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# The impact of narcissistic personality disorder on others: A study of romantic partners and family members

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# The impact of narcissistic personality disorder on others: A study of romantic partners and family members

*A thesis submitted in partial fulfilment of the requirements for the award of the degree*

**DOCTOR OF PHILOSOPHY**

**(Clinical Psychology)**


**From the University of Wollongong**

**by**

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## CERTIFICATION

I, Nicholas J. S. Day, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy (Clinical Psychology), in the School of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Nicholas J. S. Day

**13/08/2021**

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## List of Abbreviations

| | |
|---|---|
| AD | Anxiety Disorder |
| AMPD | Alternate Model of Personality Disorder |
| APA | American Psychiatric Association |
| BAS | Burden Assessment Scale |
| BPD | Borderline Personality Disorder |
| CCRT | Core Conflictual Relationship Theme |
| DD | Dysthymic Disorder |
| DEQ | Depressive Experiences Questionnaire |
| DSM-I | Diagnostic and Statistical Manual of Mental Disorders – First Edition |
| DSM-II | Diagnostic and Statistical Manual of Mental Disorders – Second Edition |
| DSM-III | Diagnostic and Statistical Manual of Mental Disorders – Third Edition |
| DSM-III-R | Diagnostic and Statistical Manual of Mental Disorders – Third Edition, Revised |
| DSM-IV | Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition |
| DSM-IV-TR | Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision |
| FFNI | Five Factor Narcissism Inventory |
| FQ | Family Questionnaire |
| GS | Grief Scale |
| HSNS | Hypersensitive Narcissism Scale |
| ICD-10 | International Classification of Diseases – Tenth Edition |
| ICD-11 | International Classification of Diseases – Eleventh Edition |
| LPFS | Level of Personality Functioning Scale |
| MD | Mood Disorder |
| MDD | Major Depressive Disorder |
| MHI-5 | Mental Health Inventory |
| NARQ | Narcissistic Admiration and Rivalry Questionnaire |
| ND | Neurotic Disorder |

| | |
|---|---|
| NGS | Narcissistic Grandiosity Scale |
| NPD | Narcissistic Personality Disorder |
| NPI | Narcissistic Personality Inventory |
| PBS | Perceived Burden Scale |
| PCAD-3 | Psychiatric Content Analysis and Diagnosis |
| PD | Personality Disorder |
| PDM | Psychodynamic Diagnostic Manual |
| PDM-2 | Psychodynamic Diagnostic Manual – Second Edition |
| PES | Psychological Entitlement Scale |
| PNI | Pathological Narcissism Inventory |
| PS | Population Sample |
| PsD | Psychotic Disorder |
| RAP | Relational Anecdote Paradigm |
| R-DEQ | Reconstructed Depressive Experiences Questionnaire |
| RQ | Relationship Questionnaire |
| SB-PNI | 'Super Brief' Pathological Narcissism Inventory |
| SB-PNI-CV | 'Super Brief' Pathological Narcissism Inventory – Carer Version |
| SD | Standard Deviation |
| SMI | Severe Mental Illness |

## Formatting statement

This thesis has been prepared in journal article compilation style format, with each manuscript written for a specific journal and target audience. All manuscripts have been re-formatted to a single style for the purpose of this thesis using American Psychological Association (APA) 7$^{th}$ Style.

## Statement of Contribution of Others

This statement of authorship identifies the nature and extent of contribution of the PhD candidate and all co-authors for chapters based on journal articles. The contributions follow the CRediT taxonomy of roles for authors.

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## ABSTRACT

Background: Narcissistic personality disorder (NPD) is a diagnosed mental health disorder that affects up to 6.2% of the population. NPD is known to have a strong interpersonal component, as individuals express their vulnerabilities to others in ways that are challenging. For instance, a person may sometimes seem grandiose and prone to intense hostility, but at other times seem vulnerable and needy, yet difficult to please. However, while the presence of interpersonal dysfunction has been identified for individuals with NPD, little is known about how this is experienced by partners and family members. This thesis presents four original studies on the impact of NPD on romantic partners and family members to progress our understanding of the disorder and improve treatment.

Method: The thesis begins with a critical review of existing literature regarding the construct of NPD to determine new research questions to be addressed (Chapter 1). Chapter 2 presents a study of partners and family in a close relationship with someone with NPD ($N$ = 683) to assess levels of grief, burden, coping and mental health. Thematic analysis of a subset of participants' qualitative descriptions of their relative was conducted ($N$ = 436), exploring the characteristics of the NPD relative (chapter 3) and their interpersonal interactions (chapter 4). Finally, some participants ($N$ = 15) were asked to provide detailed narratives comparing their relationships with their relative and with others (chapter 5), to study core conflictual relationship themes (CCRTs). Chapter 6 provides an overview of research findings and outlines implications for the assessment, diagnosis and treatment of individuals with NPD, but also targeted therapeutic supports for partners and family members.

Results: Participants living with a relative with NPD were suffering significant psychological symptoms (69% depression, 82% anxiety) and high burden (chapter 2). Levels of symptoms and burden were higher than individuals living with people diagnosed with

borderline personality disorder or other severe mental illness. Participant's descriptions of their relative (chapter 3) included both "grandiose" tendencies (including entitlement, envy and exploitativeness) but also "vulnerable" ones (including hypersensitivity, insecurity and emptiness). The relationship included themes of coercive control (chapter 4), where the relative made challenging physical, verbal, emotional, financial and sexual demands. Fluctuations in idealisation, devaluation, hostility, and dependency were often present in the relationship. Relationship narratives involving relatives with pathological narcissism involved more instances of disharmony, including relatives rejecting, subjugating and attacking behaviours, and participants rejecting and withdrawing behaviours, corresponding with a deactivation of participants attachment system (chapter 5).

Conclusion: Living with a person with NPD appears to inflict a considerable psychological toll on those closest to the person. While narcissistic grandiosity, coercive control and interpersonal antagonism may serve to protect the individual who is suffering, these have an insidious effect on partners and family members. Treatments for NPD are limited, with no randomised controlled trials. The findings presented here have two major implications for therapy. First, that the disorder has severe impacts on others, meaning the mental health needs of close relatives should be assessed. Second, that therapists will need specific, targeted support to help them work with individuals with NPD, to help navigate fluctuations of grandiosity and vulnerability in this patient group, sometimes prone to being coercive, controlling and hostile, whilst also presenting as needy and insecure.

# CHAPTER ONE

## 1.1. CRITICAL REVIEW

Narcissistic Personality Disorder (NPD) is a severe mental health disorder involving core difficulties in self and interpersonal functioning (American Psychiatric Association, 2013a). Prevalence estimates of NPD in the community vary substantially, ranging from around 1% (Dhawan et al., 2010), to as high as 6.2% (Stinson et al., 2008). Similarly, clinical population estimates vary between 1% to as high as 17% (Ronningstam, 2009). However, despite being a severe disorder with a very high prevalence estimate, there currently exists no randomised controlled trials specifically examining the treatment of NPD (King et al., 2020), leading some to view NPD as "one of the least studied personality disorders" (Caligor et al., 2015, p. 415), and certainly being under-researched compared to other severe conditions such as Borderline Personality Disorder (Boschen & Warner, 2009). Part of this lack of research focus may be due to the fact that individuals with NPD are less likely to present to treatment overtly seeking help regarding their narcissistic pathology, making direct and systematic examination more difficult (Shedler et al., 2010). Rather, such patients may instead seek support relating to interpersonal difficulties and associated life problems (Ronningstam & Weinberg, 2013). For example, a patient may seek treatment due to the threat of a relationship breakdown, however closer investigation reveals this as due to the patient's self-absorption and difficulties with intimacy stemming from narcissistic preoccupations. Similarly, a patient may be seeking help due to their struggle to maintain consistent work, however it becomes apparent this is due to their intense feelings of envy and frequent conflicts with co-workers.

Interpersonal dysfunction has been consistently related to narcissistic functioning (Cheek et al., 2018; Kealy & Ogrodniczuk, 2011; Ogrodniczuk et al., 2009), with individuals

displaying self-enhancing, vindictive, aggressive, exploitative behaviours, as well as interpersonal coldness and social avoidance (Dickinson & Pincus, 2003). Other research has indicated individuals with pathological narcissism use "game playing tactics" in their romantic relationships (Campbell et al., 2002), show self-centred, materialistic, deceptive and controlling behaviours (Brunell & Campbell, 2011) and cause pain and distress to significant others (Miller et al., 2007). This identified prominence of interpersonal dysfunction has led to clinical aphorism that "narcissistic individuals are not necessarily identified by how they feel, but according to how they make others feel" (Ogrodniczuk & Kealy, 2013, p. 114). However, despite interpersonal dysfunction being a salient feature of pathological narcissism, few studies have empirically examined the experience from the perspective of the "other" in the relationship (Byrne & O'Brien, 2014). Further, while the aforementioned studies provide a meaningful insight as to the relationship functioning of individuals with pathological narcissism, they often suffer from any combination of common conceptual or methodological limitations. These include the use of convenience samples (Henrich et al., 2010), focusing on "subclinical" narcissism (Shedler et al., 2010), utilising a very small sample size, focusing on mainly "grandiose" narcissism (Krizan & Herlache, 2017) and reliance on self-report (Russ & Shedler, 2013). Alternatively, a common agreement between disparate theoretical orientations is the role that informant research has in overcoming such limitations, providing a valid and meaningful perspective in the assessment of narcissistic pathology (Brunell & Campbell, 2011; Lukowitsky & Pincus, 2013; Miller & Lynam, 2015; Miller, Lynam, et al., 2017; Oltmanns et al., 2018; Pincus & Lukowitsky, 2010). However, there are currently limited studies that examine the impact of pathological narcissism on partners and family members combining the utilisation of 1. an informant sample, 2. empirically validated psychometric measures, 3. qualitative methods examining subjective experience, and 4. a large, representative samples. This thesis aims to address this gap in the literature.

## History of the Construct of Pathological Narcissism

### Early History

*Ovid*

The study of the narcissistic personality can be expressed as having both a long history and a short past. The "long history" of narcissism finds its roots in Greek mythology, perhaps most familiarly expressed in Metamorphoses (Ovid, 8AD/1717). Narcissus, we are told, from birth was a "lovely boy" to look at. On the verge of manhood, he had already made "many a love-sick maid in vain her flame confess", for Narcissus appears to neither need nor desire the company of others. This, perhaps, is the Narcissus we best understand and remember from the myth – the ineffably beautiful and prideful youth. However, alongside his beatific birth the oracle Tiresias delivers a troubling prophesy: "if ever he knows himself, he surely dies". This establishes the paradox of Narcissus' character. On the one hand he appears undesiring of friends and lovers, seemingly content and fulfilled by his own company. On the other hand, Narcissus has received a mortal wound from Tiresias curse to never "know himself". The discerning reader begins to suspect whether Narcissus contentment is genuine or whether its conceit conceals some deeper anguish, a mirage of perfection. This mirage is depicted later, quite literally, as Narcissus catches sight of his image in the reflection of a pool of water. At this point we are shown a figure not of surfeit character but the opposite, one consumed with longing and despair as he vents his grief: "tell me, if ever within your shades did lie a youth so tortured, so perplexed, as I?" However, the paradox remains, as Narcissus source of anguish is also his joy – himself.

Although the story of Narcissus is a tale of maladaptive relatedness to "self" it also depicts impaired relations with "other". We are told that although many suitors idealised and desired the young Narcissus, this desire appeared to only last so long before it turned sour. It

was, after all, “one fair virgin of the slighted train” who prayed to the gods in vengeance that ultimately brought about Narcissus’ downfall. However, it is the character of Echo who perhaps best encapsulates the dysfunctional interpersonal relations of Narcissus. Echo herself had been cursed by the Goddess Hera to only “mimic sounds and accents not her own” and interestingly in some versions it is this mimicry that is able to at first attract young Narcissus. When Echo mimics Narcissus own words he is drawn to her, however when in a moment of passion Echo spontaneously reaches out to embrace Narcissus he recoils (Kline, 2000). Rejected, Echo retreats to “the shady cover of the woods, in solitary caves and dark abodes.” This is the stage of their demise, with Narcissus enamoured with the reflection in the pool and Echo retreated to the woods behind, they perish.

The fable of Narcissus has often been told as a warning against self-absorption, with the characters adopting familiar roles (Narcissus as the rejecting villain, Echo as the slighted victim). A closer analysis may outline a more complicated message. For instance, is Narcissus truly so self-conceited? We are told that when Narcissus first sees the reflection in the pool, he is not aware that it is his own image: “nor knows he who it is his arms pursue, with eager clasps, but loves he knows not who”. It would appear, then, that the mirage of perfection on the surface of the water is disconnected with Narcissus’ internal experience. Perhaps, for purpose of speculation, Narcissus is enamoured with the mirage not out of recognition of his own form, but rather because this mirage appears to contain all that he himself lacks. For we are also told that when Narcissus recognises the figure in the pool as himself, he is filled not with pride but despair: “Ah wretched me! I now begin too late, to find out all the long-perplexed deceit; It is myself I love, myself I see”. One could reason that this revelation might bring despair as in realising the image as himself, Narcissus is forced to relinquish the fantasy of a perfected “other”. From this vantage, are not Narcissus and Echo

more alike than distinct? Is not Echo's conceit the same as Narcissus? Of seeing an idealised reflection of the other and desiring to have this as their own?

Time has been spent labouring aspects of the story of Narcissus and Echo because it is from this story that appears all the building blocks for what would eventually become the contemporary clinical understanding of the narcissistic personality (Grenyer, 2013). We see examples of deficits in empathy and intimacy, patterns of idealisation and devaluation, characterological grandiosity and vulnerability and impaired capacity for relating to self and others. This is remarkable, given that the story appears centuries before this behaviour was ever recognised as a clinical syndrome, much less codified in a diagnostic manual.

*Freud*

In the 19th century the "short past" of narcissism's scientific study began, notably, in the psychological writings of Ellis (1898) who described a "narcissus like" psychological attitude and shortly after by Näcke (1899) who classified auto-erotic behaviour using the term "Narcismus". However, of these early theorists it was Freud who expounded the concept, moving beyond mere behaviour in an exploration of possible causes, developmental aspects and the relationship between self and other. In his seminal paper "On Narcissism: An Introduction" Freud (1914) describes narcissism as occurring when the "libido that has been withdrawn from the external world has been directed to the ego" (p. 75), however he also distinguishes between two types of narcissism. "Primary narcissism" is described as a normal developmental period of infantile preoccupation with receiving consistent care and attention from caregivers. The eventual working through of this stage in consonance with the "reality principle" facilitates the development of the ego through distinguishing the boundaries of self and other (in this case caregivers) (Freud, 1911). "Secondary narcissism" occurs when reality is rejected in favour of the "pleasure principle" (Freud, 1911) as psychic energy is directed to

the self and separateness is denied in order to facilitate the fantasy of being "his majesty, the baby" (Freud, 1914, p. 91). This distinction is important as it was one of the first attempts to distinguish adaptive or normal elements of narcissism, as opposed to only maladaptive or pathological ones.

*Melanie Klein*

Despite not using the term "narcissism" Klein's concept of infant development is highly relevant for understanding narcissistic phenomena. Klein (1956) explored the infants inner world through a crucial dilemma that all must face: how to understand an inconsistent caregiver. For all caregivers are inconsistent when faced with the "infants longing for an inexhaustible and always present breast" (Klein, 1956, p. 212). This inconsistency, according to Klein, provokes intense feelings of love (when being nourished) and hate (when being deprived) for the infant. In an attempt to restore order to this chaotic experience, the infant "splits" the breast (representing the mother) into distinct non-overlapping categories of "bad breast" and "good breast". This is an attempt to both preserve the purity and goodness of the nourishing mother and also to punish the selfishness and badness of the withholding mother. This "splitting" into good and bad characterises what Klein labels the "paranoid-schizoid" position (Klein, 1946). In this state the infant is also protected against the distressing idea that the nourishing mother who provides love is one and the same as the withholding mother who inflicts pain. Without using the term we can see how similar this concept is to Freud's idea of "primary" and "secondary" narcissism (Freud, 1914). What Freud described as working through "primary narcissism" would be, in Kleinian terms, entering into the developmentally mature stage of the "depressive" position (Klein, 1946). This stage is labelled depressive as it involves a mournful relinquishing of the fantasy that others are only a means to an end (or "part object" i.e., the breast), and instead recognising others as ends in themselves. By the

same token, Freud's "secondary" narcissism is closer to the "paranoid-schizoid" position of Kleinian theory, reflecting a more primitive split between good and bad objects.

*Kernberg and Kohut*

Klein (1956) proposed two aspects that either hinder or help the working through of developmental milestones in the infant: envy (or hate) and gratitude (or love). These concepts, as well as Freud's (1920) life and death instincts, were fundamental to Kernberg's conceptualisation of the narcissistic personality which viewed the "profound struggle between love and hatred" (2014, p. 866) as reflecting the core of the disordered relation between self and other. Following Klein, he describes that due to the primitive nature of defences used and the intensity of affects (namely aggression) experienced by individuals with narcissistic personalities an "incapacity to depend on internalised good objects" results (Kernberg, 1967, p. 655). In this way, interpersonal and intrapersonal relations are dominated by the mechanism of splitting, alternating between extremes of idealisation and devaluation. For instance, Kernberg (2008) describes how individuals with narcissistic personalities may temporarily idealise others as they provide esteem needs in the form of love and admiration. However, intense humiliation results from the (conscious or subconscious) recognition of receiving something "good" from another, and a simultaneous fearful dependency develops on the continued provision of "goodness". Intense envy results, similar to in Kleinian theory, as the desire to completely consume or obtain the "goodness" of the other and with suspicion that the other is selfishly withholding some or all of it for themselves. In order to defend against this painful humiliation, dependency fears and feelings of envy, intense aggression facilitates the devaluation of other via rejection (or other means) and the re-idealisation of self through feelings of strength and independence. In this way we can see how "both libido and aggression are invested in the self" (Kernberg, 2014, p. 866).

This account of narcissism as a combination of aggression or destruction (death instinct) fused with libido (life instinct) and invested in the self was also shared by other theorists (e.g. Rosenfeld, 1971). Broadly these theories were consistent with Freud's initial conceptualisation of "secondary narcissism", meaning an investment in a pathological self-organisation (Freud, 1914). However, an alternate view was adopted by Kohut (1966a) who viewed narcissism not as a separate pathological organisation, but as an arrested stage of normal development (akin to Freud's "primary narcissism") that becomes maladaptive when persisting into adulthood. Kohut (1972b) viewed mutual idealisation as an important developmental stage for infants and their caregivers. For infants, idealisation of caregivers is protective, providing a sense of security in the face of overwhelming vulnerability and dependence. For caregivers, idealisation of the infant enhances their esteem and positive self-regard, which once has been internalised by the infant, develops maturity and self-reliance. In this way, Kohut de-pathologised narcissistic processes and instead proposed the idealizing libido as a necessary step towards mature development (Grenyer, 2013; Kealy & Ogrodniczuk, 2014). As such, while there are many similarities between Kohut and Kernberg's theories of the narcissistic personality, important theoretical differences exist regarding the mechanisms that sustain the disorder (continued empathic failures versus pathological self-structure) which have implications for its treatment (empathising and mirror transference versus confrontation and interpretation) (Lukačević & Bagarić, 2018).

With the proliferation of a diverse array of sophisticated theoretical accounts related to the clinical phenomena of narcissistic pathology, there was a growing need in the 1960's and 1970's to include such conceptualisations within official diagnostic systems. The following section will chart the evolution of the narcissism construct through various diagnostic and classification systems.

**Diagnostic Systems of Classification**

In 1951 the American Psychiatric Association was commissioned to standardise the diagnostic systems in the United States, resulting in the first Diagnostic and Statistical Manual (DSM-I, 1953) which described the kinds of resultant emotional difficulties an individual may experience due to certain environmental conditions (Levy et al., 2011). The DSM-II (1968) distinguished between neurotic and psychotic disorders, a distinction that would be of importance in understanding the narcissistic personality, however neither of these early editions of the DSM included a conceptualisation of narcissism. It was Kernberg (1967) who first described a personality syndrome being centred around the theme of narcissism in the "narcissistic personality structure" and Kohut (1968) who introduced the term "narcissistic personality disorder". As such, due to its increasing use in psychoanalytic literature, the third edition of the DSM (DSM-III, American Psychiatric Association, 1980) included a diagnosis of Narcissistic Personality Disorder (NPD), of which there was no precedent for in other classification systems (e.g. International Classification of Diseases, World Health Organisation). This initial conceptualisation included hallmark so called "grandiose" features of narcissism (i.e., Criterion A, B, C: self-importance and uniqueness, grandiose fantasy, exhibitionism) and related features of disturbances in interpersonal relationships (i.e., Criterion E: entitlement and non-reciprocation, interpersonal exploitativeness, idealisation and devaluation, lack empathy). Interestingly, this classification also included explicit reference to the "vulnerable" aspect of narcissism with Criterion D specifying "feelings of rage, inferiority, shame, humiliation or emptiness" due to ego threat as well as accompanying text noting the fragile nature of self-esteem (South et al., 2011). The DSM-III-R (American Psychiatric Association, 1987) revisions reflected a major change from a mixed polythetic and monothetic diagnostic format, to a solely polythetic approach to criteria. This resulted in notable revisions in the narcissism construct and the criteria for NPD. First, the overarching dimension of "disturbances in interpersonal relationships" was

separated and specified as having features of "exploitativeness" (criterion #2), "entitlement" (criterion #6) and "lack of empathy" (criterion #8). However this revision also saw the criterion of relationship "idealisation and devaluation" being removed entirely in order to reduce overlap with Borderline Personality Disorder (Reynolds & Lejuez, 2011). Second, while the criterion regarding negative responses to criticism was retained (criterion #1), it was described as "feelings of rage, shame or humiliation" with the aspects of "inferiority" and "emptiness" not included. Third, a new criterion (#9) regarding a "preoccupation with feelings of envy" was added.

The successive changes of NPD criteria in the DSM reflected a broader effort to standardise diagnostic systems in order to increase the precision and reliability of diagnoses. This, however, led diagnoses to be formulated with observable "symptoms" signifying the presence of a discrete categorical disorders (Levy et al., 2013). This reliance on symptom clusters to form prototypic descriptions of particular disorders, while particularly helpful when conducting research, has also been argued to miss relevant clinical material (Lingiardi & McWilliams, 2017). Specifically regarding NPD, this is most evident as primacy is given to typically overt "grandiose" symptoms to the exclusion of the more hidden or defended against "vulnerable" aspects (Cain et al., 2008). As such, in a marked contrast to this approach, the Psychodynamic Diagnostic Manual (PDM; PDM Task Force, 2006) was developed to offer a diagnostic framework that characterises an individual's full range of functioning, combining nomothetic and idiographic knowledge, emphasising individual variations as well as commonalities. Where the DSM places primacy on observable symptoms in diagnosing psychological disorders (notably reflected in the axial system of the DSM-IV, in which Axis I comprised symptom based clinical disorders), the PDM places a primacy on personality (P-Axis) and mental functioning (M-Axis), with symptoms (S-Axis) constituting an individual's personal expression or experience of their difficulties that may

require clinical attention. The core features of the narcissistic personality (e.g. emptiness, defensive grandiosity, preoccupation with status, personal vulnerability, idealisation, and devaluation) have remained relatively unchanged between the original PDM and the more recent PDM-2 (Lingiardi & McWilliams, 2017). However, there are a few key differences. First, reflecting a broader change in the conceptualisation of personality functioning more generally (McWilliams et al., 2018), the PDM-2 describes individuals with pathological narcissism at all levels of organisation (neurotic, borderline and psychotic), whereas the original PDM only discussed narcissistic personality "disorder" which is located more concretely within the borderline personality organisation. Second, while both the PDM and the PDM-2 describe the central tension of narcissism being a preoccupation with inflated or deflated self-esteem, the PDM delineates two subtypes of narcissistic personality disorder: "Arrogant/Entitled" and "Depressed/Depleted". While the PDM-2 does not categorise individuals as existing within these subtypes, it does outline the long clinical history of narcissism existing between the poles of "grandiosity" and "vulnerability". This change perhaps reflects the more nuanced view of these different self-states being intimately related prototypical presentations (Caligor & Stern, 2020; Levy, 2012; Ronningstam, 2009, 2011a) as opposed to being discrete categories.

The final major classification system to be briefly discussed is the World Health Organisation International Classification of Diseases, which recently revealed its 11$^{th}$ edition (ICD-11, World Health Organization, 2019). Significant problems were outlined with the previous version, ICD-10 (World Health Organization, 1992), regarding the categorical approach to personality disorders, arbitrary diagnostic thresholds, overlap between categories and difficulty with assessment in routine clinical practice (Clark, 2007; Tyrer et al., 2015; Widiger & Trull, 2007). As such, the ICD-11 has removed personality disorder labels and adopted a dimensional approach that focuses on global severity (range: "none", "personality

difficulty", "mild personality disorder", "moderate personality disorder" and "severe personality disorder") and trait qualifiers ("negative affectivity", "detachment", "disinhibition", "dissociality" and "anankastia"). One further significant feature is the option to include a "borderline pattern" which can be included with the trait qualifiers; however, this requires at least 5 out of 9 polythetic features as presented in the DSM-5 criteria for borderline personality disorder to be present. As such, whereas in the ICD-10 narcissism was labelled under "F60.8 Other: Narcissistic", in the ICD-11 individuals may be described as having the trait qualifiers of "Dissociality" (specifically grandiosity and entitlement) and "Negative Affectivity" (specifically dysregulated self-esteem, envy and sensitivity to criticism), along with an index of severity and a "borderline pattern" if applicable (Bach & First, 2018). Given the similarity between the ICD-11 and the alternate model of personality disorders in the DSM-5, no further specific discussion of the ICD-11 will be included in this thesis. We will now turn our attention to the currently used versions of classification and diagnostic systems: the DSM-5 and the PDM-2.

*Diagnostic and Statistical Manual (5th edition)*

The DSM-IV (1994) reflected an attempt to determine the empirical status of the NPD diagnosis, involving a personality disorders work group to provide expert advice, comments, references, published and unpublished data to the committee. This committee attempted to address key issues regarding prevalence, comorbidity and symptom criteria accuracy (Gunderson et al., 1995), resulting in further changes to diagnostic criteria of NPD from DSM-III-R to the DSM-IV. First, the criterion of "rage, shame or humiliation" to criticism was deleted, to reduce overlap with paranoid and borderline personality disorders. Second, criteria relating to lack of empathy was reworded, from "inability" to "unwillingness" to recognise or identify with others' feelings. Third, the wording regarding "preoccupation with envy" was changed to describe the direction of envious feelings (towards others, or towards

self from others) to increase clinician endorsement and aid with specificity. Fourth, a new criterion was added: "shows arrogant, haughty behaviours or attitudes". Finally, alongside several wording changes made to aid specificity to the narcissism construct, the feature statement of "hypersensitivity to the evaluation of others" was changed to "need for admiration". The resulting criteria for NPD as presented in the DSM-IV would be retained without modification in the DSM-IV-TR (2000) and in the current DSM-5 (American Psychiatric Association, 2013a), these criteria are outlined in table 1.1.

**Table 1.1.**

*DSM-5 Narcissistic Personality Disorder Diagnostic Criteria.*

A pervasive pattern of grandiosity (in fantasy or behaviour), 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 recognised 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 associate 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 favourable 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 recognise 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.
9. Shows arrogant, haughty behaviours or attitudes.

As mentioned, a common criticism of the DSM-5 criteria for NPD is the focus on grandiose presentations at the exclusion of vulnerable ones (Cain et al., 2008). The successive editions of DSM criteria demonstrate this highlighted grandiose presentation, with initial conceptualisations including phrases such as "inferiority", "shame", "emptiness" and "hypersensitivity", which were all removed over time. Further criticisms of the DSM categorical criteria relate to issues of severity (e.g. level of impairment, "normal" versus pathological narcissism), expression, and structure (Skodol et al., 2014). Additionally, and for the purposes of this review, where once the presence of interpersonal dysfunction reflected its own diagnostic entity within the categorical conceptualisation of NPD, interpersonal dysfunction is now only explicitly referenced once (criterion #6), otherwise being only inferred (e.g., criterion #7 and #9). A summary of items that have been removed and added over successive editions is presented in Table 1.2.

**Table 1.2.**

*Items Removed, Added or Modified Over Successive Editions of DSM for Narcissistic Personality Disorder Diagnostic Criteria*

| *DSM-III* | → | *DSM-III-R* |
|---|---|---|
| Item diagnostic content removed | | Item diagnostic content added or modified |
| N/A | → | Is preoccupied with feelings of envy |
| **Cool indifference** or marked feelings of rage, **inferiority**, shame, humiliation, or **emptiness** in response to criticism, **indifference of others or defeat**. | → | Reacts to criticism with feelings of rage, shame, or humiliation… |

| | | |
|---|---|---|
| Relationships that characteristically alternate between the extremes of over idealisation and devaluation. | → | Item deleted |
| At least two characteristics of disturbances in interpersonal relationships | → | Item deleted |
| Grandiose sense of self-importance or uniqueness | → | Has grandiose sense of self-importance… |
| | → | Believes that his or her problems are unique… |
| **Exhibitionism:** the person requires constant attention and admiration. | → | Requires constant attention and admiration… |
| *DSM-III-R* | → | *DSM-IV* |
| Reacts to criticism with feelings of rage, shame, or humiliation… | → | Item deleted |
| Lack of empathy, **inability** to empathise… | → | Lacks empathy: is unwilling to recognise or identify with the feelings and needs of others |
| Is preoccupied with feelings of envy | → | Is often envious of others, or believes others are envious of them |
| Requires **constant attention and admiration…** | → | Requires excessive admiration |
| N/A | → | Shows arrogant, haughty behaviours or attitudes |

*Note.* Within categories, items in **bold** reflect specific deleted or modified diagnostic content.

Manifest issues with the categorical approach to personality disorders in the DSM-IV led to the members of the personality disorders work group to contemplate a paradigm shift

in the diagnosis of personality, with members agreeing that this would involve a move away from DSM-IV and towards a more dimensional approach (Zachar et al., 2016). However, multiple issues arose that impeded the progress of this paradigm shift, including disagreements regarding the empirical status of the disorders, vested interests for dimensional model selection and conflict regarding clinical experience versus published research (Zachar et al., 2016; Zachar et al., 2019). Interestingly for the purposes of this review, NPD was nearly removed from the diagnostic model altogether, however in response to criticism from clinicians and researchers (e.g. Ronningstam, 2011a; Shedler et al., 2010) it was re-instated. After numerous task force and oversight committee meetings that demonstrated doubt regarding the empirical status of the emerging dimensional model (Zachar et al., 2019), a compromise was reached with the DSM-IV diagnostic criteria being re-printed in the main text of the DSM-5, but with the dimensional model being included in section III under "Alternate DSM-5 Model for Personality Disorders" (AMPD). The alternate model for NPD is presented in Table 1.3.

**Table 1.3.**

*Alternate DSM-5 Model for Narcissistic Personality Disorder*

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:
    1. *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.
    2. *Self-direction:* Goal setting based on gaining approval from others; personal standards unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.
    3. *Empathy:* Impaired ability to recognise 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.

4. *Intimacy:* Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain.

B. Both of the following pathological personality traits:
   1. *Grandiosity* (an aspect of Antagonism); Feelings of entitlement, either overt or covert; self-centeredness; firmly holding to the belief that one is better than others; condescension toward others.
   2. *Attention seeking* (an aspect of Antagonism): Excessive attempts to attract and be the focus of the attention of others; admiration seeking.

The alternate model for NPD includes criteria consisting of impairment in personality functioning (i.e., self: identity, self-direction; interpersonal: empathy, intimacy), and the presence of pathological personality traits. Importantly, in this diagnostic model, severity of the disorder is measured along a continuum labelled the "level of personality functioning" (LPFS). The rationale for the LPFS is that all personality disorders share common core features that range in severity and have implications for treatment progression and outcome (Skodol et al., 2011). The LPFS differentiates five levels of impairment, ranging "little or no impairment", "some", "moderate", "severe" and "extreme" (scored 0 – 4 respectively), with a diagnosable personality disorder requiring the presence of at least "moderate" impairment in these domains of personality functioning. The pathological personality traits are organised into five broad trait domains ("negative affectivity", "detachment", "antagonism", "disinhibition" and "psychoticism"), which reflect the maladaptive variants of the Five Factor Model of personality (or "Big Five") contrasted with healthy, adaptive traits (i.e. "emotional stability", "extraversion", "agreeableness", "conscientiousness" and "lucidity"). These five trait domains are comprised of 25 trait facets, of which specific personality disorders will include a subset (i.e., for NPD this is "grandiosity" and "attention seeking", which are elements of the broader trait "antagonism").

While not perfect, the AMPD has been viewed by many as a meaningful step forward in a number of key areas (Skodol et al., 2014). First, it makes explicit reference to both grandiose and vulnerable presentation (and the vacillation between the two) as reflecting the core identity disturbance. Second, it allows for diverse presentations in severity (via LPFS), previously unable to be specified. Third, specified difficulties in interpersonal relationships have been elevated to once again reflect a core deficit and diagnostic entity. Fourth, grandiosity is specified as existing in either overt or covert forms, as opposed to exclusively overt presentations. Overall, the AMPD has moved beyond the mere identification of the presence or absence of observable behavioural "symptoms" within arbitrary diagnostic thresholds, and instead reflects the assessment of core difficulties relating to identity and interpersonal relationships as expressed within identified prototypical personality styles or patterns. In order to highlight the applicability of the alternate diagnostic model, Pincus et al. (2016) present three cases of NPD through the lens of the alternate model. Pincus and colleagues concur with the clinical utility of the alternate model for diagnosing NPD, through its appreciation of both grandiose and vulnerable states and its ability to specify severity in personality pathology. However, the authors do suggest a potential revision to better account for narcissistic vulnerability, in the inclusion of traits "anhedonia" or "depressivity" in the domain of negative affectivity.

It should be noted, however, that some key issues with the alternate model have been highlighted. These include the omission of established personality disorders (e.g., paranoid, schizoid, histrionic) which, barring substantial criticism, would have also included NPD. The disorders not covered by the alternate model are diagnosed as "PD-Trait Specified" in which clinically significant personality traits are identified in lieu of a prototypic diagnostic label (i.e., "suspiciousness", "restricted affectivity" and "hostility" instead of "paranoid personality disorder"), raising issues relating to inclusion of trait specifiers in the alternate model more

generally. As trait models have been viewed by some as being the purview of "academic psychology", with an empirical base involving mainly "normal" populations, the relevance of the trait model for understanding and diagnosing clinical populations has been questioned (Henrich et al., 2010; Shedler et al., 2010). Specifically, in advocating for a more person centred approach, Shedler et al. (2010) state that "a clinically useful approach should focus on types of people… not in terms of deconstructed subcomponents or in terms of 30-plus separate trait dimensions to be rated" (p. 1026). Diverging from biological based trait approaches, such alternate conceptualisations include psychodynamic systems that prioritise dynamic, structural elements of the mind (Kernberg, 2018), which will be reviewed in the next section.

*Psychodynamic Diagnostic Manual (2nd edition)*

The Psychodynamic Diagnostic Manual (2nd edition, PDM-2; Lingiardi & McWilliams, 2017), promoting integration between nomothetic and idiographic perspectives, aspires to be a "taxonomy of people rather than a taxonomy of disorders" (p. 2). It is based on the contemporary, psychodynamically oriented, perspective of internalised structures (Kernberg, 2018). The PDM-2 is divided into age groups ("Adulthood", "Adolescence", "Childhood", "Infancy and Early Childhood" and "Later Life") which each has their own constellation of axes (i.e., "Personality Syndrome – P-Axis", "Mental Functioning – M-Axis" and "Symptom Patterns – S-Axis") that informs a multidimensional approach to personality assessment that captures a diverse range of an individual's overall functioning. The M-Axis pertains to an individual's "mental functioning", including capacities such as information processing, affective tolerance, impulse regulation, mentalization, identity, intimacy, self-esteem, defensive functioning, adaptive processes, self-reflexivity, moral functioning, and meaning construction. The S-Axis involves "symptom patterns", such as those listed in the descriptions of the DSM-5. However, in the PDM-2 these symptoms are not only used as a

clinical list indicating what someone "has", rather the symptom patterns are viewed as a window into a person's individual experience and the role these symptoms have played historically and in the "here and now". Such symptom patterns include anxiety, depression, insomnia, somatoform symptoms, suicidal ideations and self-harm, psychotic symptoms and so forth. The M and S Axes allow the treating clinician to adopt a person-centred approach which accounts for both the broad scope and fine-grained details of an individual's functioning and subjective experience. The P-Axis evaluates both the syndrome or pattern of an individual's personality (i.e., the personality "style" or "type") as well as their more general functioning (i.e., the "level" of personality organisation).

Regarding functioning, the level of personality organisation operates on a dimensional continuum through "healthy", "neurotic", "borderline" and "psychotic" ranges. In their operationalised psychodiagnostic chart based on the PDM-2, Gordon and Bornstein (2015, 2018) outline the typical features for individuals at different levels of functioning within the domains of "identity", "object relations", "defences" and "reality testing". The borderline level of personality organisation can be divided into a higher level (bordering neurosis) and a lower level (bordering psychoses). These different levels of functioning are presented in Table 1.4. These features are consistent with other psychodynamic authors who have previously delineated features of different levels of personality organisation, with some minor differences. For instance, Clarkin et al. (2006) add dimensions of "aggression" (borderline: self and other aggression, hatred; neurotic: inhibited aggression, guilt; healthy: modulated aggression, appropriate self-assertion) and "internalised values" (borderline: contradictory values, absence of values; neurotic: guilt, inflexibility; healthy: stable, independent, individualised).

**Table 1.4.**

*Aspects of Levels of Personality Organisation*

| | Psychotic | Borderline | Neurotic | Healthy |
|---|---|---|---|---|
| Identity | Inaccurate sense of self and others, internal and external forces | Incoherent and oscillating sense of self and others; affective intolerance and dysregulation | Coherent sense of self and others; fair affect tolerance and regulation | View self and others in complex, stable and accurate ways |
| Object Relations | Profound difficulties with maintaining relationships with others; not desiring relationships with others | Troubled or chaotic interpersonal relations; severe interference with love relations; confused internal working models of relationships | Largely able to maintain satisfying and deep relationships with others; some difficulties with sexuality and intimacy; specific conflicts with selected others | Able to maintain intimate, stable and satisfying relationships |
| Typical Defences | Delusional projection, psychotic denial, psychotic distortion | Splitting, projective identification, idealisation, devaluation, denial, acting out | Repression, reaction formation, intellectualisation, displacement, undoing | Anticipation, self-assertion, sublimation, suppression, altruism, humour |
| Reality Testing | Unable to appreciate or understand reality as conventionally perceived | Largely realistic appreciation of reality, may have occasional lapses | Realistic notion of reality and convention | Realistic notion of reality and convention |

Regarding personality syndrome, the PDM-2 has all of the types reflected in the DSM categorial dimension of personality "disorders" (e.g., dependent, obsessive compulsive, schizoid), as well as clinically relevant personality types that are not covered in current DSM categories (e.g., somatising, depressive). Importantly, while certain personality styles are more commonly found within certain dimensional "levels", personality styles do not in themselves necessarily connotate "health" or "pathology". Rather, personality style reflects the organising and motivational system of an individual that distinguishes them from others.

For the purpose of this review, we will now present the PDM-2 description of the "narcissistic" personality syndrome, within each relevant age bracket.

*PDM-2 Adulthood*: Narcissistic personalities exist along the full spectrum of neurotic to psychotic organisation. More neurotic styles are socially appropriate, charming and generally capable in work, family (although may have impaired capacity for intimacy) and interests. At more pathological levels, these individuals suffer from identity diffusion, lack internal morality and may behave in highly destructive ways – the most extreme version of this being individuals suffused with "malignant narcissism" (Kernberg, 2008) at the borderline psychotic level of personality organisation. The subjective experience is of internal emptiness, requiring external affirmation to provide meaning and value. As such, hallmark grandiose features such as preoccupation with status, wealth or success may be methods to exact external admiration in an attempt to transform inner experience. However, when attempts at external validation fail these individuals may display more typically "vulnerable" themes of depression, shame and envy. As a consequence of this, individuals may alternate between idealisation and devaluation of self and others. Idealisation of self is predominantly through indulgence in grandiose fantasy, while idealisation of others may be done to enhance the grandiose self via identification with the idealised other. Devaluation of others may be in the service of preserving the integrity of the grandiose self, while devaluation of self may be a natural consequence of failure to obtain external validation. The PDM-2 lists the key features of the narcissistic personality as presented in Table 1.5.

**Table 1.5.**

*PDM-2 Key Features of the Narcissistic Personality*

| |
|---|
| **Contributing constitutional-maturational patterns:** No clear data |
| **Central tension/preoccupation:** Inflation versus deflation of self-esteem |
| **Central affects:** Shame, humiliation, contempt, envy |

**Characteristic pathogenic belief about self:** "I need to be perfect to feel OK", "I need to feel that I am superior to others to feel OK."

**Characteristic pathogenic belief about others:** "Others enjoy riches, beauty, power and fame. The more of those I have, the better I will feel."

**Central ways of defending:** Idealisation, devaluation

*PDM-2 Adolescence (and Childhood):* The full spectrum of personality organisation again exists for the narcissistic personality in adolescence, however, as the personality is still forming in early development it is termed "emerging". The development of a healthy personality structure depends in large part to a personal sense of agency in childhood, as well as mirroring and attentive parents. Having unresponsive and preoccupied parents, or a temperament that prevents a child from feeling sufficiently soothed, can cause healthy development to be disrupted, resulting in a developmental arrest, or the formulation of a pathological grandiose self. For some, parents may heavily idealise their children as an extension of their own narcissistic needs. Rather than having their individuality and worth mirrored and internalised, this may foster in children a pre-occupation with being "good" at a performance or external level and result in a profound sense of internal emptiness and fraudulence. This focus on gaining esteem through external compliance, disconnected from any internalised sense of "goodness", has been termed the "false self" (Winnicott, 1960a, 1960b) and, if remaining unintegrated throughout development, may result in the predominance of intrapsychic "splitting" in later life. Recent research has shown support for the models of parental maltreatment and indulgence as potential avenues for the development of narcissism (Huxley & Bizumic, 2017; van Schie et al., 2020). Adolescents who are highly focused on achieving realistic pride in accomplishment display more healthy narcissistic functioning, whereas more dysfunctional patterns revolve around patterns of grandiosity in fantasy or behaviour. Similar patterns surrounding "grandiose" and "vulnerable" themes are

evident in adolescence that become entrenched in adulthood. However, the display of these features are likely to be more "childlike" in a qualitative, if not quantitative, sense (e.g. appearing "petulant" rather than devaluative, appearing "spoiled" rather than entitled).

