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Brief report

Pathological narcissism and the depressive temperament

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ABSTRACT

Background: Although relations between depressive and narcissistic pathologies have been proposed in both psychoanalytic and phenomenological literatures, empirical research generally fails to confirm this link. Common measures of narcissism, however, emphasize grandiose rather than vulnerable traits, and include both adaptive and maladaptive features. We therefore assessed the relation between narcissistic personality and depressive temperament (DT) using a recently developed measure designed to assess a wide range of pathological narcissistic (PN) traits. We also examined the distinctiveness of the association between DT and PN controlling other temperaments.

Method: The Pathological Narcissism Inventory (PNI; Pincus et al., in press), the Temperament Evaluation of the Memphis, Pisa, Paris, and San Diego Auto-questionnaire (TEMPS-A; Akiskal et al., 2005), and a modified Schedule of Fatigue and Anergia (SOFA; Hadzi-Pavlovic et al., 2000), were administered to 228 university students.

Results: Principal component analyses yielded two components of PN: Component 1 items reflect narcissistic vulnerability—negative affect when narcissistic needs are not met; Component 2 items reflect narcissistic grandiosity—positive affect related to self-enhancement. Component 1 significantly predicted DT, an effect that remained after controlling for Component 2 and other temperaments in the TEMPS-A and SOFA. A similar effect was observed for the anxious temperament.

Limitations: Our study is limited by the use of a homogenous, non-clinical university student sample unscreened for clinical depression, and by reliance on self-report questionnaires.

Conclusions: Contrary to past research, DT is associated with narcissistic disturbance, in particular with the avoidance of narcissistic injury, when the PNI is used. Clinical intervention targeting this avoidance might help patients with a DT develop self-esteem that is not overly dependant upon recognition from others.

1. Introduction

The psychoanalytic literature describes, in a variety of contexts, a relation between depressive and narcissistic traits (see Anastasopoulos, 2007 for a comprehensive review). Milrod (1988), for example, argues that depression arises from narcissistic injury caused by the self-representation falling short of the wished-for self-image, whereas Rathvon and Holmstrom (1996) posit that narcissism is a defense against a primary depression. German phenomenologists also suggest a relationship between narcissistic and depressive disturbance, although less explicitly. "Depressive psychopaths," for instance, are portrayed as feeling that they belong to "an aristocracy of suffering" (Schneider, 1958). Moreover, Kretschmer (1925) proposed that depressive disturbance underlies the "hypomanic character," a construct that Fulford et al. (2008) find overlaps considerably with narcissistic personality.

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By contrast, empirical research on narcissism and depression has found them to be uncorrelated (e.g., Corruble et al., 1996) or even inversely related (e.g., Sedikides et al., 2004). Previous study of narcissistic traits has been significantly impacted by the use of the Narcissistic Personality Inventory (NPI; Raskin and Hall, 1979), the primary or only measure of narcissistic traits used in approximately 77% of social/personality research on narcissism (Cain et al., 2008). The NPI total score is a confusing mixture of adaptive and maladaptive narcissistic traits (Emmons, 1984). Non-pathological expressions of narcissism may contribute to self-esteem and well-being and are related to assertion of interpersonal dominance, achievement motivation, and a tendency to endorse positive illusions about the self (Pincus et al, in press; Sedikides et al., 2004). It is not surprising that research using this instrument has suggested that narcissism is unrelated to, or inversely related to, depression. Notably, the NPI's more pathological subscales, Entitlement and Exploitativeness, are positively related to depression when variance associated with other, more adaptive subscales is removed (Watson and Biderman, 1993).

Pincus et al. (in press) argue that the NPI measures a limited scope of narcissistic characteristics, assessing only the more grandiose aspects of narcissism, neglecting more vulnerable narcissistic traits. A review of the clinical literature (Cain et al., 2008) reveals two phenotypic expressions narcissistic pathology, confirmed by factor-analytic studies of narcissistic traits (e.g., Rathvon and Holmstrom, 1996; Wink, 1991). The first is narcissistic grandiosity, characterized by arrogance, exploitativeness, and self-absorption. The second is narcissistic vulnerability, characterized by shyness, inhibition, and modesty, punctuated by affective dysregulation when strong needs for admiration and idealized expectations for self and others are not met. Thus narcissistic vulnerability, rather than narcissistic grandiosity, is likely related depressive risk by evoking a strong awareness of the discrepancies between what is fantasy and reality (Dickinson and Pincus, 2003). Indeed, an association between narcissism and depression has been found when using measures of vulnerable narcissistic traits (Rathvon and Holmstrom, 1996; Wink, 1991).

