



Lack of empathy in patients with narcissistic personality disorder

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ABSTRACT

The study's objective was to empirically assess cognitive and emotional empathy in patients with narcissistic personality disorder (NPD). To date, “lack of empathy” is a core feature of NPD solely based on clinical observation. The study's method was that forty-seven patients with NPD, 53 healthy controls, and 27 clinical controls with borderline personality disorder (BPD) were included in the study. Emotional and cognitive empathy were assessed with traditional questionnaire measures, the newly developed Multifaceted Empathy Test (MET), and the Movie for the Assessment of Social Cognition (MASC). The study's results were that individuals with NPD displayed significant impairments in emotional empathy on the MET. Furthermore, relative to BPD patients and healthy controls, NPD patients did not show deficits in cognitive empathy on the MET or MASC. Crucially, this empathic profile of NPD is not captured by the Structured Clinical Interview for DSM-IV for Axis I Disorders (SCID-II). The study's conclusions were that while NPD involves deficits in emotional empathy, cognitive empathy seems grossly unaffected.

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1. Introduction

Narcissistic personality disorder (NPD) is characterized by a “lack of empathy” as well as a pervasive pattern of grandiosity and need for admiration (American Psychiatric Association, 2000). It is a severe mental disorder with prevalence rates of up to 6% in the general population (Stinson et al., 2008; Ritter et al., 2010), severe functional impairment (Miller et al., 2007; Stinson et al., 2008), and high suicide rates (Pompili et al., 2004). Although narcissism as a personality trait and empathy have been shown to be negatively correlated (e.g., Watson et al., 1984; Watson and Morris, 1991; Watson et al., 1992; Porcelli and Sandler, 1995) the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV) criterion “lack of empathy” in NPD is solely based on clinical observation and expert consensus (also personal communication with E. Ronningstam) (Kohut, 1966; Kernberg, 1970; Akhtar and Thomson, 1982; Millon, 1983). Thus, to date, a congruent conceptualization and empirical evaluation of the criterion “lack of empathy” in NPD

are lacking. Therefore, the aim of the study was to empirically assess empathy in patients with NPD according to DSM-IV.

When NPD first appeared in the official psychiatric nomenclature in the Diagnostic and Statistical Manual of Mental Disorders-Third Edition (DSM-III) in 1980 (American Psychiatric Association, 1980) “lack of empathy” was established as a sub-criterion of the fifth criterion “characteristic disturbances in interpersonal relationships” (p. 317). Although DSM-III-based studies revealed that the criterion “lack of empathy” lacked discriminant validity (Morey, 1985; Gunderson et al., 1991; Gunderson and Ronningstam, 2001) (i.e., it had multiple significant correlations across other personality disorders; PDs), and offered poor interrater reliability (Pfohl et al., 1986) it was established as a separate criterion in the DSM-III-R (criterion 8), describing the “inability to recognize and experience how others feel” and was also maintained in the DSM-IV (American Psychiatric Association, 1994) and Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000) as criterion 7. Further studies based on the DSM-IV additionally revealed low diagnostic specificity of the criterion “lack of empathy” (Blais et al., 1997; Holdwick et al., 1998; Gunderson and Ronningstam, 2001; Fossati et al., 2005).

In summary, weak empirical evidence of convergent and divergent validity of the DSM criterion “lack of empathy” stands in sharp contrast

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to longstanding clinical (mostly psychoanalytic) case descriptions and the conceptualization of NPD (Kohut, 1966; Kernberg, 1970; Akhtar and Thomson, 1982; Millon, 1983). Our hypothesis is that this contradiction is due to the fact that no theoretical construct underlies the NPD criterion “lack of empathy” in the DSM (Millon, 1983), and thus, its assessment may be insufficient.