*PDM-2 Older Age:* Some features of aging may give rise to narcissistic presentations in older people (e.g., reassurance from others regarding personal value, identity, relationships; entitlement to preferential or special treatment; shortened patience or tolerance) which may, under certain circumstances, be viewed as realistic or appropriate. A "true" narcissistic syndrome in older age would have to be present in earlier stages of life, and present with the core features as described earlier (e.g., grandiose self-importance, compromised empathic ability, internal feelings of emptiness). In this case, the aging process may also exacerbate narcissistic features or cause them to shift in their expression. For instance, pre-occupation with personal strength for esteem needs may be particularly challenged by the physical changes that occur with aging (e.g., loss of energy, beauty standards, physical strength). This will also likely give rise to painful emotional experiences, with individuals feeling profound bitterness, shame, regret and envy – reflecting an Eriksonian (1998) "despair" rather than "integrity" resolution. Physical, psychological and cognitive related difficulties in older age may also lead individuals with a narcissistic syndrome to project their own preoccupation with a deteriorated self-image onto others, resulting in a prideful or fearful rejection of genuine support and care from others.

In summary, while the PDM-2 may resist categorisation in a way that makes itself less ideal as a research instrument, as a clinical tool it may account for features that are currently not encapsulated in more discrete categorical diagnostic systems (Patriarca et al., 2020). Within its conceptualisation of narcissism, the PDM-2 accounts for both grandiosity and vulnerability facets, distinguishes between expressions across the lifespan, highlights the related "self-other" core impairments, and allows for a wide variance in level of functioning

ranging from a "healthy" or "neurotic" personality *style* to a personality *disorder* at the "borderline" or "psychotic" level of personality organisation. As the field of narcissism research remains divided over a number of key issues, the PDM approach to understanding the narcissism construct likely has substantial relevance to both clinical interventions and research. We will now turn our attention to some of the key issues related to the narcissism construct.

## Issues in pathological narcissism research

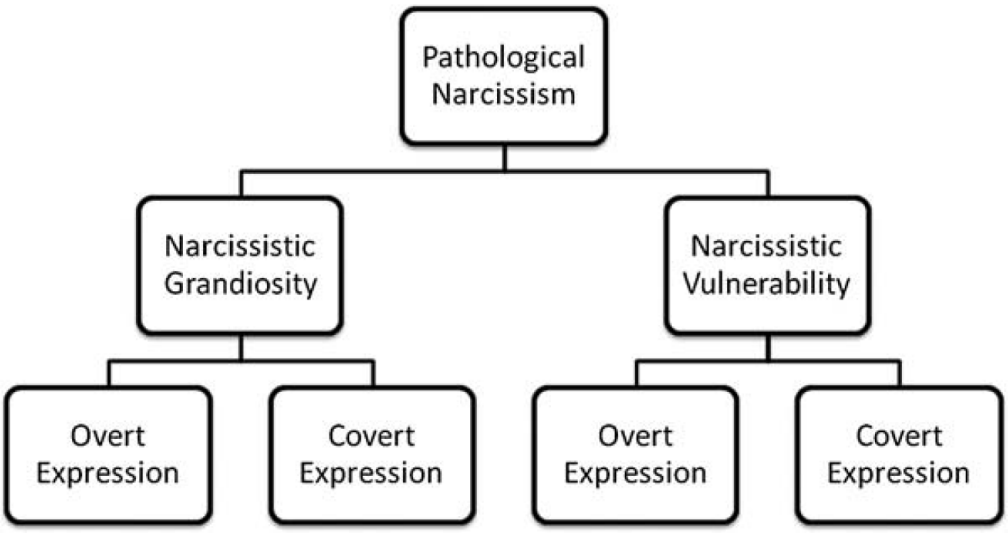
### *Dimensions of narcissism*

In their review, Cain et al. (2008) report on over 35 years of clinical, personality and psychiatric literature that described consistent variations in the expression of the narcissistic personality that revolve around two broad themes: grandiosity and vulnerability. However, the authors also report that the majority of modern research and dominant diagnostic systems emphasise overt grandiosity at the exclusion of vulnerability. For instance, Fossati et al. (2005) examination of the latent structure of the DSM criteria for NPD found that while taxometric analysis indicated DSM criteria is appropriate for distinguishing from other disorders, the criteria do not provide diagnostic accuracy as the criteria fit two related, although distinct, clusters of narcissistic features reflecting overt and covert manifestations. The empirical status of the phenotypic expression of NPD has been examined through the use of the Shedler-Westen Assessment Procedure, a research tool that has been validated within clinical and normative samples and across different age ranges (Westen, DeFife, et al., 2014; Westen & Shedler, 2007; Westen et al., 2012; Westen, Waller, et al., 2014). Results of Russ et al. (2008) outlined three subtypes of narcissism: 1) "Grandiose/malignant narcissism" which displays instances of intense anger, entitled self-importance, lack of empathy, feelings of victimisation, exploitativeness, vindictiveness and relies on externalisation. 2) "Fragile

narcissism" which also displays an entitled self-importance, however also includes instances of depressed mood, internal emptiness, interpersonal sensitivity, abandonment fears and aggression or hostility. 3) "High functioning/exhibitionistic narcissism" which displays entitled self-importance as well as grandiose fantasies, but also makes use of humour, is articulate, energetic, competitive, performative, uses effective and appropriate self-assertion, maintains good relationships and is able to find meaning and satisfaction in the pursuit of long-term goals. Based on empirical examination such as this, as well as the aforementioned history of clinical and theoretical literature Pincus and Lukowitsky (2010) recommended the integration of grandiose and vulnerable literature in order reduce the "tower of babble" that informs conceptual confusion, and instead promote investigation into the construct of "pathological narcissism" reflecting a supraordinate cluster organised around themes of grandiosity and vulnerability (each with covert and overt features) as displayed in Figure 1.1.

**Figure 1.1.**

*The hierarchical organisation of pathological narcissism*




*Note. Copied from Pincus and Lukowitsky (2010) under 'fair dealing' within Australian copyright law (Copyright Act 1968).*

Individuals with features of narcissistic "grandiosity", as empirically examined by Dickinson and Pincus (2003), were found to display instances of self-enhancing, vindictive, aggressive, exhibitionistic and exploitative behavioural styles. These features of grandiosity, as mentioned, are largely encapsulated by DSM criteria. In their analysis, Miller et al. (2008) report that the DSM criteria can be adequately explained by a 1-factor model, focusing on overt grandiosity – contrasting findings of Fossati et al. (2005). As such, Miller et al. (2008) state that while this does not preclude the existence of alternate narcissistic subtypes (i.e. vulnerable narcissism) which are not currently encapsulated within DSM criteria, the authors do believe grandiosity to be the prototypical narcissistic presentation (Miller, Lynam, et al., 2017). The differences in these findings regarding the DSM criteria suitability and relationship between grandiose and vulnerable narcissism are thought to be due to differences in measurement instruments and sample selection (Miller & Campbell, 2008), a controversy which will be discussed shortly. Regardless, these findings all indicate that narcissistic grandiosity has robustly been empirically and theoretically examined and supported regarding its importance in understanding the narcissism construct.

Individuals with features of narcissistic "vulnerability", as empirically examined by Dickinson and Pincus (2003), were found to display high entitlement and exploitation, however, also present with overt fears of relating to others, lack of confidence in their social ability and feel shame regarding their need for relationships. Similarly, while these individuals displayed vindictive and domineering interpersonal styles, greater difficulties with interpersonal coldness and social avoidance were also described than in grandiose presentations. Exploring narcissistic vulnerability through the lens of the Five Factor Model, Miller et al. (2018) report vulnerable narcissism to be primarily related to the factor "neuroticism" involving intense negative emotionality. Overall, the construct of vulnerable narcissism is an old, yet new, area of research. As despite the long acknowledged history in

clinical literature (Cain et al., 2008; Dimaggio et al., 2002) “narcissistic vulnerability has only been studied empirically with any regularity over the past 8-10 years” (Miller, Lynam, et al., 2017, p. 293).

While clinical researchers have more typically conceptualised grandiose and vulnerable narcissism as “two sides of the same coin” (Levy, 2012), with authors such as Ronningstam (2011b) bringing together seemingly disparate clinical presentations through linking self-serving and self-enhancing manifestations (i.e. grandiosity) with hypersensitive, internally distressed and fragile manifestations (i.e. vulnerability). Some leading narcissism researchers within personality/social psychology place emphasis on the divergent nomological network between grandiose and vulnerable narcissism (Miller & Campbell, 2008, 2010; Miller et al., 2008; Miller, Lynam, et al., 2017). For instance, as Miller et al. (2018) state that as “vulnerable narcissism is a construct best characterised by intense negative emotionality/emotional dysregulation, much like its near neighbour borderline personality disorder” (p. 195), the authors argue that vulnerability should be considered a “peripheral” feature. This debate is remarkably similar to the outlined historical difficulty establishing criteria for NPD within the DSM, which eventually prioritised overt grandiosity in an attempt to increase accuracy of diagnoses and to reduce “co-morbidities”. However, empirical work by Sharp et al. (2015) highlights why difficulties with “co-morbidities” may persist. Utilizing a clinical sample, the Sharp et al. (2015) examined the latent dimensions of personality disorder criteria as presented in the DSM. They found that BPD items loaded most strongly on a “general factor” that indicates broad impairment and does not denote a distinct personality disorder “type”, rather potentially represent core features of personality disorder “severity”. In contrast, they found that criteria for NPD displayed clear specific factors that distinguished it from other disorders (Sharp et al., 2015). Recently, empirical work supported this distinction in a sample with “co-morbid” BPD and NPD, with findings

outlining the specific effect narcissism has on intrapersonal and interpersonal functioning, against the more general factor of BPD dysfunction (Hörz-Sagstetter et al., 2018). In a similar vein, Euler et al. (2018) report that NPD diagnoses were representative of grandiose narcissism, whereas vulnerable narcissism was better accounted for by a BPD diagnosis.

From a diagnostic perspective, the DSM-5 AMPD and the PDM-2 present a conceptualisation of narcissism that allows for both grandiosity and vulnerability, with potentially differing presentations depending on level of severity. For instance, within the PDM-2 an individual at the "borderline" level of organisation may display significant identity disturbance, with predominant vulnerable narcissism, alongside emotional dysregulation and only transitory grandiosity (Wright & Edershile, 2017). More disturbed individuals may have a more inflexible and unrealistic pattern of object relations, heavily invested in a rigid pathological grandiose self and relying on denial and projective mechanisms to evacuate painful feelings of vulnerability. In this way Caligor and Stern (2020), utilizing a personality organisation framework, state how "manifestly vulnerable narcissists retain a connection to their grandiosity… [and] even the most stably grandiose are not protected from the experience of the devalued self, which threatens to emerge into consciousness in the setting of disappointments or failure". This view, regarding the interconnection between grandiose and vulnerable states, as well as their potential to fluctuate or oscillate in particular contexts, has been described in the empirical literature (Giacomin & Jordan, 2013, 2016; Gore & Widiger, 2016; Jauk et al., 2017; Oltmanns & Widiger, 2018).

As such, differences in theoretical conceptualisation and phenotypic expression of pathological narcissism have led to a proliferation of diverse measures used to capture key elements of the construct. Thus, the second issue in the study of pathological narcissism is measurement.

*Measures of narcissism*

One of the most popular measures of narcissism, utilised predominately by social-personality psychology researchers, is the Narcissistic Personality Inventory (NPI, Raskin & Terry, 1988). In their factor analysis, Ackerman et al. (2011) report the NPI to consist of three factors: 1) leadership/authority, 2) grandiose exhibitionism, 3) entitlement/exploitativeness. The NPI has been routinely criticised regarding its factor structure and sample selection (for a review, see Pincus & Lukowitsky, 2010) invoking the wider discussion regarding the use of non-clinical (or non "general") samples more broadly (Henrich et al., 2010; Miller & Campbell, 2008). However, the NPI has also demonstrated its structural integrity and validity regarding DSM criteria (for a review, see Miller, Lynam, et al., 2017). Notwithstanding, in order to establish a narcissism measure that is validated within a clinical sample and that captures the spectrum of narcissism across both grandiose and vulnerable dimensions, Pincus et al. (2009) created the Pathological Narcissism Inventory (PNI). The resulting scale examines grandiosity through the factors of "Exploitative", "Self Sacrificing Self Enhancement", "Grandiose Fantasy" and "Entitlement Rage"; the vulnerable dimension is captured by the factors of "Contingent Self Esteem", "Hiding the Self" and "Devaluing". However, alternate factor structures have also been proposed that consider the shared features of grandiosity-vulnerability as measured by the PNI (Weiss et al., 2020). The PNI has also been translated into a "brief" and "super brief" version (Schoenleber et al., 2015) and the full scale has demonstrated validity, reliability and clinical utility through empirical studies (Thomas et al., 2012). The PNI, however, has also drawn criticism and considerable controversy from researchers of different theoretical orientations (e.g. Fossati, Somma, Borroni, & Markon, 2017; Miller & Lynam, 2017; Miller, Lynam, et al., 2017).

In their paper, Krizan and Herlache (2017) present a unified model conceptualising narcissism as operating on a continuum from grandiosity and vulnerability with the shared

feature of "entitlement". The authors explore popular narcissism measures regarding how they access these related features. Table 1.6 displays their analysis, alongside other comparisons of popular narcissism measures by Miller et al. (2014); Wright and Edershile (2017). These reviews display that there is a breadth of available and empirically validated measures to choose from that cover the spectrum of narcissistic presentation.

**Table 1.6.**

*Comparison of Popular Measures of Narcissism*

| Narcissism Dimension | Krizan & Herlache (2017) | Wright & Edershile (2017) | Miller et al (2014) |
|---|---|---|---|
| Grandiosity | PNI, **NPI**, NARQ, PES | PNI, **NPI, FFNI, NARQ, NGS,** PES | PNI, **NPI, FFNI,** NARQ, NGS |
| Entitlement | PNI, NPI, **NARQ**, PES, HSNS | **PNI, NPI**, FFNI, **NARQ, PES** | - |
| Vulnerability | **PNI**, NARQ, PES, HSNS | **PNI, FFNI,** NARQ, HSNS | **PNI**, **FFNI, NARQ, HSNS** |

*Note.* PNI = Pathological Narcissism Inventory, NPI = Narcissistic Personality Inventory, FFNI = Five Factor Narcissism Inventory, NARQ = Narcissistic Admiration and Rivalry Questionnaire, PES = Psychological Entitlement Scale, HSNS = Hypersensitive Narcissism Scale, NGS = Narcissistic Grandiosity Scale. Bolded measures are indicated by authors as being particularly sensitive or accurate in assessing the specific narcissism dimension.

However, while a number of well validated and diverse self-report measures exist for pathological narcissism, a persistent issue regards the general validity of using self-report measures with a population that diagnostically lacks insight (Russ & Shedler, 2013). As such, informant-based measures of narcissism are argued to offer a meaningful and clinically useful perspective regarding the assessment of narcissistic pathology (Lukowitsky & Pincus, 2013; Oltmanns et al., 2018).

Notwithstanding this issue, in their review of popular narcissism measures Krizan and Herlache (2017) state that "one key issue important to narcissism scholarship has involved

determining the "normalcy" or adaptiveness of narcissism" (p. 18). This is a third unresolved issue of pathological narcissism and will be discussed in the following section.

*Severity of functioning*

Early narcissism theorists, such as Freud, Kohut and Kernberg, all identified the "normal" elements of narcissism. Whether it be the "normal" developmental stage of primary narcissism (Freud, 1914), the "healthy" narcissistic psychological constellation that supports value driven behaviours and positive self-regard (Kohut, 1966a, 1972b) or the "normal" adult narcissism of appropriate self-esteem regulation and gratification of instinctual needs within stable object relations and value systems (Kernberg, 1975, 2008). As such, the relationship between this "normal" narcissism and its pathological variant has resulted in considerable academic and clinical research. For instance, Pincus and Lukowitsky (2010) caution that the absence of pathological narcissism does not equate to the presence of adaptive or normal narcissism. Similarly, Miller, Lynam, et al. (2017) commented that a lack of personal distress should not constitute a "prima facie" case of adaptive or healthy narcissism, as this does not account for the pain and distress that may be caused to others. It has even been suggested that terms such as "normal", "adaptive" and "pathological" should be avoided, as these terms do not provide meaningful descriptive content (Krizan & Herlache, 2017), particularly as the components that are considered adaptive or normal may be variable given developmental age, situation or perspective (Gabbard & Crisp, 2018).

It is in this way that diagnostic classifications such as those espoused in the PDM-2 and the DSM-5 (AMPD) offers a conciliatory bridge. For instance, Narcissism as understood within the PDM-2 is a "prototype", outlining typical personality manifestation that is subsumed by a particular motivational themes (McWilliams, 2011). As such, the narcissistic personality style itself does not connotate health or disorder, rather it is the organisational

system (consisting of identity, relationship functioning, reality testing, defences, emotion regulation and so on) that indicates pathology. For instance, an individual may have intact reality testing, stable external relationships, capacity for impulse control, and affect tolerance through use of healthy defences (Ronningstam, 2011c), however, their personality may still display particular preoccupations with self-esteem regulation and motivations towards external validation, indicating a narcissistic style. This range of functioning is also demonstrated empirically by clinical tools such as the Shedler-Westen Assessment Procedure, as discussed earlier. Russ et al. (2008) demonstrate that, despite sharing common hallmark features of entitlement and self-importance, subtype 1 ("malignant/grandiose narcissism") and 3 ("high functioning/exhibitionistic narcissism") clearly differ in terms of their underlying personality organisation regarding their capacity for emotion regulation, sense of identity, social functioning, aggression and morality. These findings reflect the wide variability in functioning of the narcissistic personality, from healthy to a highly severe and debilitating personality disorder.

## Narcissism and interpersonal dysfunction

### Interpersonal dysfunction

*Interpersonal dysfunction in diagnostic classification systems*

Despite disagreement regarding subtype, measurement and adaptiveness of the narcissism construct, virtually all researchers from across diverse disciplines agree that interpersonal dysfunction is a core characteristic of pathological narcissism. Indeed, initial conceptualisations of NPD as they appeared in the DSM specifically included criteria related to disturbances in interpersonal relationships (Criterion E). Successive editions modified this, removing it as a core feature of the disorder and separating it into its constituent symptom parts. Interestingly, the AMPD in the DSM-5 has re-instated interpersonal dysfunction as a

core feature of personality disorders, with difficulty in the domains of "empathy" and "intimacy", which have specific manifestations for a narcissistic presentation. Further, diagnosis in the alternate model requires the presence of "antagonistic" pathological personality traits which necessitate a conflictual relational style. This is consistent with psychodynamic approaches, such as the PDM-2, which view interpersonal dysfunction as a central feature of the "borderline personality organisation" through impairments in identity and object relations. For the narcissistic personality, organised at a borderline level, this would involve interpersonal dysfunction revolving around themes of self and other idealisation and devaluation. At the psychotic level, interpersonal dysfunction is more disturbed due to severe denial and projective mechanisms, the resultant antisocial behaviour is seen in the syndrome of "malignant narcissism" (Kernberg, 2008; Lenzenweger et al., 2018).

*Interpersonal dysfunction in clinical samples*

Ogrodniczuk and Kealy (2013) state that the "hand-in-hand" nature of interpersonal dysfunction and pathological narcissism is reflected in the clinical aphorism "narcissistic individuals are not necessarily identified by how they feel, but according to how they make others feel" (p. 114). This is based on extensive clinical experience regarding the intense interpersonal difficulties for individuals with pathological narcissism (Kealy & Ogrodniczuk, 2011). However, despite the widely held lay belief that narcissism is a pre-occupation with excessive self-love, clinical researchers highlight that pathological narcissism may be better conceptualised as an impairment in the capacity to love – encompassing both love of others *and* of self (Kealy & Ogrodniczuk, 2014). In order to empirically examine these clinically observed features, Ogrodniczuk et al. (2009) utilised a sample of psychiatric outpatients with pathological narcissism and report interpersonal impairment through the presence of domineering, vindictive and intrusive behaviour – a finding that has been replicated in recent

research (Cheek et al., 2018). Similarly, Wright et al. (2017) found that patients higher in pathologically narcissistic features experienced emotional dysregulation when they perceived others as dominant, and responded with quarrelsome behaviours. This finding suggests the defensive or regulatory function that aggressive behaviours might serve for individuals with pathological narcissism, consistent with findings that highlight the links between emotional dysregulation, compromised empathic capability and impaired social functioning (Lee et al., 2020; Ronningstam, 2016, 2020a). Hörz-Sagstetter et al. (2018), using a clinical sample with comorbid BPD and NPD, found that narcissistic pathology (i.e. grandiosity) may have a stabilising function as it defends against anxiety, however it also "predisposes [these patients] to respond with antagonism/hostility and reduced reality testing when the grandiose self is threatened" (p. 571). Dashineau et al. (2019) report that for recent or current psychiatric outpatients, grandiose narcissism was associated with specific deficits in interpersonal functioning (and modest intrapersonal protective factors) whereas vulnerable narcissism was associated with all forms of dysfunction. Similarly, Edershile and Wright (2019) report that grandiose narcissism was associated with non-affiliative behaviours in general, but momentary affiliative and complementary behaviours, whereas vulnerable narcissism was associated with both general and momentary non-complementary and non-affiliative behaviour. This recent research focus utilizing clinical samples have empirically supported the long observed clinical manifestations, bridging the gap between clinical and academic accounts of narcissistic pathology (Pincus, 2020).

*Interpersonal dysfunction in social and personality psychology*

As discussed previously, intense debate has ensued regarding the study of narcissism from a personality trait perspective utilizing non-clinical samples, with claims of "reductionistic" findings and perspectives that do not inform or address the complexity of clinical practice (Kernberg, 2018; Pincus, 2020; Shedler et al., 2010). However, despite the

more recent increase in clinical and empirical research (e.g. Ronningstam, 2020b), due to a dearth of empirical studies the case has been made that trait or "subclinical" narcissism research provides a meaningful "stepping stone" to understand the narcissism construct (Miller & Campbell, 2010). Further, Miller, Lynam, et al. (2017) has argued that so called "convenience samples" (i.e. university, internet populations) may be not only more accessible for narcissism research, but more ideal, as 1) clinical samples may over-represent vulnerable features, 2) clinical research findings are harder to interpret due to "co-morbidities", 3) individuals who agree to clinical studies may be different from "typical" narcissistic individuals (who may avoid seeking treatment or not participate in research). As such, notwithstanding the limitations mentioned, trait narcissism research utilising non-clinical populations has contributed to the understanding of narcissism and its relation to impaired interpersonal functioning in meaningful ways.

Exploring primarily "grandiose" narcissism, Brunell and Campbell (2011) describe the "contextual reinforcement model" in which narcissistic functioning is relatively successful due to unstable, short-term or new interpersonal contexts, with the opposite being true for long term or stable interpersonal contexts (Campbell et al., 2005). Campbell et al. (2006) also describe the "agency model" of interpersonal functioning, in which relationships serve a primary purpose of generating "narcissistic esteem" for the self, but cause "distress to significant others" (Miller et al., 2007, p. 174). This interpersonal dysfunction is due to the described "game playing" relationship style (Campbell et al., 2002) with low investment in relationship commitment (Campbell & Foster, 2002). Regarding "vulnerable" narcissism, Krizan and Johar (2015) report vulnerability as an important driver of "narcissistic rage", uniquely influencing its expression (internalisation and externalisation), distrust of others and subsequent reactive and displaced aggression due to deficient self-esteem – supporting the observed link between disordered or pathological self-organisation and interpersonal

dysfunction. Similarly, Czarna et al. (2019) report higher trait neuroticism and poorer emotion regulation ability as associated with higher tendencies for anger and hostility in interpersonal relationships (whereas grandiosity also showed relations with anger and hostility, but was "protected" by emotion regulation capability). Hyatt et al. (2018) report that *both* grandiose and vulnerable narcissism exhibit anger in response to ego threat, however sadness, shame and guilt (Kaufman et al., 2018) were more characteristic of vulnerable narcissism. Finally, a large amount of academic research utilising non-clinical populations has been dedicated to the so called "dark triad", consisting of narcissism, machiavellianism and psychopathy. In combination these three traits are thought to reflect a particularly malevolent personality constellation, related to negative psychosocial outcomes (Muris et al., 2017). However, while meta-analyses have questioned the unique contribution of these traits (O'Boyle et al., 2015), with results indicating that psychopathy is the dominant feature (Vize et al., 2018), Muris et al. (2017) report that even when controlling for shared variance amongst negative psychosocial outcomes, narcissism is still uniquely and significantly related to interpersonal dysfunction.

*Informant ratings of interpersonal dysfunction*

Given the well-documented associations between narcissism and interpersonal dysfunction, it is not surprising that a proliferation of self-help books and support groups exist targeted at those in romantic and familial relationships with individuals with pathological narcissism (King et al., 2020). As such, despite the disagreements between academic and clinical approaches to studying narcissism, it is generally agreed that utilizing the perspective of those in romantic and familial relationships may be a potentially novel and advantageous approach to studying the narcissism construct (Miller, Lynam, et al., 2017; Pincus & Lukowitsky, 2010). Further, as self-report questionnaires pose validity issues regarding a population that diagnostically have impaired insight and reflective functioning

(Bilotta et al., 2018), researchers have proposed that the use of informant based methodologies will extend the field (Klonsky & Oltmanns, 2002; Oltmanns et al., 2018). Evidence suggests reliable discrepancies between self-report and informant-report assessment of personality and functioning exist, however high consensus is demonstrated between multiple informants regarding the same individual (Clifton et al., 2004, 2005; Thomas et al., 2003). Further, a high degree of agreement is observed for self and informant ratings regarding the presence of interpersonal dysfunction (Clifton et al., 2005). These findings are broadly replicated when specifically exploring informant assessment of pathological narcissism (Lukowitsky & Pincus, 2013) again highlighting the centrality of interpersonal functioning, and its potential to cut across perceptual biases (Pincus & Lukowitsky, 2010). For instance, a systematic review (Bailey & Grenyer, 2013) identified the significant impairment in interpersonal functioning for carers of individuals with a personality disorder. Further research using an informant sample indicated that participants in a relationship with persons with personality disorder (including NPD) reported significant levels of burden, grief, mood/anxiety/stress symptoms due to their relationship with their relative (Bailey & Grenyer, 2014). Byrne and O'Brien (2014), utilizing an informant sample, reported significant interpersonal problems with individuals with pathological narcissism, who were described as acting in avoidant and vengeful ways towards participants. Informant samples have also described the "game playing", unfaithful, over-controlling, and manipulative relationship styles of individuals with pathological narcissism (Campbell et al., 2002), however informant samples also described the positive and enjoyable short term attraction of being in a romantic relationship with someone with pathological narcissism (but with negative long term effects) (Brunell & Campbell, 2011). Finally, a study by Green and Charles (2019) utilised an informant sample to describe interpersonal dysfunction within the context of domestic violence. They report that those in a relationship with individuals with

reportedly narcissistic features described overt (e.g., verbal and physical) and covert (e.g., passive-aggressive and manipulative) expressions of abuse and that these behaviours were in response to perceived challenges to authority and to counteract fears of abandonment.

These studies provide a meaningful insight as to the relationship functioning of individuals with pathological narcissism, however, there are limited studies that specifically examine the impact these relationships have on partners and family members, either through utilizing empirically validated psychometric measures or through qualitatively exploring their subjective experience within a large sample.

**Summary**

This literature review has attempted to synthesise the empirical and theoretical basis of NPD and pathological narcissism, while also highlighting research gaps and avenues for empirical expansion. Namely, while interpersonal dysfunction is frequently cited as a core issue for pathological narcissism, there exists a dearth of studies that examine the specific impact this interpersonal functioning has on partners and family members in the relationship. Further, only limited research has focused on examining the internal disorder of pathological narcissism from the perspective of those in a close relationship as they exist in in everyday life. The aim of this thesis is to examine pathological narcissism from this perspective as this may shed light on persisting issues regarding the narcissism construct.

## 1.2. AIMS AND OUTLINE OF THESIS

The overarching aim of this thesis is to advance knowledge of the interpersonal impact of pathological narcissism on partners and family members. This aim will be examined through a series of questions and sub questions:

I. For those in a relationship with individuals with pathological narcissistic traits, what impact do these traits have on partners and family members?

i. How does this impact compare to partners and family members of other severe mental illnesses?

II. What are the character traits and challenging behaviours of individuals with pathological narcissism from the perspective of those in a close personal relationship with them?

i. How do these observed character traits inform the challenging behaviours described by partners and family members?

III. What are the core conflictual relationship patterns between individuals with pathologically narcissistic traits and their partners or family?

i. What function do these dysfunctional styles of relating serve, and how are they experienced and interpreted by partners and family members?

This first research question will be explored in Study One (Chapter Two), which includes quantitative examination of burden, symptomatology and styles of interaction between participants and their relative with pathological narcissism. The second research question will be explored in Study Two (Chapter Three), which involves analysing the qualitative responses of participants describing the character traits of their relative with pathological narcissism. Study Three (Chapter Four) will build upon these findings, and examine qualitative responses of participants describing the interpersonal behaviours and relationship functioning of their relative with pathological narcissism. The third research question will be explored in Study Four (Chapter Five), analysing the core conflictual relationship patterns between participants and their relative with pathological narcissism. In sum, the following studies sought to examine the related features of narcissistic expression and interpersonal dysfunction, in order to better understand the way the disorder expresses

itself interpersonally, to examine the impact this has on others and to identify possible opportunities for therapeutic intervention.

# CHAPTER TWO

## STUDY 1 – PATHOLOGICAL NARCISSISM: A STUDY OF BURDEN ON PARTNERS AND FAMILY

This chapter has been published as a paper in the *Journal of Personality Disorders*. Minor modifications were made to this published paper to conform to the thesis review process.

**Day, N. J. S**., Bourke, M. E., Townsend, M. L., & Grenyer, B. F. S. (2019). Pathological narcissism: A study of burden on partners and family. Journal of Personality Disorders, 33(11). doi:10.1521/pedi_2019_33_413

## ABSTRACT

Pathological narcissism is characterised by impaired interpersonal functioning, but few studies have examined the impact of the disorder on those living in a close relationship. Participants (N = 683; comprising romantic partners (77.8%), mothers (8.5%) or other family members (10%)) in a close relationship with a relative with pathological narcissism completed measures assessing levels of grief, burden, mental health and coping style. Participants reported burden was over 1.5 standard deviations above comparison carers of people with mood, neurotic or psychotic disorders, and higher than carers of people with borderline personality disorder. Similarly, caseness for depression (69% of sample) or anxiety disorders (82%) in the sample was high. Relationship type, subtype expression (vulnerable/grandiose) and coping style were all found to significantly relate to experienced psychopathology. While limitations exist regarding sample selection that may influence interpretation of results, these findings quantify the significant interpersonal impact of pathological narcissism in this sample.

## 2.1. INTRODUCTION

Pathological narcissism is often thought of as having two dimensional traits: the grandiose and vulnerable (Russ & Shedler, 2013; Russ et al., 2008). Behaviours involving grandiose narcissism include attitudes and behaviours such as dominance, vindictiveness and intrusiveness (Ogrodniczuk & Kealy, 2013). Vulnerable narcissism traits include feelings of depression, anxiety, emptiness and rumination (Pincus et al., 2014) but also attitudes that may be critical, angry and entitled (Dickinson & Pincus, 2003; Grenyer, 2013; Russ et al., 2008). These traits are associated with significant interpersonal dysfunction (Kealy & Ogrodniczuk, 2011; Ogrodniczuk et al., 2009), with some authors stating that pathological narcissism and interpersonal dysfunction go "hand in hand" (Ogrodniczuk & Kealy, 2013, p. 114). Although behaviours may differ, interpersonal dysfunction is present in both (Miller, Lynam, et al., 2017). However, while research suggests that pathological narcissism impacts others, there are few investigations of how others actually experience the relationship with a person with pathological narcissism. This study aims to address this gap in the literature.

Narcissistic personality disorder (NPD) as defined by the Diagnostic and Statistical Manual of Mental Disorders (5th edition, American Psychiatric Association, 2013a) involves a pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration and lack of empathy. This definition of NPD has been heavily criticised for its focus on only the grandiose aspects of the disorder to the exclusion of vulnerable characteristics (Skodol et al., 2014) which may have profound impacts on treatment and outcome (Pincus et al., 2014). This exclusion also runs contrary to over 35 years of clinical theories of pathological narcissism that include both vulnerable and grandiose affects and self-states (Cain et al., 2008). In addition, a clear distinction needs to be drawn between "normal" narcissism, "pathological" narcissism, and the specific diagnosis of NPD. Normal narcissism is considered to be the ability to regulate self-esteem using age-appropriate methods of

gratification (Kernberg, 2008; Pincus & Lukowitsky, 2010). Pathological narcissism is an inability to maintain self-esteem and self-cohesion (Cain et al., 2008) resulting in maladaptive methods of gratification such as aggression and narcissistic defences (Kernberg, 2008) causing distress to the self and others (Miller, Lynam, et al., 2017). However, it is not yet clear if the distinctions between these types are best understood as operating on a continuum from healthy to disordered (Pincus & Lukowitsky, 2010), or whether they differ categorically. Prevalence estimates for NPD have high variation between studies, ranging from 0 - 6.2% (Lenzenweger et al., 2007; Stinson et al., 2008), likely reflecting the conceptual confusion of the construct of narcissism (Cain et al., 2008).

While individuals with pathological narcissism experience interpersonal difficulties (Byrne & O'Brien, 2014; Kealy & Ogrodniczuk, 2011; Ogrodniczuk & Kealy, 2013; Ogrodniczuk et al., 2009) few studies have empirically examined the interpersonal psychological burden from the perspective of the "other" in in the relationship (Byrne & O'Brien, 2014) and the majority of previous research relies upon undergraduate students to form the participant pool (for more information on this limitation see: Henrich et al., 2010) Most only study grandiose narcissism (Krizan & Herlache, 2017) and romantic relationships. Despite these limitations, research suggests that in a romantic relationship people with narcissistic traits are described as using "game playing tactics" (Campbell et al., 2002) and show self-centred, materialistic, deceptive, and controlling behaviours, thus creating an "emotional toll" (p. 3) on partners (Brunell & Campbell, 2011). Miller et al. (2007) report that within a clinical population high narcissistic traits were uniquely related to causing pain and distress to significant others, stating that it appears that there are "traits specific to NPD that are especially difficult to tolerate" (p. 176). Interpersonal analyses suggest what those traits might be: intrusiveness, dominance, vindictiveness, coldness, avoidance, and exploitation (Kealy & Ogrodniczuk, 2011; Ogrodniczuk & Kealy, 2013). As such, while

previous research suggests that certain interpersonal traits of narcissism will have a psychological toll on others, they do not study that experience directly.

The majority of personality disorder research focuses on borderline personality disorder (Boschen & Warner, 2009). However, as all personality disorders are characterised by distinct maladaptive interpersonal styles, analysis of specific personality disorders is warranted (Bailey & Grenyer, 2013). Bailey and Grenyer (2014) analysed carer burden and personality disorders to provide some preliminary data on this issue. One subset of their sample, carers of relatives with NPD, reported elevated burden, grief, psychological symptoms and difficulties in emotion regulation. However, the study was limited by a small NPD sample size (n = 11) and as such the authors recommended extension with larger sample sizes. Qualitatively these carers reported distress resulting from the caregiving relationship as encompassing many aspects of life: physical health, mental health, friendships, work capacity and family life. These difficulties are consistent with literature exploring the impact of caring for individuals with severe mental illnesses, as carers report high burden and grief as a result of their caregiving relationship (Hoffman et al., 2005; Page et al., 2006; Reinhard et al., 1994). In exploring the factors that influence the impact of the caregiving relationship, Pearlin et al. (1990) outline the antecedent factors of carer distress. These include the nature of the caregiving relationship, problematic behaviours of the relative, intrapsychic strain (e.g. guilt, grief, worry), role strains (e.g. work, family, financial, time) and coping ability of carers as influencing subsequent distress.

For this research, partners and family members will be referred to as “participants”. Individuals with pathological narcissism will be referred to as the “relative”. The term “carer” refers to legal guardians, parents, family members, cultural elders, mentors, partners, spouses, friends or a main support person (Project Air Strategy for Personality Disorders, 2016). The current study aims to address gaps in the literature base by investigating levels of burden

experienced by individuals in relationship with someone who has pathologically narcissistic traits using empirically validated measures and comparing them to relevant comparison groups. First, we aim to assess for presence and severity of burden in partners and family members (or carers) of relatives with pathologically narcissistic traits. We then aim to compare how burden levels and mental health of participants compare to carers of relatives with other severe mental illness. Finally, we propose to examine the factors that influence burden in participants (i.e. narcissistic severity, participant coping style, relationship type, NPD subtype).

## 2.2. METHOD

### Recruitment

Participants provided written informed consent to participate following institutional review board approval. The participants were recruited through invitations posted on various mental health websites that provide information and support that is narcissism specific (e.g. "Narcissistic Family Support Group") and recruitment was advertised as being specifically in relation to a relative that was narcissistic. This data collection strategy via online platforms has been found to be both effective and reliable (Miller, Crowe, Weiss, Maples-Keller, & Lynam, 2017). As participants needed to be actively participating or monitoring these websites or social media pages, we may assume they were seeking information or support. In a conservative effort to ensure that included participants were appropriate to the research, three criteria were applied. First, participants had to identify as having a close personal relationship with someone who was very narcissistic. Second, participants had to complete mandatory questions as indicated on the survey. Mandatory questions included basic demographic information (age, gender, relationship type) and all measures under examination. Non-mandatory questions included more sensitive questions such as certain

demographic questions (e.g. occupation) and questions pertaining to their relative's illness and their support seeking. Third, the relative had to have a cumulative score of 36 or above on a narcissism screening measure (described in measures section), as informed by participants. A cut-off of 36 was devised based on the Likert scale of the narcissism measure in which a score of 3 indicated "a little like my relative". This only captures participants who responded on average "a little like my relative", and not at all "a little unlike my relative".

**Participants**

A total of 2231 participants consented to participate in the survey. A conservative data screening procedure was implemented to ensure that participants were appropriate to the research. First, participants were removed who indicated that they did not have a close personal relationship with someone who was narcissistic ($n$ = 43). Second, participants who clicked on the link to begin the survey but dropped out within the first 1-5 questions were deemed "non-serious" and were removed ($n$ = 1092). Third, participants who did not progress in the survey and complete all mandatory items were removed ($n$ = 295). Finally, participants identified as rating relatives narcissism below cut off score of 36 were removed ($n$ = 106). Inspection of pattern of responses indicated that none of the remaining participants had filled out the survey questions inconsistently or inappropriately (e.g. scoring the same for all questions). The remaining 683 participants formed the sample reported here. Table 2.1 outlines the demographic information of participants and the relative included in the study.

**Table 2.1.**

*Demographics for Participants (Partners and Family) and their Relatives (People High in Pathological Narcissism) (N = 683)*

| | Participants ($n$ = 683) | Relative ($n$ = 683) |
|---|---|---|
| Mean age in years (SD) | 44.3 (9.7) | 48.6 (12.3) |

| | | | |
|---|---|---|---|
| Gender | | | |
| | Male | 6% (n = 41) | 76.9% (n = 525) |
| | Female | 94% (n = 642) | 23.1% (n = 158) |
| Employment | | | |
| | Full time | 50.8% (n = 347) | 52.4% (n = 358) |
| | Part time | 18% (n = 123) | 7.8% (n = 53) |
| | Unemployed | 11.6% (n = 79) | 13.3% (n = 91) |
| | Other | 19.6% (n = 134) | 26.5% (n = 181) |
| Relationship | | | |
| | Spouse/partner | 62.1%, (n = 424) | |
| | Former spouse/partner | 15.7%, (n = 107) | |
| | Family (total) | 18.5% (n = 126) | |
| | Mother | 46% (n = 58) | |
| | Father | 10.3% (n = 13) | |
| | Child | 4.7 % (n = 6) | |
| | Sibling | 16.7% (n = 21) | |
| | Other | 22.2% (n = 28) | |
| | Other | 3.8% (n = 26) | |
| Help seeking for relationship | | | |
| | Clinical support | 37.5% (n = 256) | |
| | Self-help | 10.4% (n = 71) | |
| | Mixture | 15.5% (n = 106) | |
| | Did not state | 36.6% (n = 250) | |

## Comparison Groups

Comparison groups were drawn from the published literature, utilising studies that employed most of or all the same measures to ensure consistency in comparing and interpreting results. Table 2.1 details the comparison groups, which involved carers of

persons with a range of mental health disorders or community samples. These comparisons represent the most relevant comparable published data available for each measure. Participants in all comparison papers were actively seeking support at the time of participation in their respective studies.

## Measures

### Pathological Narcissism Inventory (Carer Version) (SB-PNI-CV)

Schoenleber et al. (2015) developed a short version of the Pathological Narcissism Inventory (SB-PNI; "super brief") as a 12 item measure consisting of the 12 best performing items for the Grandiosity and Vulnerability composites (6 of each) of the Pathological Narcissism Inventory (Pincus et al., 2009). This measure was then adapted into a carer version (SB-PNI-CV) in the current research by changing all self-referential terms (i.e. "I") to refer to the relative (i.e. "my relative"). This adaptation followed a previous published adaptation methodology (e.g. Bailey & Grenyer, 2014) in consultation with the first author of the original Pathological Narcissism Inventory (Pincus et al., 2009). The SB-PNI-CV demonstrated strong internal consistency ($\alpha = .79$), using all available data ($N = 1029$). Subscales of the measure also demonstrated internal consistency for both grandiose ($\alpha = .73$) and vulnerable ($\alpha = .75$) items. This informant-based method of investigating narcissism and its effects has previously been found to be effective and reliable (Byrne & O'Brien, 2014) with consensus demonstrated across multiple observers (Lukowitsky & Pincus, 2013).