This study investigated the premise that certain vulnerable and more maladaptive narcissistic traits are positively associated with depressive traits. We therefore assessed the relation between several components of grandiose and vulnerable pathological narcissism (PN) and depressive temperament (DT), the trait expression of major depression which persists between episodes of the disorder (Maremanni et al., 2005). In order to evaluate the distinctiveness of associations found, we controlled for other disordered temperaments and also evaluated a number of other such temperaments in terms of their own relations to PN. We predicted that DT would have a unique relation beyond the other temperaments to aspects of PN, in keeping with the psychoanalytic and phenomenological literatures.

2. Method

2.1. Participants

Our sample consisted of 228 undergraduates, 177 females and 42 males, aged 19–75 years old (mean 26). Participants, receiving extra course credit for their participation, were recruited from Concordia University's Department of Psychology Participant Pool. There were no exclusion criteria.

2.2. Measures

The Pathological Narcissism Inventory (PNI; Pincus et al., in press) is a 52-item, multifactorial questionnaire that assesses seven components of narcissism: Contingent Self-Esteem (CSE); Exploitativeness (EXP); Self-Sacrificing Self-Enhancement (SSSE); Hiding the Self (HS); Grandiose Fantasy (GF); Devaluing (DEV) and Entitlement Rage (ER). Each of the seven subscales was found to be reliable in the current sample (CSE $\alpha = .95$; EXP $\alpha = .84$; SSSE $\alpha = .73$; HS $\alpha = .80$; GF $\alpha = .92$; DEV $\alpha = .91$; ER $\alpha = .91$).

The Temperament Evaluation of the Memphis, Pisa, Paris, and San Diego Auto-questionnaire (TEMPS-A; Akiskal et al., 2005) is a 60-item, self-report questionnaire that assesses depressive, cyclothymic, irritable, hyperthymic and anxious temperaments. Each of these temperaments was internally consistent in the current sample (cyclothymic $\alpha = .89$; depressive $\alpha = .88$; angry $\alpha = .80$; hyperthymic $\alpha = .82$; anxious $\alpha = .88$), and has previously been shown to have high test–retest reliability (Spearman's coefficients: cyclothymic = .84; depressive = .79; angry = .81; hyperthymic = .87; anxious = .87; Akiskal et al., 2005).

A modified version of the Schedule of Fatigue and Anergia (SOFA; Hadzi-Pavlovic et al., 2000) was administered to assess 'asthenic temperament', an additional disordered temperament described by the early German phenomenologists (Herpertz et al., 1998). The same instructions and rating scale as the TEMPS-A were used to assess longstanding traits, instead of those occurring over the past month only, as specified in the original SOFA. This 10-item, self-report questionnaire was found to be internally consistent in the current sample ($\alpha = .77$).

2.3. Procedure

After providing informed consent, participants completed all questionnaires over the internet. Afterwards, they were presented with a written debriefing form.

3. Results

We conducted three principal component factor analyses of the PNI with promax rotation ([kappa] = 4). The PNI items yielded seven components that reflected the seven subscales of PN. Further analyses of the PNI individual items and the seven subscales were conducted, anticipating two higher-order components that reflect narcissistic grandiosity (EXP, GF, and SSSE) and narcissistic vulnerability (CSE, ER, DEV, and HS), identified in previous confirmatory factor analyses (Wright et al., 2008). Analysis of the scree plot detected two superordinate components in which all items had primary loadings greater than .40, as expected, in replication of previous results. Component 1 (narcissistic vulnerability) and Component 2 (narcissistic grandiosity) were positively correlated, $r = .16$, $p < .05$. Correlation analyses were performed assessing DT's association with PNI Components 1 and 2, as well as with the total score (see Table 1).

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The distinct relationships between each disordered temperament and component of the PNI were assessed with six hierarchical multiple regression analyses. PNI components were included in Block 1 and the disordered temperaments were entered in Block 2. Using an alpha criterion of $p < .008$ to avoid alpha inflation, depressive (see Table 2) and anxious temperaments were both positively predicted by PNI Component 1, controlling the effects of the other temperaments. Hyperthymic temperament was positively predicted by PNI Component 2 and negatively predicted by PNI Component 1 when controlling for the other temperaments.

