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Narcissistic vulnerability is a common cause for depression in patients with Gilles de la Tourette syndrome

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ABSTRACT

The aim of this study was to assess for the first time different dimensions of narcissistic self-regulation in a large cohort of adult patients with Gilles de la Tourette syndrome (GTS) ($n=50$). From preliminary studies it is suggested that narcissistic personality trait and disorder, respectively, are relatively uncommon and occur in only 6–10% of GTS patients. In this study we used the Narcissism Inventory (NI), a 163-items questionnaire that measures four different dimensions of narcissism. The main result was that the prevalence of narcissism strongly depends on the subtype of narcissism: while the vulnerable narcissism ("threatened self" and "hypochondriac self") was common, the "classic narcissistic self" (grandiose narcissism) was rare. From our data an association between comorbid depression and increased values of the "threatened self" and comorbid OCD with increased values of the "hypochondriac self" is suggested. Narcissism correlated positively with the personality domain neuroticism and had a significantly negative impact on patients' quality of life. Therefore it can be speculated that vulnerable narcissism is – among several others – one cause for depression in patients with GTS. These findings may open new psychotherapeutic perspectives in the treatment of depression in patients with GTS.

1. Introduction

Gilles de la Tourette syndrome (GTS) is a complex chronic neuropsychiatric disorder characterized by multiple motor and one or more vocal tics with childhood onset (American Psychiatric Association, 2009). The majority of patients, in addition, suffer from one or more psychiatric comorbidities such as attention deficit hyperactivity disorder (ADHD), obsessive–compulsive disorder (OCD), depression, anxiety disorders, self-injurious behavior, sleeping disorders, conduct and learning disorders. At least in clinic populations, only 12% of patients suffer only from tics and no psychiatric comorbidities (Freeman et al., 2000). During the last years, several studies have been performed to further investigate comorbidities in patients with GTS, their influence on patients' quality of life and the relation between comorbidities and tic severity (Spencer et al., 1998; Freeman and Tourette Syndrome International Database Consortium, 2007; Roessner et al., 2007a, 2007b; Gorman et al., 2010; Cavanna et al., 2013; Mol Debes, 2013; Chou et al., 2013; Shprecher et al., 2014). As a result of these studies, it has been suggested that GTS can be regarded as a "spectrum disorder" with "pure GTS" or "GTS only" (without comorbidities and simple mild tics) at the one end of the spectrum and "GTS plus" (with several psychiatric comorbidities and severe complex tics) at the other end (Robertson, 2000; Robertson and Cavanna, 2007; Cavanna and Rickards, 2013). However, until today it is unclear which of the different psychiatric comorbidities are part of this spectrum and which can be regarded as an epiphenomenon or independent entity. Unquestionably, not only the risk for ADHD and OCD, but also for depression is significantly higher in patients with GTS compared to those without (Robertson, 2006; Chou et al., 2013). However, there is substantial evidence that only comorbid OCD and depression are part of the GTS spectrum, while comorbid ADHD should be better conceptualized as a separate problem (Roessner et al., 2007a, 2007b; Lebowitz et al., 2012; Trillini and Müller-Vahl, 2015). For example, it could be demonstrated that patients with GTS and comorbid OCD suffer from greater severity of tics, depression, and anxiety (Lebowitz et al., 2012).

In contrast, so far only very few studies have been performed investigating personality disorders and traits, respectively, in patients with GTS (Robertson et al., 1997; Cath et al., 2001; Cavanna et al., 2007; Eddy et al., 2013). In general, personality traits are defined as "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts" (American Psychiatric Association, 2009). Available studies provided substantial evidence that in adult patients with GTS pathological personality traits and

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disorders, respectively, are common and occur in 64–75% of patients. In addition, a wide range of different pathological personality traits has been observed (Shapiro et al., 1978; Robertson et al., 1997; Eddy et al., 2013; Trillini and Müller-Vahl, 2015). However, so far it is unclear, which personality traits are most common in patients with GTS. While Robertson et al. (1997) most often found borderline, depressive, obsessive–compulsive, paranoid, passive–aggressive, and avoidant personality disorder, in a recent study from our group (Trillini and Müller-Vahl, 2015) the following personality traits were detected most often: demand–anxious, obsessive–insecure, asthenic, weak-willed, dependent, impulsive–explosive, depressive, disorganized, and passive–aggressive. Of interest, most of these personality traits are related to cluster C. In addition, Cavanna et al. (2007) reported about a relatively high prevalence rate of schizotypal personality disorder. Finally, increased scores for neuroticism (Cath et al., 2001), but reduced scores for extraversion, conscientiousness, emotional stability, and openness (Eddy et al., 2013) were reported in this group of patients. It is worth mentioning that in GTS patients with comorbid OCD and depression-but not ADHD-higher rates of several pathological personality traits could be demonstrated (Trillini and Müller-Vahl, 2015) a fact that further supports the concept of a GTS spectrum that includes both tics, OCD, and depression, but not ADHD.

