases for the lack of empathy in NPD patients, and found that in NPD patients or those with high narcissism, there were structural abnormalities in the frontal paralimbic brain regions (Schulze et al., 2013). The authors found here that the lower capacity for emotional empathy is accompanied by a lower gray matter volume in the left anterior insula (Schulze et al., 2013; Fan et al., 2011). However, the findings of the study have yet to be replicated.

If we take into account the findings of Study 3, one implication for research might be the hypothesis that increased shame-proneness (explicit/implicit) in NPD patients is accompanied by a lower capacity for emotional empathy. In the literature, shame is described as a self-referential emotion that focuses the sufferer’s attention on intrapsychic processes (e.g., internal attributions, vegetative symptoms, avoidance behavior). However, emotional empathy, or feeling (positively or negatively) the sentiments of another individual, requires the focus to be placed on that other person. The self-focus might prevent an empathic reaction (Tangney, 1991; 1995). The first empirical evidence of this has already been demonstrated in an independent correlation study of children, adolescents and adults: shame-proneness is inversely correlated with the capacity for empathy (Tangney, 1991; Tangney, Wagner, Burggraf, Gramzow, &

Fletcher, 1991). Studies examining this hypothesis that differentiate between cognitive and emotional empathy are needed.

Study 5: Stability

The long-term study examined the prevalence and remission rates of individual criteria of NPD, measured by means of an SCID-II interview over a period of two years. The stability of the dimensional personality pathology (measured by means of DAPP-BQ) was also recorded over the two-year period. At follow-up, the categorical diagnosis according to DSM-IV-TR displayed a moderate remission rate of 53%. The criteria 'need for admiration' and 'envy' occurred frequently and were stable, while 'lack of empathy' and 'arrogance' were less prevalent but stable. 'Belief of uniqueness' was less prevalent and unstable, while 'fantasies of unlimited success' occurred frequently and was unstable. Dimensional traits, on the other hand, were more stable over the two years.

To summarize, an inconsistent picture with respect to the prevalence and stability of the diagnostic criteria is apparent, which, however, indicates that the individual traits and thus also the diagnosis appear to be somewhat changeable. These findings contradict the definition of NPD as a "stable pattern of long duration" (American Psychiatric Association, 2013, p. 647). Other studies have also found that personality disorders display moderate-to-high remission rates (Grilo et al., 2004; Shea et al., 2002; Zimmerman, 1994). The results of the present study can therefore be situated in this strain of the literature. However, it is unclear in the present study as to what circumstances led to the changes. Hence, further research might examine the factors that might have contributed to the remission (or continuance) e.g., corrective experiences in life (Alexander, 1956) such as professional success or positive interpersonal relationships (Ronningstam & Gunderson, 1996), or psychotherapeutic support.

For treatment practice, the findings implicate that NPD appears, in principle, to be changeable. This leads to the question of how treatable the disorder is. According to the current treatment guidelines for personality disorders (Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde, 2009), psychotherapy is the method of choice. Until now there have only been interventional approaches, which contain potential for the effective treatment of NPD. Thus initial suggestions for treating patients with NPD or patients with pathological narcissism are offered by schema therapy (Behary & Dieckmann, 2013; Dieckmann, 2011), clarification-oriented psychotherapy (Sachse et al., 2011), cognitive therapy (Beck & Freeman, 1999; Freeman & Fox, 2013), transference-focused psychotherapy (Stern et al., 2013), the metallization approach (Lecours, Briand-Malenfant, & Descheneaux, 2013), and the self-psychology approach

(Liberman, 2013). Randomized controlled trials need to be held to evaluate these therapeutic approaches (e.g., Nezu & Nezu, 2007).

7.3 Integrating the results into DSM-5

The results of the studies have demonstrated that inpatients with NPD diagnosed according to DSM-IV-TR exhibit clinically relevant psychopathological characteristics that are not explicitly listed in the diagnostic DSM-IV-TR criteria (e.g., low explicit self-esteem, high explicit and implicit shame-proneness). The current DSM-5 has taken over the diagnostic criteria for describing NPD from DSM-IV-TR, and supplemented these with an alternative model (American Psychiatric Association, 2013, pp. 761-781) in order to improve the reliability, validity and clinical usefulness of the description of "Personality and Personality Disorders" (Zimmerman, 2011). Below, the results of the five studies will be integrated into the new model, because the reconceptualization in the DSM-5 carries major significance for the research community.