### Burden Assessment Scale (BAS)

The BAS (Reinhard et al., 1994) is a 19 item questionnaire used to assess presence and intensity of burden. It measures both objective (e.g. financial strain, time strain, etc.) and subjective (e.g. personal distress, guilt, etc.) aspects of burden, where higher scores indicate

greater experiences of burden. The BAS showed strong internal consistency (α = .89, N = 683).

**Grief Scale (GS)**

The GS (Struening et al., 1995) is a 15 item questionnaire that assesses the experience of grief connected to having a loved one with mental illness, with higher scores indicating higher grief. The GS showed strong internal consistency (α = .92, N = 683).

**Family Questionnaire (FQ)**

The FQ (Wiedemann et al., 2002) is a 20 item measure used to assess the way individuals behave towards relatives with mental illness. Questions assess expressed emotion in the domains of criticism and emotional over-involvement. The measure is used in this study as an overall indication of participants coping style, with higher scores indicating more maladaptive coping styles. The FQ showed strong internal consistency (α = .80, N = 683).

**Mental Health Inventory-5 (MHI-5)**

The MHI-5 (Berwick et al., 1991) is a five item questionnaire that measures five dimensions (anxiety, depression, positive affect, loss of behavioural or emotional control, and psychological well-being). The MHI-5 forms the Mental Health Scale from the Medical Outcomes Study Short Form Health Survey (Daniells et al., 2003; Ware & Sherbourne, 1992). The MHI-5 was used to assess the mental health of participants in this study. Consistent with previous research, scores on the MHI-5 are linear transformed to a scale of 0 to 100 (Berwick et al., 1991; Cuijpers et al., 2009; Rumpf et al., 2001). Higher scores are indicative of better mental health. The MHI showed strong internal consistency (α = .89, N = 683).

**Perceived Burden Scale (PBS).**

The PBS (Stueve et al., 1997) is a seven item scale used to assess objective burden and the extent to which contact with their relative interferes with other roles and relationships. Higher scores indicate higher objective burden. The PBS showed strong internal consistency ($\alpha = .73$, $N = 683$).

**Statistical Analyses**

While data were not normally distributed, sample size was large enough to approximate a normal distribution (Hays, 1994) and as such parametric tests were used. Non-parametric tests were also conducted and showed the same pattern of results, so are not reported here. A significance level of .05 was selected for statistical tests unless specifically stated otherwise. A pooled variance estimate *t*-test was used to compare sample scores from each measure against published comparison groups. This test takes into account the different number of participants in each sample by weighting the variance of each sample and is able to be used when only the participant number, mean and standard deviation are known. Pearson *r* correlation was used to assess the degree that measures were correlated. All analyses involving the MHI-5 will be negative as this item is reverse scored; it has not been un-reversed to allow for meaningful comparisons with other published literature using this measure.

## 2.3 RESULTS

**Are partners and family of individuals with NPD significantly burdened? How does this compare to carers of relatives with other severe mental illness?**

We investigated levels of burden (BAS), grief (GS), mental health (MHI-5) and objective burden (PBS) for our sample and compared this to carer comparison groups. Table 2.2 reports the mean, standard deviation and significance level for each measure in the

present sample and comparison groups. Table 2.3 displays the correlation matrix between measures.

**Table 2.2.**

*Burden and Mental Health of Partners and Family of Relatives with Pathological Narcissism (Participant) and Carer Group (Comparison) Scores*

| Measure | Participant M (SD) | Comparison M (SD) | *t* | *d* | Comparison group |
|---|---|---|---|---|---|
| BAS | 57.06 (11.73) | 55.36 (10.93) | 2.10* | 0.14 | PD (Bailey & Grenyer, 2014) |
| | | 51.41 (10.98) | 3.12** | 0.50 | BPD (Hoffman et al., 2005) |
| | | 38.54 (13.27) | 16.39** | 1.48 | MD, ND, PsD (Page et al., 2006) |
| | | 32.10 (-) | - | - | SMI (Reinhard et al., 1994) |
| | | 55.30 (-) | - | - | SMI (Reinhard et al., 1994) |
| GS | 48.35 (14.34) | 54.38 (12.60) | 6.22** | 0.45 | PD (Bailey & Grenyer, 2014) |
| | | 52.41 (10.49) | 1.85 | 0.32 | BPD (Hoffman et al., 2005) |
| MHI-5 | 46.28 (19.49) | 56.40 (20.96) | 7.24** | 0.50 | PD (Bailey & Grenyer, 2014) |
| | | < 54 indicate MDD or DD | - | - | PS (Cuijpers et al., 2009) |
| | | < 65 indicate MD or AD | - | - | PS (Rumpf et al., 2001) |
| PBS | 21.72 (4.19) | 20.47 (4.13) | 1.92 | 0.3 | BPD (Hoffman et al., 2005) |
| | | 15.10 (-) | - | - | SMI (Stueve at al., 1997) |

*Note.* *significant at less than α = 0.05, **significant at less than α = 0.01, SD = Standard Deviation, M = Mean, BAS = Burden Assessment Scale, GS = Grief Scale, MHI-5 = Mental Health Inventory-5, PBS = Perceived Burden Scale, PD = Personality Disorder, BPD = Borderline Personality Disorder, MD = Mood Disorder, ND = Neurotic Disorder, PsD = Psychotic Disorder, SMI = Severe Mental Illness, MDD = Major Depression, DD = Dysthymic Disorder, PS = Population Sample, AD = Anxiety Disorders

**Table 2.3.**

*Pearson Correlation Matrix of Measures (N = 683)*

| Measure | SB-PNI-CV | FQ | BAS | GS | MHI-5 | PBS |
|---|---|---|---|---|---|---|
| SB-PNI-CV | - | .17** | .11** | .15** | .01 | .10* |
| FQ | | - | .66** | .46** | -.42** | .45** |

| | | | | |
|---|---|---|---|---|
| BAS | - | .41** | -.49** | .59** |
| GS | | - | -.28** | .18** |
| MHI-5 | | | - | -.33** |
| PBS | | | | - |

*Note*. *α = 0.05, **α = 0.01, SB-PNI-CV = Pathological Narcissism Inventory (Carer Version), FQ = Family Questionnaire, BAS = Burden Assessment Scale, GS = Grief Scale, MHI-5 = Mental Health Inventory-5, PBS = Perceived Burden Scale.

The mean burden (BAS) score in our sample was significantly higher than carers of persons with a personality disorder (Bailey & Grenyer, 2014) and borderline personality disorder (Hoffman et al., 2005). BAS score was significantly higher than carers of persons with mood disorders, neurotic disorders and psychotic disorders (Page et al., 2006) by at least one standard deviation. Pearson *r* two-tailed correlation indicated higher burden scores significantly correlated with higher grief, objective burden and worse mental health.

The mean grief (GS) score in our sample was around half a standard deviation lower than carers of persons with a personality disorder (Bailey & Grenyer, 2014) and borderline personality disorder (Hoffman et al., 2005), this difference was only significant for the Bailey and Grenyer (2014) comparison. Pearson *r* two-tailed correlation indicated higher scores of grief significantly correlated with worse mental health and higher objective burden.

The mean objective burden (PBS) score in our sample was higher than carers of persons with borderline personality disorder (Hoffman et al., 2005), but this difference was not statistically significant. PBS score was over one standard deviation higher in our sample than carers of persons with severe mental illness (Stueve et al., 1997). Pearson *r* two-tailed correlation indicated higher scores of objective burden significantly correlated with worse mental health.

The mean mental health (MHI-5) score in our sample was significantly lower than carers of persons with a personality disorder (Bailey & Grenyer, 2014). For participants, 69% (n = 470) endorsed scores consistent with symptoms indicating major depression or dysthymic disorder (cut-off indicated in Cuijpers et al., 2009), 82% of participants (n = 560) endorsed scores representative of mood or anxiety disorders (cut-off indicated in Rumpf et al., 2001).

**What are the factors that influence burden in participants? Is burden related to severity or subtype expression of their relative's narcissism?**

We conducted correlation analysis to evaluate the degree that higher scores of narcissism (measured by SB-PNI- CV) correlated with other measures. Pearson *r* two tailed correlation indicated that higher endorsements of relatives narcissism significantly correlated with higher levels of burden, grief and objective burden. Levels of narcissism was not significantly correlated with mental health. In order to investigate subtype expression, correlation analysis explored the relationship between the subtype subscales on the SB-PNI-CV and measures under examination. Pearson *r* two tailed correlation indicated that grandiose expressions of narcissism significantly correlated with higher burden (BAS) $r = .13$, $p = .001$ and objective burden (PBS) $r = .11$, $p = .004$, while expressions of vulnerable narcissism significantly correlated with higher grief (GS) $r = .19$, $p < .001$.

**How do the coping style of participants impact levels of burden?**

We conducted correlation analysis and regression analysis to evaluate the degree that coping style (as indexed by the FQ) influences burden levels.

Pearson *r* two-tailed correlations indicated that higher scores on the FQ (indicating more maladaptive coping styles) was significantly correlated with higher levels of grief, burden, objective burden and worse mental health as displayed in Table 2.3.

An attempt to understand the way that coping style influenced burden was undertaken through analysing the two components that make up the FQ ("emotional over involvement" and "criticism"). A stepwise multiple regression was conducted to evaluate the degree that criticism and emotional over-involvement predict burden (as measured by the BAS). At step 1 of the analysis, emotional over-involvement significantly predicted burden $F$ (1, 681) = 517.18, $p < .001$, $R^2 = .43$. At step 2 of the analysis criticism was also found to significantly contribute to the model $F$ (1, 680) = 295.45, $p < .001$, $R^2 = .47$.

**Does burden level vary according to relationship type?**

We conducted means comparison across all relationship types to evaluate if different relationship types had significantly different levels of burden.

A Kruskal-Wallis analysis was conducted to assess the degree that relationship type varied for experienced distress. Of all measures, PNI score was the only measure that did not vary based on relationship type. Relationship type (current romantic partner, former romantic partner, family relative) showed significant differences for experienced burden $\chi^2$ (2) = 69.74, $p < 0.001$, $\eta^2 = 10.6$, $N = 657$, objective burden $\chi^2$ (2) = 27.71, $p < 0.001$, $\eta^2 = 4.2$, $N = 657$ and mental health $\chi^2$ (2) = 37.65, $p < 0.001$, $\eta^2 = 5.7$, $N = 657$. Post hoc analysis with Bonferroni alpha correction revealed significant differences between relationship types across measures. Current partners had scores indicating significantly higher distress across all measures compared to other relationship types (with the exception of former partners and the PBS, which were non-significant). Former partners had significantly higher burden (BAS) levels compared to family members, but was not significantly different for the other measures. Table 2.4 displays these differences.

**Table 2.4.**

*A Comparison of Relationship Type on Severity of Burden and Mental Health*

| Measure | Relationship Type | Mean (SD) | Relationship Comparison | Mean (SD) | *p* |
|---|---|---|---|---|---|
| BAS | Current Partner | 59.9 (10.1) | Family | 49.7 (12.8) | < .001** |
| | | | Ex-Partner | 55.7 (11.7) | .001** |
| | Ex-Partner | 55.7 (11.7) | Family | 49.7 (12.8) | .002** |
| PBS | Current Partner | 22.4 (4.1) | Family | 20.3 (4.1) | < .001** |
| | | | Ex-Partner | 21.4 (3.8) | .052 |
| | Ex-Partner | 21.4 (3.8) | Family | 20.3 (4.1) | .145 |
| MHI-5 | Current Partner | 42.6 (18.5) | Family | 53.1 (19.5) | < .001** |
| | | | Ex-Partner | 50.7 (19.5) | < .001** |
| | Ex-Partner | 50.7 (19.5) | Family | 53.1 (19.5) | 1.0 |

*Note*. Significance level has Bonferroni correction applied, *α = 0.05, **α = 0.01, SD = Standard Deviation, BAS = Burden Assessment Scale, MHI-5 = Mental Health Inventory-5, PBS = Perceived Burden Scale.

## 2.4. DISCUSSION

This study aimed to investigate the experience of being in a relationship with someone with pathologically narcissistic traits. Participants endorsed significantly elevated burden compared to carers of persons with other serious mental illnesses. Participants also reported impaired well-being similar to that of clinical samples diagnosed with anxiety, mood and depressive disorders. These results provide new insights into the relational impact of narcissistic traits in a way that has not, to the best of our knowledge, been empirically assessed. As NPD has an estimated prevalence rate up to 6.2% (Stinson et al., 2008), these results suggest a large base of unrecognised and psychologically burdened individuals who are in a relationship with individuals with pathologically narcissistic traits. A sub analysis of relationship type indicated that those in romantic relationships (current and former) reported significantly more distress than those in familial relationships. Within romantic relationships,

those who were current partners exhibited the most psychopathology across all measures. This may be due to the level of intensity and frequency of interaction for current partners as opposed to ex-partners and family. However, the finding that objective burden levels did not significantly differ between current and former partners suggests that there are there may be burdensome aspects of the "remembered" relationship that are maintained over time – even when the relationship is not current.

Of interest is the effect that coping style had on the variables under examination. Correlation analysis revealed that coping style was significantly related to psychopathology, with more maladaptive coping being significantly related to increased psychopathology and the opposite for adaptive coping. Regression analysis revealed that while both criticism and emotional over involvement significantly predicted an increase in burden levels, emotional over involvement contributed the most to variations in burden. This could have important clinical implications as these results could inform possible intervention programs that focus on strategies to target levels of emotional over-involvement (Grenyer et al., 2018). However, further research is needed to elucidate additional aspects of coping style that may ameliorate psychopathology.

The significantly lower levels of grief found in our study in contrast to previous comparison groups may highlight the unique impact that narcissism has on the psychopathology of partners and family. A possible explanation could be that partners and family of narcissistic relatives may not be inclined to feel sympathy or grief for their relative, in the face of the relative's narcissistic hostile interpersonal traits (Brunell & Campbell, 2011; Campbell et al., 2002; Dickinson & Pincus, 2003; Ogrodniczuk & Kealy, 2013). The subtype analysis of the SB-PNI-CV provides preliminary results indicating that this may vary based on expression of narcissism. A potential hypothesis may be that vulnerable expressions (e.g. rumination, anxiety, depression, etc.) may arouse a sympathetic reaction from carers, while

grandiose expressions may arouse other emotional reactions (e.g. anger, frustration). There are several limitations to this study that need to be acknowledged. First, gender disparity in participants and relatives was substantial. However, NPD is diagnosed more commonly in males (50-75%, American Psychiatric Association, 2013) and most participants in our sample were in a romantic, heterosexual relationship. As such, this disparity may reflect a representative NPD sample and should not significantly impact the validity of results. Second, as participants completed both measures about the relative and themselves, the possibility of biased reporting is increased. However, it is known that self- report of NPD is problematic within a population that diagnostically lack insight (Russ & Shedler, 2013) with high discrepancies between self-other ratings of narcissism (Pincus & Lukowitsky, 2010). In contrast, Lukowitsky and Pincus (2013) report high levels of convergence for informant ratings of narcissism, indicating multiple peers are likely to score the same individual similarly. Further, Byrne and O'Brien (2014) report findings utilising informant ratings of narcissism that are consistent with clinical and self-report methodology. This increases confidence in validity of results, as it suggests that informants may be able to accurately and reliably report on an individual's narcissism. However, it is acknowledged the common nomenclature of behaviours that would be labelled as "narcissistic" may be highly variable across individuals and as such results should be interpreted with this in mind. Future research could involve assessing the degree of accuracy of informant ratings in distinguishing narcissism when compared to other forms of psychopathology. Mono-method bias may also be inflated through the use of only quantitative analysis. Future research is recommended that extends this quantitative analysis by exploring the qualitative lived experience, "meaning" or subjective experience of partners and family members in their day to day lives interacting with a relative high in pathological narcissism. Third, a limitation of using online platforms for data collection is that participant motivation is unknown (e.g. participants are non-naive)

and that participant monitoring is denied. However, this is a limitation of all studies of this kind and does not prevent the meaningful interpretation of our results (Miller, Crowe, et al., 2017). Fourth, there is no way of knowing if participants had pre-existing mental health conditions prior to the relationship onset that may have impacted results reported here. This is particularly noteworthy as participants included in this study were actively seeking support in managing their relationships through online support groups, which may mean the average burden and mental health difficulties reported may be inflated. As such, teasing out participant psychopathology that is independent of relative burden could be the subject of further research. However, as participants in comparison papers were also actively support seeking this limitation does not prevent the meaningful comparison and interpretation of results. Fifth, while participants in this study had significant burden and mental health difficulties a limitation of correlation research is bi-directionality. As such it is unable to be known from the data whether narcissism informs burden and mental health scores or if the opposite is true: that participants with high burden and mental health difficulties may be more likely to ascribe the label "narcissistic" to their relative. Similarly it is unknown whether coping style informs level of burden, or if burden and mental health difficulties overwhelm an individual and result in more maladaptive coping styles. The literature reviewed suggest that it is more likely to be the first, as individuals with narcissistic traits are known to be interpersonally challenging (Brunell & Campbell, 2011; Byrne & O'Brien, 2014; Kealy & Ogrodniczuk, 2011; Miller, et al., 2017; Miller, et al., 2007 Ogrodniczuk, et al., 2009) and as carer literature demonstrate the personal distress of being in close proximity to individuals with challenging behaviours (Bailey & Grenyer, 2014) with coping ability mediating experienced distress (Pearlin, et al., 1994). However, this study is not experimental in nature and as such causal conclusions between having a relative with high perceived narcissism and significant mental health difficulties cannot be drawn.

Pathological narcissism is characterised by impaired interpersonal functioning, but few studies have examined the impact of the disorder on those living in a close relationship. Participants in a relationship with someone with high perceived pathologically narcissistic traits reported high burden, grief, and mental health difficulties. Analysis revealed significantly higher burden and worse mental health in this sample when compared to published comparison groups. Relationship type, subtype expression and coping style were all found to significantly relate to experienced psychopathology. While limitations exist regarding sample selection that may influence interpretation of results, these findings quantify the significant interpersonal impact of pathological narcissism in this sample.

# CHAPTER THREE

## STUDY 2 – LIVING WITH PATHOLOGICAL NARCISSISM: A QUALITATIVE STUDY

This chapter has been published as a paper in the *Borderline Personality Disorder and Emotion Dysregulation*. Minor modifications were made to this published paper to conform to the thesis review process.

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## ABSTRACT

**Background:** Research into the personality trait of narcissism have advanced further understanding of the pathological concomitants of grandiosity, vulnerability and interpersonal antagonism. Recent research has established some of the interpersonal impacts on others from being in a close relationship with someone having such traits of pathological narcissism, but no qualitative studies exist. Individuals with pathological narcissism express many of their difficulties of identity and emotion regulation within the context of significant interpersonal relationships thus studying these impacts on others is warranted. **Method:** We asked the relatives of people high in narcissistic traits (indexed by scoring above a cut-off on a narcissism screening measure) to describe their relationships ($N = 436$; current romantic partners [56.2%]; former romantic partners [19.7%]; family members [21.3%]). Participants were asked to describe their relative and their interactions with them. Verbatim responses were thematically analysed. **Results:** Participants described "grandiosity" in their relative: requiring admiration, showing arrogance, entitlement, envy, exploitativeness, grandiose fantasy, lack empathy, self-importance and interpersonal charm. Participants also described "vulnerability" of the relative: contingent self-esteem, hypersensitivity and insecurity, affective instability, emptiness, rage, devaluation, hiding the self and victimhood. These grandiose and vulnerable characteristics were commonly reported together (69% of respondents) Participants also described perfectionistic (anankastic), vengeful (antisocial) and suspicious (paranoid) features. Instances of relatives childhood trauma, excessive religiosity and substance abuse were also described. **Conclusions:** These findings lend support to the importance of assessing the whole dimension of the narcissistic personality, as well as associated personality patterns. On the findings reported here, the vulnerable aspect of pathological narcissism impacts others in an insidious way given the core deficits of feelings of emptiness and affective instability. These findings have clinical implications for diagnosis

and treatment in that the initial spectrum of complaints may be misdiagnosed unless the complete picture is understood. Living with a person with pathological narcissism can be marked by experiencing a person who shows large fluctuations in affect, oscillating attitudes and contradictory needs.

## 3.1 INTRODUCTION

The current diagnostic description of narcissistic personality disorder (NPD) as it appears in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, 5th edition, American Psychiatric Association, 2013a) includes a lot of information about how the person affects others, such as requiring excessive admiration, having a sense of entitlement, interpersonal exploitativeness, showing both a lack of empathy for others and feeling others are envious of their perceived special powers or personality features. Despite these features being important aspects of narcissism that have been validated through empirical research (Cain et al., 2008; Miller et al., 2008), they have been criticised for their emphasis on grandiosity and the exclusion of vulnerability in narcissism (King et al., 2020; Skodol et al., 2014), a trend that is mirrored in the field more generally and runs counter to over 35 years of clinical theory (Cain et al., 2008). The more encompassing term "pathological narcissism" has been used to better reflect personality dysfunction that is fundamentally narcissistic but allows for both grandiose and vulnerable aspects in its presentation (Pincus & Lukowitsky, 2010).

Recognising the vulnerable dimension of narcissism has significant implications for treatment (Pincus et al., 2014), including providing an accurate diagnosis and implementing appropriate technical interventions within treatment settings. Vulnerable narcissism, in marked contrast to the overt grandiose features listed in DSM-5 criteria, includes instances of depressed mood, insecurity, hypersensitivity, shame and identification with victimhood (De Panfilis et al., 2018; Kaufman et al., 2018; Levy, 2012; Russ & Shedler, 2013; Yakeley, 2018). Pincus et al. (2009) developed the Pathological Narcissism Inventory (PNI) to capture this narcissistic vulnerability in three factors. The factor "contingent self-esteem" (item example: "It's hard for me to feel good about myself unless I know other people like me") reflects a need to use others in order to maintain self-esteem. The factor "devaluing" includes

both devaluation of others who do not provide admiration needs ("sometimes I avoid people because I'm concerned that they'll disappoint me") and of the self, due to feelings of shameful dependency on others ("when others disappoint me, I often get angry at myself"). The factor "hiding the self" ("when others get a glimpse of my needs, I feel anxious and ashamed") reflects an unwillingness to show personal faults and needs. This factor may involve a literal physical withdrawal and isolation (Dimaggio et al., 2002) but may also include a subtler emotional or psychic withdrawal due to feelings of inadequacy and shame which may result in the development of an imposter or inauthentic "false self" (Kaufman et al., 2018; Winnicott, 1960a), and which may also include a disavowal of emotions, becoming emotionally "empty" or "cold" (Dimaggio et al., 2002). Another aspect described in the literature are instances of "narcissistic rage" (Kernberg, 2008) marked by hatred and envy in response to a narcissistic threat (i.e. threats to grandiose self-concept). Although commonly reported in case studies and clinical reports, it is unclear if it is a feature of only grandiose presentations or if it may more frequently present in vulnerable presentations (Krizan & Johar, 2015).

While the differences in presentation between grandiose and vulnerable narcissism appear manifest, it has been argued that they reflect both sides of a narcissistic "coin" (Levy, 2012) that may be regularly oscillating, inter-related and state dependent (Giacomin & Jordan, 2013, 2016; Jauk et al., 2017; Pincus & Lukowitsky, 2010; Ronningstam, 2009, 2011a). As such, it may not be as important to locate the specific presentation of an individual as to what "type" they are (i.e. grandiose or vulnerable), as it is to recognise the presence of *both* of these aspects within the person (Lingiardi & McWilliams, 2017). The difficulty for these patients is the pain and distress that accompanies having such disparate "split off" or unintegrated parts of the self, which result in the defensive use of maladaptive intra and interpersonal methods of maintaining a stable self-experience (McWilliams, 2011).

This defensive operation is somewhat successful, and may give the impression of a coherent and stable identity, however as noted by Caligor and Stern (2020) “manifestly vulnerable narcissists retain a connection to their grandiosity …[and] even the most grandiose narcissist may have internal feelings of inadequacy or fraudulence” (p. 113).

The vulnerable dimension of narcissism, with its internal feelings of emptiness and emotion dysregulation, may reflect a more general personality pathology similar to that of BPD (Sharp et al., 2015). For instance, Euler et al. (2018) found grandiose narcissism to be related to NPD, but vulnerable narcissism to be related to borderline personality disorder (BPD). In a similar vein, Hörz-Sagstetter et al. (2018) proposes grandiosity as a narcissistic “specific” factor that distinguishes it from other disorders (e.g. BPD). This grandiosity, however, *“*predisposes [these individuals] to respond with antagonism/hostility and reduced reality testing when the grandiose self is threatened*”* (p.571). This antagonism, hostility and the resultant interpersonal dysfunction are well-documented aspects of pathological narcissism (Byrne & O'Brien, 2014; Cheek et al., 2018; Grenyer, 2013; Ogrodniczuk & Kealy, 2013), that exacts a large toll on individuals in the relationship (Bailey & Grenyer, 2014; Day et al., 2019). As the specific features of the disorder are perhaps therefore best evidenced within the context of these relationships, gaining the perspective of the “other” in the relationship would present a unique perspective that may not be observable in other contexts (e.g. clinical or self-report research). For example, a recent study by Green and Charles (2019) provided such a perspective within the context of domestic violence. They found that those in a relationship with individuals with reportedly narcissistic features described overt (e.g. verbal and physical) and covert (e.g. passive-aggressive and manipulative) expressions of abuse and that these behaviours were in response to perceived challenges to authority and to counteract fears of abandonment. As such, informant ratings may be a novel and valid methodology to assess for personality pathology (Oltmanns et al.,

2018), as documented discrepancies between self-other ratings suggest that individuals with pathological narcissism may not provide accurate self-descriptions (Klonsky & Oltmanns, 2002). Further, Lukowitsky and Pincus (2013) report high levels of convergence for informant ratings of narcissism, indicating that multiple peers are likely to score the same individual similarly and, notably, individuals with pathological narcissism agreed with observer ratings of interpersonal dysfunction, again highlighting this aspect as central to the disorder (Pincus & Lukowitsky, 2010). The aim of this study is to investigate the reported characteristics of individuals with pathologically narcissistic traits from the perspective of those in a significant personal relationship with these individuals. For this research, partners and family members will be referred to as "participants". Individuals with pathological narcissism will be referred to as the "relative".

## 3.2 METHOD

### Recruitment

Participants were relatives of people reportedly high in narcissistic traits, and all provided written informed consent to allow their responses to be used in research, following institutional review board approval. The participants were recruited through invitations posted on various mental health websites that provide information and support that is narcissism specific (e.g. "Narcissistic Family Support Group"). Recruitment was advertised as being specifically in relation to a relative with narcissistic traits. A number of criteria were applied to ensure that included participants were appropriate to the research. First, participants had to identify as having a "significant personal relationship" with their relative. Second, participants had to complete mandatory questions as part of the survey. Mandatory questions included basic demographic information (age, gender, relationship type) and answers to qualitative questions under investigation. Non-mandatory questions included

questions such as certain demographic questions (e.g. occupation) and questions pertaining to their own support seeking. Third, the relative had to have a cumulative score of 36 (consistent with previous methodology, see Day et al., 2019) or above on a narcissism screening measure (described in measures section), as informed by participants.

**Participants**

A total of 2219 participants consented to participate in the survey. A conservative data screening procedure was implemented to ensure that participants were appropriate to the research. First, participants were removed who indicated that they did not have a "significant" (i.e. intimate) personal relationship with someone who was narcissistic ($n$ = 129). Second, participants who clicked on the link to begin the survey but dropped out within the first 1-5 questions were deemed "non-serious" and were removed ($n$ = 1006). Third, participants whose text sample was too brief (i.e. less than 70 words) to analyse were excluded ($n$ = 399) as specified by Gottschalk et al. (1969). Finally, participants identified as rating relatives narcissism below cut off score of 36 on a narcissism screening measure were removed ($n$ = 249). Inspection of pattern of responses indicated that none of the remaining participants had filled out the survey questions inconsistently or inappropriately (e.g. scoring the same for all questions). The remaining 436 participants formed the sample reported here. Table 3.1 outlines the demographic information of participants and the relative included in the study.

**Table 3.1.**
*Demographics for Participants (Partners and Family) and Their Relatives (People High in Pathological Narcissism) (N = 436)*

| | Participants ($n$ = 436) | Relative ($n$ = 436) |
|---|---|---|
| Mean age in years (SD) | 43.7 (10.1) | 48.7 (12.3) |

| | | | |
|---|---|---|---|
| Gender | | | |
| | Male | 4.8% (n = 21) | 75.7% (n = 330) |
| | Female | 79.6% (n = 347) | 24.3% (n = 106) |
| | Not Specified | 15.6% (n = 68) | - |
| Employment | | | |
| | Full time | 42.7% (n = 186) | 50.7% (n = 221) |
| | Part time | 14.9% (n = 65) | 8.3% (n = 36) |
| | Unemployed | 9.9% (n = 43) | 12.4% (n = 54) |
| | Other | 32.6% (n = 142) | 28.7% (n = 125) |
| | | Disability Pension | 3.2% (n = 14) | 4.4% (n = 19) |
| | | Self-Employed | 3.7% (n = 16) | 9.9% (n = 43) |
| | | Retired | 3.4% (n = 15) | 8.9% (n = 39) |
| | | Student | 2.1% (n = 9) | 0.2% (n = 1) |
| | | Not stated | 20.2% (n = 88) | 5.3% (n = 23) |
| Relationship | | | |
| | Spouse/partner | 56.2%, (n = 245) | |
| | Former spouse/partner | 19.7%, (n = 86) | |
| | Family (total) | 21.3% (n = 93) | |
| | | Mother | 10.6% (n = 46) |
| | | Father | 2.5% (n = 11) |
| | | Child | 1.4% (n = 6) |
| | | Sibling | 4.1% (n = 18) |
| | | Other Family | 2.8% (n = 12) |
| | Other | 2.8% (n = 12) | |

Participants were also asked to report on the diagnosis that their relative had received. These diagnoses were specified as being delivered by a mental health professional and not the participants own speculation. The majority of participants either stated that their

relative has not received a formal diagnosis, or that they did not know (*n* = 284, 65%). A total of 152 (35%) participants stated that their relative had received an official diagnosis from a mental health professional (See Table 3.2).

**Table 3.2.**

*Relatives Diagnoses as Reported by Participants (N = 152)*

| | |
|---|---|
| Personality disorder | 43% (*n* = 65) |
| Narcissistic Personality Disorder | 29% (*n* = 44) |
| Borderline Personality Disorder | 5% (*n* = 9) |
| Other | 7% (*n* = 11) |
| Not Specified | 4% (*n* = 7) |
| Attention Deficit-Hyperactivity Disorder | 12% (*n* = 18) |
| Anxiety Related Disorder | 10% (*n* = 15) |
| Obsessive-Compulsive Related Disorder | 7% (*n* = 10) |
| Substance Related and Addictive Disorders | 5% (*n* = 8) |
| Bipolar and Related Disorders | 20% (*n* = 31) |
| Depressive Disorders | 30% (*n* = 46) |
| Autism Spectrum Disorders | 1% (*n* = 2) |
| Trauma Related Disorders | 9% (*n* = 14) |
| Psychotic Disorders | 5% (*n* = 7) |

*Note*. The percentages and numbers of diagnoses endorsed are greater than the total number of participants as many relatives had been diagnosed with "co-morbid" disorders. "Other" personality disorder group includes avoidant (*n* = 3), histrionic (*n* = 2), antisocial (*n* = 4), schizoid (*n* = 1) and paranoid (*n* = 1).

## Measures

### Pathological Narcissism Inventory (Carer Version) (SB-PNI-CV)

Schoenleber et al. (2015) developed a short version of the Pathological Narcissism Inventory (SB-PNI; "super brief") as a 12 item measure consisting of the 12 best performing items for the Grandiosity and Vulnerability composites (6 of each) of the Pathological

Narcissism Inventory (Pincus et al., 2009). This measure was then adapted into a carer version (SB-PNI-CV) in the current research, consistent with previous methodology (Day et al., 2019) by changing all self-referential terms (i.e. "I") to refer to the relative (i.e. "my relative"). The scale operates on a Likert scale from 0 ("not at all like my relative") to 5 ("very much like my relative"). By summing participant responses, a total score of 36 indicates that participants scored on average "a little like my relative" to all questions, indicating the presence of pathologically narcissistic traits. The SB-PNI-CV demonstrated strong internal consistency ($\alpha = .80$), using all available data ($N = 1021$). Subscales of the measure also demonstrated internal consistency for both grandiose ($\alpha = .73$) and vulnerable ($\alpha = .75$) items. Informant-based methods of investigating narcissism and its effects has previously been found to be effective and reliable (Byrne & O'Brien, 2014) with consensus demonstrated across multiple observers (Lukowitsky & Pincus, 2013).

**Qualitative analyses**

Participants who met inclusion criteria were asked to describe their relative using the Wynne-Gift speech sample procedure as outlined by Gift et al. (1986). This methodology was developed for interpersonal analysis of the emotional atmosphere between individuals with severe mental illness and their relatives, it has also been used in the context of assessing relational functioning within marital couples. For the purpose of this study, the speech sample prompt was used to elicit descriptive accounts of relational functioning, which included participants responding to the question:

*"What is your relative like, how do you get on together?"*

Participants were given a textbox to respond to this question in as much detail as they would like. However, participants whose text responses were too brief (< 70 words), were removed from analysis as specified by Gottschalk et al. (1969). It is important to note

however that these participants who were removed ($n$ = 399) did not differ from the included participants in any meaningful way regarding demographic information. The mean response length was 233 words (SD = 190) and text responses ranged from 70 – 1279 words.

Analysis of the data occurred in multiple stages. First, a phenomenological approach was adopted which places primacy on understanding the "lived experience" of participant responses (Smith et al., 2009) whilst "bracketing" researcher preconceptions. This involved reading and re-reading all participant responses in order to be immersed in the participants subjective world, highlighting text passages regarding the phenomenon under examination (i.e. personality features, descriptions of behaviour, etc) and noting comments and personal reactions to the text in the margins. This is done in an attempt to make the researchers preconceptions explicit, in order to attend as close as possible as to the content of what is being said by the participant. Second, codebook thematic analysis was used for data analysis as outlined by Braun et al. (2019), which combines "top down" and "bottom up" approaches. Using this approach, a theory driven or "top down" perspective was taken (Hayes, 1997) in which researchers attempted to understand the reality of participants through their expressed content and within the context of the broader known features informed by the extensive prior work on the topic. In this way, the overarching themes of "grandiosity" and "vulnerability" were influenced by empirically determined features within the research literature (e.g. DSM-5 diagnostic criteria, factors within the PNI), however themes and nodes were free to be "split" or merged organically during the coding process reflecting the ongoing conceptualisation of the data by the researchers. Significant statements were extracted and coded into nodes reflecting their content (e.g. "narcissistic rage", "entitlement") using NVivo 11. This methodology of data analysis via phenomenologically analysing and grouping themes is a well-documented and regularly utilised qualitative approach (e.g. Ng et al., 2019; White & Grenyer, 1999). Once data analysis had been completed the second author

completed coding for inter-rater reliability analysis on 10% of data. The second rater was included early in the coding process and the two reviewers meet on several occasions to discuss the nodes that were included and those that were emerging from the data. 10% of the data was randomly selected by participant ID numbers. At the end of this process, it was then confirmed that the representation of the data also reflected the participant relationships (i.e. marital partner, child etc). Cohen's Kappa coefficient was used to index inter-rater reliability by calculating the similarity of nodes identified by the two researchers. This method takes into consideration the agreement between the researchers (observed agreement) and compares it to how much agreement would be expected by chance alone (chance agreement). Inter-rater reliability for the whole dataset was calculated as $\kappa = 0.81$ which reflects a very high level of agreement between researchers that is not due to chance alone (Viera & Garrett, 2005).

### Cluster Analysis

A cluster analysis dendrogram was generated using NVivo 11 for purposes of visualisation and to explore the underlying dimensions of the data (Jackson & Bazeley, 2019). This dendrogram displays the measure of similarity between nodes as coded, in which each source (i.e. participant response) is coded by each node. If the source is coded by the node it is listed as "1" and "0" if it is not. Jaccard's coefficient was used to calculate a similarity index between each pair of items and these items were grouped into clusters using the complete linkage hierarchical clustering algorithm (Rokach & Maimon, 2005).

## 3.3. RESULTS

Two broad overarching dimensions were identified. The first dimension, titled "grandiosity", included descriptions that were related to an actual or desired view of the self that was unrealistically affirmative, strong or superior. The second dimensions, titled "vulnerability", included an actual or feared view of the self that was weak, empty or

insecure. Beyond these two overarching dimensions, salient personality features not accounted for by the "grandiose" or "vulnerable" dimensions were included within a category reflecting "other personality features". Themes not relating specifically to personality style, but that may provide insights regarding character formation or expression were included within the category of "descriptive themes".

A total of 1098 node expressions were coded from participant responses ($n$ = 436), with a total of 2182 references. This means participant responses were coded with an average of two to three individual node expressions (e.g. "hiding the self", "entitlement") and there were on average 5 expressions of each node(s) in the text.

**Overarching Dimension #1: Grandiosity**

Participants described the characterological grandiosity of their relative. This theme was made up of ten nodes: "Requiring Admiration", "Arrogance", "Entitlement", "Envy", "Exploitation", "Grandiose Fantasy", "Grandiose Self Importance", "Lack of Empathy", "Belief in own Specialness" and "Charming".

**Node #1: Requiring Admiration or Attention Seeking.** Participants described their relative as requiring excessive admiration. For instance, *"He puts on a show for people who can feed his self-image. Constantly seeking praise and accolades for any good thing he does"* (#1256); *"He needs constant and complete attention and needs to be in charge of everything even though he expects everyone else to do all the work"* (#1303).

**Node #2: Arrogance.** Relatives were described as often displaying arrogant or haughty behaviours or attitudes. For instance, *" He appears to not be concerned what other people think, as though he is just "right" and "superior" about everything"* (#1476) and *"My mother is very critical towards everyone around her... family, friends, neighbours, total strangers passing by... everybody is "stupid""* (#2126).

**Node #3: Entitlement.** Relatives were also described as having a sense of entitlement. For example, *"I paid all of the bills. He spent his on partying, then tried to tell me what to do with my money. He took my bank card, without permission, constantly. Said he was entitled to it"* (#1787) and *"He won't pay taxes because he thinks they are a sham and he shouldn't have to just because other people pay"* (#380).

**Node #4: Envy and Jealousy**. Participants described instances of their relative being envious or jealous of others. Jealousy, being in relation to the threatened loss of important relationships, was described by participants. For instance, after describing the abusive behaviours of their relative one participant stated *"It got worse after our first son was born, because he was no longer the centre of my attention. I actually think he was jealous of the bond that my son and I had"* (#1419). Other participants, despite using the term "jealous", described more envious feelings in their relative relating to anger in response to recognising desirable qualities or possessions of others For instance, another participant stated *"[they have] resentment for people who are happy, seeing anyone happy or doing great things with their life makes them jealous and angry"* (#1744). Some participants described their relative believing that others are envious of them, for example *"*[*he] thought everyone was jealous he had money and good looks."* (#979) and *"[he] tried to convince everyone that people were just jealous of him because he had a nice truck"* (#1149).

**Node #5 Exploitation**. Relatives were described as being interpersonally exploitative (i.e. taking advantage of others). For instance, one participant stated *"He brags how much he knows and will take someone else's knowledge and say he knew that or claim it's his idea"* (#1293). Another participant stated "*With two other siblings that are disabled, she uses funding for their disabilities to her advantage… I do not think she cares much for their quality of life, or she would use those funds for its intended use." (#998)*

**Node #6 Grandiose Fantasy**. Participants also described their relatives as engaging in unrealistic fantasies of success, power and brilliance. For instance, the response *"He believes that he will become a famous film screen writer and producer although he has no education in film"* (#1002); *"He was extremely protective of me, jealous and woefully insecure. [He] went on "missions" where he was sure [world war three] was about to start and he was going to save us, he really believes this"* (#1230).

**Node #7 Grandiose Self Importance**. Relatives were described as having a grandiose sense of self-importance (e.g. exaggerating achievements, expecting to be recognised as superior without commensurate achievements). Examples of this include *"He thinks he knows everything … conversations turn into an opportunity for him to "educate" me"* (#1046); "He tells endless lies and elaborate stories about his past and the things he has achieved, anyone who points out inconsistencies in his stories is cut out of his life" (#178).

**Node #8 Compromised Empathic Ability**. Participants described their relatives as being unwilling to empathise with the feelings or perspectives of others. Some examples include *"she has never once apologized for her abuse, and she acts as if it never happened. I have no idea how she can compartmentalize like that. There is no remorse"* (#1099) and *"[he] is incapable of caring for all the needs of his children because he cannot think beyond his own needs and wants, to the point of his neglect [resulting in] harm to the children"* (#1488).

**Node #9 Belief in Own Specialness**. Relatives were described as believing they were somehow "special" and unique. For example, one participant described their relative as fixated with their status as an *"important [member] of the community"* (#860), another participant stated *"he considers himself a cut above everyone and everything... Anyone who doesn't see him as exceptional will suffer"* (#449). Other responses indicated their relatives

were preoccupied with being associated with other high status or "special" people. For instance, one participant stated that their relative *"likes to brag about how she knows wealthy people as if that makes her a better person"* (#318) and another stating that their relative *"loves to name drop"* (#49).

**Node #10 Charming**. Participants also described their relative in various positive ways which reflected their relatives' likeability or charm. For instance, *"He is fun-loving and generous in public. He is charming and highly intelligent"* (#1401); *"His public persona, and even with extended family, is very outgoing, funny and helpful. Was beloved by [others]"* (#1046) and *"He is very intelligent and driven, a highly successful individual. Very social and personable and charming in public, funny, the life of the party"* (#1800)

**Overarching Dimension #2: Vulnerability**

Participants described the characterological vulnerability of their relative. This theme was made up of nine nodes: "Contingent Self Esteem", "Devaluing", "Emotionally Empty or Cold", "Hiding the Self", "Hypersensitive", "Insecurity", "Rage", "Affective Instability" and "Victim Mentality".

**Node #1 Contingent Self Esteem**. Participants described their relatives as being reliant on others approval in order to determine their self-worth. For instance, *"She only ever seems to be "up" when things are going well or if the attention is on her"* (#1196) and *"He appears to be very confident, but must have compliments and reassuring statements and what not, several times a day"* (#1910).