So far, only very little is known about narcissistic personality trait and disorder, respectively, in patients with GTS. According to DSM-5 narcissistic personality disorder is defined as an all-pervasive pattern of grandiosity (in fantasy or behavior), need for admiration or adulation, and lack of empathy, usually beginning by early adulthood that is present in various contexts (American Psychiatric Association, 2013). Narcissistic personality disorder is classified as a cluster B (dramatic, emotional, and erratic) personality disorder. So far, it is unclear, whether normal and pathological narcissism lie on a continuum from healthy to disordered functioning or represent two distinct personality dimensions.

The aim of this study was to further investigate the prevalence of narcissistic personality trait in a large group of adult patients with GTS. To the best of our knowledge, so far the prevalence of narcissistic personality trait/disorder has been investigated only in two studies, but in none of these studies the prevalence of different dimensions of narcissism has been examined. Robertson et al. (1997) used the Structured Clinical Interview for DSM-III-R Personality Disorders II (SCID-II) (Spitzer et al., 1989) and found a prevalence rate of 10% for narcissistic personality disorder. Our group used the Inventory of Clinical Personality Accentuations (ICP) (Andresen, 2006) and detected pathological narcissistic personality trait in only 6% of patients (Trillini and Müller-Vahl, 2015). However, from our clinical experience, we had the impression that narcissistic personality trait is a common personality trait in adults with GTS. In this study, we, therefore, used for the first time the Narcissism Inventory (NI) (Deneke and Hilgenstock, 1989) to investigate different dimensions of narcissistic traits in more detail in patients with GTS. The NI is a self-rating instrument that measures self-regulatory processes and self-organization. It is based on a psychoanalytical understanding of the self and understands narcissism as a multi-dimensional construct. Thus, the NI assesses a wide range of different dimensions of narcissistic auto-regulation including threatened self, classic narcissistic self, ideal self, and hypochondriac self (Daig et al., 2010).

2. Methods

2.1. Subjects

In this study 50 consecutive adult patients with GTS according to DSM-IV-TR were included. All patients were recruited from the Clinic of Psychiatry, Socialpsychiatry and Psychotherapy at the Hannover Medical School between June 2010 and May 2012. Inclusion criteria were age between 18 and 65 years. Patients suffering from psychosis, autistic spectrum disorder, mental deficiency, and other significant neurological or psychiatric disorders were excluded from the study. Comorbidities such as OCD, ADHD, and depression as well as medication for GTS were no exclusion criteria. Since for the NI no reference values are given in the literature, in addition, 36 healthy controls (students, staff members, friends, and family members) were recruited as a sex- and age-matched control group. Ethics approval for this study was granted by the ethics committee of the Hannover Medical School. All participants gave written informed consent before entering the study.

2.2. Clinical assessments

The clinical assessment comprised semi-structured interviews and self-rating scales for tics, quality of life, and comorbidities (OCD, ADHD, and depression) as well as for narcissistic personality trait. The following rating scales were used:

- Yale Global Tic Severity Scale (YGTSS) (Leckman et al., 1989) was used the measure tic severity. The “total tic score” (TTS) (0–50) plus the “overall impairment score” (0–50) constitutes the “global score” (GS) (0–100). For further analyses, only the YGTSS–TTS was used.
- Gilles de la Tourette syndrome-Quality of life scale (GTS-QoL) (Cavanna et al., 2008) is a 27-items questionnaire, which measures the psychological, physical, obsessive–compulsive, and cognitive impact of GTS. The total score ranges from 0–100, the higher the sum, the lower the quality of life (QoL).
- Yale Brown Obsessive Compulsive Scale (Y–BOCS) (Goodman et al., 1989) was used to measure OCD. The scale consists of 10-items, ranging from 0–4 (0–40), separated for obsessions and compulsions. A total score ≥ 16 suggests the diagnosis of OCD.
- Wender Utah Rating Scale Short Form (WURS-K) (Ward et al., 1993; Retz-Junginger et al., 2003) is a self-rating scale for the diagnosis of ADHD in adults including 25-items on a 5-point Likert scale (ranging from 0=“not at all” or “very slightly” to 4=“very much”). A total score ≥ 30 suggests the diagnosis of ADHD.
- DSM-IV-Symptom list for ADHD (Rösler et al., 2004) consists of 18-items according to DSM-IV including 9 items each related to inattention and hyperactivity/impulsivity. The total score ranges from 0–18. A score > 6 in either domain suggests the diagnosis of ADHD.
- Conners' Adult ADHD Rating Scale (CAARS) (Christiansen et al., 2011) is a 66-items questionnaire ranging on a Likert-type scale from 0=“not at all/never” to 3=“very much/very frequently”. The raw scores have to be converted into *t*-scores (cut-off ≥ 65). The diagnosis of ADHD was obtained by combining the results of the clinical interview, WURS-K, CAARS, and DSM-IV symptom list.
- Beck Depression Inventory (BDI) (Beck et al., 1961) is a 21-items questionnaire, which evaluates the severity of depression. Items are rated on a 4-point scale. A total score < 10 is considered as no or minimal depression, 10–18 as mild, 19–29 as moderate, and > 29 as severe depression.