To the Graduate Council:

I am submitting herewith a dissertation written by Douglas L. Dunlap entitled "A Study of Interpersonal Styles of Narcissistic Men and Women." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

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We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Chancellor
Graduate Studies and Research

A STUDY OF INTERPERSONAL STYLES OF NARCISSISTIC MEN AND WOMEN

A Dissertation
Presented for the
Doctor of Philosophy
Degree

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ABSTRACT

Kohut (1971) views the narcissistic personality as having an underdeveloped "self" which is in constant need of external bolstering, the most reliable indicator of which is the self-oriented quality of the patient-to-therapist relationship. Drawing from Kohut's formulations, narcissistic personality was understood for this study to mean an individual who relates to others predominately in the "narcissistic mode," the prototype for this mode being the child's self-oriented attachments to others during normal early development. The self-enhancing "narcissistic mode" may be contrasted to the "object loving mode" in which others are recognized as separate from self. The literature on narcissistic personalities tends to focus primarily on males, and on individuals whose behavior is overtly arrogant. The objectives of this study were to examine the overt interpersonal styles of highly narcissistic individuals, to compare the styles of narcissistic women to those of narcissistic men, and to validate the notion that narcissistic individuals can be distinguished from nonnarcissistic individuals by the relative underlying predominance of the narcissistic mode. It was hypothesized that narcissistic individuals would display an array of overt styles, that the styles of narcissistic women would differ from those of

narcissistic men, and that underlying features of narcissistic individuals would differ from those of nonnarcissistic individuals.

With the aid of a criteria list, therapists identified 20 high narcissism and 20 low narcissism patients, and described patients' overt behavior on the Interpersonal Check List. They also provided information about patients' underlying features in an interview, which was then rated for Leary interpersonal themes. Although some variation in overt interpersonal styles of high narcissism patients was found, most had "traditional," overtly arrogant styles. No significant differences were found between narcissistic men and narcissistic women. Underlying differences were found, however, between high narcissism and low narcissism patients, differences which supported the narcissistic mode versus object loving mode distinction. Possible reasons for the limited range of styles among high narcissism patients, and for the absence of differences between narcissistic men and narcissistic women, were discussed.

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I. INTRODUCTION AND OBJECTIVES OF STUDY

In the most commonly known account of the Greek myth written by Ovid, Narcissus is a handsome youth who is sought after as a lover by, among others, the nymph Echo. Narcissus disdains and rejects Echo's love, however, and for this is punished by the goddess Nemisis, and made to fall in love with his own image reflected in the water. Such unrequited self admiration eventually leads to Narcissus' death, whereupon he is changed into a flower. It is from this legend that the psychological term "narcissism" was borrowed. Havelock Ellis first introduced the term "narcissus-like tendency" in 1898 to describe the phenomenon of "sexual emotions" becoming "absorbed and often entirely lost in self admiration."[1] Since the time of Ellis, the term "narcissistic" has been used to describe a variety of phenomena, including (1) an early self-oriented stage of normal human development (2) an adult mode of relating to others, and (3) a personality type.

Kohut (1971) describes the narcissistic personality as an individual who, due to interruption of the self-building process during childhood, never developed a mature and stable sense of self. The self preoccupation of the

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[1]Ellis credits Nacke with the introduction of the specific term "narcissism."

narcissistic personality reflects an ongoing predominating need for external self-bolstering of a tenuous "self." In Kohut's view, the most reliable indicator of the presence of the underdeveloped "self" structures in the narcissistic personality is the self-oriented quality of the emerging transference relationship between patient and therapist.

Drawing from Kohut's views of the narcissistic personality, especially from his view that these individuals are most reliably identified by interpersonal cues, narcissistic personality was understood for this study to mean an individual who relates to others predominantly in the "narcissistic mode," the prototype for this mode being the self-oriented type of attachments made to others by the child during the normal narcissistic stage of development. The "narcissistic mode," in which others are "used" for self enhancement, may be contrasted to the "object loving mode" in which others are recognized as separate from self.

In the investigator's view, it is the predominance of the narcissistic mode in their relationships to others by which narcissistic personalities are most meaningfully defined. Although stemming largely from Kohut's work, this interpersonal view of narcissism is admittedly only one of many inferences which might be drawn from Kohut's theoretical formulations. It is a viewpoint which this project sought, in part, to examine.

Although the clinical literature on narcissistic personalities has contributed a great deal, it has the disadvantage of being largely impressionistic and nonstandardized. With regard to content, it has tended to focus primarily on underlying similarities between narcissistic individuals rather than on stylistic differences, with descriptions of overt interpersonal behavior typically being cursory at best (e.g., Kohut, 1971, 1977; Kernberg, 1975). This literature has also focused primarily upon narcissistic males while tending to ignore and/or overlook narcissistic females (e.g., only four of 22 cases presented by Kohut, 1971 and 1977, are women); often making implicit or explicit assumptions about similarities between the two which go unquestioned and uninvestigated. In addition, there is somewhat of a trend to limit investigation of narcissistic personalities to individuals who are overtly arrogant, competitive, and exhibitionistic, a trend which reflects and may contribute to a stereotypic and unnecessarily restricted view in which narcissistic personality is equated with this particular overt style.

It is the contention of this investigator that the narcissistic mode of relating to others may predominate and be embedded in an array of overt interpersonal styles. It is also contended that highly narcissistic women tend to have interpersonal styles which are different from those of

highly narcissistic men, and furthermore that stylistic differences between the two tend to reflect sex differences which exist between men and women generally.

In light of the above, it was the primary objective of this study to systematically examine and compare the overt interpersonal styles of highly narcissistic individuals, and in particular to compare the overt interpersonal styles of narcissistic women to those of narcissistic men. The second objective of this study was to investigate the validity of the view that narcissistic personalities can in fact be meaningfully distinguished from nonnarcissistic individuals by the relative predominance at an underlying level, of the narcissistic mode.

II. NARCISSISM AND NARCISSISTIC PERSONALITIES: REVIEW OF THE LITERATURE

The Narcissistic Stage of Development

"Narcissistic" is widely used to designate an early developmental stage through which all human beings pass. Although there are different views regarding the precise time and length of the narcissistic stage, typically it is viewed as occurring from birth until some time prior to the latter half of the second year (Pulver, 1970). Abraham (1916) described this phase of development as:

> That stage in the development of the libido in which the child is himself the center of his own narrow world, and in which he receives proofs of love from other persons without himself giving any in return. (in Ellis, 1927, p. 144)

According to Piaget (1929), the narcissistic stage is a time during which:

> the child is only concerned with himself and ignores more or less completely the views of others. But, in logic also, if the child sees everything from his point of view, it is because he believes all the world to think like himself. He has not yet discovered the multiplicity of possible perspectives and remains blind to all but his own as if that were the only one possible. (p. 167)

It is a time during which the infant is utterly dependent for survival upon the emotional and physical nourishment supplied by others. Paradoxically, it is also a time of great omnipotence in which, given parents who are reasonably

empathic in their provision of these supplies, to wish is to cause to happen. The child may experience great fluctuations between omnipotence when his wishes are fulfilled, and helplessness when he wishes for something, does not get it, and cannot get it by himself (Murphy, 1960; A. Reich, 1960). It is through "partial deprivations" (Hartmann and Lowenstein, 1946) or what Winnicott (1951) calls "gradual disillusionment" during this stage that the child begins to develop a more realistic sense of his own powers and needs, and by so doing begins the process of differentiating self from others. When partial deprivations and frustrations are carried out by parents in a way which is grossly inconsistent with the child's developmental needs, the emergent rudimentary self of the child may be deficient and unstable. Under more normal circumstances, however, experiences of the infant during the narcissistic stage constitute a vital and fundamental step toward the later development of healthy, adult narcissism in the form of positive self feelings and personal ideals. In this regard, Kohut (1972) writes:

> Our archaic grandiosity and exhibitionism [are transformed] into realistic self esteem and into pleasure with ourselves, and our yearning to be at one with the omnipotent self-object [i.e., the idealized parent] into the socially useful, adaptive, and joyful capacity to be enthusiastic and to admire the great after whose lives, deeds, and personalities we can permit ourselves to model our own. (p. 365)

The child's attachments to others during the narcissistic stage are understood in different ways, and explained by differing theoretical formulations. Freud (1914) viewed the infant at this time as being in a sort of self-encapsulated, noninteractive state, and accordingly proposed that all energy was directed inward, and that no libidinal investment of others was as yet possible. Some writers have criticized this formulation on the grounds that the infant does not yet have a distinct self or ego to be "cathected," therefore self and environment must be viewed as being equally cathected (Ephron, 1967; Sandler and Rosenblatt, 1962; Sandler, Holder, & Dare, 1976; Bing, McLaughlin, & Marburg, 1959). A somewhat more radical criticism and reformulation which is consistent with Kohut's understanding of narcissism is made by Balint (1960), and others (Stolorow, 1975a; Rosenfeld, 1964; O'Connell, 1979). From this point of view, the infant is not born into an encapsulated, noninteractive state at all, but rather into a state of primary intense relateness to the environment from which he withdraws only secondarily in response to disruptions and trauma. Balint suggests that the infant's attachment to his parents during the narcissistic stage is analogous to breathing, in which air is vital for survival, but taken for granted and not thought of as separate as long as it is sufficient. Just as a disruption in the air supply unmistakably reveals one's utter dependence

upon it, parental failure to provide for some important need during the narcissistic stage may result in the "seemingly uncathected environment assum[ing] immense importance" (Balint, 1960) revealing the intense attachment to others which was there all along. Freud (1914) based his "noncathexis-of-others" theory of the infant on observations such as the withdrawal of schizophrenics, a state which he understood to resemble and stem from early infantile states. Balint points out that, despite their apparent withdrawal, schizophrenics in fact remain highly sensitive to others and capable of forming intense, albeit primitive, attachments (as anyone who has worked with them knows).

Data from studies of infants appear to lend support to Balint's point of view (O'Connell, 1979). For example, three month old infants were found to smile more often in response to a human stimulus than in response to a nonhuman one (Wolff, 1963), day old infants were found to synchronize their movements in a fashion which was directly related to the patterns of nearby adult speech (Condon & Sander, 1974), and neonates have been found to open their eyes, follow movement, and smile within their first minutes of life (Le Boyer, 1975).

At the theoretical level, Balint's viewpoint implies that the attachments of the infant during the narcissistic stage are defined not by their direction (i.e., "cathexes"

exclusively inward), but rather by their relatively primitive quality.

The Narcissistic Mode of Relating to Others

Freud (1914) distinguished the anaclitic mode of loving from the narcissistic mode. In the former, the other person represents the parents who fed and protected us. In the latter, the loved one represents what we ourselves are, what we once were, or what we would like to be. Expanding on Freud's idea, more recent formulations distinguish the "narcissistic mode" from the "object loving mode." In the object loving mode, the boundaries between self and others are relatively clearly established, and the other person is loved and appreciated predominantly for his distinct qualities. In the narcissistic mode, others are not loved for their real attributes or actual personality, but rather are needed to help buttress a sense of self, or to establish and maintain self esteem.[2] In the narcissistic relationship, the other person may be "used" to reflect back a hoped for picture of the self, or intensely idealized so that their

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[2]Stolorow (1975a) proposes a functional definition of 'narcissistic' which is consistent with the use of the term for this study: "Mental activity [or a relationship] is narcissistic to the degree that its function is to maintain the structural cohesiveness, temporal stability, and positive affective coloring of the self representation" (p. 179).

greatness may be "borrowed." The other person may also be related to as though he were an aspect of the self, or an important past figure in one's life (Friedman, 1975; Stolorow, 1975a; Eisnitz, 1969; Kohut, 1971).

One example of a predominantly narcissistic attachment is the relationship between the legendary Pygmalian and the exquisitely formed statue of the "perfect," albeit nonhuman, woman that he has created. The "other" in this case serves primarily as a reflector and potential provider of hoped for perfection in the self. The relationship between Johnny Carson and Ed McMahon on the television program The Tonight Show is another example of an attachment which is predominantly narcissistic. Rather than to interact with Carson as a competent performer in his own right, McMahon serves primarily to help bolster Carson's image as a funny and competent performer.[3] The attachments of the so called "Jewish mother" to her children may also be predominantly narcissistic, for example when her ardent desire for her son to be a doctor is based more upon her own need to feel

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[3] In an interview on the television program 60 Minutes, McMahon recounted an early incident in which he stepped out of his usual role as 'reflector' to Carson, making a joke of his own which preempted one that Carson was to make. Carson reacted with impressive anger, making it clear that independent behavior of this type on McMahon's part was neither expected nor permitted. Over the years, Carson appears to have become relatively sure of himself which has enabled him to allow McMahon a bit more autonomy on the show.

vicariously important than upon her son's need or desire to practice medicine. Homosexual relationships may often be predominantly narcissistic, with one partner representing the self image, or desired self image of the other. Hart (1947) also suggests that "falling in love with falling in love" constitutes a predominantly narcissistic mode of relating in that the attributes of the other person are less important than what the idealized state of being in love does for the self feeling.[4]

Although a predominating narcissistic mode may have more aggressive and defensive elements in adulthood than during the narcissistic stage of development, the adult version is understood for this study to be qualitatively reminiscent of the type of relatedness exhibited by the child during this early stage. In both, the other is related to primarily "in terms of the specific needs of the developing [or underdeveloped] self, without recognition of

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[4]There are clear similarities between the narcissistic attachment, and the attachment to a transitional object. The classic transitional object relationship is between child and teddy bear or blanket. The blanket has concrete existence, but at the same time is "created" by the needs of the child for protection and comfort, and is viewed by the child as being only partially separate from him at most (Winnicott, 1951). Modell (1968) describes the transitional object relationship as one in which the object is used to stand between the subject and the dangers of the outside world, its importance having to do with its protective and soothing functions rather than with any distinct qualities. The self-bolstering function which the "other" provides in the narcissistic relationship is likewise primary.

the separateness of the object and its own center of initiative" (Ornstein, 1979, p. 60). The narcissistic mode of relating to others may predominate in adulthood if disruptions and traumata during the narcissistic stage remain unresolved (Kohut, 1971).

