



Interpersonal problems associated with narcissism among psychiatric outpatients

John S. Ogronczuk^{a,*}, William E. Piper^a, Anthony S. Joyce^b, Paul I. Steinberg^a, Satna Duggal^b

^a Department of Psychiatry, University of British Columbia, Suite 420 – 5950 University Boulevard, Vancouver, BC, Canada V6T 1Z3

^b Department of Psychiatry, University of Alberta, Edmonton, Alberta, Canada

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ABSTRACT

Narcissistic personality disorder is the subject of extensive discussion in the literature. Yet, the validity of this diagnostic category remains questionable. This is owed, in large part, to the relative absence of empirical work that has examined narcissism in clinical samples. Descriptions and findings from studies involving non-clinical samples suggest that narcissism is associated with considerable interpersonal impairment. The objective of the present study was to examine this possibility in a sample of psychiatric outpatients. Consecutively admitted patients ($N = 240$) to a day treatment program completed measures of narcissism, interpersonal problems, and general psychiatric distress. Patients were categorized into high, moderate, and low narcissism groups. The groups were compared on overall interpersonal impairment, as well as on particular domains of interpersonal behavior. Treatment duration and discharge status were also compared among the three groups. Analysis of covariance and chi-square analyses were used. At baseline, higher levels of narcissism were significantly associated with greater interpersonal impairment. The interpersonal style of the more narcissistic patients was particularly characterized by domineering, vindictive, and intrusive behavior. At post-treatment, only the association between narcissism and intrusive behavior remained significant. Change in interpersonal difficulties following treatment did not differ significantly among the groups. However, failure to complete treatment was associated with narcissism. The results underscore the interpersonal impairment associated with narcissism and support the notion of narcissistic personality disorder as a valid diagnostic category.

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1. Introduction

The DSM-IV describes narcissistic personality disorder as a pervasive pattern of grandiosity, need for admiration, and lack of empathy. Narcissists are preoccupied with fantasies of unlimited success, believe they are special and unique, require excessive admiration, have a sense of entitlement, are exploitive, lack empathy, and are arrogant. They exaggerate minor achievements, expect praise and recognition without doing anything to earn it, and feel entitled to express their opinion without being burdened by listening to those of others (Rivas, 2001).

Narcissistic personality disorder was accepted as an Axis II diagnosis for the first time in DSM-III, nearly three decades ago. Yet, despite its inclusion in our official diagnostic nomenclature and its common usage among clinicians, narcissistic personality disorder is controversial and of uncertain validity (Levy et al., 2007). Indeed, Gunderson et al. (1995) acknowledge that the greatest problem with narcissistic personality disorder is its lack of validation through such external criteria as a specific etiological pathway, a specific course or treatment response, or its ability to predict important clinical phenomena. Such validation information is nec-

essary in order to help make this diagnostic category clinically useful.

An increasingly large number of studies on narcissism exist within the social-personality psychology literature. However, their relevance to clinicians and usefulness for providing the kind of findings that are required to validate the concept of narcissistic personality disorder is limited (Miller et al., 2007). This is due to the fact that these studies almost always rely on non-clinical samples (typically undergraduate students) and use measures of narcissism that do not fit well with the DSM criteria for narcissistic personality disorder. Comparatively, there has been far less research on narcissism in clinical samples (Bradley et al., 2005). The clinical literature that does address narcissism is largely composed of theoretical and descriptive reports (Levy et al., 2007).

Within the clinical literature, authors have described how narcissism significantly impairs interpersonal relationships. For the narcissist, interpersonal relationships are used to buttress or support a self that cannot internally sustain a sense of well-being (Kohut, 1984). The narcissistic individual is apt to regulate self-esteem through domination of others, denial of any form of reliance on another person, intimidating demands, denigration of others for not meeting expectations, and devaluation of people that threaten his or her sense of superiority (Campbell and Baumeister, 2006; Gabbard, 1998; Millon and Davis, 1996). Thus, interpersonal

* Corresponding author. Tel.: +1 604 822 8034; fax: +1 604 827 4106.
E-mail address: ogroncz@interchange.ubc.ca (J.S. Ogronczuk).

exploitation and exhibitionism are employed to create an illusion of self-importance. Svrankic (1990) argued that the interpersonal relations shaped by the immature superego of the narcissist are characterized by parasitism, exploitiveness, distrust of others, and pathological rivalry. Robbins and Dupont (1992) describe a vicious cycle, in which the faulty interpersonal behavior of the narcissist results in a breakdown of social relations and the concomitant reinforcement of these same faulty interpersonal behaviors that are used to bolster a fragile sense of self.

Consistent with the clinical descriptions offered above, studies of narcissism in the social-personality psychology field have found that narcissism is associated with hostility toward others (Bushman and Baumeister, 1998), interpersonal difficulties of a domineering/vindictive nature (Dickinson and Pincus, 2003; Pincus and Wiggins, 1990), and attachment behavior that is characterized as cold, defensive, and emotionally detached (Smolewska and Dion, 2005). Unfortunately, there have been few studies of interpersonal functioning associated with narcissism in clinical samples. A notable exception is a recent study by Miller et al. (2007). These authors found that narcissism was significantly related to causing pain and suffering to others, and that this interpersonal impairment mediated the association between narcissism and psychological distress. The finding suggesting that narcissism can have a negative impact on others is consistent with that of Bradley et al. (2005). Their study found that expert clinicians' accounts of counter-transference responses to patients with narcissistic personality disorder were most frequently characterized by the following responses: "I feel annoyed in sessions with him/her"; "I feel used or manipulated by him/her"; "I lose my temper with him/her"; "I feel mistreated or abused by him/her"; and "I feel resentful working with him/her".