**Node #2 Devaluing.** Relatives were described as "putting down" or devaluing others in various ways and generally displaying dismissive or aggressive behaviours. For instance, *"On more than one occasion, he's told me that I'm a worthless person and I should kill myself*

*because nobody would care"* (#1078) and *"He feels intellectually superior to everyone and is constantly calling people idiotic, moron, whatever the insult of the day is"* (#1681).

Relatives were also described as reacting to interpersonal disappointment with shame and self-recrimination, devaluing the self. For instance, *"They are extremely [grandiose] ... [but] when someone has the confidence to stand up against them they crumble into a sobbing mess wondering why it's always their fault"* (#1744) and *"I have recently started to stand up for myself a little more at which point he will then start saying all the bad things are his fault and begging forgiveness"* (#274).

**Node #3 Emotionally Empty or Cold**. Participants described regularly having difficulty "connecting" emotionally with their relative. For instance, one participant described that their relative was *"largely sexually disengaged, unable to connect, difficulty with eye contact… he used to speak of feeling dead"* (#1365); another stated *"he was void of just any emotion. There was nothing. In a situation of distress he just never had any feeling. He was totally void of any warmth or feeling"* (#323), another stated *"I gave him everything. It was like pouring myself into an emotional black hole"* (#627).

**Node #4 Hiding the Self**. Participants reported instances in which their relative would not allow themselves to be "seen", either psychologically or physically. One way in which they described this was through the construction of a "false self". For instance *"He comes across very confident yet is very childish and insecure but covers his insecurities with bullish and intimidating behaviour"* (#2109). Another way participants described this hiding of self was through a literal physical withdrawal and isolation. For example, *"He will also have episodes of deep depression where he shuts himself off from human contact. He will hide in his room or disappear in his sleeper semi-truck for days with no regard for his family or employer"* (#1458).

**Node #5 Hypersensitive**. Participants reported feeling as though they were "walking on eggshells" as their relative would respond volatilely to perceived attacks. For instance, *"She cannot take advice or criticism from others and becomes very defensive and abusive if challenged"* (#1485); *"It was an endless mine field of eggshells. A word, an expression would be taken against me"* (#532) and *"Very irrational and volatile. Anything can set her off on a rage especially if she doesn't get her way"* (#822).

**Node #6 Insecurity**. Relatives were described as having an underlying sense of insecurity or vulnerability. For instance *"He really is just a scared little kid inside of a big strong man's body. He got stuck when he was a child"* (#1481); *"At the core he feels unworthy, like a fake and so pretty much all introspection and self-growth is avoided at all costs"* (#532) and *"At night when the business clothes come off his fears eat him up and he would feel highly vulnerable and needs lots of reassurance"* (#699).

**Node #7 Rage**. Participants reported that their relatives were particularly prone to displaying explosive bouts of uncontrolled rage. For example, *"He has a very fragile ego … he will fly off the handle and subject his target to hours of screaming, insults and tantrum-throwing"* (#1078); *"he has a temper tantrum-like rage that is frightening and dangerous"* (#1476); *"He has hit me once. Left bruises on upper arms and back. He goes into rage and has hit walls, hits himself"* (#1637).

**Node #8 Affective Instability (Symptom Patterns)**. Relatives were also described as displaying affective instability which may be related to anxiety and depressive disorders. Relatives were commonly described as being "anxious" (#1091) including instances of hypochondria (#1525), agoraphobia (#756), panic (#699) and obsessive compulsive disorder (#2125). Relatives were also commonly described as having episodes of "depression" (#1106) and depressive symptoms such as low mood (#1931), problems sleeping (#1372).

Some participants also described their relative as highly suicidal, with suicidality being linked to relationship breakdowns or threats to self-image. For example, *"When I state I can't take any more or say we can't be together … he threatens to kill himself"* (#1798); *"If he feels he is being criticised or blamed for something (real or imagined) … his attacks become self-destructive"* (#1800).

**Node #9 Victim Mentality**. Participants reported that their relatives often described feeling as though they were the victim of attacks from others or taken advantage of in some way. For instance, *"He seems to think that he has been "hard done by" because after all he does for everyone, they don't appreciate him as much as they should"* (#1476); *"He will fabricate or twist things that are said so that he is either the hero or the victim in a situation"* (#447).

**Other personality features**

Participants also reported some descriptions of their relative that were not described within prior conceptualisations of narcissism. This theme was made up of 3 nodes: "Perfectionism", "Vengeful" and "Suspicious".

**Node #1 Perfectionism**. Participants repeatedly described their relative displaying perfectionistic or unrelenting high standards for others. For instance, *"I cannot just do anything at home everything I do is not to her standard and perfection*" (#1586) and *"Everything has to be done her way or it's wrong and she will put you down. She has complete control over everything"* (#1101).

**Node #2 Vengeful**. Participants described their relative as being highly motivated by revenge and displaying vindictive punishing behaviours against others. Examples include, *"[He] has expressed thoughts of wanting to hurt those who cause him problems"* (#230); *"He is degrading to and about anyone who doesn't agree with him and he is very vengeful to*

*those who refuse to conform to his desires"* (#600) and *"Once someone crosses him or he doesn't get his way, he becomes vindictive and will destroy their life and property and may become physically abusive"* (#707).

**Node #3 Suspicious**. Participants described their relative as holding paranoid or suspicious beliefs about others intentions or behaviours. For instance, *"He would start fights in public places with people because he would claim they were "looking at him and mimicking him""* (#1149) and *"She is angry most days, obsessively talking about who wronged her in the past, currently or who probably will in the future"* (#2116).

**Descriptive themes**

Several salient descriptive themes were also coded from the data that, while not relating directly to the relatives character, may provide peripheral or contextual information.

**Descriptive theme #1: Trauma.** A number of participants described their relative as having experienced a traumatic or troubled childhood. One participant stated that their relatives' father *"was extraordinarily abusive both emotionally and physically to both him and the mother… [the father] pushed [the relative] as a young boy on prostitutes as a 12th birthday gift … He was beaten on and off from age 6 to 15 when he got tall enough to threaten back"* (#1249). Another participant described the emotional upbringing of their relative *"[his mother was] prone to being easily offended, fighting with him and cutting off all contact except to tell him what a rotten son he was, for months, then suddenly talking again to him as if nothing had ever happened. His father, he said, was strict and expected a lot of him. Both rarely praised him; whenever he accomplished something they would just demand better instead of congratulating him on his accomplishment"* (#1909). Another participant reflected on how their relative's upbringing may be related to their current

emotional functioning, *"personally I think he is so wounded (emotional, physical abuse and neglect) that he had to detach from himself and others so much just to survive"* (#1640).

**Descriptive theme #2: Excessive Religiosity.** While participant's comments on their relative's religiosity were common, the content was varied. Some participants described their relative using religion as a mechanism to control, for instance *"he uses religion in an extremely malignant way. Manipulating verses and religious sayings and interpret them according to his own will"* (#132) and *"very religious. She uses scripture to manipulate people into doing what she wants on a regular basis"* (#1700). One participant described how their relative's religiosity became infused with their grandiose fantasy *"He has also gone completely sideways into fundamental religious doctrine, as if he knows more than the average "Christian" about End Times, and all kinds of illuminati type conspiracy around that topic. He says God talks to him directly and tells him things and that he has had dead people talk to him"* (#1476). Other participants described how their relative's religiosity was merely an aspect of their "false self", for example *"she has a wonderful, loving, spiritual facade that she shows to the world"* (#1073).

**Descriptive theme #3: Substance Use.** Participants regularly described their relative as engaging in substance use. Substances most frequently named were alcohol, marijuana, cocaine and "pills". Participants reported that when their relative was using substances their behaviour often became dangerous, usually through drink driving, one participant stated *"too much alcohol… he would drive back to [his work] … I was always afraid of [a driving accident]"* (#76).

**Subtype Expression**

Of 436 participants, a total of 348 unique grandiose node expressions were present and a total of 374 unique vulnerable node expressions were present. Of these, 301

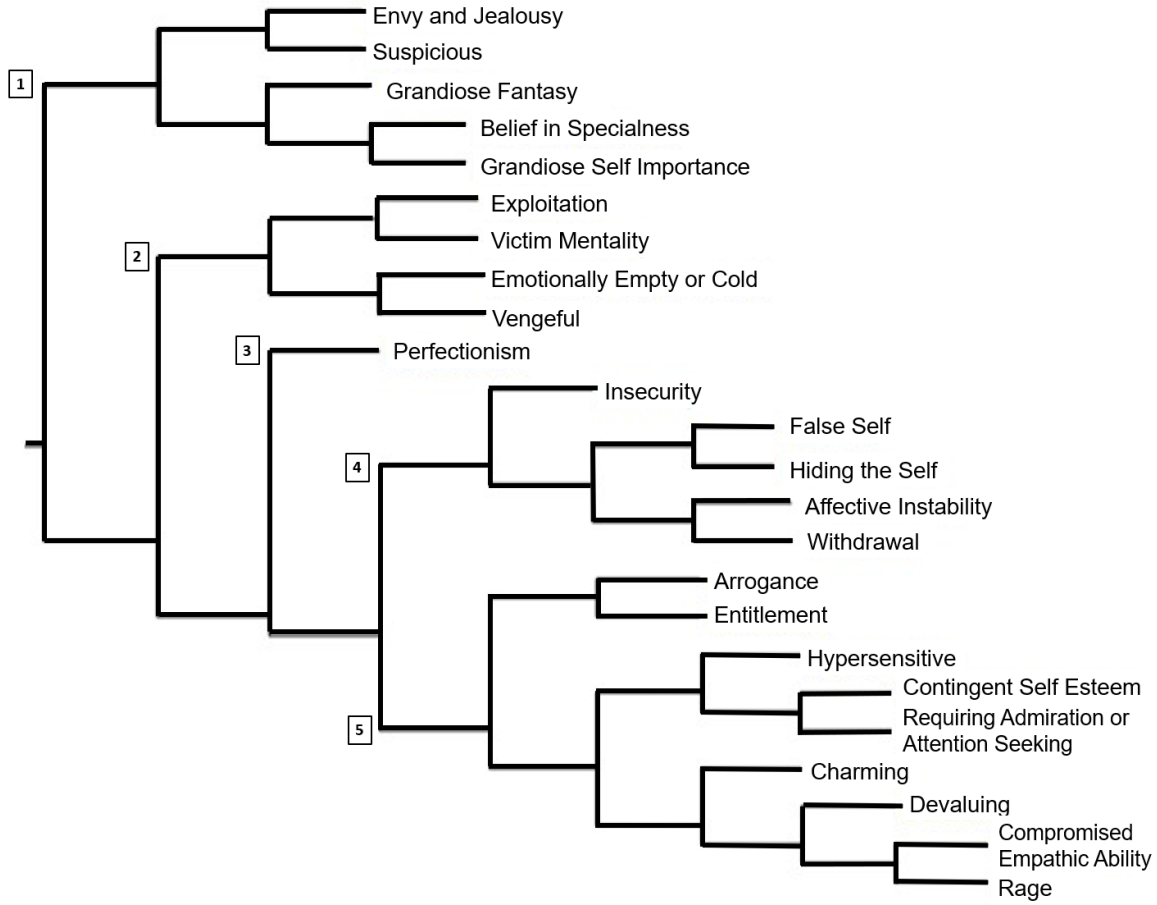
participants included both grandiose and vulnerable descriptions of their relative (69% of sample). Only 47 (11% of sample) focused on grandiose features in their description of their relative, and only 88 participants (20% of sample) focused on vulnerable features.

**Cluster Analysis**

A cluster analysis dendrogram was generated using NVivo 11 for purposes of visualising and exploring the underlying dimensions of the data (Jackson & Bazeley, 2019) and is displayed in Figure 2.1. Four clusters of nodes and one standalone node can be distinguished. The first cluster, labelled "Fantasy Proneness", includes nodes reflecting the predominance of "fantasy" colouring an individuals interactions, either intrapersonally ("grandiose self-importance, belief in specialness") or interpersonally ("suspicious, envy"). The second cluster, labelled "Negative Other", reflects nodes concerned with a detached connection with others ("emotionally empty") and fostering "vengeful" and "exploitative" drives towards others, as well as feelings of victimhood. Interestingly, despite being related to these other aspects of narcissism, "perfectionism" was factored as reflecting its own cluster, labelled "Controlling". The fourth cluster, labelled "Fragile Self", includes nodes indicating feelings of vulnerability ("affective instability", "insecurity") and shameful avoidance ("hiding the self", "false self", "withdrawal") due to these painful states. The fifth cluster, labelled "Grandiose" reflects a need ("contingent self-esteem", "requiring admiration") or expectation ("entitlement", "arrogance") of receiving a certain level of treatment from others. It also includes nodes regarding how individuals foster this treatment ("charming", "rage", and "devaluing") and a hypervigilance for if their expectations are being met ("hypersensitive").

**Figure 2.1.**

*Cluster analysis of nodes based on coding similarity.*




*Note. Clusters are labelled as follows: 1. Fantasy Proneness, 2. Negative Other, 3. Controlling, 4. Fragile Self, 5. Grandiose.*

## 3.4. DISCUSSION

This study aimed to qualitatively describe the interpersonal features of individuals with traits of pathological narcissism from the perspective of those in a close relationship with them.

### Grandiose narcissism

We found many grandiose features that have been validated through empirical research (Cain et al., 2008; Miller et al., 2008; Ronningstam, 2009). Grandiosity, as reflected in the DSM-5, has been argued to be a key feature of pathological narcissism that distinguishes it from other disorders (Hörz-Sagstetter et al., 2018; Sharp et al., 2015). One

feature regularly endorsed by participants that is not encompassed in DSM-5 criteria is relatives' level of interpersonal charm and likability. This charm as described by participants appears more adaptive than a "superficial charm" that might be more exclusively "interpersonally exploitative" in nature. However, it should be noted that this charm did not appear to persist, and was most often described as occurring mainly in the initial stages of a relationship or under specific circumstances (e.g. in public with an audience).

**Vulnerable narcissism**

We also found participants described their relative in ways consistent with the vulnerable dimensions of the pathological narcissism inventory (i.e. hiding the self, contingent self esteem and devaluing; Pincus, 2013). Dimensions that are also included in other popular measures for vulnerable narcissism were also endorsed by participants in our sample. For instance, the nodes of "hypersensitivity", "insecurity" and "affective instability" reflect dimensions covered in the Hypersensitive Narcissism Scale (Hendin & Cheek, 1997) and neuroticism within the Five Factor Narcissism Inventory (Glover et al., 2012). These aspects of narcissism have also been documented within published literature (De Panfilis et al., 2018; Euler et al., 2018; Miller et al., 2018; Wright et al., 2017).

**Subtype expression: Cluster Analysis**

Most participants (69% of sample) described both grandiose and vulnerable characteristics in their relative, which given the relatively small amount of text and node expressions provided per participant is particularly salient. Given the nature of the relationship types typically endorsed by participants (i.e. romantic partner, family member), it suggests that the degree of observational data on their relative is quite high. As such, these results support the notion that an individual's narcissism presentation may fluctuate over time

(Giacomin & Jordan, 2013, 2016) and that vulnerable and grandiose presentations are inter-related and oscillating (Levy, 2012; Ronningstam, 2009).

The cluster analysis indicates the degree to which salient co-occurring features were coded. These features can be grouped to resemble narcissistic subtypes as described in research literature, such as the subtypes outlined by Russ et al. (2008) in their Q-Factor Analysis of SWAP-II Descriptions of Patients with Narcissistic Personality Disorder. Our clusters #1-3 ("Fantasy Proneness", "Negative Other" and "Controlling") appear to resemble the "Grandiose/malignant narcissist" subtype as described by the authors. This subtype includes instances of self-importance, entitlement, lack of empathy, feelings of victimisation, exploitativeness, a tendency to be controlling and grudge holding. Our cluster #4-5 ("Fragile Self" and "Grandiose") appear to resemble the "Fragile narcissist" subtype described including instances of depressed mood, internal emptiness, lack of relationships, entitlement, anger or hostility towards others and hypersensitivity towards criticism. Finally, our "Grandiose" cluster (#5) showed overlap with the "high functioning/exhibitionistic narcissist" subtype, which displays entitled self-importance but also a significant degree of interpersonal effectiveness. We found descriptions of the relative showing "entitlement", being "charming" and "requiring admiration".

While co-occurring grandiose and vulnerable features are described at all levels of clusters in our sample, distinctions between the observed clusters may be best understood as variations in level of functioning, insight and adaptiveness of defences. As such, pathological narcissism has been understood as a characterological way of understanding the self and others in which feelings of vulnerability are defended against through grandiosity (Morf et al., 2011), and threats to grandiosity trigger dysregulating and disintegrating feelings of vulnerability (Wright et al., 2017). Recent research supports this defensive function of grandiosity, with Kaufman et al. (2018) stating *"*grandiose narcissism was less consistently

and strongly related to psychopathology … and even showed positive correlations with adaptive coping, life satisfaction and image-distorting defence mechanisms*"* (p. 18). Similarly, Hörz-Sagstetter et al. (2018) state "high levels of grandiosity may have a stabilizing function" on psychopathology (p. 569). This defence, however, comes at a high cost, whether it be to the self when the defensive grandiosity fails (triggering disintegrating bouts of vulnerability) or to others, as this style of relating exacts a high toll on those in interpersonal relationships (Day et al., 2019).

**Other personality features**

Participants described their relative as highly perfectionistic, however the perfectionism described was less anxiously self-critical and more "other oriented". This style of other oriented "narcissistic perfectionism" has been documented by others (Nealis et al., 2015) and appears not to have the hallmarks of overt shameful self-criticism at a surface level, however may still exist in covert form (Ronningstam, 2010). Regarding the "vengeful" node, Kernberg (2007, 2008) describes that as a result of a pain-rage-hatred cycle, justification of revenge against the frustrating object is an almost unavoidable consequence. Extreme expressions of acting out these "ego-syntonic" revenge fantasies may also highlight the presence of an extreme form of pathological narcissism in this sample – malignant narcissism, which involves the presence of a narcissistic personality with prominent paranoia and antisocial features (Lenzenweger et al., 2018) . Lastly, Joiner et al. (2008) report that depressive symptoms in narcissistic personalities may evoke paranoid attitudes, which may in turn be demonstrated in the behaviours and attitudes expressed in the "suspicious" node we found.

While this study focused on a narcissistic presentation, the presence in this sample of these other personality features (which could alternatively be described as "anankastic",

"antisocial" and "paranoid") is informed by the current conversation regarding dimensional versus categorical approaches (Grenyer, 2017; McWilliams et al., 2018). Personality dysfunction from a dimensional perspective, such as in the "borderline personality organisation" (Lingiardi & McWilliams, 2017) or borderline "pattern" (World Health Organization, 2018) could understand these co-occurring personality features as not necessarily aspects of narcissism or "co-morbidities", but as an individual's varied pattern of responding that exists alongside their more narcissistic functioning, reflecting a more general level of disorganisation that resists categorisation. This is particularly reflected in Table 3.2 as participants reported a wide variety of diagnosed conditions, as well as the "Affective Instability" node which may reflect various diagnostic symptom patterns.

**Descriptive features**

The relationship between trauma and narcissism has been documented (Keene & Epps, 2016; Ronningstam, 2010; Stinson et al., 2008; van Schie et al., 2020) and the term "trauma-associated narcissistic symptoms" has been proposed to identify such features (Simon, 2002). Interestingly, while participants in our sample did describe instances of overt abuse which were traumatic to their relative (e.g. physical, verbal, sexual), participants also described hostile environments in which maltreatment was emotionally abusive or manipulative in nature, as well as situations where there was no overt traumatic abuse present but which most closely resemble "traumatic empathic failures". This type of attachment trauma, stemming from emotionally invalidating environments, is central to Kohut's theory of narcissistic development (Kohut, 1966b, 1972a), and has found support in recent research (Huxley & Bizumic, 2017). Relatives religiosity was noteworthy, not necessarily due to its presence, but due to the narcissistic function that the religiosity served. Research on narcissism and religious spirituality has steadily accumulated over the years (for a review see: Sandage & Moe, 2011) and the term "spiritual bypassing" (Welwood, 2000) is used for

individuals who use religion in the service of a narcissistic defence. In our sample this occurred via alignment with an "ultimate authority" in order to bolter esteem and control needs. It may be that the construction of a "false self" rooted in spirituality is conferred by the praise and audience of a community of believers. Finally, participants reported their relative as engaging in various forms of substance use, consistent with prevalence data indicating high co-occurrence of narcissism and substance use (Stinson et al., 2008). While the motivation behind relatives substance use was not mentioned by participants, it is consistent with relatives more general use of reality distorting defences, albeit a more physicalised as opposed to an intrapsychic method.

**Implications of findings**

First, this study extends and supports the widespread acknowledged limitation of DSM-5 criteria for narcissistic personality disorder regarding the exclusion of vulnerable features (for a review of changes to dignostic criteria over time, see Levy et al., 2011; Levy et al., 2013) and we acknowledge the current discussion regarding therapist decision to provide a diagnosis of NPD (Hersh et al., 2019). However, the proliferation of alternate diagnostic labels may inform conceptualisations which do not account for the full panorama of an individual's identity (Pincus et al., 2014), adding to the already contradictory and unintegrated self-experience for individuals with a narcissistic personality. This may also impede the treatment process by informing technical interventions which may be contra-indicated. For instance, treatment of individuals with depressive disorders require different approaches than individuals with a vulnerably narcissistic presentation (Kernberg & Yeomans, 2013; McWilliams, 2011). As such, a focus of treatment would include the integration of these disparate self-experiences, through the exploration of an individual's affect, identity and relationships, consistent with the treatment of personality disorders more generally. Specifically, when working with an individual with a narcissistic personality, this

may involve identifying and clarifying instances of intense affect, such as aggression and envy, themes of grandiosity and vulnerability in the self-concept, and patterns of idealisation and devaluation in the wider relationships. The clinician will need to clarify, confront or interpret to these themes and patterns, their contradictory nature as extreme polarities, and attend to the oscillation or role reversals as they appear (Clarkin et al., 2006). Second, as the characterological themes identified in this paper emerged within the context of interpersonal relationships, this highlights the interconnection between impaired self and other functioning. As such, in the context of treating an individual with pathological narcissism, discussing their interpersonal relationships may be a meaningful avenue for exploring their related difficulties with identity and emotion regulation that may otherwise be difficult to access. This is particularly salient as treatment dropout is particularly high for individuals with pathological narcissism (King et al., 2020), and as typical reason for attending treatment is for interpersonal difficulties (Ronningstam & Weinberg, 2013). Third, treatment for individuals with narcissistic personalities can inspire intense countertransference responses in clinicians (Tanzilli et al., 2017) and often result in stigmatisation (Penney et al., 2017). As such, these findings also provide a meaningful way for the clinician to extend empathy to these clients as they reflect on the defensive nature of the grandiose presentation, the distressing internal emptiness and insecurity for these individuals, and the potential childhood environment of emotional, sexual or physical trauma and neglect which may have informed this defensive self-organisation. Finally, these findings would also directly apply to clinicians and couples counsellors working with individuals who identify their relative as having significant narcissistic traits, providing them with a way to understand the common ways these difficulties express themselves in their relationships and the impact they may have on the individuals in the relationship. Practically, these findings may inform a heightened need for treating clinicians to assess for interpersonal violence and the safety of clients in a context of

potential affective dysregulation and intense aggression. Regarding technical interventions, if working with only one of the individuals in the relationship, these findings may provide avenues for psychoeducation regarding their relatives difficulties with identity and affect regulation, helping them understand the observed oscillating and contradictory self-states of their relative. If working with both individuals or the couple, the treating clinician will need to be able to identify and interpret changes in affect and identity, and the way this manifest in the relationship functioning of the couple and their characteristic ways of responding to each other (e.g. patterns of idealisation and devaluation). This may also involve attending to the ways in which the therapist may be drawn into the relationship with the couple, noticing and interpreting efforts at triangulation or any pressure to "pick sides" from either individual.

**Limitations**

The sample selection procedure may have led to results only being true for some, but not all people living with a relative with narcissistic features. Participants were recruited online limiting the opportunity to understand participant motivation. Second, relying on informant ratings of narcissism for both screening and qualitative analysis is a limitation as we are less unable to control for severity, specificity or accuracy of participant reporting. Further, it is possible that the use of a narcissism screening tool primed participants to artificially report on particular aspects of their relative. However, the risk of biasing or priming participants is a limitation of all studies of this kind, as studies implementing informant methodology for assessing narcissism typically rely on providing participants with a set of diagnostic criteria or narcissism specific measures as their sole indicator of narcissism (e.g. Byrne & O'Brien, 2014; Lukowitsky & Pincus, 2013). As such, notwithstanding the limitations outlined, this informs the novelty and potential utility of the present approach which relies on identifying narcissism specific features amongst a backdrop of descriptions of more general functioning within intimate relationships. Third, gender disparity in participants

and relatives was substantial. However, as NPD is diagnosed more commonly in males (50-75%, American Psychiatric Association, 2013) and as most participants in our sample were in a romantic, heterosexual relationship, this disparity may reflect a representative NPD sample and should not significantly affect the validity of results. Rather, this disparity may strengthen the argument that individuals with a diagnosis of NPD (as specified by DSM-5 criteria) may have co-occurring vulnerable features, which may not be currently reflected in diagnostic categories. Finally, as a result of relying on informant ratings and not assessing narcissistic individuals via structured clinical interview, questions regarding the specificity and severity of the narcissistic sample are unable to be separated in the analysis. We thus probably studied those ranging from "adaptive" or high functioning narcissism (Miller, Lynam, et al., 2017) to more severe and disabling character disorders. Whilst we screened for narcissistic features, it was clear the sample studied also reported a broad range of other co-occurring problems.

**Summary**

We investigated the characteristics of individuals with pathologically narcissistic traits from the perspective of those in a significant personal relationship with them. The overarching theme of "Grandiosity" involved participants describing their relative as requiring admiration, displaying arrogant, entitled, envious and exploitative behaviours, engaging in grandiose fantasy, lacking in empathy, having a grandiose sense of self-importance, believing in own sense of "specialness" and being interpersonally charming. The overarching theme of "Vulnerability" involved participants describing their relative's self-esteem being contingent on others, as being hypersensitive, insecure, displaying affective instability, feelings of emptiness and rage, devaluing self and others, hiding the self through various means and viewing the self as a victim. Relatives were also described as displaying perfectionistic, vengeful and suspicious personality features. Finally, participants also

described several descriptive themes, these included the relative having a trauma history, religiosity in the relative and the relative engaging in substance use. The vulnerability themes point to the problems in the relatives sense of self, whilst the grandiose themes show how these express themselves interpersonally. The complexity of interpersonal dysfunction displayed here also points to the importance of assessing all personality traits more broadly.

# CHAPTER FOUR

## STUDY 3 – PATHOLOGICAL NARCISSISM: AN ANALYSIS OF INTERPERSONAL DYSFUNCTION WITHIN INTIMATE RELATIONSHIPS

This chapter is submitted and currently undergoing the peer review process in the journal of *Personality and Mental Health*. Minor modifications were made in order to conform to the thesis review process.

## ABSTRACT

**Background:** Pathological narcissism is marked by deficits in psychosocial functioning. Difficulties in relationships include instances of aggression, devaluation and control, however few studies have examined these relationships from the perspective of partners and family members. **Methods:** We studied participants who were in relationships with relatives high in narcissistic traits ($N = 436$; current romantic partners [57.3%]; former romantic partners [21.1%]; family members [15.4%]). Participant responses were analysed thematically, and their underlying mental health problems were also measured. **Results:** Thematic analysis of participant responses indicated themes of abuse from the relative with narcissism (physical, verbal, emotional and sexual) as well as the relative imposing challenging financial and sexual behaviours. There were complex interpersonal themes of mutual idealisation but also devaluation. In response, participants reported high levels of anxiety, depression, self-aggression, sickness and somatic concerns. Further, participants expressed overt outward hostility towards their relative with narcissism, but also dependency strivings and frustrated dependency themes. **Conclusions:** Partners and their relative with narcissism appeared locked into interpersonal and intrapersonal dynamic conflicts. Clinical implications include specific attendance to alliance issues, dependency themes and a focus on limit setting to establish personal safety.

## 4.1. INTRODUCTION

Interpersonal dysfunction is a well-documented aspect of pathological narcissism (Byrne & O'Brien, 2014; Grenyer, 2013; Kealy & Ogrodniczuk, 2011) with some authors suggesting that pathological narcissism and interpersonal dysfunction go "hand in hand" (Ogrodniczuk & Kealy, 2013, p. 114). Such dysfunctional patterns have involved controlling, vindictive and intrusive behaviours (Cheek et al., 2018; Ogrodniczuk et al., 2009), displaying dispositional and reactive anger and hostility (Czarna et al., 2019; Hyatt et al., 2018). Specifically within romantic domains, people with narcissistic traits have been described as using "game playing tactics" (Campbell et al., 2002), showing self-centred, materialistic, deceptive or controlling behaviours (Brunell & Campbell, 2011), which may also include stalking behaviour and interpersonal violence (Green & Charles, 2019; Menard et al., 2021; Menard & Pincus, 2012). Correspondingly, romantic partners and family members in relationship with individuals with pathologically narcissistic traits report significant levels of burden, grief and psychological distress (Bailey & Grenyer, 2014; Day et al., 2019). A recent study by Day et al. (2020) investigated the reported characteristics of individuals with pathological narcissism from the perspective of those in an intimate relationship. Results reflected the proposed related features of pathological narcissism, 'grandiosity' and 'vulnerability' (Pincus & Lukowitsky, 2010), with the majority (69%) of the sample describing both of these aspects in their relative. Within these relationships, challenging interpersonal themes were also described such as 'devaluation', 'narcissistic rage' and 'vengefulness'. Examined through the lens of interpersonal theory, Edershile and Wright (2019) report narcissistic grandiosity as associated with interpersonal dominance and coldness, whereas narcissistic vulnerability was associated with both displaying interpersonal coldness to others, as well as perceiving others as cold. Similarly, Wright et al. (2017) report that perceptions of dominance predicted quarrelsome behaviours for individuals with

pathological narcissism, mediated by negative affect. In this way, antagonistic and quarrelsome interpersonal behaviours may serve a regulatory or defensive function for individuals with pathological narcissism, consistent with findings that highlight the links between emotional dysregulation, compromised empathic capability and impaired social functioning (Lee et al., 2020; Ronningstam, 2016, 2020a).

Clinically, individuals are unlikely to present to treatment directly seeking help regarding their narcissistic pathology. Rather, as highlighted by Ronningstam and Weinberg (2013), narcissistic patients may seek treatment along more interpersonal themes, such as difficulty maintaining work due to frequent interpersonal conflict with co-workers, or due to receiving a relationship ultimatum due to issues of infidelity or lack of intimacy. Indeed, the prominence of interpersonal dysfunction was clearly reflected in early editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for narcissistic personality disorder (NPD) (American Psychiatric Association, 1980). Such classification systems overtly required the presence of significant interpersonal dysfunction (Criterion E), as relating to entitlement and non-reciprocation, interpersonal exploitativeness, idealisation and devaluation and lack of empathy (Levy et al., 2011; Levy et al., 2013; Reynolds & Lejuez, 2011). The current categorical criteria for NPD do not explicitly require the presence of interpersonal dysfunction in the same way, with interpersonal dysfunction being explicitly outlined in one criterion (e.g., Criterion 6: Is interpersonally exploitative) and implicit in a number of others (American Psychiatric Association, 2013a). However, the DSM's newly introduced alternate model of personality disorders (AMPD) offers a more coherent conceptualisation of narcissism (Fossati, Somma, Borroni, Pincus, et al., 2017; Pincus et al., 2016; Skodol et al., 2014), and has again prioritized interpersonal functioning as a core component of personality disorder criteria as relating to difficulties in empathy and intimacy,

along with the pathological personality trait of antagonism (American Psychiatric Association, 2013b).

Given the connection between self and other dysfunction it may be that specific features of the disorder are most evident when viewed from within the context of intimate relationships. As such, this study aims to investigate the behavioural and relational characteristics of individuals with pathological narcissism as informed by those in a close personal relationship with them. The use of informant ratings have found to be a valid methodology to assess aspects of personality pathology, including pathological narcissism (Lukowitsky & Pincus, 2013; Oltmanns et al., 2018), given the documented limitations of self-report research for this population (Klonsky & Oltmanns, 2002). For this research, partners and family members will be referred to as 'participants'. Individuals with pathological narcissism will be referred to as the 'relative'.

## 4.2. METHOD

### Recruitment

Participants provided written informed consent to participate following institutional review board approval. The participants were recruited through invitations posted on various mental health websites that provide information and support that is narcissism specific (e.g. "Narcissistic Family Support Group"). In an effort to ensure that included participants were appropriate to the research, three criteria were applied. First, participants had to identify as having a close personal relationship with someone who was very narcissistic. Second, participants had to complete mandatory questions as part of the survey. Mandatory questions included basic demographic information (age, gender, relationship type) and answers to qualitative questions under investigation. Non-mandatory questions included more sensitive questions such as certain demographic questions (e.g. occupation) and questions pertaining to

their own support seeking. Third, the relative had to have a cumulative score of 36 or above on a narcissism screening measure (described in measures section), as informed by participants (consistent with previous methodology, see Day et al., 2019). Participants who took part in this study were drawn from the same participant pool as those presented in the results of related research (Day et al., 2019; Day et al., 2020).

**Participants**

The inclusion criteria for this study were: (a) having a relative with narcissistic traits (b) relatives scores met threshold of a narcissism screening measure (c) participants provided at least a 70-word narrative about their relative and their relationship together (d) participant completed most of the survey (at least questions 1-5). Applying these inclusion criteria, a sample of 436 was studied. In reaching this sample, we began with a potential sample pool of 2219 who had initially clicked on the consent to participate link, however many did not proceed beyond this point (n = 955). We then applied the above criteria to the remaining 1264 participants. First, participants were removed who indicated that they did not have a 'close' (i.e., intimate) personal relationship with someone who was narcissistic (n = 129). Second, participants who clicked on the link to begin the survey but dropped out within the first 1-5 questions were deemed 'non-serious' and were removed (n = 51). Third, participants identified as rating relatives' narcissism below summed cut off score of 36 (average score of 3) on a narcissism screening measure (SB-PNI-CV, described in measures section) were removed (n = 249). Fourth, participants whose text sample was too brief, i.e. less than 70 words, as specified by Gottschalk et al. (1969), were excluded from analysis.

While included participants required their relative to have elevated scores on a narcissism screening measure as described, subsequent analysis found a high proportion of pathologically narcissistic characteristics in participant descriptions. Themes of 'grandiosity'

were found in 70% of participant responses, ‘vulnerability’ themes in 81% of participant responses, and descriptions of both grandiose and vulnerable descriptions in 69% of responses (see Day, Townsend [17] for more information). Table 4.1 outlines the demographic information of participants and the relative included in the study.

**Table 4.1**
*Demographics for participants (partners and family) and their relatives (people high in pathological narcissism) (N = 436)*

| | Participants (*n* = 436) | Relative (*n* = 436) |
|---|---|---|
| Mean age in years (SD) | 43.9 (10.1) | 48.7 (11.9) |
| Gender | | |
| Male | 4.2% | 77.7% |
| Female | 79.9% | 22.3% |
| Not Specified | 15.9% | - |
| Employment | | |
| Full time | 45.2% | 53.4% |
| Part time | 15.1% | 9.2% |
| Unemployed | 9.9% | 12.7% |
| Other | 13.9% | 24.3% |
| Support pension | 3% | 4.2% |
| Self-Employed | 2.5% | 8.7% |
| Retired | 4% | 7% |
| Student | 1.7% | 0.2% |
| Other | 2.7% | 4.2% |
| Not stated | 15.9% | 0.5% |
| Relationship | | |
| Spouse or partner | 57.3% | |

| | |
|---|---|
| Former spouse or partner | 21.1% |
| Family (total) | 15.4% |
| Mother | 8.9% |
| Father | 2% |
| Child | 1.2% |
| Sibling | 3.2% |
| Other | 6.2% |

*Note.* 'Other' relationship type category consisted of 'close friend', a non-blood relative, or was left unspecified. Familial relationships listed reflect the relationship of the relative with narcissistic traits.

## Measures

### Pathological Narcissism Inventory (Carer Version) (SB-PNI-CV)

Schoenleber, Roche, Wetzel, Pincus, and Roberts (2015) developed a short version of the Pathological Narcissism Inventory (SB-PNI; "super brief") as a 12 item measure consisting of the best performing items for the Grandiosity and Vulnerability composites (6 of each) of the Pathological Narcissism Inventory (Pincus et al., 2009). This measure was then adapted into a carer version (SB-PNI-CV) in the current research as consistent with previous methodology (Day et al., 2019) by changing all self-referential terms (i.e. "I") to refer to the relative (i.e. "my relative"). The SB-PNI-CV demonstrated strong internal consistency ($\alpha = .80$), using all available data ($N = 1021$). Subscales of the measure also demonstrated internal consistency for both grandiose ($\alpha = .73$) and vulnerable ($\alpha = .75$) items.

### Qualitative analysis

Participants who met inclusion criteria were asked to describe their relative using the Wynne-Gift speech sample procedure as outlined by Gift et al. (1986). This included participants responding to the question:

*"What is your relative like, how do you get on together?"*

Participants were given a textbox to respond to this question in as much detail as they would like. As described above, participants whose text responses were too brief (< 70 words), were removed from analysis as specified by Gottschalk et al. (1969). It is important to note however, that these excluded participants ($n$ = 399) did not differ from the included participants in any significant way regarding demographic information. Mean response length was 237 words, with a standard deviation of 193 words. Text responses ranged from 70 – 1279 words.

A phenomenological orientation was adopted in understanding the data, which places primacy on understanding the "lived experience" of participant responses (Smith et al., 2009). This involved reading and re-reading all participant responses in order to be immersed in the participant's subjective world, followed by highlighting text passages regarding the phenomenon under examination (i.e. personality features, descriptions of behaviour, etc) and noting comments and personal reactions to the text in the margins. The data analysis process followed the steps outlined by Braun et al. (2019) in conducting thematic analysis. In this approach, themes are meaning-based patterns that are not intended to merely summarise the data, but to provide a coherent interpretation of the data. This involved familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and writing up the analysis (Braun & Clarke, 2006). This methodology of data analysis via phenomenologically analysing and grouping themes is a well-documented and regularly utilised qualitative approach (e.g. Ng et al., 2019; White & Grenyer, 1999). To do this, significant statements were extracted and coded into nodes reflecting their content (e.g. "physical abuse", "infidelity") using NVivo 11. Nodes were then grouped together in an overarching dimension (e.g. "abuse", "sexual behaviours"). For instance, the nodes "infidelity", "pornography", and "sexually inappropriate" were all grouped together under the

theme of "sexual behaviours" as these nodes were seen to be related to a common phenomenon.

Once the data had been analysed by the first author, a second researcher completed coding for inter-rater reliability analysis on 10% of data. Cohen's Kappa coefficient was used to index inter-rater reliability by calculating the similarity of nodes identified by the two researchers. This method takes into consideration the agreement between the researchers (observed agreement) and compares it to how much agreement would be expected by chance alone (chance agreement). Inter-rater reliability for the whole dataset was calculated as $\kappa = 0.80$ which reflects a very high level of agreement between researchers that is not due to chance alone (Viera & Garrett, 2005).

**Quantitative analysis of psychological states**

We used thematic analysis of narratives of interactions with the relative, and then scored psychiatric content analysis scales to assess the resultant psychological symptoms of participants. We used the *Psychiatric Content Analysis and Diagnosis (PCAD-3)* to assess underlying psychological states in participants. PCAD-3 is a computer software program based on the Gottschalk-Gleser Content Analysis Method for measuring the magnitude of various psychological states and traits from the content analysis of verbal behaviour (Gottschalk & Gleser, 1969; Gottschalk et al., 1969). The most recent version of content analysis software was utilised (PCAD-3, Gottschalk & Bechtel, 2016). Scoring of these scales is done via software analysis of text-based data against word-based dictionaries, with analysis conducted at the clause level (as opposed to individual word level). Clauses are identified by the dictionary as reflecting the presence or absence of psychiatric content reflected in the scales described, with varying degrees of severity. For instance, self-accusation (a subscale within the depression dimension), is scored by the presence of ridicule,

shame, embarrassment, condemnation or moral disapproval in the text, and is differentially weighted if it is experienced as coming from the self (+3), others (+2) or as expressed denial (+1). Validity and reliability of the content analysis scales have been demonstrated though corroboration with theoretically related variables and sound inter-rater and test-retest coefficients (Gottschalk, 1995; Viney, 1983). Computerised scoring of content scales has demonstrated validity and reliability (Gottschalk & Bechtel, 1995).

## 4.3. RESULTS

### Qualitative analysis

A total of 795 node expressions were coded from participant responses ($n$ = 403), with a total of 1284 references. This means participant responses were coded with an average of 2 individual node expressions (e.g. "emotional abuse", "infidelity") and that there were on average 3 expressions of each node(s) in the text. Four different overarching dimensions were identified from participant responses, these included: abusive behaviours, financial problems, sexual behaviours and idealisation and devaluation.

#### Overarching Dimension: Abusive Behaviours

Abusive behaviours were spontaneously described by 43.9% of participants ($n$ = 177). This dimension was made up of four nodes: "Emotional Abuse" (present in 20.6% of responses, $n$ = 83), "Physical Abuse" (present in 17.1% of responses, $n$ = 69), "Sexual Abuse" (present in 5.7% of responses, $n$ = 23) and "Verbal Abuse" (present in 16.6% of responses, $n$ = 67). Table 4.2 displays the nodes and sample text examples that demonstrate this dimension.