As with the developmental stage of narcissism, there is considerable disagreement in the literature with regard to theoretical underpinnings. In the traditional psychoanalytic formulation, the existence of a fixed supply of psychic energy is assumed, and the narcissistic mode is viewed as being basically opposed to and in conflict with the object loving mode, since investments in the self necessarily decrease the amount of energy available for investments in others. While this theoretical explanation is superficially meaningful in the case of the highly self absorbed person who appears disinterested in his surroundings, its utility in explaining other readily observable phenomena is questionable at best (Pulver, 1970; Stolorow, 1975a; Joffe & Sandler, 1967; Bing, McLaughlin, & Marburg, 1959; Van der Waals, 1965). For example, it does not account well for the fact that a satisfying relationship with another person typically enhances a positive feeling about oneself, or conversely that a loss of an important relationship may result in an apparent decrease in self "investments" in the form of negative self feelings, or even self neglect. Nor does it

account for the axiomatic observation that real love of others stems from and coexists with a genuine love of self.

An alternate theoretical viewpoint which accommodates these otherwise discrepant phenomena is that narcissistic and object loving modes differ with respect to quality and function of attachment (i.e., self enhancement versus appreciation of others) rather than direction or quantity of energy invested. From this viewpoint, these two modes of relating are not essentially in conflict. In fact, the need for interactions to be self-enhancing is seen in most cases as a vital concommitant of healthy object loving. That is, all human relationships, quite normally and positively, are understood to include both object loving and narcissistic modes in varying proportions.[5] Those individuals who relate to others predominantly in the narcissistic mode are viewed not as being bereft of attachments to others altogether, but rather as tending out of an excessive need for self bolstering to form relationships which differ in quality from relationships which include a greater proportion of object loving. The prototype for these narcissistic relationships is understood to be the infant's attachments to others

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[5]Hart (1947) points out correctly that "pure" object love in which absolutely nothing is demanded in return is theoretical only, a feat which only God might be able to accomplish. For human beings, the fact that our contact with others serves in some measure to make us feel good or feel alive is part of the reason that we love them.

during the narcissistic stage of development in which self-building needs are appropriately pervasive.

Narcissistic Personalities

Kohut's View*

In Kohut's view, the narcissistic personality (NP) has only a rudimentary and primitive 'self," although it is stable and cohesive relative to the self of the borderline personality disorder who, unlike the NP, is liable to undergo psychotic disintegration in the face of intimacy. The NP can be identified most reliably by the narcissistic quality of the transference relationship with his or her therapist. For Kohut, the predominating narcissistic mode of relating constitutes for the NP an attempt to elicit belatedly the self-bolstering responses from the therapist (namely, "mirroring," or idealization accepting) of which he was deprived in some fashion during the narcissistic stage, but which are vital for the development of a more cohesive and functional self. That is, because he is essentially fixated at the narcissistic stage of development, the NP's attachments to others tend to be predominantly colored by frustrated and intensified self-needs which were phase appropriate at that time.

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*Material for this section is derived from the following sources: Kohut, 1966, 1971, 1972, 1977; Kohut & Wolf, 1978; Ornstein, 1974, 1979

Specifically, the NP's underlying needs for self-building manifest themselves in therapy as mirror and/or idealizing transferences. In the former, the patient recognizes the therapist as separate from himself only to the extent that he exists to admire and reflect back to him a sense of confirmation, value, or greatness. That is, the patient relates to the therapist as though he were there only to meet his frustrated exhibitionistic needs.[6] In the latter, the therapist is viewed by the patient as an all powerful, all good figure who is important to the extent that he can provide through merger a vicarious sense of safety, strength, or greatness. Although rage, coldness, superiority, devaluation, and shame are also viewed by Kohut as being prevalent features of the therapy relationship, these features are viewed as being secondary to the essential transferences described above, diminishing as the transference unfolds more fully.[7]

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[6]Kohut (1971) distinguishes two other types of transferences: the "twinship" and "merger" transferences. These are similar to the mirror transference, but are more primitive, changing with time into the more typical mirror transference as described above.

[7]Countertransference reactions are viewed by Kohut (and others) as being the most reliable means of recognizing the presence of the narcissistic mode in the therapy relationship. In response to the NP's need and demands for self validation, praise, and admiration, and his refusal to acknowledge separateness, the following reactions are common: (a) an urge to nod one's head over and over, and to agree and praise, even when viewpoints and perceptions are distorted,

NPs have marked problems regulating self esteem, and tend to be highly dependent upon the reactions of others for self validation. They often fluctuate between overestimating themselves and feeling very inadequate. Although he minimizes the diagnostic value of "surface" personality manifestations, Kohut suggests that the following features are also typical of NPs: (1) perverse sexual fantasies, lack of interest in sex, (2) work inhibitions, problems maintaining relationships, delinquent activities, (3) lack of humor, empathy, and a sense of proportion, and (4) hypochondriacal preoccupations about both physical and mental health.

Kohut's view of the NP is closely tied to his views of normal self development, and can be understood more clearly in their context. He proposes that the normal self has two

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and achievements very minor, (b) feelings of being oppressed, enslaved, and emotionally drained (Kohut, 1971; Ashby, 1978), (c) feelings of being very unimportant, or "utterly negligible" (Kohut, 1971; Goldberg, 1978), (d) "Boredom, lack of emotional involvement, precarious maintainance of attention . . . exhortations, forced interpretations of resistence, and other rationalized acting out of tensions and impatience" (Kohut, 1971, p. 273), and (e) a sense of frustration, helplessness, impatience, and lack of understanding (Kernberg, 1975). In response to the NP's intense idealization, the following reactions are typical: (a) feelings of embarrassment, shame, or self-consciousness, along with a general increase in defensiveness, discomfort, or uneasiness (Kohut, 1971), (b) increased grandiose fantasies (Kohut, 1971), and (c) an urge to deny one's importance, or to reject the patient out of shame and embarrassment (Kohut, 1971).

primary components or poles: ambitions and ideals. The child's "grandiose self," made up of primitive feelings of greatness, perfection, and vigor, is the normal developmental precursor of the ambitions pole of the self, which in its mature form consists of "the self confidence and inner security about one's own worth that sustains the healthy person throughout his life" (Kohut & Wolf, 1978, p. 417). This aspect of the self is developed through interactions with a parent who empathically mirrors and admires the child's "grandiose self." The normal precursor of the ideals pole of the self is the "idealized parental imago" which consists of a primitive, internalized image of the parent as a calm, infallible, omnipotent figure with whom the child has had the experience of soothing merger. In its mature form, the ideals pole of the self provides "the strength of our leading ideals and of the calmness we experience as we live our lives under the guidance of our inner goals" (Kohut & Wolf, 1978, p. 417). This aspect of the self requires for its maturation a parent who allows himself to be idealized by the child, and who empathically accepts the child's need to be calmed and bolstered through merger.

In Kohut's view, an individual's ambitions and ideals develop in varying degrees of maturity and intensity. One or the other pole may take on more prominence than the

other, but they remain related to each other by a "tension arc" which is "the abiding flow of actual psychological activity that establishes itself between the two poles of the self, that is, a person's basic pursuits toward which he is driven by his ambitions and led by his ideals" (Kohut, 1977, p. 180). Originally, the tension arc is determined by the individual's innate capacities and basic skills. However, it becomes progressively less dependent upon these features as the self matures.

In Kohut's framework, parents who respond to the child's needs for mirroring and idealizing serve as "self-objects" for him. That is, the parents are experienced by the child as part of his self rather than as individuals with initiative and needs which do not pertain to his needs. Through a process of "transmuting internalization," the internalized, bipolar structure of the self develops bit by bit as the parents gradually and nontraumatically fail to perfectly provide for the child's narcissistic needs. That is, the child becomes progressively more able to provide for himself those self-sustaining functions which were originally provided by the parents as self-objects. Under optimal conditions, the resultant self emerges as cohesive, vigorous, and harmonious. When the parents are "not well in tune with the child's ever changing needs" however, and do not empathically meet and then nontraumatically fail to meet the

child's needs for mirroring and idealized merger, the resultant self may emerge in varying degrees of fragmentation, enfeeblement, and/or functional chaos.[8]

In the case of the child who develops into a NP, the child-to-self-object interactions are successful to the extent that rudiments of the self are developed. However, traumatic interruption of narcissistic supplies (i.e., mirroring, idealized merger) occurs while these precursors of the adult self are still primitive and unresilient. With regard to the child's grandiose self, such trauma typically results from parental inability to empathically encourage independent, assertive activity. In the case of the

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[8] In Kohut's view, the development of self is intimately and inextricably bound to the quality and development of the child's relationships to others as self-objects. However, it is only indirectly related to the child's capacity for object love, the developmental requirements for which differ from those for the self. To account for this Kohut posits the existence of two distinct developmental tracks, one leading from narcissism to object love, and one leading from narcissism to higher forms of narcissism. This differs from the traditional psychoanalytic model which posits only one developmental line, from narcissism to object love. Kohut's formulations serve to emphasize the persistence into adulthood of important self-feelings and needs which have their roots in the normal narcissistic stage. The traditional psychoanalytic model, on the other hand, tends to imply that in normal development such feelings and needs are categorically transcended. Although Kohut notes that therapeutic improvement in the capacity for object love typically accompanies changes in the narcissistic realm, he views this as a nonspecific change which may be accounted for not by a transformation of narcissism into object love, but rather by the increased ability to offer love without fearing negative consequences made possible by the establishment of a stronger and more cohesive self.

idealized parental imago, the trauma typically involves parental failure to empathically accept the child's idealization and allow merger, or to empathically introduce limitations of their omnipotence to the child.[9] The result

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[9]The narcissistic use of the child by the parent, typically the mother, is the aetiological key to which the literature on NPs recurrently refers (e.g., Kohut, 1971; Kernberg, 1975; Bursten, 1973; Modell, 1975; Brodey, 1965; Lomas, 1962; Rinsley, 1980). Such a relationship between parent and child has been described as one in which the parent responds to the child in accordance with his or her own fantasies rather than in accordance with the child's unique maturational needs (Bach, 1977; Friedman, 1975; Rinsley, 1980). In this regard, Friedman (1975) writes:

> The child may be responded to as a commanding parent demanding obedience; as a parent whose love must be maintained by placating and seductive manipulation; as a younger sibling to be controlled or vied with, as a phallus to be aroused, flirted with, frustrated and possessed; as a needy nursling whose eating confirms what a bountiful provider one is (who can turn into a demanding devourer); as a valuable, modable, controllable anal treasure; as a doll to be dressed, toyed with, and dropped, to name just a few of the manifold possibilities which shift as the child grows. (p. 142)

Distinguishing narcissistic aetiology from borderline and psychotic aetiology, Rinsley (1980) proposes that the parents of a future NP may perceive and react to the child as a parental surrogate figure, a spouse, a sibling, or an endlessly infantile or dependent baby, while parents of the borderline or psychotic child more typically perceive and interact with the child as an inanimate object, a part or excrescense of their bodies, bodily organs, a subhuman animal or monster, or as nonexistent. The parents of the narcissistic child effectively communicate the message, "You may grow up but only if you never leave me," or, "but only if everything you do is ultimately in relationship to me and centers on me" (p. 154), while the parents of the borderline child communicate the message, "If you grow up, I will abandon you" (p. 154).

Brodey (1965) suggests that the parents of the child who grows up as an NP typically do not acknowledge activities

of such trauma during this early stage of development is that narcissistic structures are repressed and disavowed.[10] As a result of their isolation, narcissistic needs intensify and narcissistic structures remain stagnant and immature. Since the self-sustaining functions which would normally be part of a mature self are lacking, the NP must continue to look outside of himself for their provision. It is from this developmentally arrested context, then, that the adult NP's need and propensity to relate to the therapist and others as self-objects stems. In the context of an empathic therapeutic environment especially, the relationship between

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initiated by the child due to their own separation problems from their parents. In effect, the child is punished for spontaneous behavior by emotional abandonment. In order to avoid the overwhelming and disorganizing experience of maternal withdrawal, the child learns to behave only in accordance with the mother's preconceived notions. By so doing, he actually saves the mother from becoming overwhelmed by separation anxiety, an experience which contributes to the development of a heightened sense of specialness and power. The self or identity which the child assumes is split off from a "real" self since it is based not upon his own needs and abilities, but upon those of the mother. As Lomas (1962) puts it:

> in his search for identity he is dependent not on his capacity to form relationships, but on his capacity to form one particular relationship, and the qualities which would lead him to have confidence in himself are not his real qualities but only those which happen to have importance in one person's eyes. (pp. 339-340)

[10]Kohut (1971) describes repression as a "horizontal split" in the self, and disavowal, in which grandiose or idealizing aspects may be conscious but unintegrated and unacknowledged, as a "vertical split."

the NP and his therapist will increasingly resemble that of a normal child to parental self-object.[11]

Kohut and Kernberg Contrasted

The implications of Kohut's view of the NP are understood more fully when his formulations are contrasted with those of Kernberg (1975a, 1975b, 1976), an influential author who has written extensively about NPs from a different and somewhat more traditional point of view. With regard to his understanding of the NP and his development, Kernberg differs from Kohut in three essential respects.