Research has already proposed a multidimensional model of empathy (Davis, 1983; Blair, 2005a), comprising two distinct but related constructs: cognitive and emotional empathy. A third dimension of motor empathy (Blair, 2005a) was later incorporated into the model of emotional empathy (Preston and de Waal, 2002). Thus, cognitive empathy (Baron-Cohen and Wheelwright, 2004) refers to the ability to take another person's perspective and to represent others' mental states, and as such, broadly overlaps with the constructs “Theory of Mind” (Premack and Woodruff, 1978) and “mentalizing” (Frith and Frith, 2003). The construct of emotional empathy (Mehrabian and Epstein, 1972; Eisenberg and Miller, 1987) describes an observer's emotional response to another person's emotional state. Based on the multidimensional facet model of empathy, our group recently developed the Multifaceted Empathy Test (MET, Dziobek et al., 2008), a task presenting photorealistic stimulus material and simultaneously assessing both cognitive and emotional empathy in a more ecologically valid manner than previous self-rating questionnaires. To further differentiate aspects of cognitive empathy we developed the Movie for the Assessment of Social Cognition (MASC, Dziobek et al., 2006), a film-based task depicting social interactions, demanding the understanding of the emotions, thoughts, and intentions of movie characters.

To ascertain the specificity of a “lack of empathy” in NPD, we used a clinical comparison group of patients with borderline personality disorder (BPD) according to DSM-IV in which impaired cognitive empathy and unimpaired emotional empathy were found. We also compared both clinical groups to healthy controls (Fonagy et al., 1996; Harari et al., 2010).

1.1. Aims of the study

The current study was conducted, first, to empirically assess cognitive and emotional empathy in a clinical sample of patients with NPD, and second, to compare the results to a clinical comparison group of patients with BPD. We hypothesized that patients with NPD would show significantly higher impairments in cognitive and emotional empathy compared to healthy controls. Compared to patients with BPD, we hypothesized significant impairment in emotional empathy and no difference in cognitive empathy for the NPD group. The third aim was to evaluate the convergence of the DSM-IV criterion “lack of empathy” with the empirical measures used in this study.

2. Materials and method

2.1. Sample

Forty-seven inpatients with NPD were recruited from the Department of Psychiatry, Charité – Universitätsmedizin Berlin and cooperating German hospitals. Fifty-three age- and gender-parallelled healthy comparison subjects were recruited via media advertisements.

Previous studies of NPD and BPD have reported substantial comorbidity (Westen et al., 2006) between the two disorders and found overlap in the symptoms of affect dysregulation, impulsivity, and unstable relationships (Morey, 1988; Ronningstam and Gunderson, 1991; Blais et al., 1997). To show the more specific character of “lack of empathy” for NPD, we assessed a clinical comparison group with 27 BPD patients without comorbid NPD from the Department of Psychiatry, Charité – Universitätsmedizin Berlin. All BPD patients were inpatients and on a waiting list for an inpatient treatment program prior to admission, and none was admitted for acute care. Axis II diagnoses of patients and controls were assessed with the Structured Clinical Interview for DSM-IV for Personality Disorders (SCID-II, First et al., 1997, German version: Fydrich et al., 1997) by trained psychiatrists or psychologists. Interrater reliability of SCID-II diagnoses was assessed ($N = 8$) with a pairwise interview design. Interviewers were

blind to PD diagnoses. Kappa was acceptable with $\kappa = 0.797$ for NPD diagnosis and $\kappa = 0.820$ for BPD diagnosis. For the NPD criterion “lack of empathy,” however, Kappa showed a perfect agreement, $\kappa = 1.0$. Internal consistencies for NPD items (Cronbach's $\alpha = 0.896$) and BPD items (Cronbach's $\alpha = 0.876$) were good. Axis I comorbidity was assessed with the Structured Clinical Interview for DSM-IV for Axis I Disorders (First et al., 1996, German version: Wittchen et al., 1997) in the NPD sample and with the Mini International Neuropsychiatric Interview (M.I.N.I., Sheehan et al., 1998, German version: Lecrubier et al., 1998) in the BPD sample. Exclusion criteria for all patients were history of psychotic disorder, a current bipolar I or II disorder, a current manic or hypomanic episode, or substance induced disorder (e.g., intoxication or withdrawal syndrome). All procedures were approved by the Human Subjects and Ethics Committee of Charité – Universitätsmedizin Berlin. Written informed consent was obtained from each participant. Socio-demographic and clinical data are presented in Table 1.

2.2. Psychometric assessment instruments

To assess psychopathology, the general severity index (GSI) of the Symptom Checklist 90 Revised (SCL-90-R, Derogatis, 1977, German version: Franke, 2002) was calculated. The internal consistency for the GSI was good (Cronbach's $\alpha = 0.989$). For IQ screening, subtest 4 (recognizing rules) of the well-established German “Leistungs-Prüf-System” (LPS, Horn, 1983) was administered.