**Table 4.2.**

*Themes of Abuse and Representative Text Examples as Reported by Partners and Family Members in a Close Relationship with an Individual with Pathological Narcissism*

| Theme | Text Example |
|---|---|
| *Emotional Abuse* | "He was emotionally abusive, [he] made me believe that it was all my fault and I was the crazy one and I was told that if I ever left, he would take my children, make sure he destroyed me in court and that I would end up with nothing because I was a useless waste of skin who could do nothing right and had no skills" (#1689) |
| | "Able to withhold emotions and affection for months… periods of great conversation and affection… slides bit by bit until back to [being] cold, unloving, spiteful, mean" (#2183) |
| | "In his house you are his property and he can do anything to you. If you start crumbling he makes it clear that this is your fault and he does that to make you better because he loves you very badly" (#346). |
| *Physical Abuse* | "He's got a very violent temper and has assaulted me several times during our relationship including choking me, breaking my finger, thick lip, bloody nose, bruises all over me, he's also tried to bite my face and stab me with keys. He locks me in the house to prevent me from leaving him takes my mobile so I can't call anyone" (#1350) |
| | "Growing up, it was typical for him to strike me… He stopped hitting me when I was 15 because [child protection services] got involved, but it's still not unheard of for him to threaten violence if he doesn't get his way. He will violently shake his fist next to his victims head or make a motion like he's going to strike someone" (#1078) |
| | "She is violent and abusive. The attacks happen out of the blue, no provocation, no indication of it coming … I have been strangled twice, with deadly force [but] I am strong enough to force her off me" (#441) |
| *Sexual Abuse* | "The last straw came last summer when he returned home black out drunk and raped me" (#1296) |
| | "Forces sex. No intimacy … I finally decided to leave after he raped me twice" (#1488) |
| | "He has admitted to me that he masturbated while lying next to [daughter] – he was fantasizing about her (she was 17 at the time)" (#1105) |
| | "He thinks it's ok to touch his children sexually for his own satisfaction" (#1181) |
| *Verbal Abuse* | **"**He has rages which are brutally cruel, with verbal tirades that include shouting, swearing, name calling, and using my most private vulnerabilities as a weapon to hurt me and mock me" (#634) |
| | "We had major problems when he was drunk. Him yelling and calling my son names like coward and pussy, [son of a bitch], mother fucker and a spoiled piece of shit" (#724) |

| | |
|---|---|
| | "My dad yelled at me, calling me names and belittling me … I was told I was lazy, ugly and that if I kept it up like that, I would never find a husband, but who would want to marry me anyway" (#996) |

**Overarching Dimension: Imposition of financial burden**

Participants described various behaviours involving their relatives use and misuse of finances, this occurred in 32% of participant responses (n = 129). This dimension was made up of five nodes: "Debt", "Stealing", "Controlling", "Dependent" and "Irresponsible". Table 4.3 displays the nodes and sample text examples that demonstrate this dimension.

**Table 4.3.**

*Themes of Financial Burden and Representative Text Examples as Reported by Partners and Family Members in a Close Relationship with an Individual with Pathological Narcissism*

| Theme | Text Example |
|---|---|
| *Debt* | "We always had money problems and debts but to the outside world we appeared very well ... Money was always borrowed or credit cards. He had a bad gambling problem where we lost everything" [#246] |
| | "He has been in bankruptcy because he doesn't pay bills, he doesn't pay people that do work for him" [#860] |
| | "He is currently bankrupt, owes huge tax debts and child support arrears" [#1119] |
| *Stealing* | "He used my computer … to transfer $66,500 from my account" [#122] |
| | "[Stole] $25,000 … from the joint account" [#1476] |
| | "He cheated on taxes and we owed $40,000" [#1727] |
| *Controlling* | "He controlled everything. … I had to justify every penny spent but he was able to spend what he wanted when he wanted" [#1689] |
| | "He was extremely controlling. Controlled finances, made all the financial decisions" [#1316] |
| | "I never knew where all the money went. He had nothing to show for it and wouldn't discuss it with me… He lied to me about how much money we had and didn't pay our bills. Eviction notices piled up" [#1891] |
| *Dependent* | "He doesn't have a job and expects me to pay for everything" [#1211] |

| | |
|---|---|
| | "He is financially dependent on whichever woman he is with at the time" [#1009] |
| *Irresponsible* | "No self-control with money. Refuses to live on a budget" [#1944] |
| | "Believes he deserves the best of everything and will spend money on fancy cars and trips instead of paying bills or buying groceries [#788] |

**Overarching Dimension: Imposition of unwanted sexual behaviours**

Participants described various problematic sexual behaviours of their relative, occurring in 34.2% of participant responses ($n$ = 138). This theme was made up of six nodes: "Infidelity", "Addiction", "Selfish", "Demanding", "Inappropriate" and "Withholding". Table 4.4 displays the nodes and sample text examples that demonstrate this dimension.

**Table 4.4.**

*Themes of Sexual Behaviours and Representative Text Examples as Reported by Partners and Family Members in a Close Relationship with an Individual with Pathological Narcissism*

| Node | Text Example |
|---|---|
| *Infidelity* | "Had an affair with my best friend when I was pregnant with his son and told me the entire time I was imagining things because I was emotional from being pregnant" [#1619] |
| | He is a serial cheater with at least a dozen local sex and dating website accounts, and when I stumbled onto proof of any of them he threatened me with physical violence" [#1688] |
| *Addiction* | "He is addicted to pornography" [#600] |
| | "He kept trying to talk me into threesomes which disgusted me. He was obsessed with porn" [#241] |
| | "She was obsessed with sex… it was obviously not a normal obsession; she was forever talking about sex and it was almost impossible to have a conversation about anything else without her butting in and starting some kind of sexual talk" [#466] |
| *Selfish* | "He is like a robot in bed. It is only about him." [#1183] |
| | "Sex was very strange and odd. Often I would have to remind him that I was there too, not just him" [#116] |

| | |
|---|---|
| | "He is addicted to masturbating because he loves himself so much, no one else can give him as much pleasure as he can give himself" [#956] |
| *Demanding* | "He expects sex 3 times a week and will sulk if he doesn't get it" [#283] |
| | "If he didn't get sex for more than 2 days he would give the silent treatment for days and then verbally abuse me" [#1727] |
| *Inappropriate* | "There almost always had to be an element of some sort of perversion for him to get [sexually] excited" [#116] |
| | "He is an inappropriately sexual human being and is constantly making gross jokes and unnecessarily telling others about his sex life" [#1565] |
| *Withholding* | "He started withholding sex and intimacy because it mattered to me" [#1681] |
| | "Uses sex as a tool to gain power" [#1186] |
| | "Used intimacy as a punishment; wouldn't have relations with me after I got sick" [#1287] |

**Overarching Dimension: Mutual idealisation and devaluation from the relative**

Participants described the pattern of interactions with their relative as alternating between extremes of idealisation and devaluation, occurring in 31% of participant responses ($n$ = 125). Typically, at the beginning of the relationship there was a period of mutual idealisation, in which their relative presented themselves as very appealing while at the same time heavily idealising participants. For instance,

"*Our early relationship felt like a fairy tale; I'd never been adored and idealised before and was totally sucked in*" (#1046)

"*[he] was very charming in the beginning. He pursued me hard and fast and I didn't quite know what was happening … He complimented me, put me on a pedestal, and told me he loved me really early on in the game. I was flattered*" (#1419).

However, participants also described how this idealisation was inevitably followed by devaluation. For example,

"*At first, it was great. He made it seem like he was my saviour. He was kind, loving and attentive. He pressured me into getting married very quickly. After we got married he changed [and] became prone to extreme anger if I didn't compliment him enough. He is explosive, seems totally unemotional, and unstable*" (#1910)

"*When we first met he drew me in fast … I was so taken in with this guy. He made himself to be everything I had ever wanted. After several months the lectures started … he would spend hours criticizing me, blaming me for everything. I had no local family or friends and the loneliness was horrible... Over the next years the lectures became more frequent and more harsh with increased name calling and blame. Anytime he was in a bad mood or had a bad day, where something didn't go his way, he would spend the rest of the night lecturing me. He would use sex as a means to get the lectures to stop, saying that he would stop talking if I sexually gratified him*" (#1750).

**Psychological symptoms in participants**

Table 4.5 displays the selected scores of elevated psychiatric content from analysis of our participant's text samples. Participant output scores are compared with normative scores drawn from Gottschalk et al. (1969).

**Table 4.5.**

*Psychiatric Content Analysis of Verbal Behaviour*

| | Comparison Norm (SD) | Partner (*n* = 256) | Ex-Partner (*n* = 93) | Family (*n* = 97) |
|---|---|---|---|---|
| Total Anxiety | 1.48 (0.70) | 2.34* | 2.40* | 2.20* |
| Total Depression | 5.39 (1.53) | 8.53** | 8.54** | 8.34* |
| Hostility Directed Outward | 0.77 (0.33) | 1.33* | 1.33* | 1.37* |
| Hostility Inward | 0.60 (0.35) | 0.99* | 0.96* | 0.99* |

| | | | | |
|---|---|---|---|---|
| Somatic Concerns | 0.46 (0.17) | 0.79* | 0.81** | 0.79* |
| Sickness | 0.46 (0.34) | 2.46*** | 2.31*** | 2.26*** |
| Dependency Strivings | 0.54 (0.42) | 1.28* | 1.10* | 1.32* |
| Frustrated Dependency | 0.11 (0.18) | 0.54** | 0.62** | 0.50** |

*Note: Unless indicated, scores fall within the "normal range". *Indicates score is "slightly high", **Indicates score is "moderately high", ***Indicates score is "very high" as outlined by PCAD Manual (2016).*

## 4.4. DISCUSSION

This study aimed to investigate the behavioural and relational characteristics of individuals with pathologically narcissistic traits from the perspective of those in a close personal relationship with them. Analysis of participant responses indicated themes of abuse (physical, verbal, emotional and sexual), instances of idealisation and devaluation, and challenging financial and sexual behaviours from narcissistic relatives. Psychological states of participants included elevated feelings of hostility and dependency, as well as anxious, somatic and depressive symptomatology.

### Narcissistic abuse and its impact on partners and family members

Recognising 'narcissistic' abuse has been highlighted as a priority area for effective mental health care practice (Howard, 2019). Investigating the links between narcissism and abuse perpetration, Lowenstein et al. (2016) report on the roles of emotion dysregulation and narcissistic grandiosity which can "present a direct pathway to serious violence" (p. 8). The authors describe that personality comorbidities involving narcissism significantly increases the risk of serious physical violence, consistent with the severe forms of violence described in our participant sample. Day et al. (2020) report on features of affective instability, hypersensitivity and rage for individuals with pathological narcissism. Related features, such as anger, hostility and aggression, have been argued to inform significant interpersonal dysfunction for individuals with pathological narcissism (Czarna et al., 2019; Krizan & Johar,

2015; Maciantowicz et al., 2019; Reardon et al., 2020). These findings help explain the presence of such severe forms of violence described by participants in our sample.

Our findings also present descriptions of covert forms of abuse, such as emotional and psychological abuse. This is noteworthy as majority of abuse research focuses on overt manifestations occurring within these relationships (Green & Charles, 2019; Ponti et al., 2020). Further, while most research has also focused on romantic relationships, Määttä and Uusiautti (2018) describe narcissistic abuse as occurring within familial relationships and the importance of recognising and supporting these patient groups – a perspective supported by our sample and results. Our results also identified the presence of burdensome financial and sexual behaviours. Research has suggested the link between narcissism and the problematic use (and loss) of others money (Jones, 2013). Further findings have highlighted the link between narcissism, sexual coercion, infidelity and sexual aggression within romantic relationships (Altinok & Kilic, 2020; Lamarche & Seery, 2019; Moradi et al., 2019). However, while the majority of research has focused on male narcissistic samples, research has also demonstrated the presence of sexual aggression, coercion and intimate partner violence in females with pathological narcissism (Blinkhorn et al., 2015; Green et al., 2020). These themes of abuse and burdensome behaviours inform the impaired psychological states of participants in our sample. Consistent with findings of Day et al. (2019), participants in this sample were identified as having impaired mental health in both anxious and depressive symptomatology, however the current sample also reported elevated degrees self-blame, self-recrimination and hostility. Further, the elevated PCAD scores of dependency alongside identified themes describing patterns of idealisation and devaluation may highlight the difficulty of participants to leave such relationships, despite its destructiveness (Brunell & Campbell, 2011). For instance, within the idealisation and devaluation theme, one participant (#210) described the interpersonal pattern as "*addicting*" stating that they "*need him in my*

*life, [and to] play by his roles. He is outgoing and fun, and I want to be part of that, I don't want to see the bad things, the things that are bad for me*" (#210). Another (#1229) described how the cycles of "*constant negative/positive reinforcements lead to traumatic bonding which lead me to continue to take him back despite the mistreatment.*". As such, these results indicate the patterns of interpersonal dysfunction in this sample whereby participants feel both controlled or attacked by their relative and simultaneously dependent on them.

**Implications for personality assessment, diagnosis and treatment**

First, these results highlight the high prevalence of interpersonal dysfunction for individuals with pathological narcissism and support approaches that incorporate this factor as a key component of both assessment and diagnosis. For instance, the DSM's alternate model of personality disorders, which conceptualise personality relating to key areas in both self and interpersonal functioning (American Psychiatric Association, 2013b). Consistent with the AMPD, these results clearly indicate relational deficits in both empathy and intimacy for individuals with pathological narcissism towards their partners and family. These results also support the proposed superordinate pathological personality trait domain of antagonism within the alternate model as involving the presence of challenging interpersonal behaviours. However, beyond grandiosity and attention seeking, these results suggest potential for meaningful expansion of additional traits within the antagonism domain to indicate the severity of pathology in interpersonal functioning (e.g., manipulativeness, callousness, hostility), such as that described in the 'malignant narcissism' subtype (Kernberg, 2008; Lenzenweger et al., 2018; Russ et al., 2008). Further, trait domains of detachment (withdrawal, intimacy avoidance, depressivity) or negative affectivity (emotional lability, hostility) may also be of relevance (Pincus et al., 2016), given links between negative affect and quarrelsome behaviours (Wright et al., 2017), and interpersonal coldness (Edershile & Wright, 2019), for individuals with pathological narcissism. Finally, these results also

implicate interpersonal patterns of idealisation and devaluation for individuals with narcissistic pathology. While early DSM criteria also included this for NPD (e.g., American Psychiatric Association, 1980), it was subsequently removed in order to reduce overlap with other personality disorders (Levy et al., 2011; Levy et al., 2013), however these results suggest that it may remain a potentially salient feature of narcissistic functioning as has been suggested in alternate diagnostic and theoretical frameworks (Lingiardi & McWilliams, 2017).

These results inform approaches to treatment that consider significant interpersonal dysfunction as relevant, both internally and externally, to the treatment. First, this study highlights the importance for clinicians who are working with individuals with a partner with suspected narcissistic traits to conduct a direct assessment of abuse perpetration and current safety for these individuals. Second, these findings may also provide avenues for therapeutic interventions, such as the systematic exploration of the identified 'fragile' or 'dependent' self that partners of individuals with pathologically narcissistic traits may identify with, as this may perpetuate such individuals to remain within destructive relationships.

Regarding the treatment of individuals with pathological narcissism, interventions to promote interpersonal safety may involve the creation of a 'treatment contract'. The treatment contract establishes clear expectations and consequences that inform treatment progression, such as those described in transference focused psychotherapy (Caligor et al., 2018), which has specific modifications for the treatment of pathological narcissism (Diamond & Hersh, 2020; Diamond et al., 2021; Stern et al., 2017). For instance, a treatment contract may include the fact that treatment progression is contingent on the client not acting out violent urges against intimate partners, or even the therapist, and rather treatment would involve exploring these impulses in therapy in a safe way, with specific consequences (e.g., contacting authorities, therapy termination) if the contract is significantly or repeatedly

violated. Further, therapists need to be adequately prepared to tolerate strong countertransference reactions as related to patterns of idealisation and devaluation that may occur in the therapeutic alliance (Crisp & Gabbard, 2020; Tanzilli & Gualco, 2020; Tanzilli et al., 2017).

**Limitations**

First, as we relied on informant ratings for both endorsement of relative's narcissism and their described behaviours the possibility of biased reporting is increased. While the common nomenclature of 'narcissistic' behaviours may be highly variable across individuals, research has demonstrated the reliability of informant-based methods of assessing narcissism (Lukowitsky & Pincus, 2013; Oltmanns et al., 2018). Second, as participants were reporting on a specific relationship at a specific time, it is unknown if the relational characteristics of participants are specific to the relationship with their relative or if they are also observable in current or previous social or romantic relationships (for instance, regarding hostility, dependency strivings, idealisation and devaluation). A potential avenue for future research may be to investigate the quality (e.g. attachment) and features (e.g. patterns or schemas) of an individual's interpersonal interactions with their relative with narcissistic features compared to their wider relationships. Third, there was significant gender disparity in this sample, with the majority of participants being female and majority of relatives with pathological narcissism being male. This disparity was not unexpected, as narcissistic personality has a high gender imbalance in diagnosis and research (American Psychiatric Association, 2013b; Grijalva et al., 2015) and most participants in our sample were in a romantic, heterosexual relationship. As such, this imbalance does not preclude its relevance to the study of narcissism as typically examined, however it does highlight the need for broader research efforts to examine diverse narcissistic presentations, such as those in females. Fourth, while use of a narcissism screening measure was utilised, there were no

exclusion criteria implemented to screen out participants with co-morbid or alternate diagnoses (e.g., antisocial personality disorder). As such, while these results clearly indicate the co-occurrence of pathological narcissism and interpersonal dysfunction, the specific function of pathological narcissism is unable to be specified against other potential personality features in this sample, and is a suggested avenue for future research. Finally, while this study was strengthened by its large sample size, a limitation is the relatively brief length of text supplied by participants. As such, it is open to interpretation the degree of generalisability of the descriptions of relationships provided. For instance, it is unclear whether a participant who focused on describing a pattern of idealisation and devaluation would have also described instances of overt physical abuse if they had provided more text. However, as participant were not asked specifically to describe dysfunctional aspects of their relationship, it is noteworthy that such descriptions were provided with regularity.

**Conclusions**

This study examined interpersonal behaviours of relatives with pathological narcissism from the perspective of partners and family members. Themes of abuse from the relative were described, involving physical, verbal, emotional and sexual abuse, as well as descriptions of imposed financial and sexual burden from the relative. Complex interpersonal themes were also present, such as participants and relatives engaging in mutual idealisation, with subsequent devaluation from the relative. Participants psychological state was measured, revealing heightened levels of anxiety, depression, as well as heightened dependent longings. Interpersonal dysfunction is a prominent feature of pathological narcissism, and these findings provide clear examples within the context of intimate relationships. These findings also inform clinical interventions, such as the need to assess for interpersonal violence in the treatment of individuals with pathological narcissism, as well as attending to potential conflicts around dependency for partners and family members with a narcissistic relative.

Treating clinicians may also need to carefully examine the therapeutic alliance with individuals with pathological narcissism, attending to themes of idealisation and devaluation, as well as potentially needing to set limits and establish a sense of personal safety in the treatment.

# CHAPTER FIVE

## STUDY 4 – LIVING WITH PATHOLOGICAL NARCISSIM: CORE CONFLICTUAL RELATIONAL THEMES WITHIN INTIMATE RELATIONSHIPS

This chapter is submitted and currently undergoing the peer review process in the journal of *BMC Psychiatry.* Minor modifications were made to conform to the thesis review process.

## ABSTRACT

**Background:** Pathological narcissism is a severe mental health condition that includes disturbances in interpersonal functioning. Interpersonal difficulties by those affected include aggressive, domineering, cold and coercive behaviours which often result in strong negative reactions from others. We sought to examine the moment-to-moment patterns that emerge within close relationships between intimate partners and family members. **Methods:** Participants ($N = 15$) were romantic partners (73.3%) and family members (26.6%) in a close and long-term relationship (+10 years) with an individual with pathological narcissism. Participants told verbatim relationship narratives involving five narrative interactions with their relative with pathological narcissism and five narrative interactions with others. Transcripts were coded using the using Core Conflictual Relationship Theme method. Participants also completed three versions of the Relationship Questionnaire, reporting on 1. their relationship style 'in general', 2. their relationship style 'with their relative' and 3. the relationship style of their relative. **Results:** A total of 133 relationship episodes were analysed, comprising 783 components (wishes, responses of others and responses of self). While the identified wishes (e.g., for love, for support) were consistent between relative and non-relative narratives, there was significantly higher disharmony and lower harmony in narratives involving relatives with pathological narcissism. Described disharmony in these relationships involved the relative's rejecting, subjugating and attacking behaviours, and participants rejecting and withdrawing behaviours. There was a prominent deactivation of participants attachment system when interacting with their relative with pathological narcissism, endorsing predominately dismissing relationship styles. Individuals with pathological narcissism were similarly rated as predominately dismissing, but also fearful in their relationship style. **Conclusions:** Together, these results reflect the cycles of interpersonal dysfunction for individuals with pathological narcissism and their partners and

family members. Treatment implications point to the risk of therapists withdrawing and dismissing a patient with high pathological narcissism in the countertransference. Strategies to monitor and manage these core relational themes in treatment remain a challenge.

## 5.1. INTRODUCTION

Interpersonal dysfunction is a well-documented aspect of pathological narcissism (Cheek et al., 2018; Hörz-Sagstetter et al., 2018; Ogrodniczuk & Kealy, 2013; Ogrodniczuk et al., 2009). Indeed, a number of the criteria for narcissistic personality disorder as they appear in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, American Psychiatric Association, 2013a) infer or overtly state an impairment of interpersonal relationships (e.g. "Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends" [criteria 6], p. 670). Similarly, the alternate model of personality disorders specifies the instrumental function of interpersonal relationships towards self-esteem (identity and self-direction criteria) and impaired quality of relationships, which may present as a lack of empathy, superficiality and trait antagonism for individuals with narcissistic personality disorder.

One avenue for understanding interpersonal dysfunction for individuals with pathological narcissism has been in the treatment context, given documented difficulties in establishing an effective therapeutic alliance with patients with narcissistic preoccupations (Ronningstam, 2012, 2017). The concept of 'transference' was described by Freud (1905) as "a whole series of [revived] psychological experiences … not as belonging to the past, but as applying to the person of the physician of the present moment" (p. 116). In the treatment of patients with narcissistic personalities, patterns of transference and countertransference can be particularly intense (Penney et al., 2017; Tanzilli & Gualco, 2020), as "dysfunctional modes of relatedness are inevitably recreated in the treatment context" (Tanzilli et al., 2017, p. 185). Corresponding countertransference from clinicians have been documented, such as feeling a difficulty connecting, feeling excluded, becoming overly solicitous, becoming aggressive and competitive, feeling idealised and grandiose, feeling scrutinised and engaging in mutual admiration (Gabbard, 2013). When activated, the reconciliation of such intense

transference and countertransference patterns have been identified as crucial for effective therapeutic work (Hayes et al., 2018; Hayes et al., 2015), however outside of therapy such relationship patterns are the cause of significant pain and distress to others (Day et al., 2019).

This study aims to extend this research by investigating the "dysfunctional modes of relatedness" (Tanzilli et al., 2017, p. 185) of individuals with pathological narcissism through the relationship patterns described by partners and family members. One method of exploring an individuals relationship patterns is via the Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1998), in which individuals describe specific relationship narratives. The CCRT explores not only an individual's characteristic way of interacting with others, but also their fantasised or longed for outcomes of interactions, and has been used to understand the dysfunctional relationship patterns of individuals with personality disorders (Drapeau & Perry, 2009; Grenyer, 2012; Hegarty et al., 2019). For instance Bourke and Grenyer (2010), utilising the CCRT, describe the disharmonious relationship patterns of mutual disengagement and withdrawal between therapists and patients with borderline personality disorder (Bourke & Grenyer, 2010), potentially linked to therapists intense emotional reactions to such patients (Bourke & Grenyer, 2017). Such research highlights a complex intersubjective dynamic at play (Benjamin, 2004), whereby pathological intrapersonal processes appear as both the cause of – and simultaneously in response to – negative interpersonal perceptions and interactions with others (Drapeau & Perry, 2009; Sadler et al., 2015; Wiseman & Tishby, 2017).

Indeed, recent research on pathological narcissism highlights the complex interactions between perceptions of self and other, and related affective processes with corresponding shifts in mentalizing modes or defensively split object relations (Pincus, 2020). For instance, narcissistic features were found to be associated with both perceptions of others as cold whilst acting cold towards others (Edershile & Wright, 2019), associated with both acting

aggressively towards other and receiving aggression from others (Keller et al., 2014), and to perceive others as dominant and respond with negative emotionality and antagonism (Wright et al., 2017). Understanding such dysfunctional interpersonal patterns and perceptions is crucial, as it not only helps identify and contain destructive enactments within the therapy (Symington, 1993), but also for fostering positive relationship patterns for both individuals with pathological narcissism and their partners and family members.

**Aims**

This study seeks to understand patterns of interpersonal functioning for individuals with pathological narcissism and their partners and family members. For this research, partners and family members will be referred to as 'participants', individuals with pathological narcissism will be referred to as the 'relative' and others will be described as 'non-relatives'.

Given the documented interpersonal dysfunction identified for individuals with pathological narcissism (Cheek et al., 2018; Ogrodniczuk & Kealy, 2013) and the intense countertransference reported by clinicians treating individuals with NPD (Crisp & Gabbard, 2020; Tanzilli et al., 2017), it is predicted that relationship narratives with individuals with pathological narcissism will have significantly higher incidence of disharmony and lower levels of harmony than other relationship narratives. Regarding relationship style, it has been suggested that dismissing attachment is the prototypical organisation for individuals with narcissistic personality disorder (Meyer & Pilkonis, 2011). Further, as being in a relationship with individuals with pathological narcissism may inspire feelings of dependency, insecurity and vulnerability (Day et al., 2021), it is expected that individuals with pathological narcissism will be described as displaying a dismissing relationship style and that participants will report insecure relationship styles in general. However, it is also expected that

participants will report greater insecurity in their relationship style when interacting with their relative with pathological narcissism.

## 5.2. METHOD

### Recruitment

Participants were partners and family members in a close relationship with an individual with pathologically narcissistic traits. All participants provided written informed consent for their responses to be used in research, following institutional review board approval. Participants that had taken part in previous research (e.g. Day et al., 2020) were separately invited to participate in the current study. These participants were recruited through invitations posted on various mental health websites that provide information and support that is narcissism specific (e.g. 'Narcissistic Family Support Group'). Recruitment was advertised as being specifically in relation to a relative with narcissistic traits. Presence of pathologically narcissistic traits were screened through completing an informant version of a brief pathological narcissism inventory (described in measures section).

### Participants

Inclusion criteria were: (1) Participants having a long term relationship (> 10 years) with a relative with pathological narcissism. (2) Relatives being rated as displaying prominent features of pathological narcissism, adopting a cut off of 36 (average 3) on a narcissism screening measure (SB-PNI-CV). (3) Participants narratives being of sufficient length (> 70 words, Gottschalk & Gleser, 1969) and receiving an adequate completeness of narrative rating (> 2.5, Luborsky & Crits-Christoph, 1998) for purposes of analysis. (4) Participants completing measures and demographic information as part of the survey. The sample consisted of 15 participants, achieving a redundancy in themes and sufficient saturation for analysis, reflecting a sample size similar to other studies analysing qualitative

responses (Crouch & McKenzie, 2006; Guest et al., 2006) and comparative with other studies utilizing the CCRT (Luborsky & Diguer, 1998).

Table 5.1 outlines the demographic information of participants and the relative included in the study. All participants stated they had been in a relationship with their relative with pathological narcissism for over 10 years, 40% ($n$ = 6) of participants stated their relative has received a formal diagnosis of a mental health condition, a subsample of which included a diagnosis of a personality disorder (26.7%, $n$ = 4).

**Table 5.1.**

*Demographics for Participants (Partners and Family) and their Relatives (People High in Pathological Narcissism) (N = 15)*

| | | Participants ($n$ = 11) | Relative ($n$ = 11) |
|---|---|---|---|
| Mean age in years (SD) | | 52.7 (12.6) | 54.9 (11.5) |
| Gender | | | |
| | Male | 6.7% (n = 1) | 73.3% (n = 11) |
| | Female | 93.3% (n = 14) | 26.7% (n = 4) |
| Employment | | | |
| | Full time | 54.5% (n = 6) | 54.5% (n = 6) |
| | Part time | 27.3% (n = 3) | 18.2% (n = 2) |
| | Unemployed | 18.2% (n = 2) | 27.3% (n = 3) |
| Relationship | | | |
| | Spouse/partner | 33.3% (n = 5) | |
| | Former spouse/partner | 40% (n = 6) | |
| | Family – Mother | 13.3% (n = 2) | |
| | Family – Sibling | 13.3% (n = 2) | |

| | | |
|---|---|---|
| Is your relationship still current? | | |
| | Yes | 46.7% (*n* = 7) |
| | No | 53.3% (*n* = 8) |

## Measures

### Pathological Narcissism Inventory (Carer Version) (SB-PNI-CV)

Schoenleber, Roche, Wetzel, Pincus, and Roberts (2015) developed a short version of the Pathological Narcissism Inventory (SB-PNI; super brief) as a 12-item measure consisting of the 12 best performing items for the Grandiosity and Vulnerability composites (6 of each) of the Pathological Narcissism Inventory (Pincus et al., 2009). This measure was then adapted into a carer version (SB-PNI-CV) in the current research, consistent with previous methodology (see Day et al., 2018) by changing all self-referential terms (i.e. 'I') to refer to the relative (i.e. 'my relative'). The scale operates on a Likert scale from 0 ('not at all like my relative') to 5 ('very much like my relative') in which higher scores indicate the presence of pathologically narcissistic traits. Informant-based methods of investigating narcissism and its effects have previously been found provide meaningful perspectives on clinical phenomenon not captured in self-report methods (Byrne & O'Brien, 2014; Lukowitsky & Pincus, 2013). The SB-PNI-CV demonstrated acceptable internal consistency (α = .75). This measure utilised a cut off score of 36 (average score of 3) consistent with previous research (e.g., Day et al., 2019), requiring included participants to, on average, endorse the presence of narcissistic pathology in their relative.

### Core Conflictual Relationship Theme - Leipzig/Ulm

The Core Conflictual Relationship Theme – Leipzig/Ulm (CCRT-LU, Albani et al., 2002; Luborsky & Crits-Christoph, 1998) is an established method for understanding and

formulating an individual's central relationship patterns. Luborsky (1998) developed the Relational Anecdote Paradigm (RAP) for a research setting and involves participants describing events in relationships that include specific interactions with specific people. Participants were given a textbox to respond to the prompt in as much detail as they would like. Participants were asked to provide 10 narratives in total (five involving their relative with pathological narcissism, five involving someone who is not their relative). Participants were presented with the following text, specified as either relative or non-relative narratives:

*Tell us of five incidents or events, each involving yourself and your relative. Each one should be a specific incident. Some should be current and some old incidents. For each one tell (1) where it occurred, (2) some of what your relative said or did (3) some of what you said or did, (4) what happened at the end, and (5) when the event happened. They can be any incident you want, it just has to be about a specific event that was personally important or a problem to you in some way.*

Analysis of relationship narratives involves the identification of specific units as they appear, classified as wishes (W), response of other (RO) and response of self (RS). Each scorable unit is then coded according to the Leipzig/Ulm hierarchical categories (reflecting dichotomous harmonious and disharmonious interactions) when forming an individual's CCRT-LU profile (Albani et al., 2002). All codable units were included in analysis. For example, the text "My friend and I had dinner and my relative phoned me non-stop during dinner so that I had to keep excusing myself. I was embarrassed and did not attempt to visit with friends after that" contains elements such as a 'wish' (to enjoy time with a friend, code: 'C. Loving, Feeling Well'), a *disharmonious* 'response of other' (being pressured and interrupted by relative, code: 'K. Subjugating') and *disharmonious* 'response of self' (feeling embarrassed, avoiding friend, codes: 'F. Being Dissatisfied', 'M. Withdrawing').

The CCRT-LU has demonstrated reliability and validity for a range of psychological disorders (Barber et al., 1998; Drapeau & Perry, 2009; Hegarty et al., 2019; Luborsky & Diguer, 1998; Luborsky et al., 1998; Parker & Grenyer, 2007). Inter-rater reliability for CCRT-LU coding was completed on 10% of data by a second, independent and trained rater. Overall inter-rater reliability was calculated at $k = 0.78$, consisting of reliability for coding *presence* (agreement of relevant sections of text for coding, $k = 0.72$) and coding *agreement* (raters coding the same interactions within harmonious and disharmonious clusters, $k = 0.84$). This score reflects a very good consensus between independent raters (Viera & Garrett, 2005).

**Relationship Questionnaire (RQ)**

The RQ (Bartholomew & Horowitz, 1991) is a 4-item questionnaire designed to measure adult relationship styles across the dimensions: “secure”, “pre-occupied”, “dismissing” and “fearful”. Participants respond on a 7-point Likert scale (1 = not at all like me; 7 = very much like me). In order to increase specificity and generalizability of the RQ results, an adapted version was used in which participants respond 1. In general relationships, 2. In specific relationships and 3. providing a rating of their relative. Informant versions of the RQ have been validated in empirical research (Griffin & Bartholomew, 1994). The scale has demonstrated convergent validity with other measures of attachment and structured interviews, correctly classifying 92% of cases (Bartholomew & Horowitz, 1991). Evidence for the reliability and stability of the RQ have been demonstrated (Scharfe & Bartholomew, 1994) as well as cross-cultural validation (Schmitt et al., 2004).

## 5.3. RESULTS

Participant scores on the brief informant narcissism measure (SB-PNI-CV) indicated the presence of pathologically narcissistic traits, ranging from the endorsement of minor

pathology to some participants reporting severe pathologically narcissistic traits in their relative. Participant scores on measures of mental health (MHI-5, R-DEQ) ranged from indications of severe mental health concerns to "healthy" mental health functioning. In general, participant scores on the MHI-5 suggest some mental health concerns (Cuijpers et al., 2009; Rumpf et al., 2001). Similarly, scores on the R-DEQ are consistent with "normal" population comparisons (Bagby et al., 1994), however the sample exhibited a large range with some participants scoring more similarly with depressed or panic disordered comparison groups. These scores are presented in table 5.2.

**Table 5.2.**

*Descriptive Statistics of Participant Scores (N = 15) for all Measures Under Examination*

| Measure | Subfactor | Mean (SD) |
|---|---|---|
| Pathological Narcissism Inventory (Carer Version) | | 3.7 (0.8) |
| | Grandiose | 4 (0.9) |
| | Vulnerable | 3.4 (1) |
| Relationship Questionnaire (of Self) | | |
| | Secure | 47.6 (31.7) |
| | Fearful | 48.6 (36.5) |
| | Pre-occupied | 33.3 (32.2) |
| | Dismissing | 58.1 (29.3) |
| Relationship Questionnaire (of Relative) | | |
| | Secure | 18.1 (24.4) |
| | Fearful | 44.8 (38.5) |
| | Pre-occupied | 29.5 (34.3) |
| | Dismissing | 54.3 (43.3) |
| Relationship Questionnaire (of Self with Relative) | | |
| | Secure | 2.9 (5.9) |
| | Fearful | 57.1 (40) |
| | Pre-occupied | 28.6 (41.8) |
| | Dismissing | 75.2 (39.1) |

## Relationship Narratives

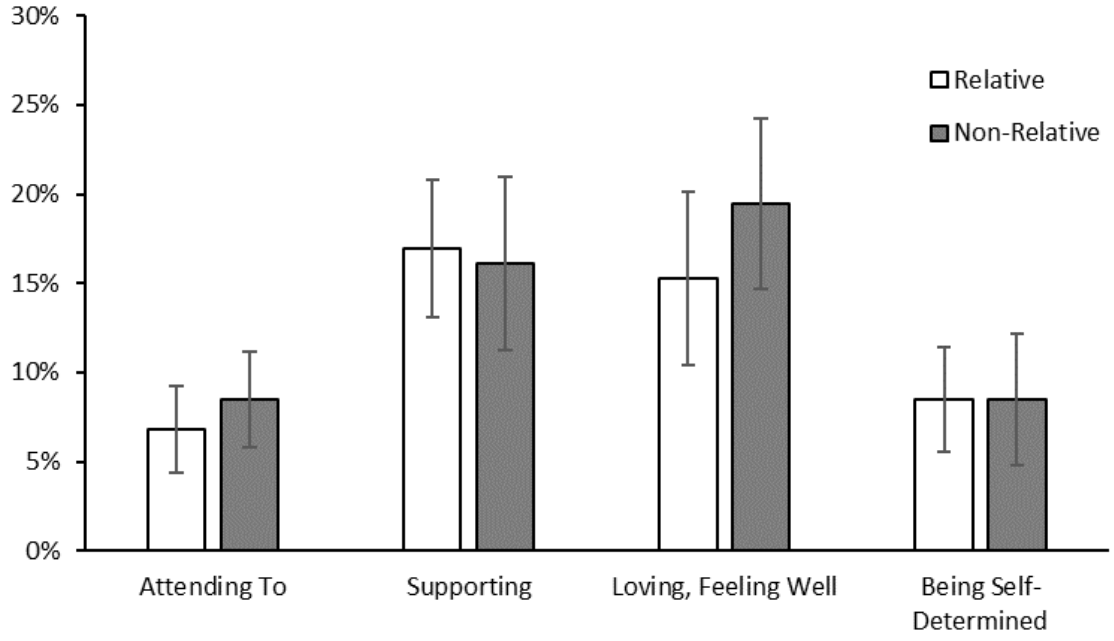
A total of 133 relationship narratives were described by participants, with a total of 783 individual components identified within participant narratives comprising either wishes (W, $n$ = 118), response of other (RO, $n$ = 358) and response of self (RS, $n$ = 307) categories.

### Wishes

A total of 118 wishes were coded from participant narratives. There were no significant differences in wishes between relative and non-relative narratives. However, regardless of relationship type (relative or non-relative), participants consistently indicated significantly higher wishes for love and support, compared to other wishes $t(28) = 2.6$, $p$ = 0.2. Percentage of wishes identified within participant narratives are displayed in Figure 5.1.

**Figure 5.1.**

*Percentage of wishes as described by participants.*



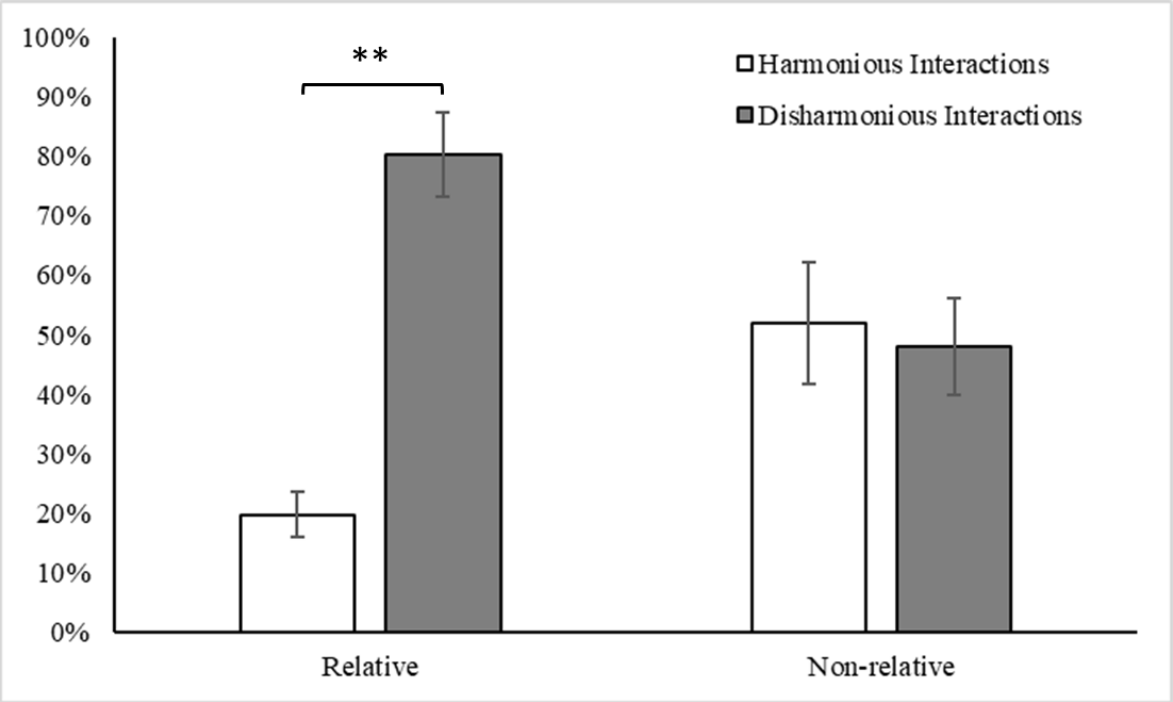

*Note*. Error bars indicate standard error.

**Interpersonal Dysfunction**

Participant narratives involving non-relatives contained approximately equivalent harmonious ($M$ = 10.9, $SD$ = 8.3) and disharmonious ($M$ = 10.1, $SD$ = 6.6) interactions. Conversely, narratives involving a relative with pathological narcissism involved significantly lower harmony ($M$ = 4.5, $SD$ = 3.3) and elevated disharmony ($M$ = 18.2, $SD$ = 6.3), $t(28) = 7.5$, $p = .001$. Percentage of harmonious and disharmonious interactions between relatives and non-relatives are presented in Figure 5.2.

**Figure 5.2.**

*Percentage of harmonious and disharmonious interactions between relatives with pathological narcissism and non-relatives.*



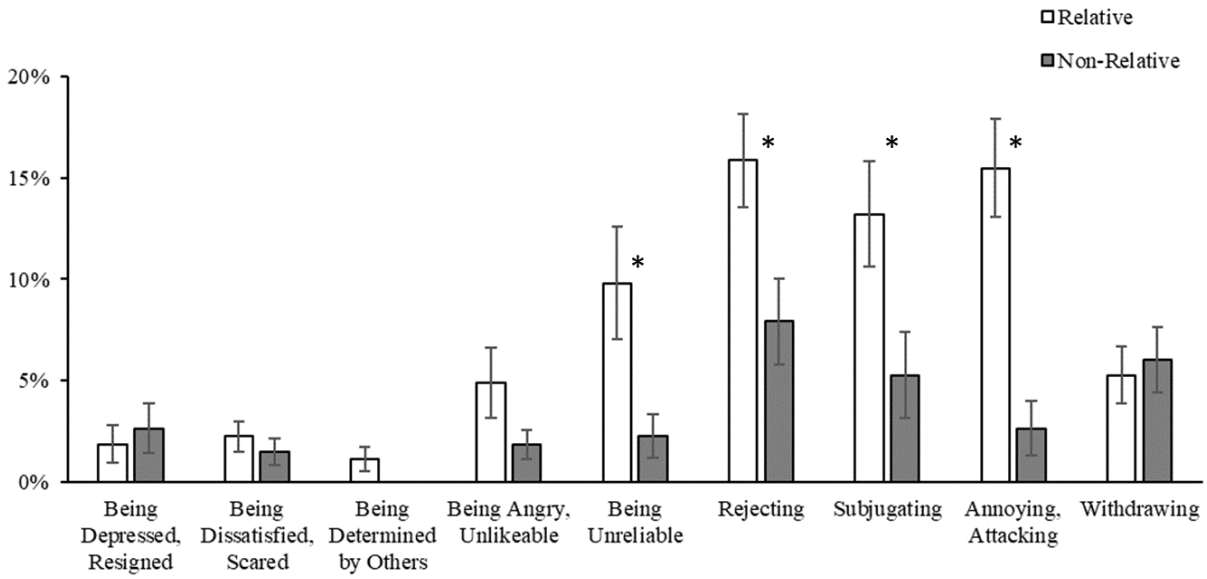

*Note*. Error bars indicate standard error. **significant at $\alpha < .01$.