First of all, Kernberg considers the inflated notion of self which makes up the "grandiose self" of the NP to be an abnormal development which arises from the child's need to defend himself against further traumatic events during the narcissistic stage of development, and which serves to compensate for underlying feelings of worthlessness. Kohut on the other hand considers such feelings to be normal developmental precursors to important parts of the self. In Kernberg's view, the grandiose self blocks development and normal differentiation of internalized representations of

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[11] In Kohut's view, the therapeutic task with NPs is to provide empathic reparenting so that the primitive self, through interaction with the therapist as self-object and a belated process of transmuting internalization, can mature and develop into a more cohesive, vigorous, and functionally harmonious adult self.

self[12] and others, and also interferes with normal ego and superego development. In Kohut's view, the grandiose self does not block development, but rather, its isolation by repression and disavowal precludes its maturation into the "self confidence and inner security" which is part of the normal adult self. Kernberg views primitive idealization in the NP as a defensive development which stems from the (abnormal) grandiose self, while Kohut considers this to stem from frustrated needs and feelings which were once phase appropriate.

Secondly, whereas Kohut views aggression in the NP (e.g., hatred, rage, etc.) to be a response to the frustration of narcissistic needs for mirroring and idealized merger, Kernberg views aggression as primary in the NP's development, and predominant in the adult NP. For Kohut, aggression is a reaction to traumatic events; for Kernberg, it is an inherent, instinctual, and vital feature of the NP which is exacerbated by traumatic events.

Thirdly and most importantly for the present study, Kernberg emphasizes the NPs treatment of the therapist as a

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[12]Kernberg uses the term "self" in a different and more limited way than Kohut. For Kohut, the self is the primary psychic structure consisting of the ambitions and ideals "poles" and a tension arc by which they are related. For Kernberg, the self is a part of the broader structure of the ego, and consists of multiple internalized self-representations and their affective correlates.

"worthless appendix," and understands his mode of relating to others to be an angry defense against "real" involvement. Kohut, on the other hand, considers narcissistic attachments to be real relationships of a nature which is qualitatively similar to that of the small child to its self-objects during the narcissistic stage of development. To be more precise, Kohut views the NP's manner of relating to the therapist as a similar but distorted version of what was phase appropriate at the time that the developmental arrest took place. Toward the end of clarifying this important point, Kohut writes:

> [T]he patient's demandingness is not simply the present day expression of normal self assertive needs of childhood that have persisted because they had not been appropriately responded to in the past. Because of the intensity of these needs and, PAR EXCELLENCE, because of these patients' conviction that they will not find an echo of understanding empathy, they arouse deep shame which, in turn, leads to their suppression, manifested by depressed and hopeless withdrawal--the latter behavior sometimes . . . alternating with bursts of enragedly expressed but not effectively pursued demands that the wrong that had been done be set right. (Kohut & Wolf, 1978, p. 421)

> It must be admitted that even the purest forms of mirror transference . . . encountered in the analysis of narcissistic personality disturbances are not direct replicas of a normal developmental phase. They, too, are regressively altered editions of a child's demands for attention, approval, and for the confirmatory echoing of its presence, and they always contain an admixture of the tyranny and over-possessiveness which betrays a heightening of oral sadistic and anal sadistic drive elements produced by intense frustration and

> disappointments . . . nevertheless, . . . in a correctly conducted analysis, . . . the mirror transference tends to become more and more akin to the normal developmental phase, i.e., the sadistic elements diminish and the demands for affection and response take on the vigor, and approximate giving the pleasure, which is encountered in the corresponding phase-appropriate interactions between parent and child. (Kohut, 1971, pp. 124-125)

Although Kohut does not deny that defensive and aggressive features of the NP may indeed be prominent, he views the underlying need for buttressing of a tenuously developed self as the primary and more compelling feature which leads to real involvements in which attempts are made to use others as self-objects.[13] The NP's relationships outside of the therapeutic environment will tend to be more anger-laden and unstable than the relationship with a

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[13] With regard to the treatment of NPS, Kernberg believes the primary task of the therapist to be active, confrontive interpretation of the defensive function which angry, devaluating, grandiose, and idealizing behavior serves. Kernberg's aim is to help the patient overcome his narcissistic defenses so that a more typical "object loving" transference can be established. Kohut, on the other hand, proposes a much less confrontive approach in which expression of grandiosity and desire for idealized merger is accepted as an important step toward eventual maturation and integration of a more normal self.

It is possible that the relatively intense anger of Kernberg's patients is to some extent a reaction on their parts to his confrontive approach. Kohut's approach tends to provoke less anger, hence his patients are described as being less angry (D. Friedman, 1981).

therapist who can empathically encourage and accept a fuller expression of frustrated narcissistic needs.[14]

Narcissistic Styles

Despite somewhat of a trend in the literature on NPs to focus only on underlying dynamics and on individuals who are overtly arrogant, competitive, or exhibitionistic, some allusions are made to other interpersonal styles among narcissistic patients. A review of case examples of narcissistic patients in which some idea about overt interpersonal style could be discerned reveals individuals described as obsessive-compulsive, perfectionistic, depressed, hysterical, disorganized, ineffectual, schizoid, shy, sadistic, self-punitive, and masochistic (Kohut, 1971, 1977; Kernberg, 1975a; Goldberg, 1978; Segel, 1969; Stolorow & Lachmann, 1975; A. Reich, 1953, 1960; Rothstein, 1979; Lomas, 1962; Rosenfeld, 1964).

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[14] It has been suggested that with respect to underlying dynamics there are two different types of NPs, one in which narcissistic configurations are a defense against involvement with others, and one in which defects of the self are primary and based upon developmental arrest (Goldberg, 1976; Lachmann & Stolorow, 1980). If this is true, then differences between the formulations of Kohut and Kernberg may in part reflect differences in the respective patient populations upon which they are based. Although this is an area which needs further investigation, such investigation is beyond the scope of the present study in which defensive aspects are viewed as being secondary to the fundamental developmental arrest of the NP's self.

The literature on narcissistic styles per se is brief. Perhaps the first to address this issue was Fenichel (1945) who distinguished two types of narcissists: the aggressive type who tries to procure what he needs by force, and the nonaggressive type who seeks to get his needs met by a demonstration of submission and suffering, that is, via masochism. He suggests that both styles can be employed by the same individual as well. The aggressive narcissist to which Fenichel refers has been widely recognized and studied by others. However, the masochistic narcissistic style has received less notice in the literature on NPs, possibly because the underlying narcissistic components are less obvious. Stolorow (1975b) points out that masochistic features can serve the following narcissistic functions:

1. Actual physical pain sought by the masochist may serve as external validation of a sense of self and of being alive.

2. A display of suffering and martyrdom may contain an attempt to elicit admiring, self-bolstering responses from others. (Stolorow emphasizes that an audience is a consistent requirement of the masochist.)

3. The devaluation of self worth and sacrifice of independence and competence may constitute an attempt to sustain an image of an idealized, all good, all powerful figure of the other, in merger with whom a sense of strength and self worth can be drawn.

In addition, the masochist may bolster a tenuous sense of self through the vicarious experience of omnipotence by identification with the sadistic partner, by the experience of feeling magically in control of the other through "seduction of the aggressor," by feeling able to triumph over the dangers of punishment and rejection, and by experiencing all types of "victories through defeats."

In a more recent paper, Bursten (1973) distinguishes four types of narcissistic personalities.

1. The Craving Type makes his demands for narcissistic gratification in a fairly transparent manner. He tends to be clinging, demanding, and whining, like a "little bird with a wide open beak."

2. The Paranoid Type is vigilant, rigid, and angrier than the craving type. He is more envious of other people, and tends to externalize blame.

3. The Manipulative Type is typically known as the sociopath or psychopath. He uses deception to influence others, and actively and fairly ruthlessly arranges the environment to fit his reality. He experiences little guilt, and tends to have very superficial relationships and to feel contemptuous of others.

4. The Phallic Type is more overtly exhibitionistic and arrogant than the others, often behaving in reckless, "macho" fashion.

Bursten views these NP types as being on a continuum with regard to degree of differentiation of self from others, the Craving Type being least well differentiated, and the Phallic Type being the most differentiated. By distinguishing these different personality types, all of which are identifiably narcissistic with regard to the quality of their relationships to others, Bursten emphasizes that gratification of narcissistic needs may be accomplished in a variety of ways, for example straightforwardly (the Craving Type), indirectly (the Paranoid and Manipulative Types), or with a very hostile edge (the Paranoid Type. Grandiosity and exhibitionism may be acted out overtly (the Phallic Type), or may be masked behind timidity and weakness (the Craving Type). A major limitation of Bursten's work in terms of the present study is that he bases his observations almost entirely on a male population. Although he suggests that these personality types are equally applicable to women, there is in fact insufficient data from which to draw such a conclusion with confidence.

In another paper, Kohut and Wolf (1978) distinguish five different NP types which follow directly from Kohut's developmental formulations (Kohut, 1971, 1977). Three of the personality types, Mirror-hungry Personalities, Ideal-hungry Personalities, and Alter-ego Personalities, may be characteristic of individuals who are "normal," as well as

of the least disturbed type of NP. Among those individuals whose defects of the self are more extensive, they distinguish two more personality types: the Merger-hungry Personality, and the Contact-shunning Personality. These different narcissistic styles are characterized in the following ways:

1. Mirror-hungry Personalities "thirst for self-objects whose confirming and admiring responses will nourish their famished self" (Kohut & Wolf, 1978, p. 421). Toward the end of eliciting the desired responses from others, they tend to behave in overtly exhibitionistic, attention-getting fashion. They feel frightened and ashamed, however, and are typically sustained only for short periods of time in their relationships with others.

2. Ideal-hungry Personalities are constantly in search of others whom they can admire and idealize since they feel worthwhile only when involved in such a relationship. These relationships may be long lasting, but more typically they end at the inevitable discovery of a defect in the idealized self-object, at which point the search continues.

3. Alter-ego Personalities "need a relationship with a self-object that by conforming to the self's appearance, opinions, and values confirms the existence, the reality of the self" (Kohut & Wolf, 1978, pp. 421-422). Again, relationships established may be fairly long lasting, but typically end when the "alter ego" self-object is discovered to be different than expected.

4. Merger-hungry Personalities are more disturbed than the above personality types. They have an intense need to control the other person who serves as a self-object for them, and a great need also for external structure. In relationships, these individuals are intolerant of independent activity on the other person's part, and tend to demand constant attentiveness to their own needs.

5. Contact-shunning Personalities avoid social contact and stay to themselves. This behavior stems not from a disinterest in others, but from a need for self-objects which is so intense that they fear dissolution of their selves, and are hypersensitive to rejection. This type of NP attracts the least notice, but may in fact be the most common.

The existence of these different NP types proposed by Kohut and Wolf again serves to emphasize the variety in the ways in which the narcissistic mode can be enacted. One drawback of the authors' descriptions with respect to the present study is that distinctions between overt behavior and underlying dynamics are not consistently drawn. For example, while overt behavior is fairly clear in the cases of the Mirror-hungry and Contact-shunning Personalities (overtly exhibitionistic and socially isolated respectively), the behavioral and stylistic implications in the case of Alter-ego Personalities are less clear. Although this

personality type needs a conforming self-object for self maintenance, the question of how this is accomplished remains open. Kohut's and Wolf's NP personality types are broader than Bursten's, and not easily equated either behaviorally or theoretically.

Narcissism and Gender

Sex differences. It is the contention of this investigator that stylistic differences between narcissistic men and narcissistic women tend to reflect differences between men and women generally. What are these differences?

Several exhaustive reviews of the existing research on sex differences (Hoyenga & Hoyenga, 1979; Maccoby & Jacklin, 1974; Garai & Scheinfeld, 1968; Kagan, 1964) agree that men have been conclusively shown to be more aggressive than women, both physically and verbally.[15] They find also that women tend to suppress their aggression more readily than men, and generally to express it in more indirect and generalized ways. Although the evidence is somewhat less clear cut, men have been found to be more concerned with the issue of dominance in their relationships with others, and to assume roles which are more overtly dominant than those of women. Evidence that women are as a rule more submissive

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[15]All reviewers conclude that this most likely has a biological as well as a cultural basis.

than men, on the other hand, is equivocal. Although Kagan reports this to be the case, both Maccoby and Jacklin and Hoyenga and Hoyenga consider the evidence for this to be minimal, although they do find that women tend to assume more submissive physical postures than men, and that women tend to be more compliant than men with respect to authority figures (only). Although Kagan concludes that women are more passive and dependent than men, neither Hoyenga and Hoyenga nor Maccoby and Jacklin find there to be convincing evidence that this is true. With regard to nurturing behavior, there is also ostensible disagreement: Kagan, and Garai and Scheinfeld conclude that women have been shown to be more nurturant than men, while Maccoby and Jacklin and Hoyenga and Hoyenga conclude that men and women are equally nurturant. It is likely, however, that this discrepancy reflects the fact that women tend to be more directly nurturing, while men tend more often to give help via instrumental problem solving (Hoyenga & Hoyenga, 1979).