According to the alternative model, the first step is to assess the "Level of Personality Functioning", i.e., self-functioning (identity and self-direction) and interpersonal functioning (empathy and intimacy). The results of Studies 2-4 can be integrated here. The following was defined for NPD: "Identity: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal inflated or deflated, or vacillating between extremes; emotional regulation mirrors fluctuations in self-esteem […]" (American Psychiatric Association, 2013, p. 767). Explicit negative self-esteem and explicit and implicit high shame-proneness can be integrated here. The fact that DSM-5 does not differentiate between explicit and implicit characteristics is limiting here, but nonetheless the grandiose and vulnerable aspects of the disorder that have been postulated to co-exist can be taken into account (Levy et al., 2007; Cain et al., 2008; Ronningstam, 2009, 2010; Miller et al., 2010). With regard to interpersonal functioning (empathy and intimacy), DSM-5 offers the following description: "Empathy: Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimate of own effect on others" (American Psychiatric Association, 2013, p. 767). The results of Study 4 (limited capacity for emotional empathy, unimpaired capacity for cognitive empathy) can be integrated here. Thus DSM-5 points out that empathy is an "ability", and not a motivational aspect as described in the specific diagnostic criteria for NPD by such language as "unwilling…" (American Psychiatric Association, DSM-5, p. 670). No explicit differentiation between cognitive and emotional aspects of empathy is made, so the terms must be specified in the future. One could assume that "recognize"

might be an allusion to the cognitive components and “excessively attuned to reactions of others” an allusion to the emotional components of empathy. But then the results of Study 4 would be contrary to the definition in DSM-5, which indicates that the formulations are crucial to the interpretation and should therefore be stated in concrete terms.

The second step in the alternative DSM-5 model is to assess pathological personality traits. Here grandiosity and attention seeking are defined as being typical of NPD as aspects of antagonism (American Psychiatric Association, 2013). Study 5 points out that particularly the diagnostic criteria “need for admiration” (subsumed under attention seeking), “grandiosity”, “arrogance”, and “belief of uniqueness” (subsumed under grandiosity) appear to be the most stable traits and can thus be regarded as characteristic of NPD. However, because grandiosity and attention-seeking cannot cover the entire profile of the disorder and the assumed vulnerable aspects of the disorder are not apparent here, the manifestation of all the other personality disorder trait domains suggested by the alternative DSM-5 model (negative affectivity, detachment, antagonism, disinhibition, and psychoticism) and their facets must also be described (American Psychiatric Association, 2013).

The problem of the high comorbidities particularly between personality disorders (“innere Komorbidität [internal comorbidity]”, Fydrich, 2008; Livesley et al., 1994) that has come under criticism must be addressed by DSM-5. Yet diagnoses that exhibit high rates of co-prevalence with other personality disorders, such as BPD, are still included in the alternative DSM-5 model. Thus the problem of “internal comorbidity” might continue to exist even if only 6 personality disorders (instead of the previous 11 plus 2 research diagnoses) can now be diagnosed (Bornstein, 2011; Zimmerman, 2011).

At present it is impossible to provide an unambiguous answer to the question of whether the dimensional model suggested in DSM-5 illustrates the structure of NPD better than did the previous categorical approach in accordance with DSM-IV-TR. A newly developed instrument for measuring personality functioning is currently undergoing evaluation in the form of the General Assessment of Personality Disorder (GAPD; Hentschel & Livesley, 2013), but further research is needed.

7.3 Strengths and limits of the study

The present study examined the manifestation of NPD. One strength of the study is that a respectable number of cases (n = 124) with a standardized diagnosis of NPD in accordance with DSM-IV-TR were included in a naturalistic sample, and a second measurement was undertaken after two years. In addition, not only was a non-clinical

control group included, but the results were also compared to a clinical comparative sample to investigate whether the findings are specific to NPD or reflect only a general psychopathology within an inpatient sample.

The quality of personality disorder diagnoses is repeatedly questioned and criticized (Fydrich, Schmitz, Dietrich, Heinicke & König, 1996; Saß et al., 1996; Mulder, 2002; Fydrich, 2008). In the studies submitted, a multi-method approach was employed when measuring the personality disorders. In the interest of maintaining objectivity and reliability, the categorical diagnosis was undertaken by means of a standardized and structured interview (SCID-II, First et al., 1997; Fydrich et al., 1997) and the dimensional diagnosis by means of self-report questionnaires. These were based upon the Dimensional Assessment of Personality Psychopathology – Basic Questionnaire (DAPP-BQ), which particularly illustrates pathological narcissism (Livesley & Jackson, 2009). This was intended to support the validity of the NPD diagnosis. In addition, agreement among three interviewers who demonstrated high reliability values for the two diagnoses of relevance to the study was obtained (Cohen's κ = .797 for NPD and Cohen's κ = .820 for BPD). One might criticize the fact that the calculation was based on a very small sample size (n = 8 patients, with 3 raters each time). Reliability analyses should be undertaken with larger samples. The validity of the diagnoses should also be supported by third-party assessments (e.g., from relatives or people who have known the patients for many years).