4. Discussion

Our results replicated two dimensions of PN representing narcissistic grandiosity and narcissistic vulnerability (Cain et al., 2008; Pincus et al., in press; Pincus and Lukowitsky, in press; Wright et al., 2008). Our analyses suggest the two-component structure of PN can be, in part, distinguished by the affectively positive or negative content of the items. Vulnerability items tend to reflect negative affects when a narcissistic need is not met, whereas grandiosity items tend to reflect positive affects associated with narcissistic self-enhancement strategies.

Davidson's (1993) approach-withdrawal motivational model of emotion may help to explain our identification of two components of PN, only one of which is related to DT. This model, supported by over 70 studies (see Coan and Allen, 2003 for review), proposes that left asymmetrical brain activation in the prefrontal cortex is associated with dispositional tendencies to approach rewarding incentives, whereas relative right-frontal brain activation indicates motivational tendencies to withdrawal or avoid in response to negative stimuli.

Narcissistic grandiosity seems to involve approach motivation towards self-enhancement experiences. Approach motivation (both trait and state), associated with relative left anterior brain activation, is linked with decreased depressive affect (e.g., Henriques and Davidson, 1991). Narcissistic vulnerability, on the other hand, reflects avoidance motivation that is associated with relative right-frontal brain activation and increased depressive affect. Individuals with narcissistic personality may only be vulnerable to develop DT, as hypothesized in the psychoanalytic literature, when they have high trait-levels of avoidance motivation.

On the other hand, narcissism has been conceived of as a defense against depression. If this is the case, then we would expect that narcissistic individuals might not admit to their depressive affect in a self-report questionnaire. Tomarken and Davidson (1994) find that resting anterior asymmetrical left-hemisphere brain activation that is associated with approach motivation is linked with a repressive–defensive coping style, which leads them to conclude that the link between relative left-frontal brain activation and low scores on self-reported depressive symptoms might be due to enhanced levels of self-deception. This suggestion highlights the complex nature of trying psychometrically to assess symptoms of depression within the narcissistic personality. Future research employing physiological and neuropsychological – in addition to self-report – measures might facilitate more objective study of the relation between narcissistic and depressive-spectrum disorders.

Our initial results showed that narcissistic vulnerability is positively related to anxious, cyclothymic, and asthenic, in addition to depressive, temperaments. Hierarchical regression analyses demonstrated, however, that depressive and anxious temperaments are separately and uniquely related to narcissistic vulnerability, over-and-above the effects of other temperaments. These findings imply that the relation of depressive and anxious temperaments with narcissistic vulnerability cannot simply be attributed to shared variance with a more general construct, such as negative emotionality or neuroticism, or to a negative style of self-presentation. As well, this approach eliminates the possibility that the lack of a relation between narcissistic grandiosity and DT is due to overlap with other disordered temperaments. It is especially striking that narcissistic vulnerability was predictive of DT while controlling for anxious temperament as these constructs have considerable conceptual overlap and comorbidity (Watson, 2005) and were found to be significantly correlated (see Table 2) in the present study. Moreover, the PNI items – unlike the TEMPS – assess narcissistic content, negating the possibility that the observed relationships are due to item similarity in the two questionnaires.

DT appears to be associated specifically with the avoidance of narcissistic injury rather than approach of grandiose desires. This is consistent with the proposal (e.g., Sorotzkin, 1985) that individuals with depressive disorders try to live up to a grandiose self-image in order to avoid humiliation and shame. Research should further examine the role of narcissism and the maintenance of self-esteem in the depressive temperament. Clinicians might find it useful to address these issues in the treatment of DT.

Anxious temperament was unexpectedly predicted by Component 1 while controlling for other disordered temperaments. These results are consistent with Watson and Biderman's (1993) finding of a relation between trait anxiety and the Entitlement and Exploitative subscales of the NPI.

The results of the present study may have important implications for the ongoing debate about the validity of including Depressive Personality Disorder (DPD), currently listed as a diagnosis in need of further study, in the American Psychiatric Association's fourth edition of the Diagnostic and Statistical Manual of Mental Disorders - Text Revision (APA, 2000). Temperament represents the biological 'core' of personality and its extreme or pathological expression (Maremanni et al., 2005). Therefore, the results of the current study can likely be generalized to depressive personality as well as DPD. While much debate and empirical research have focused on DPD's distinctiveness from dysthymia and other Axis II

Table 1
Intercorrelations for the TEMPS-A dimensions with PNI total and factor scores ($N = 228$).