Research findings with regard to achievement and affiliation are particularly pertinent to the present study. Both Kagan, and Garai and Scheinfeld conclude that men have a greater need for achievement than women, and that women have a greater need for affiliation than men. In this same vein, they find men to have a greater need than women for power and control, and women to have a greater need than men

for approval from others. With regard to these conclusions they write:

> Males appear to possess 'intrinsic' achievement motivation which finds its main satisfaction in the successful accomplishment of the task itself, whereas females appear to be guided by 'extrinsic' achievement motivation which makes them derive greater satisfaction from the praise and recognition bestowed by other people for successful task performance. (Garai & Scheinfeld, 1968, p. 270)

Slightly different conclusions regarding achievement and affiliation, conclusions which this investigator finds more compelling, are reached by Maccoby and Jacklin and Hoyenga and Hoyenga. These reviewers conclude that there are no significant differences between men and women with respect to overall need for achievement. Hoyenga and Hoyenga find, however, that there are differences in the ways in which this need is characteristically enacted. According to these authors, men pursue power, independence, prestige, and leadership positions in ways which are more direct and overtly competitive than those employed by women. For women, achievement is more closely associated with affiliation than for men, and consequently they tend, more frequently than men, to try and combine the two. They state that "women are socialized to achieve in order to affiliate and to achieve by affiliation" (Hoyenga and Hoyenga, 1979, p. 316). These differences may explain the prevalence of the well known arrangement in which the woman places more importance on the family than on a job, while the man does

the reverse. They suggest that the achievement strivings underlying both types of behavior, however, may be equal.

In summary, research on sex differences reveals that with respect to men, women tend to be less aggressive overall, less direct in their expression of aggression, less overtly dominant, somewhat more compliant with respect to authority figures, and more overtly nurturant. Although there is some disagreement, data further suggest that although achievement is just as vital to women as it is to men, men tend to enact achievement strivings relatively straightforwardly, while women tend to pursue power and prestige in ways which are more overtly other-oriented. Most recent studies suggest that men and women do not differ significantly with respect to overall passivity or dependency (although the tendency for women to try and integrate achievement with affiliation may make them appear less active and independent than men), and that women are not significantly more submissive than men.

Narcissistic women. Research findings regarding the close association between achievement and affiliation for women, coupled with the findings that women are less aggressive than men and tend to express aggression more indirectly, suggest that women may enact narcissistic needs (i.e., needs for self-enhancement) in ways which are more overtly other-oriented, less overtly competitive and exhibitionistic, and

generally less obviously self-serving than those characteristically employed by men. The overt interpersonal styles of highly narcissistic women then, would tend to reflect these differences. A possible result of this trend is that narcissistic women tend to bolster themselves through idealized relationships (Kohut's & Wolf's "Ideal-hungry" Type) rather than in exhibitionistic, "mirroring" relationships since in the former, power is indirectly obtained while power is more overtly assumed in the latter. This would also be consistent with the finding that women tend to be less overtly dominant than men in their relationships, since in the idealizing relationship, the other person retains a role which is more overtly dominant.

In one of the few papers written specifically about narcissistic women, A. Reich (1953) does indeed describe women who seek to repair and bolster injured self esteem by way of idealization of--and masochistic submission to--their husbands. More recently, Lowenstein (1977) has suggested that the primary cultural outlet for narcissistic (i.e., self-enhancing) activities available to women is child rearing, an activity which--consistent with feminine behavioral trends as revealed by research--requires overtly nurturant, affiliative behavior, and is not overtly competitive. Lowenstein's observation suggests the possibility that highly narcissistic women may also tend to enact their

frustrated narcissistic needs primarily through their children, a conclusion which would be consistent with the fact that although the literature on NPs tends to focus on males, recurrent references are made to the narcissistic mother as having been of primary aetiological importance.

A review of case examples of female NPs reveals individuals described as idealizing, masochistic, hysterical, obsessive-compulsive, depressed, and schizoid (Kohut, 1971; Kernberg, 1975; Goldberg, 1978; Lomas, 1962; Segel, 1969; Stolorow & Lachmann, 1975). Although these examples do not in themselves lend strong support to the contention that the interpersonal styles of narcissistic women reflect sex differences in the general population, they suggest at least that highly narcissistic women do present with an array of interpersonal styles.[16]

Previous Relevant Research

With regard to the issue of different narcissistic styles in general, or the respective interpersonal styles of

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[16]The emphasis on narcissistic men in the literature on NPs is curious in light of the fact that Freud (1914) originally believed women to be more narcissistic than men. Based upon his belief that women sought to be loved by men in order to vicariously acquire a penis, Freud proposed that women could love only themselves as actively and intensely as men could love others. He did suggest, however, that there were women who loved "according to the masculine type," that is, in the object loving mode.

narcissistic men and narcissistic women in particular, there has been no systematic empirical research of which the investigator is aware, although a study by Cole (1979) which examined narcissistic traits in left radical activists touched upon these issues. Of some theoretical relevance to the present study was an investigation by Frank (1979) in which he sought to experimentally resolve the Kernberg-Kohut debate regarding whether or not narcissism interferes with or is independent of object love. Studies by Wolman (1967) and Young (1959) attempted to validate the developmental concept of narcissism, and are therefore of related theoretical relevance to the present study. How to identify narcissistic individuals for the purpose of research was a question of practical concern to the above investigators, as it was for this investigator. Several studies have focused directly upon this issue, notably Exner (1969, 1973), Raskin and Hall (1980), Harder (1979), and Ashby (1978). Other studies whose primary foci were not measurement of narcissism, but which examined narcissistic issues, have also grappled with this question, including those of Eichler (1973), Carillio (1979), and Grayden (1958). Unfortunately, the question of how to measure narcissism remains to be answered satisfactorily, despite the efforts made by researchers in this regard.

Cole (1979) attempted to examine discrete narcissistic personality types among left radical activists. She

administered the Christie Radicalism Scale, and a six card TAT to 189 male and female college students and recent graduates who were left activists. To assess narcissistic traits, Cole developed a coding scale for the TAT stories which focused on (1) homogeneity versus heterogeneity of themes, (2) task or object-centered versus self-centered orientations, (3) object instinctual versus narcissistic motives, affects, and preoccupations, and (4) adequate or high versus pathologically low boundaries between self and others. She also examined TAT stories for more general personality traits. Cole found that Jewish radical males tended to have phallic-exhibitionistic personalities with narcissistic features, while Christian radical males tended to have obsessional or paranoid/schizoid personalities with narcissistic features. The validity of Cole's measures for narcissism is unproven. However, these data would otherwise tend to support the notion proposed in the present study that narcissistic needs are embedded in a variety of interpersonal styles. Interestingly, Cole found that female left activists were not as narcissistic as their male counterparts, a finding which she was unable to explain. This investigator's guess would be that narcissistic traits of the females were different and less readily apparent than those of the males.

In his study "On Narcissism and Love," Frank (1979) sought to examine the relationship between narcissism and

the capacity for "mature" love of others, that is, the relationship between the narcissistic mode and the object loving mode of relating to others. Kohut suggests that these two modes develop independently. Kernberg, on the other hand, suggests that the two are developmentally inextricable, and furthermore that a predominance of the narcissistic mode interferes with the development of the capacity for object love. Toward the end of resolving these differences, Frank proposed a "multidimensional theory" of narcissism in which two different "strands" of narcissism are differentially related to object love. Specifically, he hypothesized that an aggressive strand of narcissism would correlate negatively with object love, while a nonaggressive, exhibitionistic strand would have a negligible correlation with object love. Operationally, Frank used the Dean Romanticism Scale and the Love dimension of the Interpersonal Check List as measures of object love. To measure aggressive narcissism, he used the Verbal Aggression Scale of the Dynamic Personality Inventory; exhibitionistic narcissism was measured by the Exhibitionism Scale of the same inventory. Two subject groups were composed of 32 university students, and 20 adult patients at a community mental health center. Data gathered supported both of the hypotheses, especially the latter in which it was proposed that exhibitionistic narcissism was unrelated to object love. A weakness of

Frank's study is the unproven validity of his measures for narcissism which makes it difficult to know for sure what the correlations really mean. Assuming that the results are valid, they lend support to the notion that two kinds of narcissistic personalities exist: those in which defensive aspects are primary, and those which stem from developmental arrest in the narcissistic realm only.

To investigate the validity of the notion of narcissism in normal development, Wolman (1967) attempted to demonstrate the gradual decrease with age of narcissism and egocentrism in interpersonal relationships, a progression which is suggested by traditional psychoanalytic theory. Wolman hypothesized that, as they get older, children would tend to see others increasingly less as tools to be used for their own desired ends, and increasingly more as individuals with their own rights and needs. Using children of different ages, he elicited definitions of other people (e.g., mother, father, etc.) and then determined the extent to which these definitions reflected ideas which were personally functional, or reflected the unique characteristics of the people defined. Wolman found that the children's perceptions of others did change with age from relatively self centered to relatively other directed. Changes were independent of intelligence level. His findings lend support to the traditional psychoanalytic notion that self-love precedes

love of others, and are also consistent with Kohut's notion that the quality of the attachments to others changes with age, while the fact of attachment remains constant.

Young (1959) attempted to investigate the validity of the notion that schizophrenics are more narcissistic than neurotics, and that neurotics are more narcissistic than normal individuals, indirectly examining the traditional psychoanalytic concept that narcissism declines with maturity inasmuch as schizophrenics are understood to be developmentally more regressed than neurotics, and neurotics more regressed than normals. Young determined from the psychoanalytic literature that narcissism could be characterized by excessive admiration of self, feelings of superiority, subjective orientation, attention demanding, exhibitionistic tendencies, feelings of omnipotence, lack of genuine interest in others, and preference for occupations that permit egocentric gratification. Using these traits as guides, he compiled seven measures of narcissism: The Occupational Appeal Card Sort, the Subjectivity versus Objectivity Scale (from the Guilford-Zimmerman Temperament Survey), the Superiority versus Inferiority Scale (from the Guilford-Martin Inventory of Factors), the Need for Attention Scale (from the Dynamic Factors Opinion Survey), and an experimental Omnipotence Scale. He also used TAT cards 1, 14, and 17 BM, and Blacky cartoon #11m, determining whether or not

stories were self-oriented. He administered these measures to 30 schizophrenics, 30 neurotics, and 30 normals, all males. Results supported the hypothesis that narcissism would increase with severity of regression, with data from measures of subjectivity, need for attention, and self-admiration (Blacky picture) being most significant. Contrary to his hypothesis regarding superiority, however, Young found that schizophrenics felt more inferior than neurotics, and neurotics more inferior than normals. This last finding is consistent with the notion that underlying the narcissistic individual's tendency to relate predominantly in the narcissistic mode is a tenuous sense of self and self esteem.

Exner has recently made efforts toward the development of a valid research measure of narcissism. In the process of analyzing Rorschach profiles, he discovered, somewhat by accident, that overt homosexuals tended to give a relatively high number of reflection responses. Since homosexuals were understood theoretically to be relatively narcissistic, Exner wondered whether reflection responses might reflect narcissism. As part of a study to help validate this hypothesis, Exner (1969) developed a sentence completion blank as a possible corroborating measure of narcissism.[17]

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[17]Exner modelled his measure after a sentence completion test developed by Watson (1965) in her study of narcissism and its relationship to intellectual subjectivity.

He had clinical psychologists determine on a yes/no basis whether completed sentences were self-focused, external world oriented, or neutral. He then administered the Rorschach and the sentence completion test to 1,547 subjects and found that a high narcissism group as determined by a relatively high frequency of self-focused responses on the sentence completion test gave significantly more reflection responses on the Rorschach than a low narcissism group determined by relatively infrequent self-focused responses. The high narcissism group also gave significantly more pair responses on the Rorschach.

Next, Exner (1973) condensed the number of items of the Self Focus Sentence Completion test (SFSC) from 50 to 30, and administered the test to a variety of subjects in an effort to provide a nomothetic baseline from which to

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Watson rated the responses on a fifty word sentence completion blank with regard to three variables: (1) object cathexis, that is, responses reflecting more than minimal investment in the person referred to in the sentence stem as judged by the degree of familiarity with, knowledge of, or feel for the object as an entity separate from the subject (similar to Wolman, 1967), (2) narcissistic fantasy, that is, responses reflecting grandiosity, omnipotence, megalomania, merging or oceanic feelings or yearnings, or other signs which suggest denial of the existence of a separate and potentially frustrating real world, and (3) real world anchorage, that is, responses reflecting anchorage in the real, everyday world of actual people and things. Subjects who scored high with respect to these variables were considered to be high in narcissism. Watson found that intellectual subjectivity was significantly correlated to object cathexis, but not to either of the other variables.

compare groups and individuals. Altogether, 2,592 protocols were collected (1,407 males and 1,185 females) from college students, high school students, blue collar workers, Peace Corps trainees, and medical technicians. He found that the mean self-focus scores were similar for all groups, except for high school students who had significantly higher self-focus scores. There were no differences in the means for males and females. Exner also administered the SFSC to 273 psychiatric patients and found that these subjects as a group showed a greater discrepancy between number of self-focused responses and number of external world responses than nonpsychiatric groups. Psychiatric groups which are commonly thought to be highly narcissistic (schizophrenics, psychopaths, homosexuals, adolescent behavior problems, and involutionals) did in fact give significantly more self-focused responses than external world oriented responses. Depressives, suicidal patients, and psychosomatic patients on the other hand gave significantly more external world oriented responses than self-focused responses. These data suggest that either an excessive concern with self at the expense of others, or an excessive concern with others at the expense of self may result in maladjustment. Exner proposed that the ratio between self-focus and external world focus coincides with the notion of "narcissistic" or "egocentric balance" in which concern with both self and

others is viewed as being necessary for optimum functioning. These findings are certainly consistent with the idea proposed in the present study that narcissism and object loving modes necessarily and adaptively accompany each other.

Although Exner's SFSC holds promise as a research measure of narcissism, it has yet to be well validated for individuals who have been identified as being narcissistic by other valid independent measures. In one study of this type, Exner (1973) examined verbal self-references in interviews, and mirror gazing behavior, finding that subjects who scored high on self-focus on the SFSC tended to do both significantly more frequently than low self-focus subjects. He also found that self-focus scores of psychiatric patients tended to decrease as they improved with treatment.