A further strength of the study is the multi-method design. The studies used reliable and valid measurement methods from social and personality psychology in the central area of application of clinical psychology and psychiatry, and thus enabled the traits specific to NPD to be studied (especially shame-proneness, self-esteem and the capacity for empathy). As a positive factor, we can highlight the fact that two approaches were selected each time, one direct (through self-report questionnaires) and one indirect (through the PC-based procedures IAT, MET and MASC). This allowed for access to unconscious processes that might be inaccessible to verbalization (Fazio and Towles-Schwen, 1999, Rüsch et al., 2007b; Greenwald and Banaji, 1995; Pelham and Hetts, 1999). In addition, this approach also took into account the tendency towards self-expression in narcissistic subjects (Klonsky, Oltmanns, & Turkheimer, 2002; Paulhus & John, 1998).

The studies in this paper highlight limits that must be discussed. The basis of the studies was a naturalistic sample; in other words, patients were studied in the way in which they would be encountered in the inpatient settings of general psychiatry. This meant that the generalizability of the findings had to be limited, because there is limited

scope for directly transferring these to the outpatient setting or to people with NPD in the general population who are not undergoing psychiatric treatment or psychotherapy. The patients were in fact only examined for the study after they had been in the inpatient setting for two weeks in order to rule out acute mental crises and distortions of the personality disorder diagnosis (Fydrich et al., 1997), but all the same it can be assumed that patients initially treated as inpatients exhibit a higher general mental stress or greater severity of the disorder than outpatients. Conversely it can, of course, also be assumed that NPD patients with higher vulnerable elements (negative self-esteem, angry, shameful, and depressed affectivity, suicidal tendencies, interpersonal hypersensitivity, social withdrawal) will tend to seek treatment due to the pressure of suffering these cause them (Cain et al., 2007; Levy et al., 2009). The specific factors that brought the patients to inpatient treatment (symptoms of the comorbid axis I or axis II disorder or symptoms of the grandiose/vulnerable side of NPD) must be examined in future studies.

In this context, we should be critical of the fact that most patients were treated psychopharmacologically. This was necessary insofar as most patients exhibited an Axis I disorder requiring drug-based treatment. However, the studies submitted here only included patients who were not treated with sedative drugs (e.g., Benzodiazepines). The possibility of the results being confounded by drugs was ruled out by means of a corresponding statistical control of the results (by ensuring internal validity).

To further ensure the internal validity, age and gender were included in the statistical analyses as possible confounding variables (by means of covariance analyses) because the samples were too small to account for age and gender as additional factors when designing multi-factorial variance analyses. A reasonable alternative would have been to parallelize the samples with respect to these characteristics, but this was not feasible because of the naturalistic samples. Here it should be pointed out that the NPD sample was expected to contain a preponderance of men, and the BPD sample was expected to contain a preponderance of women. According to the American Psychiatric Association, 50-75% of NPD patients are male (American Psychiatric Association, 1994). Meta-analysis has revealed that BPD patients in the clinical sector are 76% women (Paris, 2003). The sample in this study was based upon a similar ratio, which means that the findings can well be generalized to other inpatient settings. To date, no data is available on the average age of NPD patients in an inpatient setting. Stinson and colleagues (2008) reported that most of the subjects with NPD in a general sample of the population in the USA were between the ages of 30 and 44. The present sub-sample (n = 62) display an average age of 36, which lies within this range. There is data

demonstrating that the distribution of the average age of BPD patients receiving inpatient treatment has two peaks: the first peak is in adolescence (14 years), and the second is in early adulthood (24 years; Jerschke, Meixner, Richter, & Bohus, 1998). The younger average age of the BPD patients in the present study as compared to the NPD patients is thus understandable.

However, it should be discussed whether a sample with BPD patients forms a suitable comparison sample. BPD is one of the personality disorders that has best been studied empirically (Gunderson, 2011) and provides a great deal comparative data and previous findings. The manifestations of both disorders exhibit a large overlap of symptoms such as affective dysregulation, impulsiveness and unstable relationships (Blais et al., 1997), and a high comorbidity rate (Westen, Shedler, & Bradley, 2006). The BPD group is thus an appropriate comparison group for examining whether the results obtained are specific to NPD and thus could also be used where appropriate as features to differentiate between NPD and BPD. This will require not only analyses of the differences between the groups, but also, among others, the use of logistical regression analyses to study the likelihood of a person belonging to one group depending on independent variables (Backhaus, Erichson, Plink, & Weiber, 2006). However, it would be prudent to have further clinical comparison groups. As an example, patients with an antisocial personality disorder/psychopathy would be suitable with regard to studying the question of lack of empathy, because in these subjects, impairments of their emotional empathy have been identified while their cognitive empathy remains unimpaired (Wiehe, 2003; Blair 2005b, Goldberg et al., 2007). Patients with Cluster C personality disorders would serve as a suitable comparison group with regard to the questions of low self-esteem and high shame-proneness because increased shame-proneness has been reported amongst such patients (Schoenleber & Berenbaum, 2010).