Variables	PNI score	PNI Factor 1	PNI Factor 2
TEMPS-A— depressive	.48*	.60*	.01
TEMPS-A— anxious	.45*	.52*	.04
TEMPS-A— cyclothymic	.51*	.55*	.13
TEMPS-A— aesthenic	.24*	.35*	−.11*
TEMPS-A— angry	.43*	.40*	.19*
TEMPS-A— hyperthymic	−.06	−.28*	.50*

Note. TEMPS-A = The Temperament Evaluation of the Memphis, Pisa, Paris, and San Diego Auto-questionnaire; PNI = The Pathological Narcissism Inventory.
* $p < .05$.

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Table 2
Summary of beta values for regression analyses predicting temperaments ($N = 228$).

Predictor variables	Regression analyses (dependent variable)					
	Analysis 1 (depressive)	Analysis 2 (anxious)	Analysis 3 (cyclo.)	Analysis 4 (aesthenic)	Analysis 5 (angry)	Analysis 6 (hyper.)
Model 1: two pathological narcissism dimensions						
PNI Factor 1	.61*	.53*	.55*	.38*	.38*	−.35*
PNI Factor 2	−.11	−.05	.05	−.17*	.13	.56*
Model 2: two pathological narcissism and five temperament dimensions						
PNI Factor 1	.29*	.25*	.15	.02	.13	−.33*
PNI Factor 2	−.06	−.05	.12	−.18*	.10	.54*
TEMPS-A— depressive	N/A	.21*	.25*	.07	.05	−.10
TEMPS-A— anxious	.17*	N/A	.09	.07	.19*	.01
TEMPS-A— cyclothymic	.30*	.12	N/A	.51*	.27*	−.01
TEMPS-A— aesthenic	.60*	.07	.35*	N/A	−.01	.00
TEMPS-A— angry	.04	.17*	.16*	−.01	N/A	.06
TEMPS-A— hyperthymic	−.08	.01	−.01	.00	.07	N/A

Note. PNI = The Pathological Narcissism Inventory; TEMPS-A = The Temperament Evaluation of the Memphis, Pisa, Paris, and San Diego Auto-questionnaire.
* $p < .008$ (.05/6 analyses).

personality disorders, its overlap with NPD has been largely ignored. Many researchers (e.g. Cain et al., 2008) argue that the DSM NPD criteria are in need of revision to include vulnerable, as well as grandiose, and strictly pathological criteria. Close inspection of the relation between PN and DPD is needed to figure out the best method of classification in the DSM.

Future research should examine the specific combinations of temperaments that underlie pathological personalities such as narcissistic PD. For instance, various combinations of depressive, anxious, and hyperthymic temperaments may contribute to the development of narcissistic personality.

Our study is limited by the use of a homogenous, mostly female, non-clinical college student sample, not screened for clinical depressive-spectrum disorders. The results may well, however, apply to patient populations, because personality structure is essentially the same in clinical and non-clinical samples (O'Connor, 2002). Nonetheless, further analyses with NPD and DPD populations, with an equal number of males and females, will be necessary to establish further the clinical relevance of these findings. A second limitation is the reliance on self-report questionnaires, which are susceptible to social desirability biases and may also be affected by the mood of the respondent (Chamberlain and Huprich, submitted for publication). Future research would be strengthened by the addition of observer rating scales and implicit tests. Moreover, this preliminary investigation suggests a need for more refined testing of specific psychoanalytic and phenomenological hypotheses about the dynamic relation between narcissistic personality and depressive temperament.

Unlike previous studies that only measured narcissistic grandiosity and found no relationship between depressive and narcissistic features, this study demonstrated that when the full scope of pathological narcissism is assessed, a link between DT and narcissism is confirmed. DT is clearly indicating narcissistic oversensitivity to the lack of admiration by others. The clinical implications of this finding are significant: it is crucial to find ways to help patients with a DT develop self-esteem that is less contingent upon recognition from others. This may also require a therapeutic focus on their affective reactivity, interpersonal coldness, and social avoidance.

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Conflict of interest
All authors declare that they have no conflicts of interest.

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