Since self-focus scores have been found to correlate with pair-reflection responses on the Rorschach (Exner, 1969), studies using the latter are of some relevance here. Winter and Exner (1973) found 18 successfully performing artists without psychiatric histories to have significantly more pair-reflection responses on the Rorschach than nonartist normals, results which appear to corroborate the common belief that artists are highly narcissistic. In a study of schizophrenics, nonschizophrenic psychotics, and normals, Copeland (1979) found that a high pair-reflection

index was positively correlated with psychological immaturity, field dependence, and confused identity.

More recently, Raskin and Hall (1980) devised the Narcissistic Personality Inventory (NPI) with the intent of developing a valid measure of narcissism. The NPI in its present form consists of 54 paired statements, one of which is a narcissistic item, and one of which is not. Subjects are asked to pick the item which best applies to themselves.[18] These items were chosen from 223 original items which were based upon the eight criteria for Narcissistic Personality Disorder in DSM III. These criteria are:

1. Grandiose sense of one's self importance or uniqueness, e.g., exaggerates achievements and talents, focuses on how special one's problems are.

2. Preoccupation with fantasies of unlimited success, power, brilliance, beauty or ideal love.

3. Exhibitionistic; requires constant admiration and attention.

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[18] Sample items on the NPI:

A. I am a fairly sensitive person.
B. I am more sensitive than most other people. (N)

A. I prefer to blend in with the crowd.
B. I like to be the center of attention. (N)

A. I will be a success. (N)
B. I am not too concerned about success.

4. Responds to criticism, indifference of others, or defeat with either cool indifference, or with marked feelings of rage, inferiority, shame, humiliation, or emptiness.

5. Entitlement; expectation of special favors without assuming reciprocal responsibilities.

6. Interpersonal exploitiveness; takes advantage of others to indulge own desires for self-aggrandizement.

7. Relationships characteristically vascillate between the extremes of over-idealization and devaluation.

8. Lack of empathy; inability to recognize how others feel.[19]

In an initial sample of college students, the NPI items were found to significantly differentiate two groups. Since that time, high-narcissism responses of the NPI have been found to correlate positively with the Extraversion and Psychoticism scales of the Eysenck Personality Questionnaire (Raskin, 1980a), with internal locus of control as measured by the Rotter I-E scale (Raskin, 1980b), with the use of first person plural pronouns (Raskin, 1980c), and to a minor degree with high scores on the Barron Symbolic Equivalents Test (thought to measure creativity) (Raskin, 1980d). Emmons (1980) also found a significant positive correlation

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[19] A somewhat modified version of these criteria are used in the present study as an aid to therapists in identifying highly narcissistic patients (see Appendix A).

between scores on the NPI and the Disinhibition Subscale of the Sensation Seeking Scale for males and females. For males, high narcissism scores on the NPI also correlated positively with Boredom Susceptibility scores, while scores on the General and Experience seeking scales correlated positively with narcissism in females. Although the NPI may eventually be found to be a useful measure of narcissism, more research is needed in order to establish its validity for individuals.

In another study, Harder (1979) attempted to assess the ambitious-narcissistic character style by constructing elaborate rating scales to be used in conjunction with early memories, TAT stories, and Rorschach responses. He based his scales for the ambitious-narcissistic style on the psychoanalytic literature on the phallic-narcissistic personality, determining this personality style to be reflected by (1) intrusive thrusting, (2) exhibitionism/voyeurism, (3) urethral excitation, symbolized by burning sensations and gushing liquids, (4) mastery, competence, power, that is, pleasure in prowess, achievement, competitive victory and striving, and (5) self-potency pleasure, symbolized by admiration of, or exposure of, a phallus, or of relatively blatant symbolic substitutes. Trained clinicians rated the protocols of 40 college students from 0 (not at all ambitious-narcissistic) to 3 (strikingly ambitious-

narcissistic). Interrater reliability was found to be above .80. Harder found low but positive and significant intercorrelation among the measures (below .40) and considered this to be provisional evidence that they all measured a common dimension. He also found significant differences on the measures between the strikingly ambitious and the nonambitious groups which he considered to be further validation of his scales. His conclusions notwithstanding, the validity of Harder's scales needs further experimental corroboration. They were not useful for the present study since they pertain only to one particular narcissistic style.

In an interesting and thoughtful study of NPs based, like the present study, upon Kohut's formulations, Ashby (1978) attempted to develop an MMPI scale for use in the diagnosis of NPs prior to the emergence of the mirror or idealizing transferences. His method for obtaining narcissistic subjects is of particular interest since it was similar to that originally proposed for the present study. In order to use the empirical MMPI methodology which has been applied in the construction of most MMPI scales, Ashby sought to contrast the item responses of individuals identified as NPs to those of nonnarcissistic individuals. To obtain 20 narcissistic subjects, he requested therapists to provide patients who in their clinical judgment were NPs.

Judgments were to be based upon the quality of the emergent transference relationship. He then interviewed the therapists about their narcissistic patients (tape recording these interviews), and borrowed process notes and tapes of two or three sequential therapy sessions with these patients. As an independent measure, he had a psychoanalyst well versed in the diagnosis and treatment of NPs (Dr. Ernest Wolf) listen to the taped interviews and therapy sessions, and give his opinion as to whether patients were or were not NPs. Only those patients who were also viewed as NPs by this analyst were included among the 20 narcissistic subjects.[20] Ashby then compared and analyzed the MMPI

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[20] In the Discussion of his dissertation, Ashby proposes eight questions to be asked of the therapists with regard to their narcissistic patients, "at least four of which if answered affirmatively" should "indicate fairly confidently the presence of a Narcissistic Personality Disorder, and should dispense with the need for a consulting analyst-expert." These questions are (Ashby, 1978, p. 114):

1. Does your patient have problems regulating self esteem?
2. Does your patient have dreams that indicate grandiose themes such as flight, freedom from ordinary restraints, etc.?
3. Does your patient actively seek your admiration and/or attention?
4. Do you feel that your patient demands a great deal of you emotionally and leaves you feeling drained?
5. Does your patient's idealization of you take up the central focus of the transference?
6. Did your patient present himself with feelings of emptiness and boredom?
7. Would you say your patient has difficulty seeing the needs, rights, and privileges of others?

responses of these 20 NPs with those of 50,000 patients from the Mayo Clinic, 50 seminary students and 20 nonnarcissistic psychotherapy patients. From this analysis, he derived two MMPI scales which discriminated the narcissistic group from nonnarcissistic groups fairly well, the most effective scale (the NPD Scale) containing 19 items.[21] This appears to be a promising avenue of research for which further validating studies will be very important.

Eichler (1973) attempted to examine different types of "feminine narcissism," a term which she understood to mean "the positive evaluation of oneself and of one's body and the perception of oneself as distinctly feminine," an understanding which differs basically from the understanding of narcissism for the present study. Essentially, Eichler wanted to study the attitudes of career women and homemakers about themselves. Using a variety of paper and pencil tests, she found that the two groups of women viewed feminine roles differently. Career women tended to view the ideal

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8. Is your patient extremely sensitive to criticism by others, or extremely embarrassed by faux pax, or extremely hurt by the withdrawal of others from him?

A modified and condensed version of those questions which did not overlap with DSM III criteria were included in the present study as part of the Criteria for HN Patients (see Appendix A).

[21]NPD Scale items are: 12F, 20F, 53F, 70F, 137F, 142T, 148T, 168T, 175F, 249F, 267F, 301T, 310F, 314T, 335T, 338T, 354T, 422T, and 431T.

feminine role as embodying pursuit of one's extrafamilial personal goals, while homemakers tended to view the feminine role in a more traditional fashion, as one in which one's own goals were secondary to those of one's family. Career women tended to view the two sexes as ideally being quite similar, while homemakers viewed the two as being ideally quite different. With regard to the present study, these results are consistent with the expectation that narcissistic women would tend to manifest their narcissistic needs in a variety of ways. They also suggest that narcissistic women with careers may tend to have overt interpersonal styles which are more traditionally "masculine" than those of narcissistic women who are homemakers.

In another study, Carrilio (1979) attempted with some success to validate the theoretical underpinnings of the broad category of borderline/narcissistic personality by rating interviews with 36 outpatient subjects according to a scheme based upon psychoanalytic formulations. These ratings entailed observations of direction of focus (on the self or on others) as well as the relative degree of separateness from others. Ratings were compared to the diagnoses of the same subjects by independent clinicians. Borderline/narcissistic individuals were found to be poorly differentiated with regard to self and others, and to be relatively "uncoordinated" in their focus on the self and others.

These results support the notion of a continuum of mental health with regard to degree of differentiation of self from others and coordination of focus upon self and others. A major drawback of Carrilio's rating scheme is its highly elaborate nature.

Finally, Graydon (1958) attempted to investigate the relationship between neurotic hypochondriasis and narcissism, guilt, and feelings of being unloved, using the LNG card sort and the Blacky Pictures to measure all three variables. Although he found some support for the hypothesis that hypochondriasis is positively correlated to feelings of being unloved and to guilt, Grayden found no support for a positive relationship between hypochondriasis and narcissism.

Hypotheses

1. Based upon the view that narcissistic personalities are defined by the predominance of the narcissistic mode which underlies and is embedded in their overt behavioral styles, and contrary to the notion that narcissistic necessarily implies an overtly arrogant, competitive, and exhibitionistic style, it was hypothesized that:

High Narcissism patients would display an array of overt interpersonal styles, as measured by therapists' descriptions on the Interpersonal Check List.

2. Based upon the existence of sex differences generally, and upon the specific nature of these differences as revealed by research (especially with respect to the ways in which achievement needs are characteristically enacted by men and women), it was hypothesized that:

a. High Narcissism Females would tend to display overt interpersonal styles which were different from those displayed by High Narcissism Males.

b. Specifically, it was hypothesized that High Narcissism Females would tend to display overt interpersonal styles (as measured by therapists' descriptions on the Interpersonal Check List) which fell in the relatively affiliative (and nondominant) octants of the Leary interpersonal circle (octants 5, 6, 7, and 8), while High Narcissism Males would tend to display overt styles which fell in the relatively nonaffiliative (and dominant) octants (1, 2, 3, and 4).

3. With respect to the validity of the view that narcissistic personalities are defined by the predominance of the narcissistic mode which underlies their overt behavior, it was hypothesized that:

a. Underlying themes regarding "self" and "others" among High Narcissism patients, as measured by rated interviews with therapists, would be different from those of Low Narcissism patients. And, that:

b. Among High Narcissism patients, underlying themes would be more similar to each other than overt interpersonal behavior among these same patients.

III. METHOD

Subjects

Forty individuals were studied for this project. All of these individuals were aged 20 or above, were currently, or had recently been, in individual psychotherapy for a period of at least two months, and were nonpsychotic. Twenty of these patients were judged by their therapists to meet criteria for High Narcissism patients. These criteria were DSM III criteria for Narcissistic Personality Disorder (Spitzer et al., 1980) which had been modified so as to be more consistent with Kohut's views of narcissistic personalities, plus a condensed version of the criteria proposed by Ashby (1978) for identification of Narcissistic Personality Disorders (see Appendix A). The 20 patients in the Low Narcissism group were judged by their therapists not to meet any of the major criteria for High Narcissism patients. Both High and Low Narcissism groups were composed of ten males and ten females.

The actual "subjects" for this project were 24 psychotherapists from whom information about High and Low Narcissism patients was obtained. These therapists consisted of 11 Ph.D. clinical psychologists, five psychiatrists (M.D.s), five post M.A. level clinical psychology doctoral students, two M.S.W.s, and one M.A. psychologist, ranging in

age from late twenties to early fifties. Seventeen of these therapists were males and seven were females. Although an effort was made to obtain both High and Low Narcissism patients from the same therapists, this was not always possible. Most therapists provided information about one or two qualifying patients (the mean number of patients provided was 1.67). The greatest number of patients used from one therapist was four.

Instruments

It was the objective of this project to examine both overt interpersonal behavior as well as the interpersonal "mode" underlying this overt behavior. Because it is capable of measuring and accounting for a wide array of different types of interpersonal behavior and themes, the Leary interpersonal system of diagnosis was adapted for use in this study.