2.3. Measures of cognitive and emotional empathy

The Interpersonal Reactivity Index (IRI; Davis, 1983; German version: Paulus, 2006) was employed as a multidimensional self-report estimate of empathy. In this study we focus on the scales “perspective taking” (the ability to assume another individual's point of view) and “empathic concern” (the capacity to experience sympathy for others). An example perspective-taking item is: “When I'm upset at someone, I usually try to ‘put myself in his shoes’ for a while.” An example empathic-concern item is: “I often have tender, concerned feelings for people less fortunate than me.” The IRI has been shown to correlate with other measures of empathy, providing support for the construct validity of the measure (Davis, 1980). Both subscales have good internal consistencies (perspective taking: $\alpha = 0.747$, empathic concern: $\alpha = 0.776$). In the sample of all participants of the present study both scales correlate moderately with $r = 0.457$, $P < 0.001$ (NPD: $r = 0.322$, $P = 0.144$, BPD: $r = 0.534$, $P = 0.004$; healthy controls: $r = 0.398$, $P = 0.004$).

The Multifaceted Empathy Test (MET, Dziobek et al., 2008) is a PC-assisted test consisting of photographs that show 23 pairs of picture stimuli with people in emotionally charged situations. To assess cognitive empathy, participants were required to infer the mental state of the subject in the photo, and were asked to indicate the correct one from a list of four. After giving feedback about the displayed people's actual mental states, emotional empathy was assessed. First, participants were required to rate the amount of mirroring of an emotion (i.e., emotional contagion) that took place in response to a picture (e.g., if the mental state of the person was anxious, subjects were asked to rate how anxious they felt). Participants indicated their responses on a visual analogue scale ranging from 0 to 9 (0 = not at all, 9 = very much). As an additional measure of more mature emotional empathy, subjects were also asked to rate the degree of empathic concern they felt for the person in the picture (visual analogue scale, 0 = not at all, 9 = very much). All pictures were presented in two forms: First, all emotionally charged situations (background) were presented without a person; then, in a second step, all of the situations were presented with a person expressing a relevant emotion. All background pictures were first independently rated for arousal in order to enable us to control for this general level of arousal when establishing group differences in empathic processing. Internal consistency of the MET's scales ranged from $\alpha = 0.71$ to $\alpha = 0.92$, and convergent and divergent validity were highly satisfactory (Dziobek et al., 2008). In the study sample, the scales emotion recognition and empathic concern were not correlated (All: $r = 0.146$, $P = 0.150$; NPD: $r = 0.125$, $P = 0.578$, BPD: $r = 0.297$, $P = 0.140$; healthy controls: $r = -0.071$, $P = 0.626$); nor were the scales emotion recognition and mirroring emotions (All: $r = 0.114$, $P < 0.265$; NPD: $r = -0.034$, $P = 0.879$, BPD: $r = 0.362$, $P = 0.069$; healthy controls: $r = -0.137$, $P = 0.341$). MET cognitive empathy was not correlated with emotional empathy assessed by the MET either for healthy controls (for empathic concern: $r = -0.071$, $P = 0.626$, for mirroring emotions: $r = -0.137$, $P = 0.341$) or for NPD patients (for empathic concern: $r = -0.010$, $P = 0.949$; for mirroring emotions: $r = -0.020$, $P = 0.893$).

To assess cognitive empathy (in terms of Theory of Mind) we also used the video-based Movie for the Assessment of Social Cognition (MASC, Dziobek et al., 2006). Not only did the test prove to have high interrater reliability and internal consistency and sensitivity, but the results also seem to be highly stable over time (Dziobek et al., 2006). The test involves watching a 15 min movie about four characters spending an evening together. It shows everyday social interactions, and is stopped 46 times for questions about the actors' feelings, thoughts, and intentions. Participants are required to choose the correct answer out of four possible ones. The test allows for a more differentiated analysis of specific patterns of social cognitive functioning with separate scores for the recognition of emotions, thoughts, and intentions. Sum scores for correct answers in all three sub-categories and a total score were computed. Moreover, the MASC also includes control questions that assess a participant's inferential processing concerning nonsocial stimulus material. The MASC has a good internal consistency with Cronbach's

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