Direction of disharmony was further investigated as either *from* relatives/non-relatives (i.e., response of other, RO) or *towards* relatives/non-relatives (i.e., response of self, RS). Figure 5.3 displays disharmonious RO's, which include elevated instances of rejecting,

subjugating, annoying, attacking, and unreliable responses from individuals with pathological narcissism.

**Figure 5.3.**

*Percentage disharmonious RO's as described by participants.*

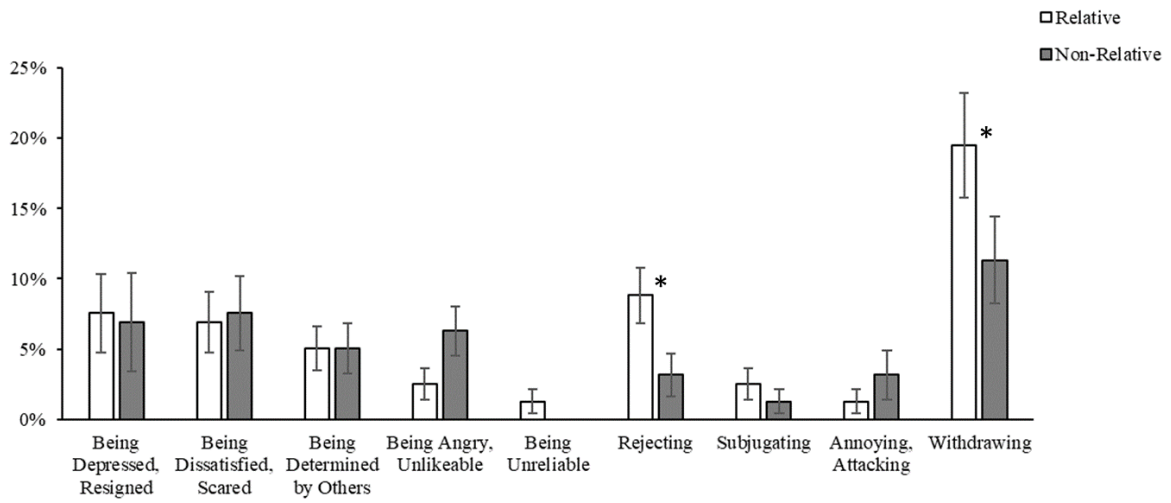



*Note.* Error bars indicate standard error. *significant at $\alpha < .05$.

Figure 5.4 displays disharmonious RS's, which include elevated instances of participants rejecting and withdrawing behaviour towards relatives with pathological narcissism.

**Figure 5.4.**

*Percentage disharmonious RS's as described by participants.*



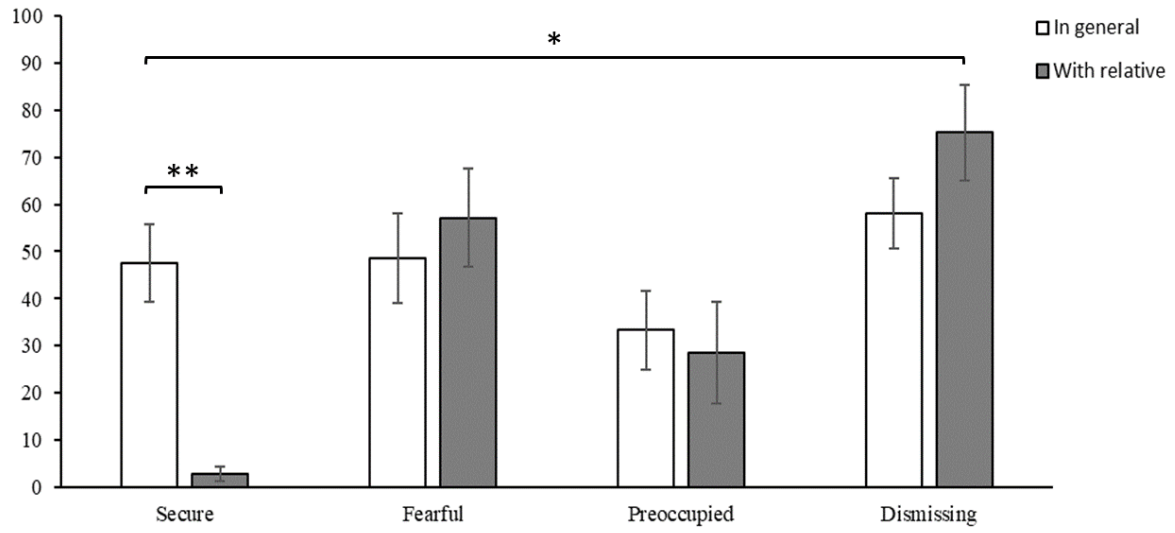

*Note*. Error bars indicate standard error. *significant at $\alpha < .05$

**Relationship Styles**

Categorical ratings of participants relationship style indicated that the majority of participants indicated a predominately fearful self-report relationship style (73%) compared to other styles (secure 18%, preoccupied 9% dismissing 0%). However, continuous scores of participant relationship style 'in general' found no significant differences between relationship styles. When interacting with their relative, participants most frequently endorsed a dismissing style (55%) as opposed to other styles (fearful 36%, preoccupied 9%, secure 0%) on categorical indices. When measured continuously, participants reported a significantly decreased 'secure' relationship style $t(28) = 5.36$, $p = .001$. Participants also reported a significantly greater 'dismissing' relationship style when interacting with their relative, compared to 'secure' scores in general $t(28) = 2.1$, $p = .04$. These scores are displayed in Figure 5.5.

**Figure 5.5.**

*Change in self-report relationship style 'in general', compared to when interacting with relative with pathological narcissism.*

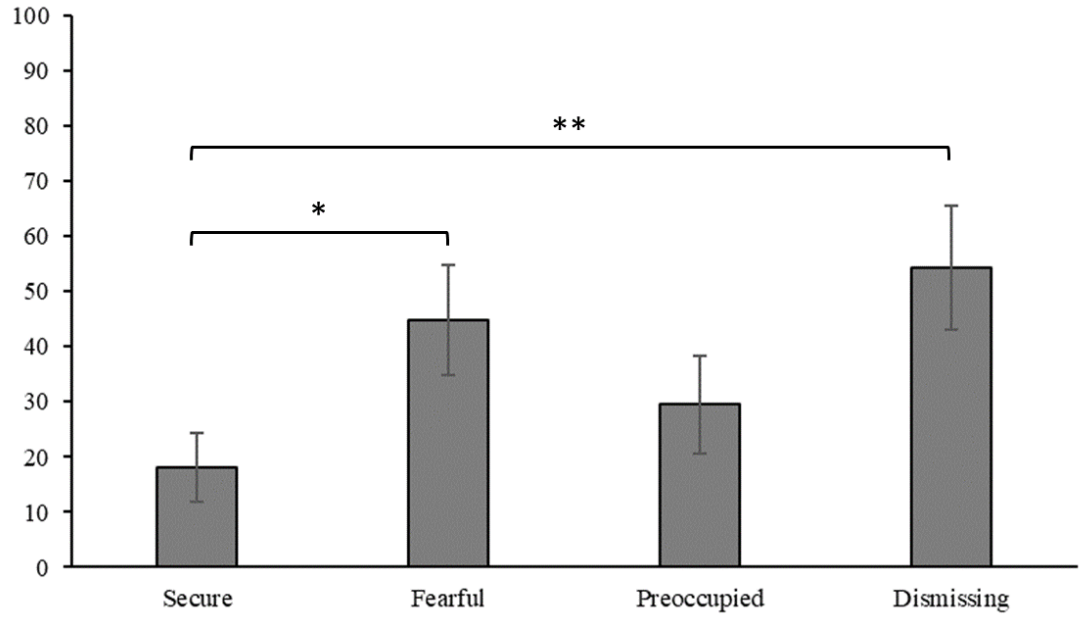



*Note.* Error bars indicate standard error. *significant at α < .05, **significant at α < .01.

Participants also completed an informant version of the RQ, reporting on the perceived style of their relative with pathological narcissism. Categorical ratings indicated that relatives were perceived as displaying a predominately 'dismissing' style (64%), compared to other styles (fearful 18%, preoccupied 18%, secure 0%), and this is consistent with continuous scores where significant differences were observed between relatives 'dismissing' and 'secure' scores $t(28) = 2.8$, $p = .009$. Interestingly, significant differences were also found for relatives 'fearful' and 'secure' scores $t(28) = 2.2$, $p = .03$. These results are displayed in Figure 5.6.

**Figure 5.6.**

*Informant report of relationship style of relatives with pathological narcissism.*




*Note*. Error bars indicate standard error. *significant at α < .05, **significant at α < .01.

## 5.4. DISCUSSION

This study examined the described interpersonal style and patterns of interaction between an individual with pathological narcissism and informant participants. While relationship wishes (e.g., for love, support) were not significantly different between groups, narratives with relatives with pathological narcissism had significantly greater disharmony, involving instances of relatives attacking, rejecting and subjugating behaviours, and participants rejecting and withdrawing behaviours. Overall, narratives with non-relatives typically involved equal instances of harmony and disharmony, where relationship conflicts were satisfactorily resolved, and relationship wishes were fulfilled. In contrast, narratives with relatives with pathological narcissism involved escalating relationship conflicts, whereby both participants and relatives became increasingly conflictually entrenched and disconnected, and relationship wishes remained unfulfilled. Further, when interacting with their relative with pathological narcissism, participants rated their relationship style to be significantly less secure, and more dismissive, and similarly rated their relative as predominately dismissive and fearful.

These results provide meaningful examples of interpersonal patterns whereby both participants and relatives became locked in dysfunctional modes of relatedness. Interestingly, the prevalence of wishes was not significantly different between relative and non-relative narratives. This is perhaps not surprising as early writings and findings regarding CCRT elements found that wishes are stable across relationships as "apparently, one's wishes, needs and intentions in relationships are relatively intractable" (p. 160, Crits-Christoph & Luborsky, 1998). This finding strengthens the confidence in the results, as the relationships could not be viewed as having fundamentally different motivations between relatives and non-relatives, but rather suggests a unique pathological interpersonal process that occurs within relative narratives that disrupts functioning. These findings do suggest, however, that participants in this sample were particularly motivated by interpersonal wishes for love and support in their interpersonal relationships, perhaps indicating primacy of dependency rather than autonomy. This is consistent with previous research, suggesting that those in relationships with individuals with pathological narcissism may be particularly fragile and vulnerable to interpersonal exploitation (Day et al., 2021).

Typically, narratives involving individuals with pathological narcissism were more concrete, included non-mentalising descriptions of behaviour, and ended with unresolved relationship ruptures. For example,

*"While visiting my relative at his home, he made several insults to my appearance including my weight, hair style and colour, and clothing. I walked away. He then insulted my children and used several inappropriate racial epithets towards them. I got my family up and we left."* (Participant #24).

This is in contrast with narratives involving non-relatives, which were typically more reflective, involving consideration of the others mind and perspective, and in which relationship ruptures were reconciled in mutually satisfying ways. For example,

*"I have a co-worker whom I respect greatly. We were co-teaching, but she had been out of town for some time. During this time, I had run the class by myself and had gotten in the mental habit of thinking it was my class. When she got back, she said she felt that I had put her in the role of being an assistant instead of a co-teacher. I reviewed things I said to the students, and I realized she was right. I apologized to her and made sure we had equal responsibility from then on."* (Participant #9).

Interpersonal dysfunction is known to be a highly prevalent feature of pathological narcissism (Dashineau et al., 2019), involving vindictive, domineering and cold interpersonal styles (Cheek et al., 2018; Dickinson & Pincus, 2003; Kealy & Ogrodniczuk, 2011; Ogrodniczuk et al., 2009). However recent research has highlighted the complex dynamics that inform such dysfunctional interpersonal processes (Pincus, 2020). Involving, for instance, individuals with pathological narcissism perceiving others as more dominant, cold or aggressive, and thereby respond in similar ways (Edershile & Wright, 2019; Keller et al., 2014; Sadler et al., 2015; Wright et al., 2017). The results of the current study highlight that it may not only a perception of others that inform pathological interpersonal processes, but that in reality individuals become more withdrawn, dismissive and rejecting towards individuals with pathological narcissism. It is important to note, however, that we are not suggesting that participants are somehow 'wrong' or 'bad' in responding to their relatives in such withdrawn or rejecting ways, as there may be very necessary reasons for doing so. For instance, research has indicated individuals with pathological narcissism to exhibit emotional, sexual, physical and verbal abuse towards their partners and family members (Day et al., 2021; Green & Charles, 2019), and indeed narratives shared within this research indicated similar themes.

However, this finding does underscore the importance of understanding the way that others interact with and react to individuals with pathological narcissism, in order to understand the way the dysfunctional intrapersonal and interpersonal mechanisms of the disorder are sustained.

Two potential implications of the current research are presented. First, broadly, participants can be described as responding to their relative with a deactivated attachment (Fonagy et al., 2018), likely to preserve the integrity of self-functioning and to minimise intense and destabilising affective processes associated with such relationships (Day et al., 2019). In this, it is interesting that participants reported relationship style became less secure and more similar to their relatives when interacting with them. As research and theoretical accounts have indicated the defensive nature of narcissistic grandiosity, providing a façade of self-stability in an attempt to regulate potentially overwhelming affects (Caligor & Stern, 2020; Kaufman et al., 2018), it may be that when interacting with their relative, participants relational style begins to mirror that of their relative for similar purposes. Second, these findings have crucial implications regarding the psychological treatment of narcissistic pathology. Research reports that common therapist countertransference towards individuals with pathological narcissism involves feelings of anger, disengagement and inadequacy (Tanzilli & Gualco, 2020; Tanzilli et al., 2017). These findings highlight the possibility that patients with pathological narcissism may replicate patterns of interpersonal dysfunction within the therapeutic relationship, involving instances of dismissiveness and antagonism towards clinicians (e.g., Caligor et al., 2015; Stern et al., 2017). As such, in such instances it is important for treating clinicians to not 'enact' reciprocal dysfunctional behaviours (Benjamin, 2004), involving a defensive withdrawal, deactivation of attachment systems and engagement of non-mentalising modes. But rather, therapists attempt to explore with the

patient the co-created atmosphere of disengagement, and attempt to facilitate the generation of insight through the process of rupture and repair.

## Limitations

A number of limitations should be considered in the interpretation of this study. First, while the included sample is adequate for CCRT methodology (Luborsky & Diguer, 1998) as well as for qualitative analyses more broadly (Crouch & McKenzie, 2006; Guest et al., 2006), it is still relatively small. As such, a standalone interpretation of quantitative results such as the RQ may require caution, and should be viewed as supporting information regarding the qualitative results presented, which involved over 500 coded relationship elements. Second, the use of only a brief informant narcissism measure may limit the ability to infer conclusions regarding the narcissism construct in this study. While informant reporting of personality pathology, and pathological narcissism specifically, has been demonstrated to provide meaningful and valid clinical information (Clifton et al., 2004, 2005; Lukowitsky & Pincus, 2013), a formal diagnosis of the relatives would strengthen results. Similarly, while in depth analysis of informant participant responses provides one window into understanding complex personality features, another would be the direct observation of dyad interactions between participants and relatives within a clinical or research setting.

## Conclusion

Kealy and Ogrodniczuk (2014) outline the "obstruction of love" for individuals with pathological narcissism, which includes both love of others, and paradoxically, love of self. In this way, individuals with pathological narcissism struggle with healthy self-regulation and positive self-regard (Ronningstam, 2011b), as the inflated and grandiose self is fragile, unable to tolerate the normal experience of human fallibility, and rather necessitates a constant rigid view of the self as exceptional (Caligor & Stern, 2020). As such, interpersonal relationships

for individuals with pathological narcissism serve two, contradictory functions. First, they serve to bolster the grandiose self through identification with idealised, perfected others. Second, they serve as a platform to evacuate all negative projections of the self onto devalued, rejected others. This cycle, repeated with employers, friends, family and romantic partners, typifies the tragedy of intimate relationships for individuals with pathological narcissism in that "they are unable to elicit the responses from others that will stabilize their self-esteem that they so desperately long for" (Gabbard, 2013, p. 208). Indeed, this is reflected in the findings of our sample, as participants did not become more solicitous, caring and attentive when interacting with their relative with pathological narcissism - they became more rejecting, withdrawing and dismissing. As such, our results demonstrate a dynamic of interpersonal dysfunction between participants and their relatives that are likely both in response to, and sustain the, disorder of pathological narcissism. Treatment implications include therapists attending to patterns of transference and countertransference in the therapeutic alliance that may mirror patterns of interpersonal dysfunction within the patients' wider relationships, including instances of mutual dismissal, rejection and withdrawal.

# CHAPTER SIX

## 6.1. GENERAL CONCLUSION

### Overview of research findings

The overarching aim of this thesis was to understand the interpersonal impact of pathological narcissism on partners and family members. Study 1 involved participants ($N$ = 683) in a close relationship with a relative with pathological narcissism completing measures assessing levels of grief, burden, mental health and coping style. Results indicated participants had significant psychological symptoms including depressive and anxiety disorders and reported significantly higher burden levels than carers of people with borderline personality disorder, as well as other severe mental illness. Study 2 involved participants ($N$ = 436) qualitatively describing their relative with pathological narcissism. Descriptions of grandiosity (requiring admiration, showing arrogance, entitlement, envy, exploitativeness, grandiose fantasy, lack empathy, self-importance and interpersonal charm) co-occurred with descriptions of vulnerability (contingent self-esteem, hypersensitivity and insecurity, affective instability, emptiness, rage, devaluation, hiding the self and victimhood). Participants also described perfectionistic (anankastic), vengeful (antisocial) and suspicious (paranoid) features. Instances of relative's childhood trauma, excessive religiosity and substance abuse were also described. Study 3 asked participants ($N$ = 436) to qualitatively describe their relationship and interactions with their relative with pathological narcissism. Relationships were described with themes of abuse (physical, verbal, emotional and sexual), as well as the relative imposing challenging financial and sexual behaviours. There were complex interpersonal themes of mutual idealisation but also devaluation, as well as participants feelings of dependency on their relative with pathological narcissism. Study 4 involved participants ($N$ = 15) completing questionnaires regarding their relationships style

and providing qualitative relationship narratives involving their relative with pathological narcissism and non-relatives. Narratives with non-relatives typically involved equal instances of harmony and disharmony, where relationship conflicts were satisfactorily resolved, and relationship wishes were fulfilled. In contrast, narratives with relatives with pathological narcissism involved escalating relationship conflicts, whereby both participants and relatives became increasingly conflictually entrenched and disconnected, and relationship wishes remained unfulfilled.

## Issues in pathological narcissism research – integration with research findings

### Dimensions of narcissism

Narcissism has a robust clinical and theoretical literature that describe core features of grandiosity and vulnerability (Cain et al., 2008). However, the vast amount of research in recent history has focused on grandiosity at the exclusion of vulnerability, as reflected in both popular narcissism measures (e.g. NPI, Raskin & Terry, 1988), and diagnostic systems (American Psychiatric Association, 2013a). Despite this, in the last 10 years a renewed interest in narcissistic vulnerability has resulted in significant research output and the creation of sophisticated theoretical models that account for both grandiosity and vulnerability as "two sides of the same coin" (Levy, 2012), couched within a supraordinate construct of pathological narcissism (Pincus & Lukowitsky, 2010). This research supports such perspectives, with results demonstrating the identification of both grandiosity and vulnerability as distinct expressions, but with 69% of participants describing these themes as co-occurring in their relative with pathological narcissism. However, the results also extend phenotypic research, both through the use of an informant sample that offers a unique and meaningful perspective (Lukowitsky & Pincus, 2013; Oltmanns et al., 2018), and through the identification of narcissistic expressions as related to an interpersonal context. In this way,

the current findings are also consistent with research exploring narcissism subtypes as related to specific impairments in interpersonal functioning (Dickinson & Pincus, 2003; Edershile & Wright, 2019; Roche et al., 2013). For instance, results of study 2 describe individuals who are entrenched in grandiose narcissistic fantasies of specialness and self-importance, but who also felt intensely paranoid, envious, persecuted and acted in vengeful ways towards others. Less severe expressions involved individuals who were charming and attention seeking, yet devaluative and angry in some instances, and socially avoidant, insecure and moody in others.

**Measures of narcissism**

As the majority of narcissism research is conducted using self-report methodology, there are a diverse range of empirically validated self-report measures of narcissism that capture different dimensions of the construct (Krizan & Herlache, 2017; Miller et al., 2014; Wright & Edershile, 2017). These include measures that examine adaptive, grandiose presentations (e.g., NPI), entitled, vulnerable presentations (e.g., HSNS), pathological subtype dimensions (e.g., PNI), trait domains (e.g., FFNI), and others. One such self-report scale, the PNI ('super brief' version), was adapted for use by informants to assess the presence of pathologically narcissistic features in others as a part of the methodology for each study in this thesis. The use of the PNI in this way is novel and, based on the findings presented throughout this manuscript, suggest both the validity of the adapted measure, as well as potential limitations. For instance, a stringent summed cut-off score of 36 was required for participant inclusion in the research. This score requires participants to identify narcissistic features to be on average "like my relative" (and screens out participants who identified narcissistic features as "unlike my relative"). Importantly, participant qualitative responses corroborated the presence of narcissistic features in their relative for both 'grandiose' and 'vulnerable' features (study 2), suggesting the validity of this approach, however further research is needed regarding

the appropriate cut-off score for optimum detection of narcissistic features. Conversely, findings of study 3 and 4 indicate prominent interpersonal antagonism present for individuals with pathological narcissism as identified in participant qualitative responses. As the PNI has been criticised by some authors as not adequately reflecting grandiose-antagonistic domains (Krizan & Herlache, 2017; Wright & Edershile, 2017), and given these features were regularly described by participants in this sample, it does suggest a potential limitation of the measure to adequately capture such features.

As discussed, while such measures have been robustly empirically examined, a persistent issue regards the use of self-report methodology in narcissism research more broadly (Russ & Shedler, 2013), given the diagnostic lack of accurate self-appraisal and reflective functioning for such individuals (Bilotta et al., 2018; Thomas et al., 2003). Given this limitation, research has indicated the applicability of informant ratings in studying personality pathology (Klonsky & Oltmanns, 2002; Oltmanns et al., 2018), in order to provide a complementary perspective that may otherwise be missed via self-report methods. Indeed, validity of such approaches has been investigated with scoring consensus demonstrated between multiple informants, as well as agreement between self-report and informant report regarding specific and salient features (Clifton et al., 2005; Thomas et al., 2003). These findings have been broadly replicated regarding informant assessment of pathological narcissism (Lukowitsky & Pincus, 2013), highlighting the ability for untrained individuals to reliably detect pathological personality features. As such, the approach of this thesis was to examine the perspective of informant participants in a close relationship with an individual with pathological narcissism, in the hopes that this also provides a unique perspective and meaningful addition in the understanding complex personality features and interpersonal dynamics. While the current research did utilise an informant version of a narcissism measure as described prior, the most meaningful data was related to the phenomenological analysis of

informants' descriptions of their relationship in their own words. The findings of this data complements findings as presented within self-report research regarding the identification of narcissistic subtypes (study 2) and patterns of interpersonal dysfunction (study 3 & 4). But also extends such research, not only through the rich lived experience perspective such data provides, but also in highlighting the real world impact such dysfunction has on others (study 1).

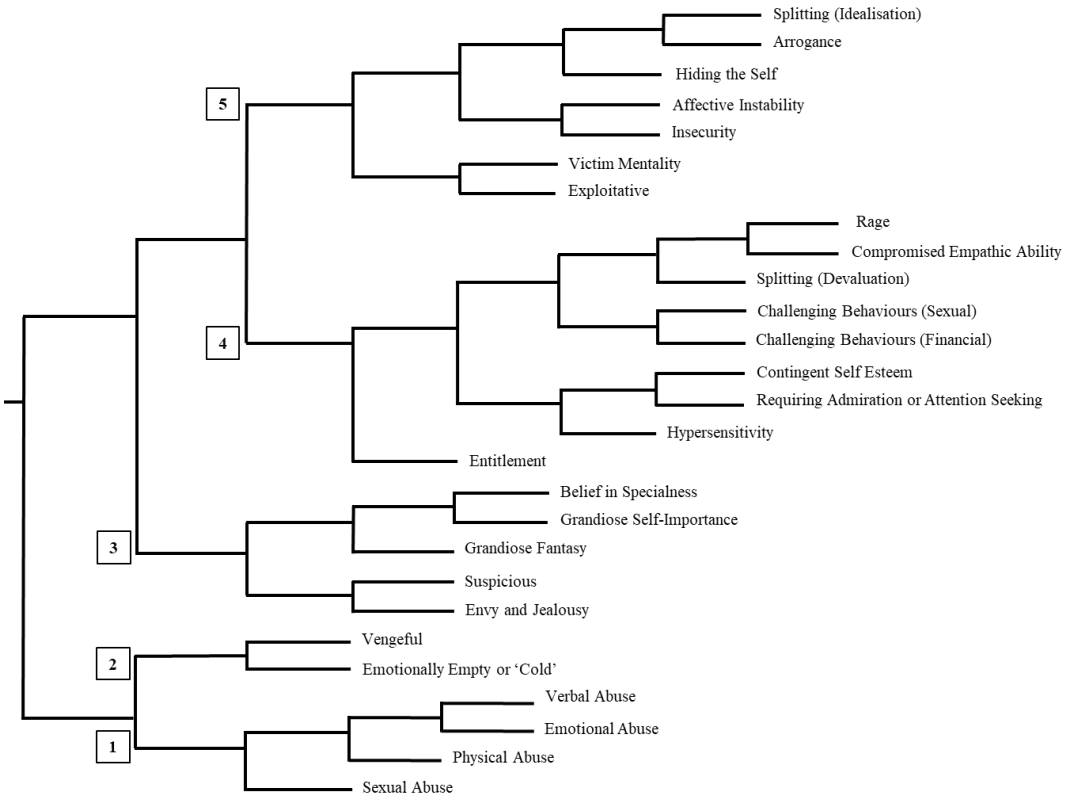
**Severity of functioning**

Dashineau et al. (2019) report that pathological narcissism, irrespective of subtype, is a severe disorder with marked dysfunction. However, early theorists also include adaptive or "normal" elements of narcissistic functioning (Freud, 1914; Kernberg, 1975; Kohut, 1966a), indicating a spectrum of functioning ranging from minor impairment to a severe personality disorder. Psychodynamic diagnostic systems have utilised an index of severity, the "personality organisation" (Kernberg, 1967), for decades (e.g., Operationalized Psychodynamic Diagnosis Task Force, 2008; PDM Task Force, 2006). More recently, the DSM-5 (American Psychiatric Association, 2013a) has also introduced an index of severity within the alternate model of personality disorders that is conceptually similar (Schalkwijk et al., 2021). A particularly severe expression of pathological narcissism has been proposed via theoretical and clinical accounts, termed "malignant narcissism" (Kernberg, 2007, 2008; Lenzenweger et al., 2018), that involves the combination of severe intrapsychic and interpersonal deficits involving prominent paranoia, narcissistic grandiosity, sadism, psychopathy and interpersonal violence. However, despite some empirical support for variations in severity of functioning for pathological narcissism (including the malignant narcissism construct) having previously been outlined (Russ et al., 2008), few further analysis have been conducted. To investigate the "malignant narcissism" construct as reflecting a severe expression of narcissistic pathology, a cluster analysis was created combining the

qualitatively identified narcissistic characteristics (study 3) and behaviours (study 4) as presented in the results, in order to identify related themes. This cluster analysis is presented in Figure 6.1.

**Figure 6.1.**

*Cluster analysis of characterological themes (study 2) and challenging behaviours (study 3).*




Clusters 1 – 3 reflect prominent antisocial traits, envy, paranoia and narcissistic grandiosity. While these clusters form distinct groups, their proximity to one another reflect their shared variance. The descriptions of individuals located in this range include instances of hatred and aggression as the dominant emotional experience, perceived external persecution as a central organising feature, un-nuanced self-appraisal centred on self-aggrandisement, use of splitting and projective defence constellations, profound difficulties in connecting with others and severe impairment in moral functioning. As such, these descriptions reflect an 'extreme' impairment within DSM-5 alternate model's 'personality functioning' continuum (American Psychiatric Association, 2013), or within the 'low-

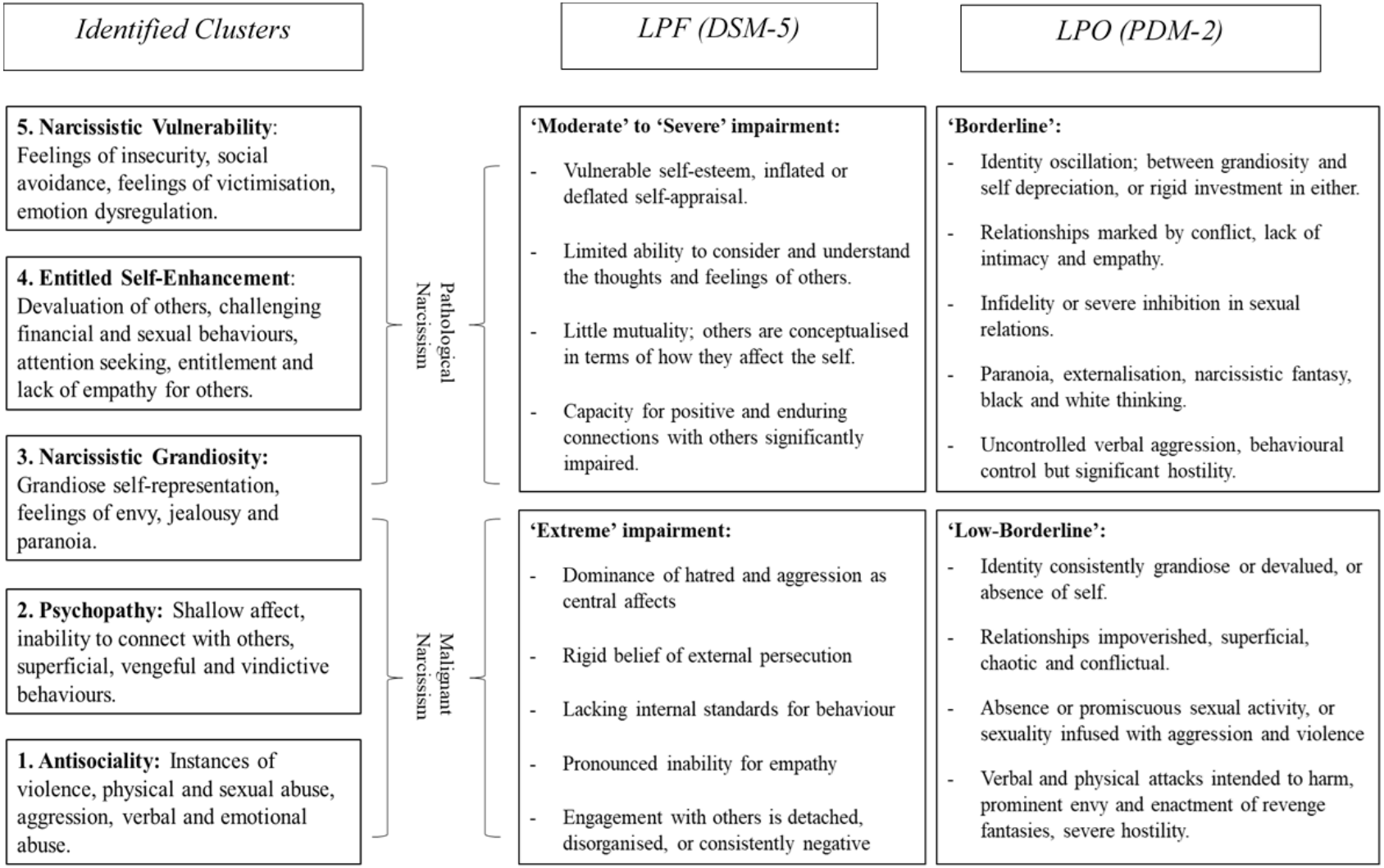
borderline' range of the 'personality organisation' (Kernberg & Caligor, 2005; Lingiardi & McWilliams, 2017; Operationalized Psychodynamic Diagnosis Task Force, 2008). Taken together, these clusters empirically portray the syndrome of 'malignant narcissism' (Kernberg, 2007, 2008; Lenzenweger et al., 2018).

Clusters 3 – 5 reflect narcissistic grandiosity and narcissistic vulnerability, with a shared cluster reflecting entitled, angry and attention seeking features. Again, these clusters were distinct, but demonstrated overlap. The central feature of entitlement between these grandiose and vulnerable features are particularly consistent with Krizan and Herlache (2017) formulation of the 'narcissism spectrum model' of pathological narcissism. The descriptions of individuals located in this range include instances of rage and shame as the dominant emotional experience, a fragile self-esteem and incoherent self-image which combines elements of self-loathing and self-aggrandisement, a preoccupation with others evaluation with self-esteem based on external validation, relationships used primarily for self-regulatory/self-esteem needs, and impaired capacity for enduring intimate relationships with others. As such these descriptions reflect a 'moderate' or 'severe' impairment within DSM-5 alternate model's 'personality functioning' continuum (American Psychiatric Association, 2013), or within the 'borderline' range of the 'personality organisation' continuum (Kernberg & Caligor, 2005; Lingiardi & McWilliams, 2017; Operationalized Psychodynamic Diagnosis Task Force, 2008).

As such, the results of this thesis support both dimensional approaches conceptualising personality along dimensions of severity, as well as proposed prototypical subtype expressions. This variation in both subtype expression and severity of pathology is presented, alongside relevant diagnostic systems, in Figure 6.2.

**Figure 6.2.**

*Narcissism as a function of both subtype expression and severity.*



*Note: LPF = Level of Personality Functioning, DSM-5 = Diagnostic and Statistical Manual of Mental Disorders (5th Edition), LPO = Level of Personality Organisation, PDM-2 = Psychodynamic Diagnostic Manual (2nd Edition).*

## Treatment implications of research

The culmination of results presented in this thesis have wide ranging implications, not only in furthering our understanding of the construct of narcissism, but also relating to providing accurate diagnoses, implementing effective technical interventions in treatment, and supporting the partners and family members of individuals with pathological narcissism.

### Diagnostic implications

Diagnostic implications of the current research findings centre around three main themes. First, the results presented highlight features not currently included in categorical diagnostic criteria for narcissistic personality disorder, such as interpersonal dysfunction including patterns of idealisation and devaluation, and negative affectivity including feelings of emptiness and insecurity. These features were included in early editions of the DSM (e.g. American Psychiatric Association, 1980), with criterion D specifying feelings of "inferiority, shame, humiliation or emptiness" and criterion E outlining "disturbances in interpersonal relationships" relating to entitlement, exploitativeness, lack of empathy and patterns of idealisation and devaluation. While these features were later removed to reduce overlap with other disorders, the results suggest these features remain clinically relevant for identifying and understanding the presentation of pathological narcissism. For instance, the results indicate prominent vulnerable features of negative affect, emptiness and insecurity (study 2); as well as patterns of interpersonal dysfunction including instances of physical and verbal abuse alongside fluctuations in idealisation and devaluation (study 3) for individuals with pathological narcissism. As such, the results support the proposed alternate model of personality disorders, which has re-emphasised the prominence of interpersonal dysfunction with a focus on core impairments relating to both self and interpersonal functioning

(American Psychiatric Association, 2013a) as well as psychodynamic systems utilising object relations approaches (Lingiardi & McWilliams, 2017).

Second, the results presented highlight support for proposed empirical taxonomies of pathological narcissism expression, either utilising a trait model or within subtype descriptions. Regarding trait domains, current diagnostic criteria within the alternate model of personality (American Psychiatric Association, 2013a) specifies two elements, attention seeking and grandiosity, within the trait domain of antagonism. While these results empirically support such elements, with results of study 2 involving descriptions of relatives behaving in attention seeking and grandiose ways, the results also suggest avenues for meaningful expansion of relevant personality trait domains. Within the antagonism domain, this may include features of manipulativeness, callousness and hostility, as reflected in results of study 2 (themes of rage, devaluation, vengefulness) and 3 (themes of abusive and coercive behaviours). However, other trait domains may also be relevant such as negative affectivity (e.g., emotional lability, hostility) and detachment (e.g., withdrawal, intimacy avoidance, depressivity), given the findings presented in results of study 2 (themes of insecurity, affective instability, emptiness, social withdrawal) and consistent with empirical research (Edershile & Wright, 2019; Pincus et al., 2016; Wright et al., 2017). These results also support psychodynamic conceptualisations (e.g., Lingiardi & McWilliams, 2017), which focus on descriptions of types of people (e.g. subtypes) with specific prototypical internalised representations, rather than of combinations of trait domains and facets (Shedler et al., 2010). Results of both study 2 and study 3 support proposed subtypes involving ‘grandiose’ narcissism (involving preoccupations with external validation, envy, entitlement, contempt of others), ‘vulnerable’ narcissism (involving feelings of shame, intimacy avoidance, negative affect) and ‘malignant’ narcissism (involving intense paranoia, sadism, aggression), as well

as their possibility to co-occur and oscillate (Caligor & Stern, 2020; Diamond & Hersh, 2020).

Third, as presented in figure 6.2. Results of the research support dimensional approaches to classification and diagnosis of personality disorders, whether it be the DSM-5 alternate model utilising the level of personality functioning scale (American Psychiatric Association, 2013a), psychodynamic approaches utilising the concept of personality organisation (Lingiardi & McWilliams, 2017; Operationalized Psychodynamic Diagnosis Task Force, 2008), or the ICD-11 spectrum of personality severity (World Health Organization, 2019).

### Therapeutic implications

#### *Partners and family*

First and foremost, these results demonstrate the high levels of burden, grief and mental health concerns for partners and family members in a relationship with an individual with pathological narcissism through both empirically validated psychometric measures (study 1) and identified psychiatric content within qualitative responses (study 3). Dysfunctional styles of relating were also identified, with participants alternating between extremes of idealisation, overidentification and enmeshment in some instances, but at other times responding to their relative with devaluation, rejection and hostility (studies 1, 3, & 4). Further, partners and family members described being subjected to a host of challenging interpersonal behaviours (study 2), including instances of overt physical, sexual and verbal abuse (study 3). In general, descriptions provided by partners and family members regarding their relationship functioning with their relative with pathological narcissism indicated a

psychological atmosphere of coercive control, and instance of domestic violence (Carney & Barner, 2012).

As such, there is a need for the development of targeted interventions to support partners and family members of individuals with pathological narcissism, as these findings indicate they are both vulnerable to exploitation and may suffer acute psychological symptoms. Such interventions for this population need to target not only the improvement of psychological symptoms (e.g., anxiety and depressive disorders) but also improve relationship functioning, as such individuals may struggle with insecure styles of relating and preoccupations with issues of dependency that are generalised beyond their relationship with their relative with pathological narcissism. Further, as these studies outline instances of abuse exhibited towards partners and family members, this highlights the importance for clinicians who are working with individuals with a partner with suspected narcissistic traits to conduct a direct assessment of abuse perpetration and prioritize establishing safety for these individuals. Finally, as many individuals who participated in this research indicated that their relationship was still current, these studies point to the need for further development of therapeutic strategies for couples and family therapy that can involve all members as a part of the treatment. For instance, these results highlight the shifting intrapsychic states of partners and family members, as linked to patterns of idealisation and devaluation within the relationship (and corresponding representations of self and other as either victim or persecutor), that sustain at times both mutually gratifying and simultaneously destructive interpersonal patterns.

*Countertransference*

A common complication in the treatment of pathological narcissism involves difficulties in establishing an effective therapeutic alliance (Ronningstam, 2016, 2020a), as "dysfunctional modes of relatedness are inevitably recreated in the treatment context" (Tanzilli et al., 2017, p. 185). The results presented from these studies indicate patterns of interpersonal dysfunction between individuals with pathological narcissism and their partners and family which may shed light on difficulties related to therapist countertransference and alliance building (Ronningstam, 2017). This is crucial, as effective treatment requires the management of interpersonal difficulties as it related to the therapeutic relationship – or put another way, that "despite the exclusive self-focus inherent in the concept of narcissism, treatment and improvement are fundamentally an interpersonal process" (Huprich, 2020, p. 207). For instance, examining the mechanisms of change in the treatment of NPD, Maillard et al. (2020) report that improvements in the therapeutic relationship over time contributed to both improvement in relational problems outside of therapy, and in symptomatic experiences, such as depression, for individuals with NPD.

Study findings presented in this thesis report that relationships between family members and individuals with pathological narcissism may alternate between 1. mutual idealisation, emotional overinvolvement, and enmeshment, and 2. devaluation, defensive criticism, rejection and withdrawal (studies 1, 3, & 4). Similarly, using an object relations perspective Diamond and Hersh (2020) describe how the therapist may find themselves drawn into the dominant object relation that corresponds with the "pathological grandiose self", reflecting either 1. an idealised self-representation relating to a depreciated object-representation (e.g., the patient acting haughty, belittling the therapist, treating them as unhelpful, useless or even persecutory), or 2. a depreciated self-representation relating to a grandiose object-representation (e.g., the patient feeling depressed, worthless and treating the

therapist as a saviour, an idealised caring figure). Indeed, empirical portraits of therapist countertransference are remarkably similar to descriptions of partners and family members, with clinicians reporting negative countertransference including feeling "hostile/angry", "criticised/devalued", "helpless/inadequate" and "disengaged" when working with patients with pathological narcissism (Tanzilli et al., 2017). Crisp and Gabbard (2020) also report transference patterns involving idealisation, mutual admiration, overidentification and empathy with vulnerability, and a loss of neutrality. Further, the findings of study 1 indicated differing emotional responses to narcissistic subtypes, with vulnerability eliciting higher levels of grief, and grandiosity eliciting higher burden for partners and family members. This is also consistent with findings that "angry/criticised" and "disengaged/hopeless" therapist responses corresponded to "grandiose/malignant narcissism" subtype, whereas "overinvolved/worried" therapist responses were related to "fragile narcissism" subtype (Tanzilli & Gualco, 2020).