The Leary System: Background Information

Based upon large samples of raw data from a variety of interpersonal situations, Leary (1957) constructed a circle consisting of 16 categories of behavior which he viewed as being generic of all behavior (see Figure 1). The interpersonal circle is built around two axes: the horizontal love-hate axis (lov-hat) which represents a continuum from affiliative to nonaffiliative behavior, and the vertical

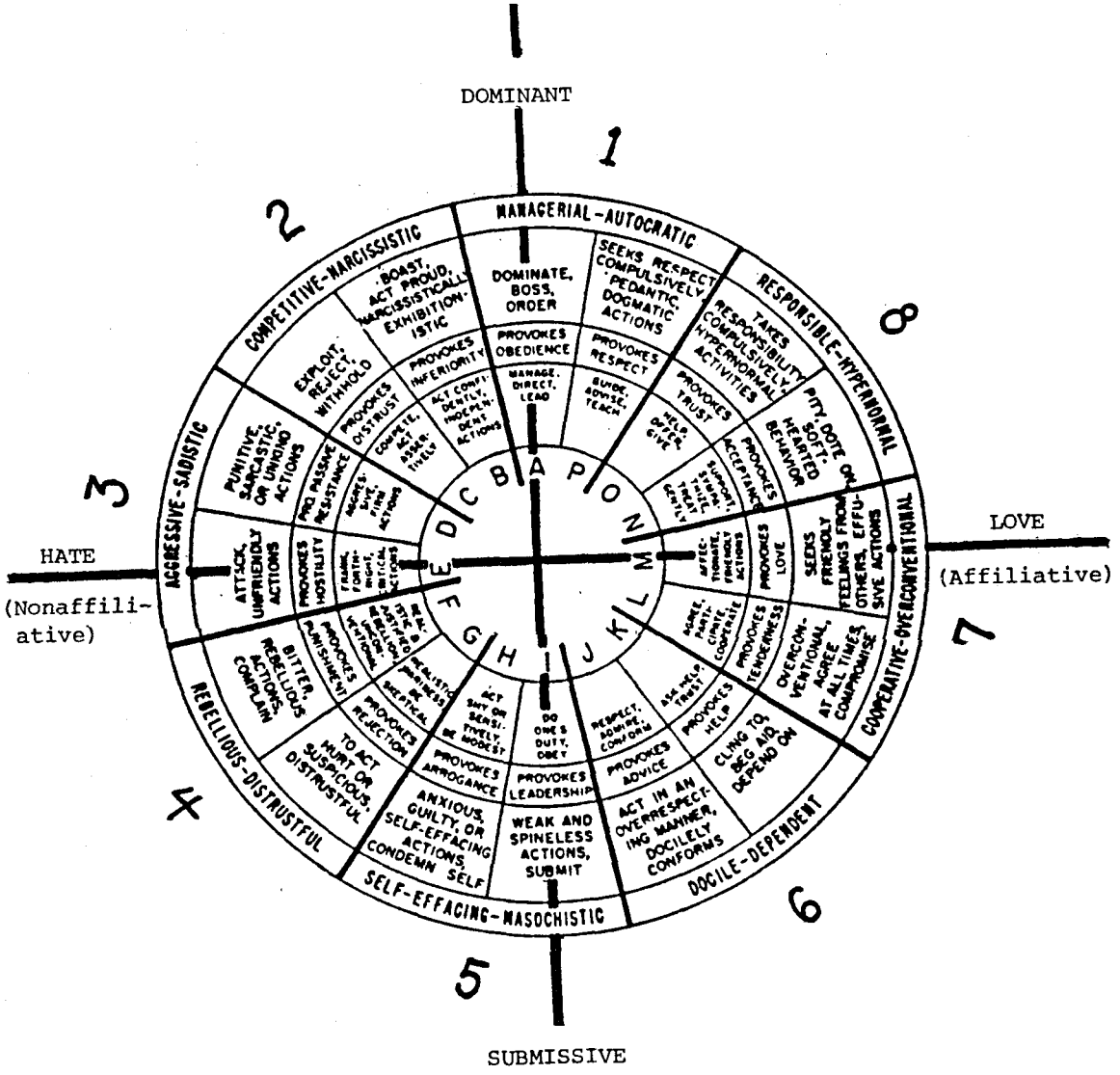

Figure 1. The Leary interpersonal circle (Leary, 1957).

dominance-submission axis (dom-sub) which represents the relative power orientation of behavior. Qualitative differences in behavior are designated by different segments of the circle. Types of behavior which are relatively similar are relatively contiguous on the circle; types of behavior which are relatively dissimilar fall in segments which are relatively distant from each other on the circle. The relative strength or intensity of behavior is represented by the distance from the center of the circle toward the periphery for any particular segment; the closer to the periphery, the stronger the behavior. Although the circle was developed around 16 original categories, Leary typically combined these into eight segments called "octants" for the purpose of research, and it was these eight categories of behavior which served as a primary measuring tool for this project. Leary posited that each of the types of interpersonal behavior tended to provoke certain responses from others, and included this as part of the interpersonal circle (see Figure 1).

Leary also identified five different "levels" of behavior or personality, each of which could be measured and plotted on the interpersonal circle. Only two of Leary's five levels are pertinent to the present study: Level I, and Level III.

Level I is described by Leary as "the level of public communication." This level concerns the ways in which an individual typically appears to others. Simply put, Level I is the overt, surface behavior of an individual. In this study, "overt interpersonal behavior" and "overt interpersonal style" were considered to correspond to Level I. Although Leary typically assessed this level by using various scales of the MMPI which were assumed to be predictive of ratings by others, Level I is more accurately assessed by obtaining descriptions of the individual from people with whom he comes into contact. The latter method was used in the present study.

Level III is described by Leary as "the level of preconscious symbolization" or, "the level of underlying operations." This level concerns an individual's underlying motives and self images which may or may not be apparent in overt behavior. In this study, Level III was understood specifically to mean preconscious and unconscious images, feelings, and motives which are associated with internalized representations of self and others. The interpersonal "mode," as defined earlier, was understood to reflect and to stem from these underlying features which comprise Level III. In the Leary system proper, Level III is typically measured by obtaining ten TAT stories from the individual, which are then rated for themes which correspond to the various types

of behavior on the interpersonal circle. "Heroes" of the stories (really, the "self") are rated separately from "others." Although Leary proposed that "other" themes represented motives and self images which were at a somewhat deeper level than "hero" themes, a more straightforward interpretation of "other" themes was made in the present study: they were considered to represent underlying views of and concerns about others. Since projective measures from patients themselves could not be obtained for this project, information about "underlying operations" was obtained from therapists.[22]

As a measuring tool to be used in conjunction with the Leary interpersonal circle, LaForge and Suczek developed an adjective checklist called the Interpersonal Check List, or the ICL (Leary, 1957). The ICL in its present form (see Appendix E) was developed over a period of more than four years. The initial source of items was a 334 item adjective checklist prepared by Sudzek to be representative of trait lists in existence in the psychological literature up to 1950. As different variations of the ICL were constructed and administered, various changes in the items were made.

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[22]Leary's other levels are: Level II — the level of conscious communication (self description); Level IV — the level of unexpressed unconscious (themes which are absent from levels I, II, and III); and Level V — the ego ideal (the individual's description of his ideal self).

The relative intensity of items was determined on the basis of an empirical four point scale. Intensity 1 items were answered "yes" by about 90% of those completing the form, intensity 2 items were answered "yes" by about 67%, intensity 3 items by about 33%, and intensity 4 items by about 10%. Those words which were unintelligible to sizable portions of the population were discarded, as were those which were too ambiguous. Some problems were encountered in that words and phrases used to describe behavior on the right hand side of the circle (the affiliative side) tended to have more positive connotations than those on the left hand side (the nonaffiliative side), and efforts were made to correct for this.

In scoring the ICL, the intensity of behavior for any given octant (or sixteenth) is obtained by counting the number of items checked for that octant (or sixteenth), since it is assumed that the individual who checks a relatively intense item as descriptive of the person in question will tend to check corresponding less intense items as well (LaForge, 1976). For this project, the ICL was used to measure overt interpersonal behavior (i.e., Level I).

In the Leary system, measurements of behavior can be plotted on the interpersonal circle across all octants for a graphic summary of that behavior at any level. Leary also

developed a formula for computing a summary point.[23] The summary point consists of a single point plotted on the interpersonal circle, with the "lov-hat" and "dom-sub" axes serving as its reference directions. This point is used as a means of simplifying the general behavioral tendency of an individual as represented on the interpersonal circle, and in the present study was used with respect to overt behavior as an indicator of overall "interpersonal style."[24] It is worth noting that the use of the summary point necessarily involves the loss of nuances of information about an individual's interpersonal functioning, especially if it constitutes a resolution of conflicting tendencies, as it sometimes does. At the same time, however, it is useful for the purpose of comparison between groups and individuals, especially when used in conjunction with the more complete summaries of behavior across octants.

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[23]Formula for computing Leary summary point (octant numbers):

$$\text{Dom} = 0.7(2 + 8 - 4 - 6) + 1 - 5$$

$$\text{Lov} = 0.7(6 + 8 - 2 - 4) + 7 - 3$$

[24]In this study, summary points could not be used for underlying themes regarding self and others since at Level III they were developed for use with and standardized on TAT stories only.

Procedure

Therapists in Houston, Texas, and Knoxville, Tennessee, were initially contacted by letter and phone by the investigator. Therapists were sent a letter which described the procedures in which they would be asked to participate, and which assured them and their patients of anonymity. Letters also contained a copy of the Criteria for High Narcissism Patients, and a copy of the Interview Format (see Appendices A, B, and C). When it had been established that a therapist was willing to participate, and that he or she had at least one qualifying High or Low Narcissism patient, the following procedures were carried out subsequent to getting Informed Consent forms signed (see Appendix D):

1. For assessment of overt interpersonal behavior and style, therapists filled out the ICL with regard to each patient provided. The directions on the ICLs given to therapists were modified slightly in order to emphasize that descriptions were to be of overt behavior rather than of underlying motives (see Appendix E). Therapists also completed a brief Patient Information Sheet on each patient (see Appendix F). These tasks took therapists about ten minutes per patient.

Octant scores and summary points were computed for each patient on the ICL.

2. For assessment of underlying themes regarding self and others, therapists participated in a tape-recorded, semistructured interview with the investigator which typically took about 30 to 45 minutes per patient. In this interview, therapists were asked primarily to provide information about the patient's underlying views of and concerns about himself, and others (see Interview Format, Appendix C).

Tape recorded interviews with therapists were rated by the investigator for underlying themes with regard to "self" and "others" following a procedure which was a modified version of the one prescribed by Leary (1956) for rating TAT stories. The Rating Manual for this procedure can be found in Appendix G. Ratings of interviews yielded two sets of octant scores per patient (those for "self" themes, and those for "other" themes) on an intensity scale of zero to six. To establish the reliability of this rating system, a trained clinician who was familiar with the Leary system also rated 50% of the interviews (i.e., twenty out of forty) selected randomly from each of the four patient subgroups (i.e., High Narcissism Females, High Narcissism Males, Low Narcissism Females, and Low Narcissism Males). The rating system was taught by way of eight practice tape recordings of interviews with therapists. Interrater reliability was found to be .82 for "self" themes, and .80 for "other"

themes. For statistical analysis, the averages of the two raters' scores were computed for these 20 interviews.

Original Proposal

In the original proposal for this study, data regarding both overt interpersonal behavior and underlying themes regarding self and others were to be obtained, in addition to the therapists' ICLs, directly from the patients themselves, by way of an interview with the investigator. The first part of this interview focused on the patient's typical overt behavior with others, and was later scored on the ICL by the investigator and by an independent rater (see Original Interview Format, Appendix H). In the latter part of the interview, the investigator was to elicit six early memories which would then be rated for underlying themes regarding self and others, using the procedure prescribed by Leary (1956) for TAT stories. The original procedure was revised to its present form after an extended attempt to obtain qualifying patients who were willing to participate in this fashion proved to be unsuccessful: only five patient-subjects were obtained over a period of several months. Although the data from these five original subjects were considered to be insufficient grounds upon which to base confident conclusions about the nature of the data obtained by the revised procedure, a comparison of these two types of data was made, and will be presented later.

Statistical Analysis

Overt Interpersonal Behavior

Summary points for all subjects were compared separately on the "dom-sub" and "lov-hat" dimensions of the interpersonal circle by way of two-way analysis of variance tests (ANOVA) for differences between all groups and subgroups, i.e., between High Narcissism patients (HN group), Low Narcissism patients (LN group), females, males, High Narcissism Females (HNF), High Narcissism Males (HNM), Low Narcissism Females (LNF), and Low Narcissism Males (LNM).

As a further means of testing for differences in overt interpersonal behavior, two-way ANOVA tests were performed on ICL data by octant, for all patients.

Hypothesis 2b predicted that HNFs would fall in octants 5, 6, 7, and 8, while HNMs would fall in octants 1, 2, 3 and 4. To test for significant differences between these two groups with respect to these interpersonal circle halves, a Fischer's exact test was performed on ICL data.

Underlying Themes

Two-way ANOVA tests were performed by octant on ratings of interviews with therapists in order to test for differences between groups and subgroups. These were performed separately for "self" themes and "other" themes.

In order to compare ratings of underlying themes directly to ICL scores, octant scores for both levels were converted to standard scores for all groups by application of the following formulas: first, x - mean/S.D.; then, 10X + 50. In this way, all scores assumed a mean of 50, with a standard deviation of 10. These formulas were applied separately to ICL scores, underlying "self" ratings, and underlying "other" ratings. In addition to graphic comparison, treatment-by-subjects (or repeated measures) ANOVA tests were used to test for significant differences in octant scores between "self" ratings and ICL scores, and "other" ratings and ICL scores.

A p of .05 or less was considered to be indicative of significant differences.

IV. RESULTS

Description of Patients Studied

The forty patients about whom information was obtained from therapists ranged in age from 22 to 58 years, with diverse marital status. Table 1a summarizes these data by HN and LN groups, and by gender, while Table 1b presents these same data by subgroup.

Table 1

Age and Marital Status of Patients Studied

	Avg. age	Age range	S	M	D	Sep.	Prev. marr.
			(a) By Group				
HN group	33.1	23-46	11	4	2	1	3
LN group	36.3	22-58	5	8	5	2	4
Females	33.8	22-53	6	7	3	2	2
Males	35.6	22-58	10	5	4	1	5
			(b) By Subgroup				
HNF	32.5	24-46	4	3	0	1	2
HNM	33.6	23-43	7	1	2	0	1
LNF	35.0	22-53	2	4	3	1	0
LNM	37.6	22-58	3	4	2	1	4

Table 1a shows that the average age for all patients was over thirty, and that HN patients tended to be slightly younger than LN patients. Twice as many HN patients as LN patients were single. Twice as many LN patients as HN

patients were married, and twice as many were divorced as well. With regard to gender, differences in age and marital status were minimal. Table 1 shows among other things that the HNM group had more single individuals than any other patient group.