Given the consistency in clinical accounts and the convergence of these accounts with findings from studies of non-clinical samples, it seems logical to examine the association between narcissism and interpersonal functioning in a clinical sample in an effort to contribute to the validation of narcissistic personality disorder. Thus, the objectives of the current study are as follows: (1) To assess the association between narcissism and interpersonal problems, both concurrently and longitudinally; and (2) To assess the unique predictive power of narcissism in predicting interpersonal problems, when controlling for the other Cluster B personality disorders (i.e., Histrionic, Antisocial, Borderline). A third objective of the study is to assess whether narcissism is associated with therapy duration and discharge status. This objective addresses interpersonal functioning less directly (i.e., dropping out of treatment might be interpreted as reflecting immature interpersonal behavior). Nevertheless, it examines the relevance of narcissism to an important clinical phenomenon. It is important to note that the present study focused solely on symptoms of narcissism that are consistent with the DSM-IV definition of NPD, and cannot speak to the broader construct of narcissistic pathology, such as covert narcissism, that is discussed in the literature (Cain et al., 2008).

2. Method

2.1. Patients and recruitment

Participants were 240 consecutively admitted outpatient psychiatry patients from the Day Treatment Program of the University of Alberta Hospital in Edmonton, Canada. It is an intensive outpatient group therapy program directed at improving the individual's well-being and effective functioning in the community. There are generally 35 patients attending. Two or three patients enter treatment on the Monday of a given week, and two or three patients are discharged per week (i.e., the program has a rolling enrolment). Pa-

tients meet for seven hours per day, five days per week. The program consists of a variety of small and large groups. No individual therapy is offered. Although predominantly guided by psychodynamic theory and systems theory, it includes cognitive-behavioral, interpersonal, art, vocational, and physical exercise group interventions. The Day Treatment Program staff consists of five therapists (drawn from the disciplines of nursing, occupational therapy, psychology, and social work), a psychiatrist, and a teacher. The psychiatrist shares leadership of the program with one of the therapists who is an occupational therapist. The psychiatrist also assumes medical responsibility, including medication management, for all patients in the program. Most patients receive psychotropic medication: mainly antidepressants, but in some cases mood stabilizers and neuroleptics. A thorough description of the program can be found in Piper et al. (1996). The primary inclusion criteria for the program were the presence of a DSM-IV personality disorder or significant personality dysfunction that does not fully meet criteria for any particular DSM-IV Axis II disorder, not being currently engaged in employed activity or academic study, and a minimum age of 18. Exclusion criteria included active psychosis (e.g., schizophrenia), organic mental disorder, acute suicidality, active substance abuse in need of primary attention, and involvement with another mental health agency. Patients participate in the program for a time-limited period of 18 weeks (seven hours per day, 4½ days per week). Usually, 35 patients are enrolled at any time. Each week, two or three new patients enter the program as a similar number successfully complete and terminate treatment. After complete description of the study to the subjects, written informed consent was obtained.

2.2. Assessment measures

Each patient completed three self-report measures for the purpose of this study. These included the Wisconsin Personality Inventory-IV (WISPI-IV; Smith et al., 2003), the Inventory of Interpersonal Problems-64 (IIP-64; Horowitz et al., 1988), and the Brief Symptom Inventory-53 (BSI-53; Derogatis, 1993). The WISPI-IV was completed at baseline only. The IIP-64 and BSI-53 were completed at baseline and at the end of treatment.

Axis II diagnoses were determined by the SCID-II PQ and Auto-SCID II (First et al., 2000). The SCID-II PQ is a self-report questionnaire. Patients respond to personality-related questions on a computer. The SCID-II PQ is administered to shorten the time it takes for an interviewer to conduct an Axis II assessment. It highlights the behaviors that are endorsed or rated "unsure" by the patient. The SCID-II PQ thus serves as a screening tool. The Auto-SCID II is a computer-assisted Axis II interview assessment that is used subsequent to the SCID-II PQ. If the patient has provided a "yes" or "unsure" response to any of the items on the SCID-II PQ, the interviewer follows the program to inquire in multiple ways about the criterion behavior in question, and eventually determines if the patient satisfies criteria for a specific personality disorder. Rater reliability for Axis II diagnoses was calculated for 20 randomly selected cases and 5 raters (all of whom had at least 3 years experience with the SCID). Independent raters reviewed audiotaped Auto-SCID sessions to determine rater reliability. After listening to the patient's responses to questions associated with each of the Axis II categories, the raters indicated whether the criterion was met, and subsequently, whether the diagnosis could be assigned. Reliability reflected the extent to which the original interviewer and independent rater agreed concerning each diagnosis for each patient. A Kappa was calculated for each pair of raters for each disorder. The mean Kappa for all pairs and disorders was 0.68. DSM-IV Axis I diagnoses were assigned jointly by an intake assessor and a psychiatrist, both of whom saw the patient on the day of intake. A structured assessment procedure using the SCID was not

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