In Study 5, there were a substantial number of dropouts. The analyses are based on endpoint analyses, which only include patients who were present at the first and second measurement dates in the data evaluation. According to Hollis and Campbell (1999), this might have led to the clinical efficacy being overestimated. However, because no therapeutic interventions were examined in this study, intent-to-treat analyses (which replace the missing values by estimates based on the values at the first measurement date; Hollis & Campbell, 1999), for example, are less suitable in terms of their content. A valid estimate of the symptoms after two years would be subject to some doubt because the patients were no longer all in a clinical setting at the follow-up measurement. The dropout analysis (Chapter 6.3.1) demonstrated that the severity of the pathological narcissism and the prevalence rates of the NPD criteria did not differ

between the patients who took part in the follow-up measurement and those who did not. This means that the categorical and dimensional pathological narcissism values, the general mental stress and depressivity at the baseline measurement did not cause any significant distortion of the data, and thus had no adverse effect on the validity of the findings. One might criticize the high dropout rate, but in previous studies this rate has been as high as 64% (Hilsenroth et al., 1998). The dropout rate here of approximately 58% is actually below this level.

In the present study, relatively clear inclusion and exclusion criteria for participation in the study were defined. As a result, there might be a bias with respect to the exclusion of especially severely ill patients. This decision is justified insofar as in these patients, especially as a result of cognitive impairments (concentration disorders, formal and content-related thought disorders, IQ < 80[8], acute suicidality), self-reports by means of questionnaires and also working through PC-based procedures would not be possible, and in the case of the acute suicidality, would not be ethically defensible.

7.6 Summary and conclusion

Narcissistic personality disorder (NPD) is characterized as “A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy […]” (American Psychiatric Association, 2000, p. 669), but this description does not tell the whole story. With regard to intrapsychic processes, here self-referential cognitions and emotions, various authors (e.g., Pincus & Lukowitsky, 2009; Russ et al., 2008; Cain et al., 2008) note that in addition to the diagnostic criteria that describe the grandiose element of the disorder (Miller et al., 2008), NPD patients also exhibit psychopathological traits that clarify the vulnerable side of NPD. This assumption is supported by the results of the present study: inpatient NPD patients demonstrate lower explicit self-esteem and higher explicit and implicit shame-proneness than do control subjects. Thus the validity of the first diagnostic criterion of NPD (grandiosity) is thrown into question. These findings and the high symptomatic stress in the NPD sample examined here indicate that aspects of narcissistic vulnerability play a major role in those NPD patients who enter inpatient treatment, and accordingly should also be taken into account during psychiatric treatment/psychotherapy. This confirms the existence of one of the additional diagnostic criteria of NPD.

With respect to the interpsychic processes, the present study of social cognitions and emotions demonstrated that the lack of empathy defined in DSM-IV-TR only relates

[8] Self-assessments are less reliable in patients with an IQ below 80 (von Zerssen, 1975).

to the emotional components, and that the cognitive capacity for empathy is unimpaired. Thus the seventh diagnostic criterion is only partially confirmed in terms of its validity.

With regard to stability, a moderate remission rate after two years was ascertained, although the diagnostic criteria proved to be stable to differing degrees. It thus becomes clear that there is a need to question the definition of NPD as a “stable pattern of long duration” (American Psychiatric Association, 2013, p. 647), the basic criteria for personality disorders. In principle, the findings clarify that the diagnosis varies, but that it might be confirmed by psychotherapeutic interventions as appropriate. Generally it is apparent that the definitions of NPD and its characteristics are still too imprecise, and the conceptualization of NPD and thus its validity need to be the subject of further empirical study. For this, consideration should also be given to the alternative suggestion in DSM-5 that the symptoms of narcissism be described dimensionally.

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Curriculum vitae

For reasons of data protection the curriculum vitae in not available in the online version of this dissertation.

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Selbständigkeitserklärung

Ich versichere, dass ich die Dissertation selbständig und ohne unerlaubte Hilfe angefertigt habe. Die benutzten Hilfsmittel sowie die Literatur sind vollständig angegeben. Ich habe die Dissertation an keiner anderen Universität eingereicht und besitze keinen Doktorgrad im Fach Psychologie. Die Promotionsordnung der Mathematisch-Naturwissenschaftlichen Fakultät II der Humboldt-Universität zu Berlin vom 17.01.2005, zuletzt geändert am 13.02.2006, veröffentlicht im Amtlichen Mitteilungsblatt Nr. 34/2006 ist mir bekannt.

Berlin, 21.08.2013

Kathrin Ritter