All patients studied were white Americans, with the exception of one Dutch in the HNF group, one Black, one Chinese, one German, and one Australian in the LNF group, and two Mexican-Americans in the HNM group. The educational level of patients ranged from high school graduate to Ph.D.s and M.D.s (see Table 4 in Appendix I). There was also a wide variation in occupation among patients, including factory workers, secretaries, housewives, artists, business-persons, a lawyer, and a physician (see Table 6 in Appendix I for a list of occupations by subgroup).

Among patients studied for this project, the length of time in therapy with current therapists ranged from about four months to four years, and the length of time previously in therapy ranged from zero to 15 years. The average overall time which patients had spent in psychotherapy (including group, family, and marital therapy) was two and a half years for LN patients, and close to four years for HN patients (see Table 5 in Appendix I).

With several exceptions, diagnoses among HN patients tended to be Narcissistic Personality Disorder and Borderline Personality Disorder, often with other personality features

as well. Diagnoses of LN patients varied more widely, from Adjustment Disorder to Passive-Dependent Personality, with Obsessive-Compulsive diagnoses being most frequent (see Table 8 in Appendix I for a list of diagnoses by subgroup).

Table 7 in Appendix I presents information about sibling configurations of the patients studied.

Hypotheses

Hypothesis 1 stated that High Narcissism patients would display an array of overt interpersonal styles, as measured by therapists' descriptions on the ICL.

Figure 2 shows Leary summary points on the interpersonal circle for the 20 HN patients. These ICL summary points were considered to represent overt interpersonal styles. It can be seen from this graph that summary points of HN patients fell in octants 2, 3, 4, 5, and 6, representing behavior which was "competitive-narcissistic," "aggressive-sadistic," "rebellious-distrustful," "self-effacing-masochistic," and "docile-dependent." There was, however, a preponderance of interpersonal styles in the "competitive-narcissistic" and "aggressive-sadistic" segments of the interpersonal circle (i.e., octants 2 and 3). It can also be seen from Figure 2 that "cooperative-overconventional," "responsible-hypernormal," and "managerial-autocratic" styles were not represented among HN patients. Table 2 summarizes the octant locations of the 20 HN summary points.

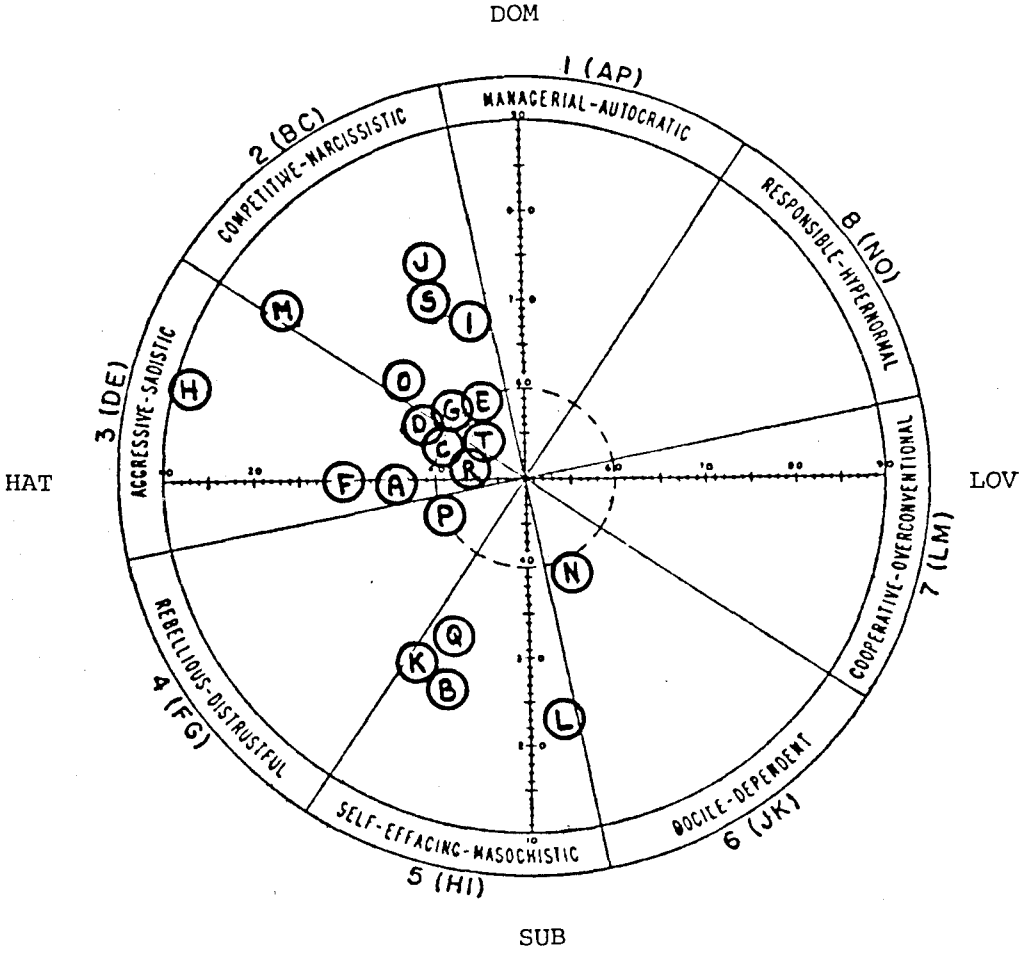


Figure 2. ICL summary points for HN patients (N = 20).

Table 2

Octant Locations of HN Summary Points

Octant:	1	2	3	4	5	6	7	8
	0	8	6	1	4	1	0	0

With respect to the dom-sub axis, summary points for HN patients were fairly evenly distributed. That is, HN patients tended to display interpersonal styles which ranged from overtly dominant to overtly submissive. With respect to the lov-hat axis, however, summary points were not evenly distributed. As Figure 2 clearly shows, the summary points of HN patients tended to fall almost exclusively on the nonaffiliative side (i.e., the left side) of the interpersonal circle. Only two summary points fell on the affiliative side at all, and neither of these was strongly affiliative. This means that, despite the variation with regard to the dominance-submission dimension, the overt interpersonal styles displayed by HN patients were viewed by therapists as being limited to nonaffiliative types of behavior.

These results constituted only partial support of hypothesis 1. Although they suggested a fairly wide variation of overt interpersonal styles among HN patients, this variation stopped short of being an "array" inasmuch as it

excluded virtually all styles which were overtly affiliative. The fact that 70% of HN patients (14 out of 20) had summary points which fell either in the overtly "competitive-narcissistic" octant (2), or the adjacent "aggressive-sadistic" octant (3) suggested, moreover, that the majority of HN patients in this study tended to display interpersonal styles which were more or less overtly narcissistic.

In addition to ICL data, verbal descriptions of HN patients' overt interpersonal behavior were informally elicited from therapists during the interviews with them (see Table 9 in Appendix J). Although these data were not used to test hypothesis 1, it is noteworthy that verbal descriptions of HN patients tended to contain more affiliative adjectives than ICL descriptions of these same patients. This finding suggests that ICL descriptions of surface behavior may have been somewhat inaccurate.

Hypothesis 2a stated that HNFs would tend to display overt interpersonal styles which were different from those displayed by HNMs.

As discussed previously, in order to test for differences in overt styles, two-way ANOVAs were performed on ICL summary points, and on mean ICL scores for individual octants.

ICL summary point data for the 20 HN patients are presented in Figure 3. Male and female subgroups are

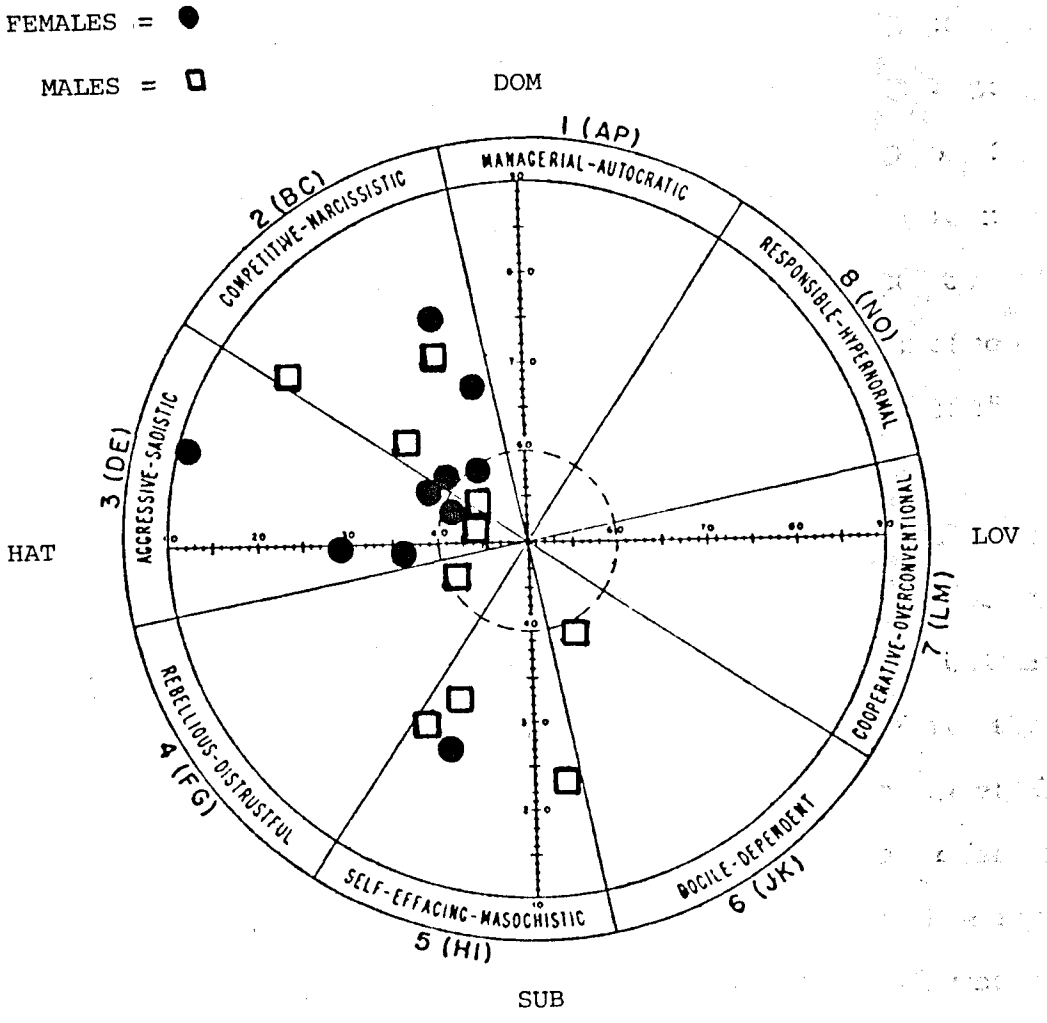
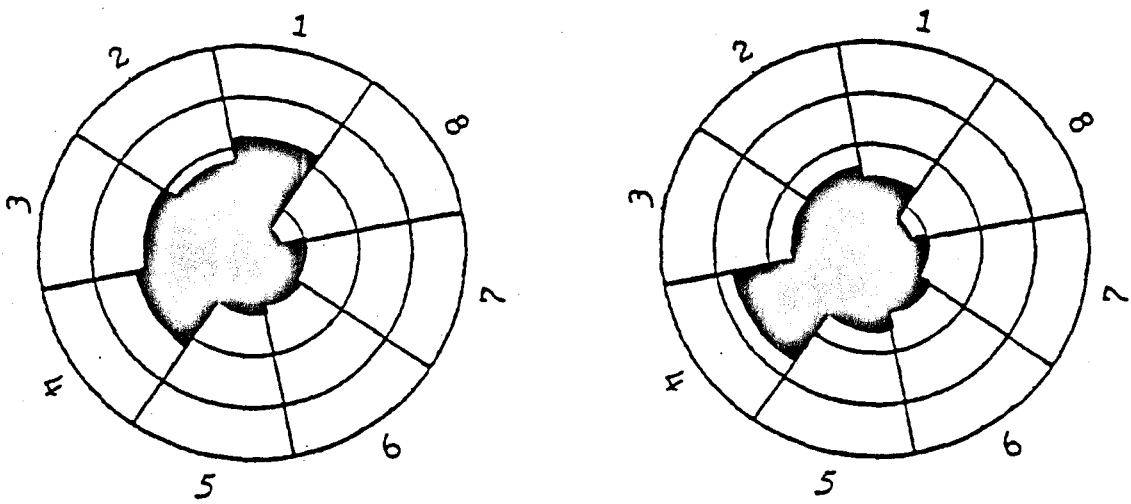


Figure 3. ICL summary points for HN patients (N = 20), by subgroup.

identified within the larger HN group. (See Table 10 in Appendix J for a list of mean dom-sub and lov-hat raw scores.) A visual examination of Figure 3 suggests that HNMs tended to have a somewhat wider range of overt interpersonal styles than HNFs. Whereas overt styles of HNMs appear to be fairly evenly distributed across octants representing nonaffiliative behavior, HNFs tended to have overt styles which were predominantly "competitive-narcissistic" (octant 2) or "aggressive-sadistic" (octant 3).

Although two-way ANOVA tests revealed significant differences between the larger HN and LN patient groups, they revealed no significant interaction effects between subgroups with respect to either dom-sub or lov-hat dimensions of the ICL summary points (see Table 11 in Appendix J for ANOVA results). These results indicated the absence of significant differences between HNFs and HNMs with respect to overt interpersonal style, hence hypothesis 2a was not supported.