*Treatment of NPD*

Understanding the spectrum of pathological narcissism, across both levels of functioning and expression (as presented in study 2 and 3, figure 6.2), has crucial implications for diagnoses and delivering evidence based therapeutic interventions. For instance, Pincus et al. (2014) note the difficulty of providing accurate diagnoses given the overly narrow construct definition as it appears in the DSM-V for narcissistic grandiosity and vulnerability in psychotherapy. This conceptual and diagnostic confusion may misinform technical interventions as narcissistic patients may be more likely to seek treatment when they are in a vulnerable self-state (Ellison et al., 2013) and thus receive alternate diagnostic labels (e.g., major depression; Kernberg & Yeomans, 2013). As such, the findings presented

in this thesis help provide empirical data to inform therapists delivering accurate diagnoses, either utilising symptom, subtype or trait based approaches.

This is important as understanding distinctions between narcissistic functioning and its 'near neighbour' disorders helps avoiding misdiagnosis and informs appropriate technical interventions. For instance, despite sharing similarities in low mood, depressive disorders are differentiated from narcissism through instances of perfectionism, shame and aggression being higher in the latter (Fjermestad-Noll et al., 2020) and as such interventions such as sympathetic dismantling of the self-persecutory superego and internalised aggression may be soothing to depressive patients, but not narcissistic ones (Huprich, 2020). Similarly, working through of guilt, undoing and omnipotence may free up an obsessive compulsive personality, but not those who are narcissistically oriented (McWilliams, 2011). Further, given the interpersonal nature of difficulties for pathological narcissism, therapies that are fundamentally interpersonal in nature (e.g. transference focused psychotherapy) or have an explicit focus on dysfunctional relationship patterns (e.g. core conflictual relationship themes), may be at a particular advantage in this regard, with some findings suggesting superior efficacy in the treatment of clients with borderline and narcissistic pathologies (Diamond et al., 2014). However, many therapeutic approaches have been tailored for the treatment of pathological narcissism including mentalization based (Drozek & Unruh, 2020), motive oriented (Kramer et al., 2013), compassion focused (Kramer et al., 2018), cognitive behavioural (Cukrowicz et al., 2011), schema (Behary & Dieckmann, 2011) and dialectical behavioural (Reed-Knight & Fischer, 2011). However, regardless of therapeutic orientation, the results of this thesis inform generalist approaches in treating pathological narcissism, such as that described by Weinberg and Ronningstam (2020). This includes the need to recognise and integrate grandiose and vulnerable self-states (study 2), to anticipate interpersonal

challenges and power struggles (study 3) and to tolerate and be aware of intense countertransference reactions (study 4) in the treatment.

By the same token, these results highlight the importance of assessing severity of personality functioning in routine clinical practice to guide the implementation of an appropriate therapeutic approach. For instance, patients who are less severe may be more suited to particular therapeutic orientations and interventions, such as treatments focusing on symptoms and conflicts, such patients may also benefit from a more unstructured and exploratory therapy style (Kernberg, 2008). Alternatively, while patients who are more severe demonstrate a worse treatment prognosis (e.g., malignant narcissism, Lenzenweger et al., 2018), specific treatment approaches may be more useful such as those that have a strict adherence to a treatment frame and explicitly address self-destructive and treatment interfering behaviour (Clarkin et al., 2006). For instance, the modified variant of transference focused psychotherapy for narcissistic personality disorder (TFP-N, Diamond & Hersh, 2020; Diamond et al., 2021; Stern et al., 2017) utilises a 'treatment contract' that establishes clear expectations and consequences that inform treatment progression and is mutually agreed upon by both the patient and therapist. Regarding the findings of the current research, this may include contracting that treatment progression is contingent on the client not acting out violent urges against intimate partners, or even the therapist, and rather treatment would involve exploring these impulses in therapy in a safe way, with specific consequences (e.g., contacting authorities, therapy termination) if the contract is significantly or repeatedly violated.

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e+in+maternal+anxiety+and+stress+in+the+short+and+intermediate+term%3F&id=pmid:12547867

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# 8. APPENDICES

8.1. Appendix 1 – PDF of Study 1 published in Journal of Personality Disorders

8.2. Appendix 2 – PDF of Study 2 published in Borderline Personality Disorder and Emotional Dysregulation

## 8.1. Appendix 1 – PDF of study 1 published in Journal of Personality Disorders

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# PATHOLOGICAL NARCISSISM: A STUDY OF BURDEN ON PARTNERS AND FAMILY

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Pathological narcissism is characterized by impaired interpersonal functioning, but few studies have examined the impact of the disorder on those living in a close relationship. Participants ($N$ = 683; comprising romantic partners [77.8%], mothers [8.5%] or other family members [10%]) in a close relationship with a relative with pathological narcissism completed measures assessing levels of grief, burden, mental health, and coping style. Participants' reported burden was over 1.5 standard deviations above comparison carers of people with mood, neurotic, or psychotic disorders, and higher than carers of people with borderline personality disorder. Similarly, caseness for depression (69% of sample) or anxiety disorders (82%) in the sample was high. Relationship type, subtype expression (vulnerable/grandiose), and coping style were all found to significantly relate to experienced psychopathology. Although limitations exist regarding sample selection that may influence interpretation of results, these findings quantify the significant interpersonal impact of pathological narcissism in this sample.

*Keywords:* narcissism, personality disorder, pathological, partner, family, carer, relative

Pathological narcissism is often thought of as having two dimensional traits: the grandiose and the vulnerable (Russ & Shedler, 2013; Russ, Shedler, Bradley, & Westen, 2008). Behaviors involving grandiose narcissism include attitudes and behaviors such as dominance, vindictiveness, and intrusiveness (Ogrodniczuk & Kealy, 2013). Vulnerable narcissism traits include feelings of depression, anxiety, emptiness, and rumination (Pincus, Cain, & Wright, 2014), but also attitudes that may be critical, angry, and entitled (Dickinson & Pincus, 2003; Grenyer, 2013; Russ et al., 2008). These traits are associated with significant interpersonal dysfunction (Kealy & Ogrodniczuk, 2011; Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009), with some authors stating that pathological narcissism and interpersonal dysfunction go "hand in hand" (Ogrodniczuk & Kealy, 2013, p. 114). Although behaviors may differ, interpersonal dysfunction is present in both (Miller, Lynam, Hyatt, &

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Campbell, 2017). However, while research suggests that pathological narcissism affects others, there are few investigations of how others actually experience the relationship with a person with pathological narcissism. This study aims to address this gap in the literature.

Narcissistic personality disorder **(NPD)** as defined by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) involves a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy. This definition of **NPD** has been heavily criticized for its focus on only the grandiose aspects of the disorder to the exclusion of vulnerable characteristics (Skodol, Bender, & Morey, 2014), which may have profound impacts on treatment and outcome (Pincus et al., 2014). This exclusion also runs contrary to more than 35 years of clinical theories of pathological narcissism that include both vulnerable and grandiose affects and self-states (Cain, Pincus, & Ansell, 2008). In addition, a clear distinction needs to be drawn between "normal" narcissism, "pathological" narcissism, and the specific diagnosis of NPD. Normal narcissism is considered to be the ability to regulate self-esteem using age-appropriate methods of gratification (Kernberg, 2008; Pincus & Lukowitsky, 2010). Pathological narcissism is an inability to maintain self-esteem and self-cohesion (Cain et al., 2008), resulting in maladaptive methods of gratification such as aggression and narcissistic defenses (Kernberg, 2008), causing distress to the self and others (Miller, Lynam, et al., 2017). However, it is not yet clear if the distinctions between these types are best understood as operating on a continuum from healthy to disordered (Pincus & Lukowitsky, 2010), or whether they differ categorically. Prevalence estimates for NPD have high variation between studies, ranging from 0% to 6.2% (Lenzenweger, Lane, Loranger, & Kessler, 2007; Stinson et al., 2008), likely reflecting the conceptual confusion of the construct of narcissism (Cain et al., 2008).

While individuals with pathological narcissism experience interpersonal difficulties (Byrne & O'Brien, 2014; Kealy & Ogrodniczuk, 2011; Ogrodniczuk & Kealy, 2013; Ogrodniczuk et al., 2009), few studies have empirically examined the interpersonal psychological burden from the perspective of the "other" in in the relationship (Byrne & O'Brien, 2014), and the majority of previous research relies upon undergraduate students to form the participant pool (for more information on this limitation, see Henrich, Heine, & Norenzayan, 2010). Most study only grandiose narcissism (Krizan & Herlache, 2017) and romantic relationships. Despite these limitations, research suggests that in a romantic relationship, people with narcissistic traits are described as using "game playing tactics" (Campbell, Foster, & Finkel, 2002) and show self-centered, materialistic, deceptive, and controlling behaviors, thus creating an "emotional toll" (Brunell & Campbell, 2011, p. 346) on partners. Miller, Campbell, and Pilkonis (2007) report that within a clinical population, high narcissistic traits were uniquely related to causing pain and distress to significant others, stating that it appears that there are "traits specific to NPD that are especially difficult to tolerate" (p. 176). Interpersonal analyses suggest what those traits might be: intrusiveness, dominance, vindictiveness, coldness, avoidance, and exploitation (Kealy & Ogrodniczuk,

2011; Ogrodniczuk & Kealy, 2013). Thus, while previous research suggests that certain interpersonal traits of narcissism will have a psychological toll on others, the researchers did not study that experience directly.

Most personality disorder research focuses on borderline personality disorder (BPD) (Boschen & Warner, 2009). However, because all personality disorders are characterized by distinct maladaptive interpersonal styles, analysis of specific personality disorders is warranted (Bailey & Grenyer, 2013). Bailey and Grenyer (2014) analyzed carer burden and personality disorders to provide some preliminary data on this issue. One subset of their sample, carers of relatives with **NPD,** reported elevated burden, grief, psychological symptoms, and difficulties in emotion regulation. However, the study was limited by a small NPD sample size ($n$ = 11), and thus the authors recommended extension with larger sample sizes. Qualitatively, these carers reported distress resulting from the caregiving relationship as encompassing many aspects of life: physical health, mental health, friendships, work capacity, and family life. These difficulties are consistent with literature exploring the impact of caring for individuals with severe mental illnesses, as carers report high burden and grief as a result of their caregiving relationship (Hoffman et al., 2005; Page, Hooke, O'Brien, & de Felice, 2006; Reinhard, Gubman, Horwitz, & Minsky, 1994). In exploring the factors that influence the impact of the caregiving relationship, Pearlin, Mullan, Semple, and Skaff (1990) outlined the antecedent factors of carer distress. These include the nature of the caregiving relationship, problematic behaviors of the relative, intrapsychic strain (e.g., guilt, grief, worry), role strains (e.g., work, family, finances, time), and coping ability of carers as influencing subsequent distress.

For this research, partners and family members will be referred to as *participants.* Individuals with pathological narcissism will be referred to as the *relative.* The term *carer* refers to legal guardians, parents, family members, cultural elders, mentors, partners, spouses, friends, or a main support person (Project Air Strategy, 2016). The current study aims to address gaps in the literature base by investigating levels of burden experienced by individuals in relationship with someone who has pathologically narcissistic traits using empirically validated measures and comparing them to relevant comparison groups. First, we aim to assess for presence and severity of burden in partners and family members (or carers) of relatives with pathologically narcissistic traits. We then aim to compare how burden levels and mental health of participants compare to those of carers of relatives with other severe mental illness. Finally, we propose to examine the factors that influence burden in participants (i.e., narcissistic severity, participant coping style, relationship type, NPD subtype).

## METHOD

### RECRUITMENT

Participants provided written informed consent to participate following institutional review board approval. The participants were recruited through invitations posted on various mental health websites that provide informa-

tion and support that is narcissism specific (e.g., Narcissistic Family Support Group), and recruitment was advertised as being specifically in relation to a relative who was narcissistic. This data collection strategy via online platforms has been found to be both effective and reliable (Miller, Crowe, Weiss, Maples-Keller, & Lynam, 2017). Because participants needed to be actively participating or monitoring these websites or social media pages, we may assume they were seeking information or support. In a conservative effort to ensure that included participants were appropriate to the research, three criteria were applied. First, participants had to identify as having a close personal relationship with someone who was very narcissistic. Second, participants had to complete mandatory questions as indicated on the survey. Mandatory questions included basic demographic information (age, gender, relationship type) and all measures under examination. Nonmandatory questions included more sensitive questions, such as certain demographic questions (e.g., occupation) and questions pertaining to their relative's illness and their support seeking. Third, the relative had to have a cumulative score of 36 or above on a narcissism screening measure (described in the Measures section), as informed by participants. A cutoff of 36 was devised based on the Likert scale of the narcissism measure in which a score of 3 indicated *a little like my relative.* This only captures participants who responded on average *a little like my relative,* and not at all *a little unlike my relative.*

## PARTICIPANTS

A total of 2,231 participants consented to participate in the survey. A conservative data screening procedure was implemented to ensure that participants were appropriate to the research. First, participants were removed who indicated that they did not have a close personal relationship with someone who was narcissistic (n = 43). Second, participants who clicked on the link to begin the survey but dropped out within the first 1-5 questions were deemed "nonserious" and were removed (n = 1,092). Third, participants who did not progress in the survey and complete all mandatory items were removed (n = 295). Finally, participants identified as rating relatives' narcissism below the cutoff score of 36 were removed (n = 106). Inspection of pattern of responses indicated that none of the remaining participants had filled out the survey questions inconsistently or inappropriately (e.g., scoring the same for all questions). The remaining 683 participants formed the sample reported here. Table 1 outlines the demographic information of participants and the relative included in the study.

## COMPARISON GROUPS

Comparison groups were drawn from the published literature, utilizing studies that employed most of or all the same measures to ensure consistency in comparing and interpreting results. Table 2 details the comparison groups, which involved carers of persons with a range of mental health disorders or community samples. These comparisons represent the most relevant comparable published data available for each measure. Participants in all compari-

TABLE 1. Demographics for Participants (Partners and Family) and Their Relatives (People High in Pathological Narcissism) (N = 683)

| | Participants N = 683 | Relative N=683 |
|---|---|---|
| Mean age, years (SD) | 44.3 (9.7) | 48.6 (12.3) |
| Gender, % (n) | | |
| Male | 6.0 (41) | 76.9 (525) |
| Female | 94.0 (642) | 23.1 (158) |
| Employment, % (n) | | |
| Full time | 50.8 (347) | 52.4 (358) |
| Part time | 18.0 (123) | 7.8 (53) |
| Unemployed | 11.6 (79) | 13.3 (91) |
| Other | 19.6 (134) | 26.5 (181) |
| Relationship, % (n) | | |
| Spouse/partner | | 62.1 (424) |
| Former spouse/partner | | 15.7 (107) |
| Family (total) | | 18.5 (126) |
| Mother | | 46.0 (58) |
| Father | | 10.3 (13) |
| Child | | 4.7 (6) |
| Sibling | | 16.7 (21) |
| Other | | 22.2 (28) |
| Other | | 3.8 (26) |
| Help seeking for relationship, % (n) | | |
| Clinical support | 37.5 (256) | |
| Self-help | 10.4 (71) | |
| Mixture | 15.5 (106) | |
| Did not state | 36.6 (250) | |

son articles were actively seeking support at the time of participation in their respective studies.

## MEASURES

*Pathological Narcissism Inventory (Carer Version) (SB-PNI-CV).* Schoenleber, Roche, Wetzel, Pincus, and Roberts (2015) developed a short version of the Pathological Narcissism Inventory (SB-PNI; "super brief") as a 12-item measure consisting of the 12 best performing items for the Grandiosity and Vulnerability composites (six of each) of the Pathological Narcissism Inventory (Pincus et al., 2009). This measure was then adapted into a carer version (SB-PNI-CV) in the current research by changing all self-referential terms (e.g., "I") to refer to the relative (e.g., "my relative"). This adaptation followed a previous published adaptation methodology (e.g., Bailey & Grenyer, 2014) in consultation with the first author of the original Pathological Narcissism Inventory (Pincus et al., 2009). The SB-PNI-CV demonstrated strong internal consistency (a= .79), using all available data (N = 1,029). Subscales

TABLE 2. Burden and Mental Health of Partners and Family of Relatives with Pathological Narcissism (Participant) and Carer Group (Comparison) Scores

| Measure | Participant, *M* (SD) | Comparison, *M* (SD) | *t* | *d* | Comparison group |
|---|---|---|---|---|---|
| BAS | 57.06 (11.73) | 55.36 (10.93) | 2.10"" | 0.14 | PD (Bailey & Grenyer, 2014) |
| | | 51.41 (10.98) | 3.12»,- | 0.50 | BPD (Hoffman et al., 2005) |
| | | 38.54 (13.27) | 16.39""" | 1.48 | MD, ND, PsD (Page et al., 2006) |
| | | 32.10 (- ) | | | SM! ( Reinhard et al., 1994) |
| | | 55.30 (- ) | | | SM! ( Reinhard et al., 1994) |
| GS | 48.35 (14.34) | 54.38 (12.60) | 6.22""" | 0.45 | PD (Bailey & Grenyer, 2014) |
| | | 52.41 (10.49) | 1.85 | 0.32 | BPD (Hoffman et al., 2005) |
| MHl-5 | 46.28 (19.49) | 56.40 (20.96) | 7.24** | 0.50 | PD (Bailey & Grenyer, 2014) |
| | | < 54 indicate MOD or DD | - | - | PS (Cuijpers et al., 2009) |
| | | < 65 indicate MD or AD | - | - | PS (Rumpf et al., 2001) |
| PBS | 21.72 (4.19) | 20.47 (4.13) | 1.92 | 0.3 | BPD (Hoffman et al., 2005) |
| | | 15.10 (-) | - | - | SM! (Stueve at al., 1997) |

*Note.* NPD = Narcissistic Personality Disorder; SD = Standard Deviation; M = Mean; *BAS*= Burden Assessment Scale; GS = Grief Scale; MHI-5 = Mental Health lnventory-5; PBS= Perceived Burden Scale; PD = Personality Disorder; BPD = Borderline Personality Disorder; *MD*= Mood Disorder; ND = Neurotic Disorder; PsD = Psychotic Disorder; *SM!*= Severe Mental Illness; MOD= Major Depression; DD = Dysthymic Disorder; PS= Population Sample; *AD*= Anxiety Disorders. *significmt at les s than *a= .05;* *'•significant at less than *a=* .01.

of the measure also demonstrated internal consistency for both grandiose ($\alpha$ = .73) and vulnerable ($\alpha$ = .75) items. This informant-based method of investigating narcissism and its effects has previously been found to be effective and reliable (Byrne & O'Brien, 2014), with consensus demonstrated across multiple observers (Lukowitsky & Pincus, 2013).

*Burden Assessment Scale (BAS).* The BAS (Reinhard et al., 1994) is a 19-item questionnaire used to assess presence and intensity of burden. It measures both objective (e.g., financial strain, time strain) and subjective (e.g., personal distress, guilt) aspects of burden, where higher scores indicate greater experiences of burden. The BAS showed strong internal consistency ($\alpha$ = .89, $N$ = 683).

*Grief Scale (GS).* The GS (Struening et al., 1995) is a 15-item questionnaire that assesses the experience of grief connected to having a loved one with mental illness, with higher scores indicating higher grief. The GS showed strong internal consistency ($\alpha$ = .92, $N$ = 683).

*Family Questionnaire (FQ).* The FQ (Wiedemann, Rayki, Feinstein, & Hahlweg, 2002) is a 20-item measure used to assess the way individuals behave toward relatives with mental illness. Questions assess expressed emotion in the domains of criticism and emotional overinvolvement. The measure is used in this study as an overall indication of participants' coping style, with higher scores indicating more maladaptive coping styles. The FQ showed strong internal consistency ($\alpha$ = .80, $N$ = 683).

*Mental Health Inventory-5 (MHI-5).* The MHI-5 (Berwick et al., 1991) is a five-item questionnaire that measures five dimensions (anxiety, depression, positive affect, loss of behavioral or emotional control, and psychological well-being). The MHI-5 forms the Mental Health Scale from the Medical Outcomes Study Short-Form Health Survey (SF-36; Daniells et al., 2003; Ware & Sherbourne, 1992). The MHI-5 was used to assess the mental health of participants in this study. Consistent with previous research, scores on the MHI-5 are linear transformed to a scale of 0 to 100 (Berwick et al., 1991; Cuijpers, Smits, Donker, ten Have, & de Graaf, 2009; Rumpf, Meyer, Hapke, & John, 2001). Higher scores are indicative of better mental health. The MHI-5 showed strong internal consistency ($\alpha$ = .89, $N$ = 683).

*Perceived Burden Scale (PBS).* The PBS (Stueve, Vine, & Struening, 1997) is a seven-item scale used to assess the carer's objective burden and the extent to which contact with the relative interferes with other roles and relationships. Higher scores indicate higher objective burden. The PBS showed strong internal consistency ($\alpha$ = .73, $N$ = 683).

## STATISTICAL ANALYSES

Although data were not normally distributed, the sample size was large enough to approximate a normal distribution (Hays, 1994), and thus parametric tests were used. Nonparametric tests were also conducted and showed

the same pattern of results, so are not reported here. A significance level of .05 was selected for statistical tests unless specifically stated otherwise. A pooled variance estimate *t* test was used to compare sample scores from each measure against published comparison groups. This test takes into account the different number of participants in each sample by weighting the variance of each sample and is able to be used when only the participant number, mean, and standard deviation are known. Pearson *r* correlation was used to assess the degree that measures were correlated. All analyses involving the MHI-5 will be negative because this item is reverse scored; it has not been unreversed to allow for meaningful comparisons with other published literature using this measure.

## RESULTS

*Are partners and family of individuals with NPD significantly burdened? How does this compare to carers of relatives with other severe mental illness?* We investigated levels of burden (BAS), grief (GS), mental health (MHl-5), and objective burden (PBS) for our sample and compared this to carer comparison groups. Table 2 reports the mean, standard deviation, and significance level for each measure in the present sample and comparison groups. Table 3 displays the correlation matrix between measures.

The mean burden (BAS) score in our sample was significantly higher than for carers of persons with a personality disorder (Bailey & Grenyer, 2014) and BPD (Hoffman et al., 2005). The BAS score in our sample was also significantly higher than for carers of persons with mood disorders, neurotic disorders, and psychotic disorders (Page et al., 2006) by at least one standard deviation. A Pearson *r* two-tailed correlation indicated that higher burden scores correlated significantly with higher grief, objective burden, and worse mental health.

The mean grief (GS) score in our sample was around half a standard deviation lower than for carers of persons with a personality disorder (Bailey & Grenyer, 2014) and BPD (Hoffman et al., 2005); this difference was significant only for the Bailey and Grenyer (2014) comparison. Pearson *r* two-tailed correlation indicated that higher scores for grief correlated significantly with worse mental health and higher objective burden.

The mean objective burden (PBS) score in our sample was higher than for carers of persons with BPD (Hoffman et al., 2005), but this difference was not statistically significant. The PBS score was more than one standard deviation higher in our sample than for carers of persons with severe mental illness (Stueve et al., 1997). Pearson *r* two-tailed correlation indicated that higher scores of objective burden correlated significantly with worse mental health.

The mean mental health (MHI-5) score in our sample was significantly lower than for carers of persons with a personality disorder (Bailey & Grenyer, 2014). For participants, 69% (n = 470) endorsed scores consistent with symptoms indicating major depression or dysthymic disorder (cutoff indicated in Cuijpers et al., 2009), and 82% of participants (n = 560) en-

TABLE 3. Pearson Correlation Matrix of Measures ($N = 683$)

| Measure | SB-PNI-CV | FQ | BAS | GS | MHI-5 | PBS |
|---|---|---|---|---|---|---|
| SB-PNI-CV | — | .17** | .11** | .15** | .01 | .10* |
| FQ | | — | .66** | .46** | −.42** | .45** |
| BAS | | | — | .41** | −.49** | .59** |
| GS | | | | — | −.28** | .18** |
| MHI-5 | | | | | — | −.33** |
| PBS | | | | | | — |

*Note.* SB-PNI-CV = Pathological Narcissism Inventory (Carer Version); FQ = Family Questionnaire; BAS = Burden Assessment Scale; GS = Grief Scale; MHI-5 = Mental Health Inventory-5; PBS = Perceived Burden Scale. *$\alpha$ = .05; **$\alpha$ = .01.

dorsed scores representative of mood or anxiety disorders (cutoff indicated in Rumpf et al., 2001).

*What are the factors that influence burden in participants? Is burden related to severity or subtype expression of their relative's narcissism?* We conducted correlation analysis to evaluate the degree that higher scores of narcissism (measured by SB-PNI- CV) correlated with other measures. Pearson *r* two-tailed correlation indicated that higher endorsements of relatives' narcissism correlated significantly with higher levels of burden, grief, and objective burden. Level of narcissism was not significantly correlated with mental health. In order to investigate subtype expression, correlation analysis explored the relationship between the subtype subscales on the SB-PNI-CV and measures under examination. Pearson *r* two-tailed correlation indicated that grandiose expressions of narcissism correlated significantly with higher burden (BAS; $r = .13$, $p = .001$) and objective burden (PBS; $r = .11$, $p = .004$), while expressions of vulnerable narcissism significantly correlated with higher grief (GS; $r = .19$, $p < .001$).

*How does the coping style of participants affect levels of burden?* We conducted correlation analysis and regression analysis to evaluate the degree that coping style (as indexed by the FQ) influences burden levels.

Pearson *r* two-tailed correlations indicated that higher scores on the FQ (indicating more maladaptive coping styles) were significantly correlated with higher levels of grief, burden, objective burden, and worse mental health (as displayed in Table 3).

An attempt to understand the way that coping style influenced burden was undertaken by analyzing the two components that make up the FQ (emotional overinvolvement and criticism). A stepwise multiple regression was conducted to evaluate the degree that criticism and emotional overinvolvement predict burden (as measured by the BAS). At Step 1 of the analysis, emotional overinvolvement significantly predicted burden, $F(1, 681) = 517.18$, $p < .001$, $R^2 = .43$. At Step 2 of the analysis, criticism was also found to significantly contribute to the model, $F(1, 680) = 295.45$, $p < .001$, $R^2 = .47$.

*Does burden level vary according to relationship type?* We conducted means comparison across all relationship types to evaluate if different relationship types had significantly different levels of burden.

A Kruskal-Wallis analysis was conducted to assess the degree that relationship type varied for experienced distress. Of all measures, PNI score

TABLE 4. A Comparison of Relationship Type on Severity of Burden and Mental Health

| Measure | Relationship Type | Mean (SD) | Relationship Comparison | Mean (SD) | *p* |
|---|---|---|---|---|---|
| BAS | Current Partner | 59.9 (1 0.1) | Family | 49.7 (12.8) | < .001** |
| | | | Ex-Partner | 55.7 (11.7) | .001** |
| | Ex-Partner | 55.7 (11.7) | Family | 49.7 (1 2.8 ) | .002** |
| PBS | Current Partner | 22.4 (4.1) | Family | 20.3 (4.1) | < .001* |
| | | | Ex-Partner | 21.4 (3 . 8) | .052 |
| | Ex-Partner | 21.4 (3.8) | Family | 20.3 (4.1) | .145 |
| MHI-5 | Current Partner | 42.6 (1 8.5 ) | Family | 53.1 (19.5) | < .001" |
| | | | Ex-Partner | 50.7 (19.5) | < .001* |
| | Ex-partner | 50.7 (19 .5) | Family | 53.1 (19.5) | 1.0 |

*Note. SD*= Standard Deviation; BAS= Burden Assessment Scale; PBS= Perceived Burden Scale; MHI-5 = Mental Health Inventory-5. Significance level has Bonferroni correction applied; "·a = .05; "·**a=** .01.

was the only measure that did not vary based on relationship type. Relationship type (current romantic partner, former romantic partner, family relative) showed significant differences for experienced burden, $X^2(2) = 69.74$, $p < .001$, $11^2 = 10.6$, $N = 657$; objective burden, $X^2(2) = 27.71$, $p < .001$, $11^2 = 4.2$, $N = 657$; and mental health, $X^2(2) = 37.65$, $p < .001$, $11^2 = 5.7$, $N = 657$. Post hoc analysis with Bonferroni alpha correction revealed significant differences between relationship types across measures. Current partners had scores indicating significantly higher distress across all measures compared to other relationship types (with the exception of former partners and the PBS, which were nonsignificant). Former partners had significantly higher burden (BAS) levels compared to family members, but burden level was not significantly different for the other measures. Table 4 displays these differences.

## DISCUSSION

This study aimed to investigate the experience of being in a relationship with someone with pathologically narcissistic traits. Participants endorsed significantly elevated burden compared to carers of persons with other serious mental illnesses. Participants also reported impaired well-being similar to that of clinical samples diagnosed with anxiety, mood, and depressive disorders. These results provide new insights into the relational impact of narcissistic traits in a way that has not, to the best of our knowledge, been empirically assessed. Because **NPD** has an estimated prevalence rate up to 6.2% (Stinson et al., 2008), these results suggest a large base of unrecognized and psychologically burdened individuals who are in a relationship with individuals with pathologically narcissistic traits. A subanalysis of relationship type indicated that those in romantic relationships (current and former) reported significantly more distress than those in familial relationships. Within romantic relationships, those who were current partners exhibited the most psychopathology across all measures. This may be due to the level of intensity and frequency of interaction for current partners as opposed to ex-partners and family. However, the finding that objective burden levels did not significantly differ between current and former partners suggests that there may be burdensome aspects of the "remembered" relationship that are maintained over time-even when the relationship is not current.

Of interest is the effect that coping style had on the variables under examination. Correlation analysis revealed that coping style was significantly related to psychopathology, with more maladaptive coping being significantly related to increased psychopathology and the opposite for adaptive coping. Regression analysis revealed that while both criticism and emotional overinvolvement significantly predicted an increase in burden levels, emotional overinvolvement contributed the most to variations in burden. This could have important clinical implications because these results could inform possible intervention programs that focus on strategies to target levels of

emotional overinvolvement (Grenyer et al., 2018). However, further research is needed to elucidate additional aspects of coping style that may ameliorate psychopathology.

The significantly lower levels of grief found in our study in contrast to previous comparison groups may highlight the unique impact that narcissism has on the psychopathology of partners and family. A possible explanation could be that partners and family of narcissistic relatives may not be inclined to feel sympathy or grief for their relative in the face of the relative's narcissistic hostile interpersonal traits (Brunell & Campbell, 2011; Campbell et al., 2002; Dickinson & Pincus, 2003; Ogrodniczuk & Kealy, 2013). The subtype analysis of the SB-PNI-CV provides preliminary results indicating that feelings of sympathy or grief may vary depending on how narcissism is expressed. A potential hypothesis may be that vulnerable expressions (e.g., rumination, anxiety, depression) may arouse a sympathetic reaction from carers, while grandiose expressions may arouse other emotional reactions (e.g., anger, frustration).

There are several limitations to this study that need to be acknowledged. First, gender disparity in participants and relatives was substantial. However, NPD is diagnosed more commonly in males (50%-75%, American Psychiatric Association, 2013), and most participants in our sample were in a romantic, heterosexual relationship. Thus, this disparity may reflect a representative NPD sample and should not significantly affect the validity of results. Second, because participants completed measures about both the relative and themselves, the possibility of biased reporting is increased. However, it is known that self- report of NPD is problematic within a population that diagnostically lacks insight (Russ & Shedler, 2013), with high discrepancies between self and other ratings of narcissism (Pincus & Lukowitsky, 2010). In contrast, Lukowitsky and Pincus (2013) reported high levels of convergence for informant ratings of narcissism, indicating that multiple peers are likely to score the same individual similarly. Furthermore, Byrne and O'Brien (2014) reported findings utilizing informant ratings of narcissism that are consistent with clinical and self-report methodology. This increases confidence in validity of results because it suggests that informants may be able to accurately and reliably report on an individual's narcissism. However, we acknowledge that the common nomenclature of behaviors that would be labeled as "narcissistic" may be highly variable across individuals, and thus results should be interpreted with this in mind. Future research could involve assessing the degree of accuracy of informant ratings in distinguishing narcissism when compared to other forms of psychopathology. Mono-method bias may also be inflated through the use of only quantitative analysis. Future research is recommended that extends this quantitative analysis by exploring the qualitative lived experience, "meaning," or subjective experience of partners and family members in their day-to-day lives interacting with a relative high in pathological narcissism. Third, a limitation of using online platforms

for data collection is that participant motivation is unknown (e.g., participants are nonnaive) and that participant monitoring is denied. However, this is a limitation of all studies of this kind and does not prevent the meaningful interpretation of our results (Miller, Crowe, et al., 2017). Fourth, there is no way of knowing if participants had preexisting mental health conditions prior to the relationship onset that may have affected results reported here. This is particularly noteworthy because participants included in this study were actively seeking support in managing their relationships through online support groups, which may mean that the average burden and mental health difficulties reported may be inflated. Thus, teasing out participant psychopathology that is independent of relative burden could be the subject of further research. However, because participants described in comparison articles were also actively seeking support, this limitation does not prevent the meaningful comparison and interpretation of results. Fifth, while participants in this study had significant burden and mental health difficulties, a limitation of correlation research is bidirectionality. Thus, it cannot known from the data whether narcissism informs burden and mental health scores, or if the opposite is true: that participants with high burden and mental health difficulties may be more likely to ascribe the label "narcissistic" to their relative. Similarly, it is unknown whether coping style informs level of burden, or if burden and mental health difficulties overwhelm an individual and result in more maladaptive coping styles. The literature reviewed suggests that it is more likely to be the former, because individuals with narcissistic traits are known to be interpersonally challenging (Brunell & Campbell, 2011; Byrne & O'Brien, 2014; Kealy & Ogrodniczuk, 2011; Miller et al., 2007; Miller, Lynam, et al., 2017; Ogrodniczuk, et al., 2009) and because carer literature demonstrates the personal distress of being in close proximity to individuals with challenging behaviors (Bailey & Grenyer, 2014), with coping ability mediating experienced distress (Pearlin et al., 1990). However, this study is not experimental in nature, and thus causal conclusions between having a relative with high perceived narcissism and significant mental health difficulties cannot be drawn.

Pathological narcissism is characterized by impaired interpersonal functioning, but few studies have examined the impact of the disorder on those living in a close relationship. Participants in a relationship with someone with high perceived pathologically narcissistic traits reported high burden, grief, and mental health difficulties. Analysis revealed significantly higher burden and worse mental health in this sample when compared to comparison groups described in the published literature. Relationship type, subtype expression, and coping style were all found to significantly relate to experienced psychopathology. While limitations exist regarding sample selection that may influence interpretation of results, these findings quantify the significant interpersonal impact of pathological narcissism in this sample.

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## 8.2. Appendix 2 – PDF of study 2 published in Borderline Personality Disorder and Emotion Dysregulation

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Borderline Personality Disorder and Emotion Dysregulation

RESEARCH ARTICLE Open Access

# Living with pathological narcissism: a qualitative study

Nicholas J. S. Day, Michelle L. Townsend and Brin F. S. Grenyer*

**Abstract**

**Background:** Research into the personality trait of narcissism have advanced further understanding of the pathological concomitants of grandiosity, vulnerability and interpersonal antagonism. Recent research has established some of the interpersonal impacts on others from being in a close relationship with someone having such traits of pathological narcissism, but no qualitative studies exist. Individuals with pathological narcissism express many of their difficulties of identity and emotion regulation within the context of significant interpersonal relationships thus studying these impacts on others is warranted.

**Method:** We asked the relatives of people high in narcissistic traits (indexed by scoring above a cut-off on a narcissism screening measure) to describe their relationships ($N = 436$; current romantic partners [56.2%]; former romantic partners [19.7%]; family members [21.3%]). Participants were asked to describe their relative and their interactions with them. Verbatim responses were thematically analysed.

**Results:** Participants described 'grandiosity' in their relative: requiring admiration, showing arrogance, entitlement, envy, exploitativeness, grandiose fantasy, lack empathy, self-importance and interpersonal charm. Participants also described 'vulnerability' of the relative: contingent self-esteem, hypersensitivity and insecurity, affective instability, emptiness, rage, devaluation, hiding the self and victimhood. These grandiose and vulnerable characteristics were commonly reported together (69% of respondents). Participants also described perfectionistic (anankastic), vengeful (antisocial) and suspicious (paranoid) features. Instances of relatives childhood trauma, excessive religiosity and substance abuse were also described.

**Conclusions:** These findings lend support to the importance of assessing the whole dimension of the narcissistic personality, as well as associated personality patterns. On the findings reported here, the vulnerable aspect of pathological narcissism impacts others in an insidious way given the core deficits of feelings of emptiness and affective instability. These findings have clinical implications for diagnosis and treatment in that the initial spectrum of complaints may be misdiagnosed unless the complete picture is understood. Living with a person with pathological narcissism can be marked by experiencing a person who shows large fluctuations in affect, oscillating attitudes and contradictory needs.

**Keywords:** Narcissistic personality disorder, Pathological narcissism, Personality disorder, Grandiosity, Vulnerability, Interpersonal functioning, Qualitative research

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## Introduction

The current diagnostic description of narcissistic personality disorder (NPD) as it appears in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, 5th edition, [1]) includes a lot of information about how the person affects others, such as requiring excessive admiration, having a sense of entitlement, interpersonal exploitativeness, showing both a lack of empathy for others and feeling others are envious of their perceived special powers or personality features. Despite these features being important aspects of narcissism that have been validated through empirical research [2, 3], they have been criticised for their emphasis on grandiosity and the exclusion of vulnerability in narcissism [4, 5], a trend that is mirrored in the field more generally and runs counter to over 35 years of clinical theory [3]. The more encompassing term 'pathological narcissism' has been used to better reflect personality dysfunction that is fundamentally narcissistic but allows for both grandiose and vulnerable aspects in its presentation [6].

Recognising the vulnerable dimension of narcissism has significant implications for treatment [7], including providing an accurate diagnosis and implementing appropriate technical interventions within treatment settings. Vulnerable narcissism, in marked contrast to the overt grandiose features listed in DSM-5 criteria, includes instances of depressed mood, insecurity, hypersensitivity, shame and identification with victimhood [8–12]. Pincus, Ansell [13] developed the Pathological Narcissism Inventory (PNI) to capture this narcissistic vulnerability in three factors. The factor 'contingent self-esteem' (item example: 'It's hard for me to feel good about myself unless I know other people like me') reflects a need to use others in order to maintain self-esteem. The factor 'devaluing' includes both devaluation of others who do not provide admiration needs ('sometimes I avoid people because I'm concerned that they'll disappoint me') and of the self, due to feelings of shameful dependency on others ('when others disappoint me, I often get angry at myself'). The factor 'hiding the self' ('when others get a glimpse of my needs, I feel anxious and ashamed') reflects an unwillingness to show personal faults and needs. This factor may involve a literal physical withdrawal and isolation [14] but may also include a subtler emotional or psychic withdrawal due to feelings of inadequacy and shame which may result in the development of an imposter or inauthentic 'false self' [11, 15], and which may also include a disavowal of emotions, becoming emotionally 'empty' or 'cold' [14]. Another aspect described in the literature are instances of 'narcissistic rage' [16] marked by hatred and envy in response to a narcissistic threat (i.e. threats to grandiose self-concept). Although commonly reported in case studies and clinical reports, it is unclear if it is a feature of only grandiose presentations or if it may more frequently present in vulnerable presentations [17].

While the differences in presentation between grandiose and vulnerable narcissism appear manifest, it has been argued that they reflect both sides of a narcissistic 'coin' [9] that may be regularly oscillating, inter-related and state dependent [6, 18–22]. As such, it may not be as important to locate the specific presentation of an individual as to what 'type' they are (i.e. grandiose or vulnerable), as it is to recognise the presence of *both* of these aspects within the person [23]. The difficulty for these patients is the pain and distress that accompanies having such disparate 'split off' or unintegrated parts of the self, which result in the defensive use of maladaptive intra and interpersonal methods of maintaining a stable self-experience [24]. This defensive operation is somewhat successful, and may give the impression of a coherent and stable identity, however as noted by Caligor and Stern [25] "manifestly vulnerable narcissists retain a connection to their grandiosity … [and] even the most grandiose narcissist may have internal feelings of inadequacy or fraudulence" (p. 113).

The vulnerable dimension of narcissism, with its internal feelings of emptiness and emotion dysregulation, may reflect a more general personality pathology similar to that of borderline personality disorder (BPD) [26]. For instance, Euler, Stobi [27] found grandiose narcissism to be related to NPD, but vulnerable narcissism to be related to BPD. In a similar vein, Hörz-Sagstetter, Diamond [28] proposes grandiosity as a narcissistic 'specific' factor that distinguishes it from other disorders (e.g. BPD). This grandiosity, however, "predisposes [these individuals] to respond with antagonism/hostility and reduced reality testing when the grandiose self is threatened" (p.571). This antagonism, hostility and the resultant interpersonal dysfunction are well-documented aspects of pathological narcissism [29–32], that exacts a large toll on individuals in the relationship [33, 34]. As the specific features of the disorder are perhaps therefore best evidenced within the context of these relationships, gaining the perspective of the 'other' in the relationship would present a unique perspective that may not be observable in other contexts (e.g. clinical or self-report research). For example, a recent study by Valashjardi and Charles [35] provided such a perspective within the context of domestic violence. They found that those in a relationship with individuals with reportedly narcissistic features described overt (e.g. verbal and physical) and covert (e.g. passive-aggressive and manipulative) expressions of abuse and that these behaviours were in response to perceived challenges to authority and to counteract fears of abandonment. As such, informant

ratings may be a novel and valid methodology to assess for personality pathology [36], as documented discrepancies between self-other ratings suggest that individuals with pathological narcissism may not provide accurate self-descriptions [37]. Further, Lukowitsky and Pincus [38] report high levels of convergence for informant ratings of narcissism, indicating that multiple peers are likely to score the same individual similarly and, notably, individuals with pathological narcissism agreed with observer ratings of interpersonal dysfunction, again highlighting this aspect as central to the disorder [6]. The aim of this study is to investigate the reported characteristics of individuals with pathologically narcissistic traits from the perspective of those in a significant personal relationship with these individuals. For this research, partners and family members will be referred to as 'participants'. Individuals with pathological narcissism will be referred to as the 'relative'.

## Method

### Recruitment

Participants were relatives of people reportedly high in narcissistic traits, and all provided written informed consent to allow their responses to be used in research, following institutional review board approval. The participants were recruited through invitations posted on various mental health websites that provide information and support that is narcissism specific (e.g. 'Narcissistic Family Support Group'). Recruitment was advertised as being specifically in relation to a relative with narcissistic traits. A number of criteria were applied to ensure that included participants were appropriate to the research. First, participants had to identify as having a 'significant personal relationship' with their relative. Second, participants had to complete mandatory questions as part of the survey. Mandatory questions included basic demographic information (age, gender, relationship type) and answers to qualitative questions under investigation. Non-mandatory questions included questions such as certain demographic questions (e.g. occupation) and questions pertaining to their own support seeking. Third, the relative had to have a cumulative score of 36 (consistent with previous methodology, see [33]) or above on a narcissism screening measure (described in Measures section), as informed by participants.

### Participants

A total of 2219 participants consented to participate in the survey. A conservative data screening procedure was implemented to ensure that participants were appropriate to the research. First, participants were removed who indicated that they did not have a 'significant' (i.e. intimate) personal relationship with someone who was narcissistic ($n = 129$). Second, participants who clicked on the link to begin the survey but dropped out within the first 1–5 questions were deemed 'non-serious' and were removed ($n = 1006$). Third, participants whose text sample was too brief (i.e. less than 70 words) to analyse were excluded ($n = 399$) as specified by Gottschalk, Winget [39]. Finally, participants identified as rating relatives narcissism below cut off score of 36 on a narcissism screening measure were removed ($n = 249$). Inspection of pattern of responses indicated that none of the remaining participants had filled out the survey questions inconsistently or inappropriately (e.g. scoring the same for all questions). The remaining 436 participants formed the sample reported here. Table 1 outlines the demographic information of participants and the relative included in the study.

Participants were also asked to report on the diagnosis that their relative had received. These diagnoses were specified as being delivered by a mental health professional and not the participants own speculation. The

**Table 1** Demographics for participants (partners and family) and their relatives (people high in pathological narcissism) ($N = 436$)

| | Participants($n = 436$) | Relative ($n = 436$) |
|---|---|---|
| Mean age in years (SD) | 43.7 (10.1) | 48.7 (12.3) |
| Gender | | |
| Male | 4.8% ($n = 21$) | 75.7% ($n = 330$) |
| Female | 79.6% ($n = 347$) | 24.3% ($n = 106$) |
| Not Specified | 15.6% ($n = 68$) | – |
| Employment | | |
| Full time | 42.7% ($n = 186$) | 50.7% ($n = 221$) |
| Part time | 14.9% ($n = 65$) | 8.3% ($n = 36$) |
| Unemployed | 9.9% (n = 43) | 12.4% ($n = 54$) |
| Other | 32.6% ($n = 142$) | 28.7% ($n = 125$) |
| Disability Pension | 3.2% (n = 14) | 4.4% ($n = 19$) |
| Self-Employed | 3.7% ($n = 16$) | 9.9% ($n = 43$) |
| Retired | 3.4% (n = 15) | 8.9% (n = 39) |
| Student | 2.1% ($n = 9$) | 0.2% (n = 1) |
| Not stated | 20.2% ($n = 88$) | 5.3% ($n = 23$) |
| Relationship | | |
| Spouse/partner | 56.2%, ($n = 245$) | |
| Former spouse/partner | 19.7%, ($n = 86$) | |
| Family (total) | 21.3% ($n = 93$) | |
| Mother | 10.6% ($n = 46$) | |
| Father | 2.5% ($n = 11$) | |
| Child | 1.4% (n = 6) | |
| Sibling | 4.1% (n = 18) | |
| Other Family | 2.8% (n = 12) | |
| Other | 2.8% (n = 12) | |

majority of participants either stated that their relative has not received a formal diagnosis, or that they did not know ($n = 284$, 65%). A total of 152 (35%) participants stated that their relative had received an official diagnosis from a mental health professional (See Table 2).

## Measures

### *Pathological narcissism inventory (Carer version) (SB-PNI-CV)*

Schoenleber, Roche [40] developed a short version of the Pathological Narcissism Inventory (SB-PNI; 'super brief') as a 12 item measure consisting of the 12 best performing items for the Grandiosity and Vulnerability composites (6 of each) of the Pathological Narcissism Inventory [13]. This measure was then adapted into a carer version (SB-PNI-CV) in the current research, consistent with previous methodology [33] by changing all self-referential terms (i.e. 'I') to refer to the relative (i.e. 'my relative'). The scale operates on a Likert scale from 0 ('not at all like my relative') to 5 ('very much like my relative'). By summing participant responses, a total score of 36 indicates that participants scored on average 'a little like my relative' to all questions, indicating the presence of pathologically narcissistic traits. The SB-PNI-CV demonstrated strong internal consistency ($\alpha = .80$), using all available data ($N = 1021$). Subscales of the measure also demonstrated internal consistency for both grandiose ($\alpha = .73$) and vulnerable ($\alpha = .75$) items. Informant-based methods of investigating narcissism and its effects has previously been found to be effective and reliable [30] with consensus demonstrated across multiple observers [38].

**Table 2** Relatives diagnoses as reported by participants ($n = 152$)

| | |
|---|---|
| Personality disorder | 43% ($n = 65$) |
| Narcissistic Personality Disorder | 29% ($n = 44$) |
| Borderline Personality Disorder | 5% ($n = 9$) |
| Other | 7% ($n = 11$) |
| Not Specified | 4% ($n = 7$) |
| Attention Deficit-Hyperactivity Disorder | 12% ($n = 18$) |
| Anxiety Related Disorder | 10% ($n = 15$) |
| Obsessive-Compulsive Related Disorder | 7% ($n = 10$) |
| Substance Related and Addictive Disorders | 5% ($n = 8$) |
| Bipolar and Related Disorders | 20% ($n = 31$) |
| Depressive Disorders | 30% ($n = 46$) |
| Autism Spectrum Disorders | 1% ($n = 2$) |
| Trauma Related Disorders | 9% ($n = 14$) |
| Psychotic Disorders | 5% ($n = 7$) |

*Note.* The percentages and numbers of diagnoses endorsed are greater than the total number of participants as many relatives had been diagnosed with 'co-morbid' disorders. 'Other' personality disorder group includes avoidant ($n = 3$), histrionic ($n = 2$), antisocial ($n = 4$), schizoid ($n = 1$) and paranoid ($n = 1$)

## Qualitative analyses

Participants who met inclusion criteria were asked to describe their relative using the Wynne-Gift speech sample procedure as outlined by Gift, Cole [41]. This methodology was developed for interpersonal analysis of the emotional atmosphere between individuals with severe mental illness and their relatives, it has also been used in the context of assessing relational functioning within marital couples [41]. For the purpose of this study, the speech sample prompt was used to elicit descriptive accounts of relational functioning, which included participants responding to the question:

> *'What is your relative like, how do you get on together?'*

Participants were given a textbox to respond to this question in as much detail as they would like. However, participants whose text responses were too brief (< 70 words), were removed from analysis as specified by Gottschalk, Winget [39]. It is important to note however that these participants who were removed ($n = 399$) did not differ from the included participants in any meaningful way regarding demographic information. The mean response length was 233 words (SD = 190) and text responses ranged from 70 to 1279 words.

Analysis of the data occurred in multiple stages. First, a phenomenological approach was adopted which places primacy on understanding the 'lived experience' of participant responses [42] whilst 'bracketing' researcher preconceptions. This involved reading and re-reading all participant responses in order to be immersed in the participants subjective world, highlighting text passages regarding the phenomenon under examination (i.e. personality features, descriptions of behaviour, etc) and noting comments and personal reactions to the text in the margins. This is done in an attempt to make the researchers preconceptions explicit, in order to attend as close as possible as to the content of what is being said by the participant. Second, codebook thematic analysis was used for data analysis as outlined by Braun, Clarke [43], which combines 'top down' and 'bottom up' approaches. Using this approach, a theory driven or 'top down' perspective was taken [44] in which researchers attempted to understand the reality of participants through their expressed content and within the context of the broader known features informed by the extensive prior work on the topic. In this way, the overarching themes of 'grandiosity' and 'vulnerability' were influenced by empirically determined features within the research literature (e.g. DSM-5 diagnostic criteria, factors within the PNI), however themes and nodes were free to be 'split' or merged organically during the coding process reflecting the ongoing conceptualisation of the

data by the researchers. Significant statements were extracted and coded into nodes reflecting their content (e.g. 'narcissistic rage', 'entitlement') using Nvivo 11. This methodology of data analysis via phenomenologically analysing and grouping themes is a well-documented and regularly utilized qualitative approach (e.g. [45, 46]). Once data analysis had been completed the second author completed coding for inter-rater reliability analysis on 10% of data. The second rater was included early in the coding process and the two reviewers meet on several occasions to discuss the nodes that were included and those that were emerging from the data. 10% of the data was randomly selected by participant ID numbers. At the end of this process, it was then confirmed that the representation of the data also reflected the participant relationships (i.e. marital partner, child etc). Cohen's Kappa coefficient was used to index inter-rater reliability by calculating the similarity of nodes identified by the two researchers. This method takes into consideration the agreement between the researchers (observed agreement) and compares it to how much agreement would be expected by chance alone (chance agreement). Inter-rater reliability for the whole dataset was calculated as $\kappa = 0.81$ which reflects a very high level of agreement between researchers that is not due to chance alone [47].

### Cluster analysis

A cluster analysis dendrogram was generated using Nvivo 11 for purposes of visualisation and to explore the underlying dimensions of the data [48]. This dendrogram displays the measure of similarity between nodes as coded, in which each source (i.e. participant response) is coded by each node. If the source is coded by the node it is listed as '1' and '0' if it is not. Jaccard's coefficient was used to calculate a similarity index between each pair of items and these items were grouped into clusters using the complete linkage hierarchical clustering algorithm [49].

## Results

Two broad overarching dimensions were identified. The first dimension, titled 'grandiosity', included descriptions that were related to an actual or desired view of the self that was unrealistically affirmative, strong or superior. The second dimensions, titled 'vulnerability', included an actual or feared view of the self that was weak, empty or insecure. Beyond these two overarching dimensions, salient personality features not accounted for by the 'grandiose' or 'vulnerable' dimensions were included within a category reflecting 'other personality features'. Themes not relating specifically to personality style, but that may provide insights regarding character formation or expression were included within the category of 'descriptive themes'.

A total of 1098 node expressions were coded from participant responses ($n = 436$), with a total of 2182 references. This means participant responses were coded with an average of two to three individual node expressions (e.g. 'hiding the self', 'entitlement') and there were on average 5 expressions of each node(s) in the text.

### Overarching dimension #1: grandiosity

Participants described the characterological grandiosity of their relative. This theme was made up of ten nodes: 'Requiring Admiration', 'Arrogance', 'Entitlement', 'Envy', 'Exploitation', 'Grandiose Fantasy', 'Grandiose Self Importance', 'Lack of Empathy', 'Belief in own Specialness' and 'Charming'.

#### *Node #1: requiring admiration or attention seeking*

Participants described their relative as requiring excessive admiration. For instance, *"He puts on a show for people who can feed his self-image. Constantly seeking praise and accolades for any good thing he does"* (#1256); *"He needs constant and complete attention and needs to be in charge of everything even though he expects everyone else to do all the work"* (#1303).

#### *Node #2: arrogance*

Relatives were described as often displaying arrogant or haughty behaviours or attitudes. For instance, *"He appears to not be concerned what other people think, as though he is just 'right' and 'superior' about everything"* (#1476) and *"My mother is very critical towards everyone around her... family, friends, neighbours, total strangers passing by... everybody is 'stupid'"* (#2126).

#### *Node #3: entitlement*

Relatives were also described as having a sense of entitlement. For example, *"I paid all of the bills. He spent his on partying, then tried to tell me what to do with my money. He took my bank card, without permission, constantly. Said he was entitled to it"* (#1787) and *"He won't pay taxes because he thinks they are a sham and he shouldn't have to just because other people pay"* (#380).

#### *Node #4: envy and jealousy*

Participants described instances of their relative being envious or jealous of others. Jealousy, being in relation to the threatened loss of important relationships, was described by participants. For instance, after describing the abusive behaviours of their relative one participant stated *"It got worse after our first son was born, because he was no longer the centre of my attention. I actually think he was jealous of the bond that my son and I had"* (#1419). Other participants, despite using the term

'jealous', described more envious feelings in their relative relating to anger in response to recognising desirable qualities or possessions of others. For instance, another participant stated *"[they have] resentment for people who are happy, seeing anyone happy or doing great things with their life makes them jealous and angry"* (#1744). Some participants described their relative believing that others are envious of them, for example *"[he] thought everyone was jealous he had money and good looks."* (#979) and *"[he] tried to convince everyone that people were just jealous of him because he had a nice truck"* (#1149).

#### *Node #5 exploitation*

Relatives were described as being interpersonally exploitative (i.e. taking advantage of others). For instance, one participant stated *"He brags how much he knows and will take someone else's knowledge and say he knew that or claim it's his idea"* (#1293). Another participant stated *"With two other siblings that are disabled, she uses funding for their disabilities to her advantage ... I do not think she cares much for their quality of life, or she would use those funds for its intended use." (#998).*

#### *Node #6 grandiose fantasy*

Participants also described their relatives as engaging in unrealistic fantasies of success, power and brilliance. For instance, the response *"He believes that he will become a famous film screen writer and producer although he has no education in film"* (#1002); *"He was extremely protective of me, jealous and woefully insecure. [He] went on 'missions' where he was sure [world war three] was about to start and he was going to save us, he really believes this"* (#1230).

#### *Node #7 grandiose self importance*

Relatives were described as having a grandiose sense of self-importance (e.g. exaggerating achievements, expecting to be recognised as superior without commensurate achievements). Examples of this include *"He thinks he knows everything ... conversations turn into an opportunity for him to 'educate' me"* (#1046); *"He tells endless lies and elaborate stories about his past and the things he has achieved, anyone who points out inconsistencies in his stories is cut out of his life"* (#178).

#### *Node #8 compromised empathic ability*

Participants described their relatives as being unwilling to empathise with the feelings or perspectives of others. Some examples include *"she has never once apologized for her abuse, and she acts as if it never happened. I have no idea how she can compartmentalize like that. There is no remorse"* (#1099) and *"[he] is incapable of caring for all the needs of his children because he cannot think beyond his own needs and wants, to the point of his neglect [resulting in] harm to the children"* (#1488).

#### *Node #9 belief in own specialness*

Relatives were described as believing they were somehow 'special' and unique. For example, one participant described their relative as fixated with their status as an *"important [member] of the community"* (#860), another participant stated *"he considers himself a cut above everyone and everything... Anyone who doesn't see him as exceptional will suffer"* (#449). Other responses indicated their relatives were preoccupied with being associated with other high status or 'special' people. For instance, one participant stated that their relative *"likes to brag about how she knows wealthy people as if that makes her a better person"* (#318) and another stating that their relative *"loves to name drop"* (#49).

#### *Node #10 charming*

Participants also described their relative in various positive ways which reflected their relatives' likeability or charm. For instance, *"He is fun-loving and generous in public. He is charming and highly intelligent"* (#1401); *"His public persona, and even with extended family, is very outgoing, funny and helpful. Was beloved by [others]"* (#1046) and *"He is very intelligent and driven, a highly successful individual. Very social and personable and charming in public, funny, the life of the party"* (#1800).

### Overarching dimension #2: vulnerability

Participants described the characterological vulnerability of their relative. This theme was made up of nine nodes: 'Contingent Self Esteem', 'Devaluing', 'Emotionally Empty or Cold', 'Hiding the Self', 'Hypersensitive', 'Insecurity', 'Rage', 'Affective Instability' and 'Victim Mentality'.

#### *Node #1 contingent self esteem*

Participants described their relatives as being reliant on others approval in order to determine their self-worth. For instance, *"She only ever seems to be 'up' when things are going well or if the attention is on her"* (#1196) and *"He appears to be very confident, but must have compliments and reassuring statements and what not, several times a day"* (#1910).

#### *Node #2 devaluing*

Relatives were described as 'putting down' or devaluing others in various ways and generally displaying dismissive or aggressive behaviours. For instance, *"On more than one occasion, he's told me that I'm a worthless person and I should kill myself because nobody would care"* (#1078) and *"He feels intellectually superior to everyone*

*and is constantly calling people idiotic, moron, whatever the insult of the day is"* (#1681).

Relatives were also described as reacting to interpersonal disappointment with shame and self-recrimination, devaluing the self. For instance, *"They are extremely [grandiose] ... [but] when someone has the confidence to stand up against them they crumble into a sobbing mess wondering why it's always their fault"* (#1744) and *"I have recently started to stand up for myself a little more at which point he will then start saying all the bad things are his fault and begging forgiveness"* (#274).

#### *Node #3 emotionally empty or cold*

Participants described regularly having difficulty 'connecting' emotionally with their relative. For instance, one participant described that their relative was *"largely sexually disengaged, unable to connect, difficulty with eye contact ... he used to speak of feeling dead"* (#1365); another stated *"he was void of just any emotion. There was nothing. In a situation of distress he just never had any feeling. He was totally void of any warmth or feeling"* (#323), another stated *"I gave him everything. It was like pouring myself into an emotional black hole"* (#627).

#### *Node #4 hiding the self*

Participants reported instances in which their relative would not allow themselves to be 'seen', either psychologically or physically. One way in which they described this was through the construction of a 'false self'. For instance *"He comes across very confident yet is very childish and insecure but covers his insecurities with bullish and intimidating behaviour"* (#2109). Another way participants described this hiding of self was through a literal physical withdrawal and isolation. For example, *"He will also have episodes of deep depression where he shuts himself off from human contact. He will hide in his room or disappear in his sleeper semi-truck for days with no regard for his family or employer"* (#1458).

#### *Node #5 hypersensitive*

Participants reported feeling as though they were 'walking on eggshells' as their relative would respond volatilely to perceived attacks. For instance, *"She cannot take advice or criticism from others and becomes very defensive and abusive if challenged"* (#1485); *"It was an endless mine field of eggshells. A word, an expression would be taken against me"* (#532) and *"Very irrational and volatile. Anything can set her off on a rage especially if she doesn't get her way"* (#822).

#### *Node #6 insecurity*

Relatives were described as having an underlying sense of insecurity or vulnerability. For instance *"He really is just a scared little kid inside of a big strong man's body. He got stuck when he was a child"* (#1481); *"At the core he feels unworthy, like a fake and so pretty much all introspection and self-growth is avoided at all costs"* (#532) and *"At night when the business clothes come off his fears eat him up and he would feel highly vulnerable and needs lots of reassurance"* (#699).

#### *Node #7 rage*

Participants reported that their relatives were particularly prone to displaying explosive bouts of uncontrolled rage. For example, *"He has a very fragile ego ... he will fly off the handle and subject his target to hours of screaming, insults and tantrum-throwing"* (#1078); *"he has a temper tantrum-like rage that is frightening and dangerous"* (#1476); *"He has hit me once. Left bruises on upper arms and back. He goes into rage and has hit walls, hits himself"* (#1637).

#### *Node #8 affective instability (symptom patterns)*

Relatives were also described as displaying affective instability which may be related to anxiety and depressive disorders. Relatives were commonly described as being 'anxious' (#1091) including instances of hypochondria (#1525), agoraphobia (#756), panic (#699) and obsessive compulsive disorder (#2125). Relatives were also commonly described as having episodes of 'depression' (#1106) and depressive symptoms such as low mood (#1931), problems sleeping (#1372). Some participants also described their relative as highly suicidal, with suicidality being linked to relationship breakdowns or threats to self-image. For example, *"When I state I can't take any more or say we can't be together ... he threatens to kill himself"* (#1798); *"If he feels he is being criticised or blamed for something (real or imagined) ... his attacks become self-destructive"* (#1800).

#### *Node #9 victim mentality*

Participants reported that their relatives often described feeling as though they were the victim of attacks from others or taken advantage of in some way. For instance, *"He seems to think that he has been 'hard done by' because after all he does for everyone, they don't appreciate him as much as they should"* (#1476); *"He will fabricate or twist things that are said so that he is either the hero or the victim in a situation"* (#447).

### Other personality features

Participants also reported some descriptions of their relative that were not described within prior conceptualisations of narcissism. This theme was made up of 3 nodes: 'Perfectionism', 'Vengeful' and 'Suspicious'.

#### *Node #1 perfectionism*

Participants repeatedly described their relative displaying perfectionistic or unrelenting high standards for others. For instance, *"I cannot just do anything at home everything I do is not to her standard and perfection"* (#1586) and *"Everything has to be done her way or it's wrong and she will put you down. She has complete control over everything"* (#1101).

#### *Node #2 vengeful*

Participants described their relative as being highly motivated by revenge and displaying vindictive punishing behaviours against others. Examples include, *"[He] has expressed thoughts of wanting to hurt those who cause him problems"* (#230); *"He is degrading to and about anyone who doesn't agree with him and he is very vengeful to those who refuse to conform to his desires"* (#600) and *"Once someone crosses him or he doesn't get his way, he becomes vindictive and will destroy their life and property and may become physically abusive"* (#707).

#### *Node #3 suspicious*

Participants described their relative as holding paranoid or suspicious beliefs about others intentions or behaviours. For instance, *"He would start fights in public places with people because he would claim they were 'looking at him and mimicking him'"* (#1149) and *"She is angry most days, obsessively talking about who wronged her in the past, currently or who probably will in the future"* (#2116).

### Descriptive themes

Several salient descriptive themes were also coded from the data that, while not relating directly to the relatives character, may provide peripheral or contextual information.

#### *Descriptive theme #1: trauma*

A number of participants described their relative as having experienced a traumatic or troubled childhood. One participant stated that their relatives' father *"was extraordinarily abusive both emotionally and physically to both him and the mother … [the father] pushed [the relative] as a young boy on prostitutes as a 12th birthday gift … He was beaten on and off from age 6 to 15 when he got tall enough to threaten back"* (#1249). Another participant described the emotional upbringing of their relative *"[his mother was] prone to being easily offended, fighting with him and cutting off all contact except to tell him what a rotten son he was, for months, then suddenly talking again to him as if nothing had ever happened. His father, he said, was strict and expected a lot of him. Both rarely praised him; whenever he accomplished something they would just demand better instead of congratulating him on his accomplishment"* (#1909). Another participant reflected on how their relative's upbringing may be related to their current emotional functioning, *"personally I think he is so wounded (emotional, physical abuse and neglect) that he had to detach from himself and others so much just to survive"* (#1640).

#### *Descriptive theme #2: excessive religiosity*

While participant's comments on their relative's religiosity were common, the content was varied. Some participants described their relative using religion as a mechanism to control, for instance *"he uses religion in an extremely malignant way. Manipulating verses and religious sayings and interpret them according to his own will"* (#132) and *"very religious. She uses scripture to manipulate people into doing what she wants on a regular basis"* (#1700). One participant described how their relative's religiosity became infused with their grandiose fantasy *"He has also gone completely sideways into fundamental religious doctrine, as if he knows more than the average 'Christian' about End Times, and all kinds of illuminati type conspiracy around that topic. He says God talks to him directly and tells him things and that he has had dead people talk to him"* (#1476). Other participants described how their relative's religiosity was merely an aspect of their 'false self', for example *"she has a wonderful, loving, spiritual facade that she shows to the world"* (#1073).

#### *Descriptive theme #3: substance use*

Participants regularly described their relative as engaging in substance use. Substances most frequently named were alcohol, marijuana, cocaine and 'pills'. Participants reported that when their relative was using substances their behaviour often became dangerous, usually through drink driving, one participant stated *"too much alcohol … he would drive back to [his work] … I was always afraid of [a driving accident]"* (#76).

### Subtype expression

Of 436 participants, a total of 348 unique grandiose node expressions were present and a total of 374 unique vulnerable node expressions were present. Of these, 301 participants included both grandiose and vulnerable descriptions of their relative (69% of sample). Only 47 (11% of sample) focused on grandiose features in their description of their relative, and only 88 participants (20% of sample) focused on vulnerable features.

### Cluster analysis

A cluster analysis dendrogram was generated using Nvivo 11 for purposes of visualising and exploring the underlying dimensions of the data [48] and is displayed in Fig. 1. Four clusters of nodes and one standalone

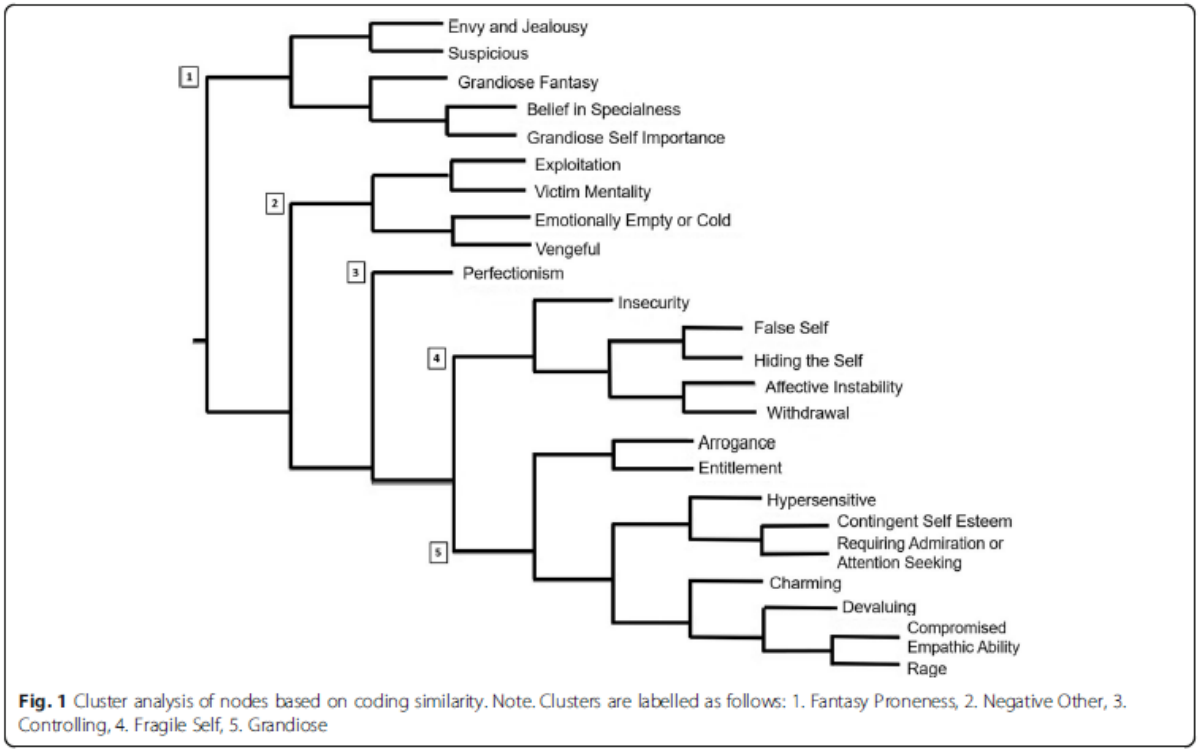


**Fig. 1** Cluster analysis of nodes based on coding similarity. Note. Clusters are labelled as follows: 1. Fantasy Proneness, 2. Negative Other, 3. Controlling, 4. Fragile Self, 5. Grandiose

node can be distinguished. The first cluster, labelled 'Fantasy Proneness', includes nodes reflecting the predominance of 'fantasy' colouring an individuals interactions, either intrapersonally ('grandiose self-importance, belief in specialness') or interpersonally ('suspicious, envy'). The second cluster, labelled 'Negative Other', reflects nodes concerned with a detached connection with others ('emotionally empty') and fostering 'vengeful' and 'exploitative' drives towards others, as well as feelings of victimhood. Interestingly, despite being related to these other aspects of narcissism, 'perfectionism' was factored as reflecting its own cluster, labelled 'Controlling'. The fourth cluster, labelled 'Fragile Self', includes nodes indicating feelings of vulnerability ('affective instability', 'insecurity') and shameful avoidance ('hiding the self', 'false self', 'withdrawal') due to these painful states. The fifth cluster, labelled 'Grandiose' reflects a need ('contingent self-esteem', 'requiring admiration') or expectation ('entitlement', 'arrogance') of receiving a certain level of treatment from others. It also includes nodes regarding how individuals foster this treatment ('charming', 'rage', and 'devaluing') and a hypervigilance for if their expectations are being met ('hypersensitive').

## Discussion

This study aimed to qualitatively describe the interpersonal features of individuals with traits of pathological narcissism from the perspective of those in a close relationship with them.

### Grandiose narcissism

We found many grandiose features that have been validated through empirical research [2, 3, 19]. Grandiosity, as reflected in the DSM-5, has been argued to be a key feature of pathological narcissism that distinguishes it from other disorders [26, 28]. One feature regularly endorsed by participants that is not encompassed in DSM-5 criteria is relatives' level of interpersonal charm and likability. This charm as described by participants appears more adaptive than a 'superficial charm' that might be more exclusively 'interpersonally exploitative' in nature. However, it should be noted that this charm did not appear to persist, and was most often described as occurring mainly in the initial stages of a relationship or under specific circumstances (e.g. in public with an audience).

### Vulnerable narcissism

We also found participants described their relative in ways consistent with the vulnerable dimensions of the pathological narcissism inventory (i.e. hiding the self, contingent self esteem and devaluing [50];). Dimensions that are also included in other popular measures for vulnerable narcissism were also endorsed by participants in

our sample. For instance, the nodes of 'hypersensitivity', 'insecurity' and 'affective instability' reflect dimensions covered in the Hypersensitive Narcissism Scale [51] and neuroticism within the Five Factor Narcissism Inventory [52]. These aspects of narcissism have also been documented within published literature [12, 27, 53, 54].

#### Subtype expression: cluster analysis

Most participants (69% of sample) described both grandiose and vulnerable characteristics in their relative, which given the relatively small amount of text and node expressions provided per participant is particularly salient. Given the nature of the relationship types typically endorsed by participants (i.e. romantic partner, family member), it suggests that the degree of observational data on their relative is quite high. As such, these results support the notion that an individual's narcissism presentation may fluctuate over time [20, 21] and that vulnerable and grandiose presentations are inter-related and oscillating [9, 19].

The cluster analysis indicates the degree to which salient co-occurring features were coded. These features can be grouped to resemble narcissistic subtypes as described in research literature, such as the subtypes outlined by Russ, Shedler [55] in their Q-Factor Analysis of SWAP-II Descriptions of Patients with Narcissistic Personality Disorder. Our clusters #1–3 ('Fantasy Proneness', 'Negative Other' and 'Controlling') appear to resemble the 'Grandiose/malignant narcissist' subtype as described by the authors. This subtype includes instances of self-importance, entitlement, lack of empathy, feelings of victimisation, exploitativeness, a tendency to be controlling and grudge holding. Our cluster #4–5 ('Fragile Self' and 'Grandiose') appear to resemble the 'Fragile narcissist' subtype described including instances of depressed mood, internal emptiness, lack of relationships, entitlement, anger or hostility towards others and hypersensitivity towards criticism. Finally, our 'Grandiose' cluster (#5) showed overlap with the 'high functioning/exhibitionistic narcissist' subtype, which displays entitled self-importance but also a significant degree of interpersonal effectiveness. We found descriptions of the relative showing 'entitlement', being 'charming' and 'requiring admiration'.

While co-occurring grandiose and vulnerable features are described at all levels of clusters in our sample, distinctions between the observed clusters may be best understood as variations in level of functioning, insight and adaptiveness of defences. As such, pathological narcissism has been understood as a characterological way of understanding the self and others in which feelings of vulnerability are defended against through grandiosity [56], and threats to grandiosity trigger dysregulating and disintegrating feelings of vulnerability [53]. Recent research supports this defensive function of grandiosity, with Kaufman, Weiss [11] stating "grandiose narcissism was less consistently and strongly related to psychopathology … and even showed positive correlations with adaptive coping, life satisfaction and image-distorting defense mechanisms" (p. 18). Similarly, Hörz-Sagstetter, Diamond [28] state 'high levels of grandiosity may have a stabilizing function' on psychopathology (p. 569). This defence, however, comes at a high cost, whether it be to the self when the defensive grandiosity fails (triggering disintegrating bouts of vulnerability) or to others, as this style of relating exacts a high toll on those in interpersonal relationships [33].

#### Other personality features

Participants described their relative as highly perfectionistic, however the perfectionism described was less anxiously self-critical and more 'other oriented'. This style of other oriented 'narcissistic perfectionism' has been documented by others [57] and appears not to have the hallmarks of overt shameful self-criticism at a surface level, however may still exist in covert form [58]. Regarding the 'vengeful' node, Kernberg [16], Kernberg [59] describes that as a result of a pain-rage-hatred cycle, justification of revenge against the frustrating object is an almost unavoidable consequence. Extreme expressions of acting out these "ego-syntonic" revenge fantasies may also highlight the presence of an extreme form of pathological narcissism in this sample – malignant narcissism, which involves the presence of a narcissistic personality with prominent paranoia and antisocial features [60]. Lastly, Joiner, Petty [61] report that depressive symptoms in narcissistic personalities may evoke paranoid attitudes, which may in turn be demonstrated in the behaviours and attitudes expressed in the 'suspicious' node we found.

While this study focused on a narcissistic presentation, the presence in this sample of these other personality features (which could alternatively be described as 'anankastic', 'antisocial' and 'paranoid') is informed by the current conversation regarding dimensional versus categorical approaches [62, 63]. Personality dysfunction from a dimensional perspective, such as in the 'borderline personality organisation' [23] or borderline 'pattern' [64] could understand these co-occurring personality features as not necessarily aspects of narcissism or 'comorbidities', but as an individual's varied pattern of responding that exists alongside their more narcissistic functioning, reflecting a more general level of disorganisation that resists categorisation. This is particularly reflected in Table 2 as participants reported a wide variety of diagnosed conditions, as well as the 'Affective Instability' node which may reflect various diagnostic symptom patterns.

### Descriptive features

The relationship between trauma and narcissism has been documented [58, 65–67] and the term 'trauma-associated narcissistic symptoms' has been proposed to identify such features [68]. Interestingly, while participants in our sample did describe instances of overt abuse which were traumatic to their relative (e.g. physical, verbal, sexual), participants also described hostile environments in which maltreatment was emotionally abusive or manipulative in nature, as well as situations where there was no overt traumatic abuse present but which most closely resemble 'traumatic empathic failures'. This type of attachment trauma, stemming from emotionally invalidating environments, is central to Kohut's theory of narcissistic development [69, 70], and has found support in recent research [71]. Relatives religiosity was noteworthy, not necessarily due to its presence, but due to the narcissistic function that the religiosity served. Research on narcissism and religious spirituality has steadily accumulated over the years (for a review see: [72]) and the term 'spiritual bypassing' [73] is used for individuals who use religion in the service of a narcissistic defence. In our sample this occurred via alignment with an 'ultimate authority' in order to bolter esteem and control needs. It may be that the construction of a 'false self' rooted in spirituality is conferred by the praise and audience of a community of believers. Finally, participants reported their relative as engaging in various forms of substance use, consistent with prevalence data indicating high co-occurrence of narcissism and substance use [65]. While the motivation behind relatives substance use was not mentioned by participants, it is consistent with relatives more general use of reality distorting defences, albeit a more physicalised as opposed to an intrapsychic method.

### Implications of findings

First, this study extends and supports the widespread acknowledged limitation of DSM-5 criteria for narcissistic personality disorder regarding the exclusion of vulnerable features (for a review of changes to dignostic criteria over time, see [74, 75]) and we acknowledge the current discussion regarding therapist decision to provide a diagnosis of NPD [76]. However, the proliferation of alternate diagnostic labels may inform conceptualisations which do not account for the full panorama of an individual's identity [7], adding to the already contradictory and unintegrated self-experience for individuals with a narcissistic personality. This may also impede the treatment process by informing technical interventions which may be contra-indicated. For instance, treatment of individuals with depressive disorders require different approaches than individuals with a vulnerably narcissistic presentation [24, 77]. As such, a focus of treatment would include the integration of these disparate self-experiences, through the exploration of an individual's affect, identity and relationships, consistent with the treatment of personality disorders more generally. Specifically, when working with an individual with a narcissistic personality, this may involve identifying and clarifying instances of intense affect, such as aggression and envy, themes of grandiosity and vulnerability in the self-concept, and patterns of idealization and devaluation in the wider relationships. The clinician will need to clarify, confront or interpret to these themes and patterns, their contradictory nature as extreme polarities, and attend to the oscillation or role reversals as they appear [78]. Second, as the characterological themes identified in this paper emerged within the context of interpersonal relationships, this highlights the interconnection between impaired self and other functioning. As such, in the context of treating an individual with pathological narcissism, discussing their interpersonal relationships may be a meaningful avenue for exploring their related difficulties with identity and emotion regulation that may otherwise be difficult to access. This is particularly salient as treatment dropout is particularly high for individuals with pathological narcissism [4], and as typical reason for attending treatment is for interpersonal difficulties [79]. Third, treatment for individuals with narcissistic personalities can inspire intense countertransference responses in clinicians [80] and often result in stigmatisation [81]. As such, these findings also provide a meaningful way for the clinician to extend empathy to these clients as they reflect on the defensive nature of the grandiose presentation, the distressing internal emptiness and insecurity for these individuals, and the potential childhood environment of emotional, sexual or physical trauma and neglect which may have informed this defensive self-organisation. Finally, these findings would also directly apply to clinicians and couples counsellors working with individuals who identify their relative as having significant narcissistic traits, providing them with a way to understand the common ways these difficulties express themselves in their relationships and the impact they may have on the individuals in the relationship. Practically, these findings may inform a heightened need for treating clinicians to assess for interpersonal violence and the safety of clients in a context of potential affective dysregulation and intense aggression. Regarding technical interventions, if working with only one of the individuals in the relationship, these findings may provide avenues for psychoeducation regarding their relatives difficulties with identity and affect regulation, helping them understand the observed oscillating and contradictory self-states of their relative. If working with both individuals or the couple, the treating clinician will need to be able to identify and interpret

changes in affect and identity, and the way this manifest in the relationship functioning of the couple and their characteristic ways of responding to each other (e.g. patterns of idealization and devaluation). This may also involve attending to the ways in which the therapist may be drawn into the relationship with the couple, noticing and interpreting efforts at triangulation or any pressure to 'pick sides' from either individual.

### Limitations

The sample selection procedure may have led to results only being true for some, but not all people living with a relative with narcissistic features. Participants were recruited online limiting the opportunity to understand participant motivation. Second, relying on informant ratings of narcissism for both screening and qualitative analysis is a limitation as we are less unable to control for severity, specificity or accuracy of participant reporting. Further, it is possible that the use of a narcissism screening tool primed participants to artificially report on particular aspects of their relative. However, the risk of biasing or priming participants is a limitation of all studies of this kind, as studies implementing informant methodology for assessing narcissism typically rely on providing participants with a set of diagnostic criteria or narcissism specific measures as their sole indicator of narcissism (e.g. [30, 38]). As such, notwithstanding the limitations outlined, this informs the novelty and potential utility of the present approach which relies on identifying narcissism specific features amongst a backdrop of descriptions of more general functioning within intimate relationships. Third, gender disparity in participants and relatives was substantial. However, as NPD is diagnosed more commonly in males (50–75%, American Psychiatric Association, 2013) and as most participants in our sample were in a romantic, heterosexual relationship, this disparity may reflect a representative NPD sample and should not significantly affect the validity of results. Rather, this disparity may strengthen the argument that individuals with a diagnosis of NPD (as specified by DSM-5 criteria) may have co-occurring vulnerable features, which may not be currently reflected in diagnostic categories. Finally, as a result of relying on informant ratings and not assessing narcissistic individuals via structured clinical interview, questions regarding the specificity and severity of the narcissistic sample are unable to be separated in the analysis. We thus probably studied those ranging from 'adaptive' or high functioning narcissism [82] to more severe and disabling character disorders. Whilst we screened for narcissistic features, it was clear the sample studied also reported a broad range of other co-occurring problems.

## Conclusions

We investigated the characteristics of individuals with pathologically narcissistic traits from the perspective of those in a significant personal relationship with them. The overarching theme of 'Grandiosity' involved participants describing their relative as requiring admiration, displaying arrogant, entitled, envious and exploitative behaviours, engaging in grandiose fantasy, lacking in empathy, having a grandiose sense of self-importance, believing in own sense of 'specialness' and being interpersonally charming. The overarching theme of 'Vulnerability' involved participants describing their relative's self-esteem being contingent on others, as being hypersensitive, insecure, displaying affective instability, feelings of emptiness and rage, devaluing self and others, hiding the self through various means and viewing the self as a victim. Relatives were also described as displaying perfectionistic, vengeful and suspicious personality features. Finally, participants also described several descriptive themes, these included the relative having a trauma history, religiosity in the relative and the relative engaging in substance use. The vulnerability themes point to the problems in the relatives sense of self, whilst the grandiose themes show how these express themselves interpersonally. The complexity of interpersonal dysfunction displayed here also points to the importance of assessing all personality traits more broadly.

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**Authors' contributions**
ND contributed in conceptualisation, design, coordination, data collection, analysis, interpretation and writing of the manuscript. MT contributed in data collection, analysis, interpretation and writing of manuscript. BG contributed in conceptualisation, design, coordination, interpretation and writing of manuscript. All authors read and approved the final manuscript.

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**Availability of data and materials**
The datasets generated during and/or analysed during the current study are not publicly available due to the sensitive and personal nature of participant responses but are available from the corresponding author on reasonable request.

**Ethics approval and consent to participate**
University of Wollongong Institutional Review Board approval was received from the University of Wollongong Human Research Ethics Committee (16/079). All participants provided informed consent to participation.

**Consent for publication**
Not applicable.

**Competing interests**
The authors declare that they have no competing interests.

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## Publisher's Note