With regard to individual octant scores of HN patients, a visual examination of Figure 4 suggests that HNFs tended to be somewhat more "managerial-autocratic" (octant 1) and "aggressive sadistic" (octant 3) than HNMs. (See Table 12 in Appendix J for a list of mean ICL octant scores.)



Scale: Unit = 4; Center Point = 0

Figure 4. Mean ICL octant scores for HNFs and HNMs.

Although two-way ANOVA tests revealed significant differences between the larger HN and LN patient groups, no significant interaction effects were found. Only a trend toward significant interaction effects was indicated for octant 1 (see Table 13 in Appendix J for ANOVA results). As did summary point data, these results indicated a lack of significant differences between HNFs and HNMs with respect to overt interpersonal behavior, and failed to support hypothesis 2a.

Although not in accordance with strict statistical procedure, t tests for differences between the mean octant

scores of HNF and HNM subgroups were performed since two-way ANOVAs suggested a trend toward significant differences in octant 1. These tests did in fact reveal significant differences in octant 1, suggesting that HNFs were significantly more "managerial-autocratic" than HNMs (see Table 3 below for *t* test results).

Table 3

ICL Octant Scores: *t* Test Results for HNFs and HNMs (*df* = 18)

	Octant							
	1	2	3	4	5	6	7	8
T	2.01	.42	1.0	.78	.73	.47	.43	.69
p	.05	n.s.*	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.

*Nonsignificant.

To summarize, both ICL summary point and individual octant score data indicated that differences between overt interpersonal styles displayed by HNFs and those displayed by HNMs were not significant. That is, hypothesis 2a was not supported. Although *t* test results suggested that HNFs tended to behave in ways which were more overtly "managerial-autocratic" than HNMs, these data were considered to be inconclusive in light of the absence of significant interaction effects revealed by ANOVA.

Although data regarding the overt interpersonal styles of patients other than HNFs and HNMs were not directly pertinent to the testing of hypothesis 2a, they were of related interest, and are therefore presented below.

Figure 5 presents ICL summary points for the 20 LN patients, with male and female subgroups identified within the larger LN group. Figures 6 and 7 present summary points for all 40 patients by gender, with HN and LN subgroups identified within each of these larger groups.

A visual comparison of Figure 5 and Figure 3 (page 76) reveals that with respect to HN patients, LN patients tended to display a wider variation in overt interpersonal styles. Whereas HN patients tended to display interpersonal styles which were both dominant and submissive but largely nonaffiliative, LN patients tended to display overt styles which were relatively evenly distributed with respect to affiliative, nonaffiliative, dominant, and submissive types of behavior. Whereas HN patients had summary points which fell in only five of eight octants and preponderantly in octants 2 and 3, LN summary points fell in all eight octants. A two-way ANOVA test indicated that differences between HN and LN groups with respect to the lov-hat axis were in fact significant at the .001 level (see Table 11 in Appendix J). No significant differences were found on the dom-sub dimension between these two groups.

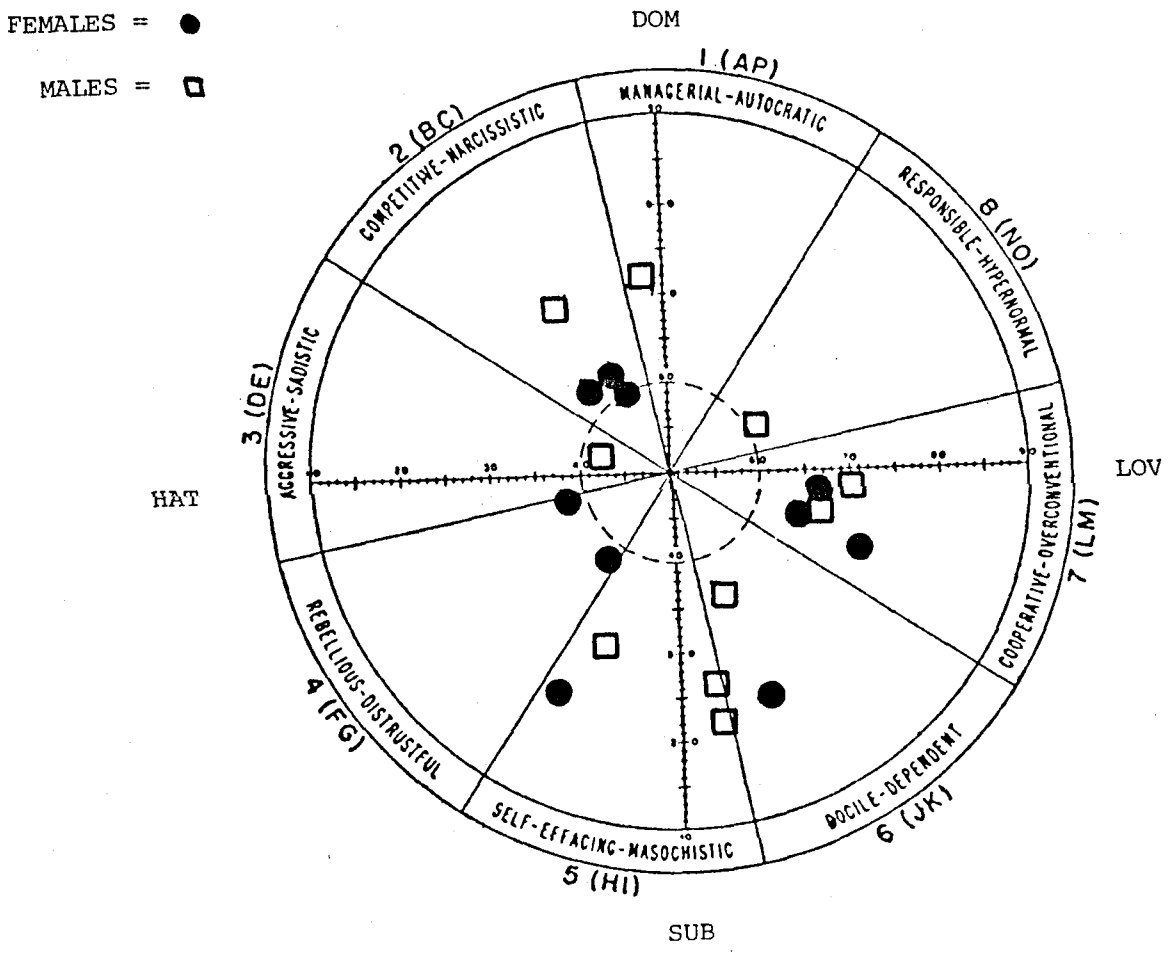


Figure 5. ICL summary points for LN patients (N = 20), by subgroup.

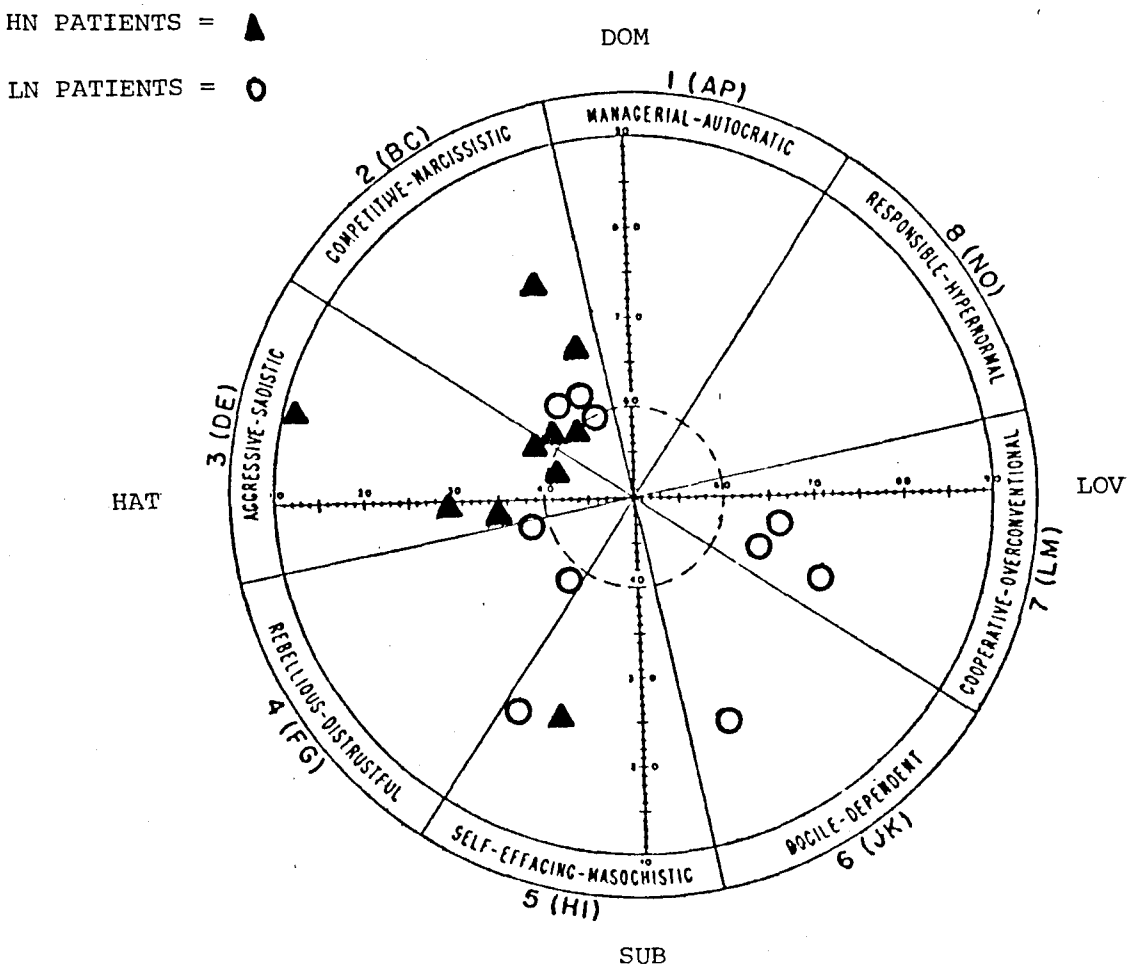


Figure 6. ICL summary points for female patients, (N = 20), by subgroup.

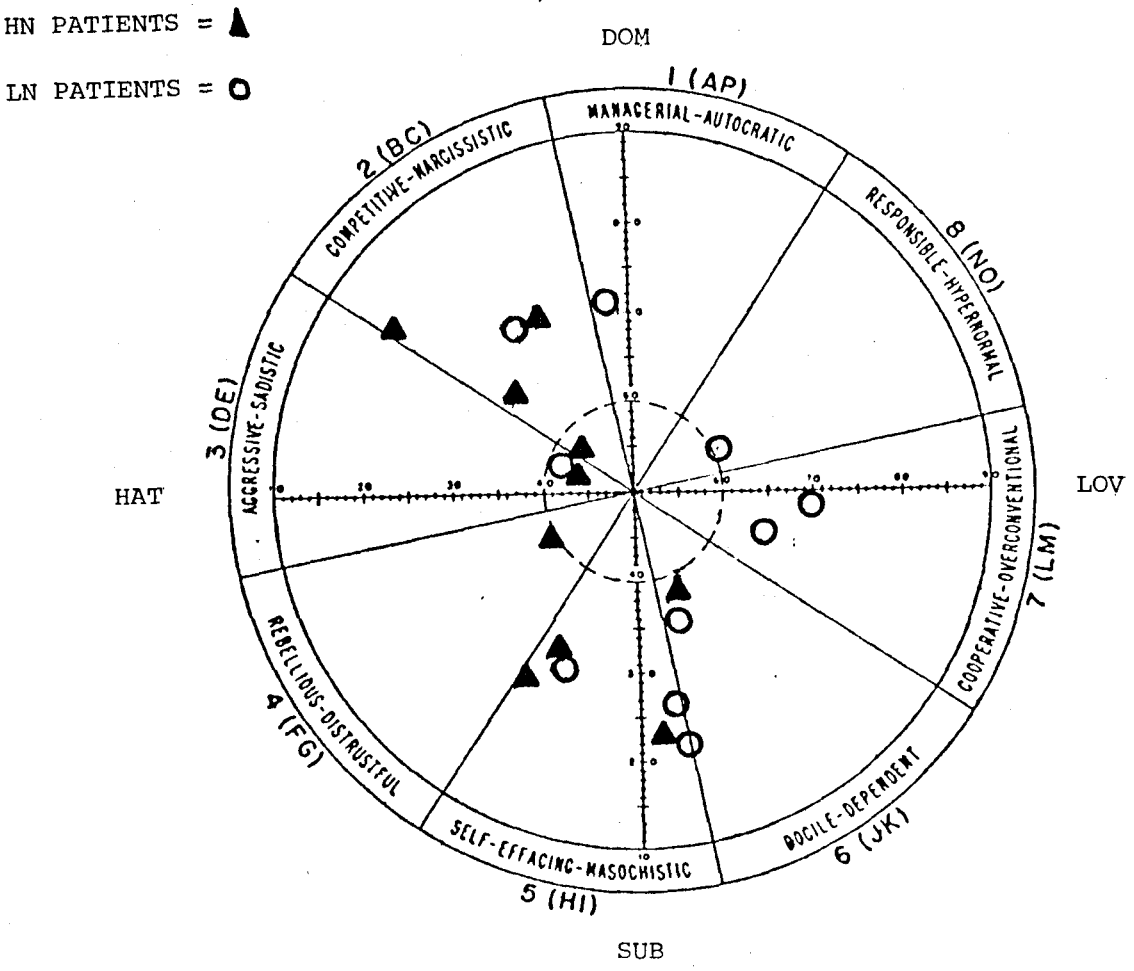
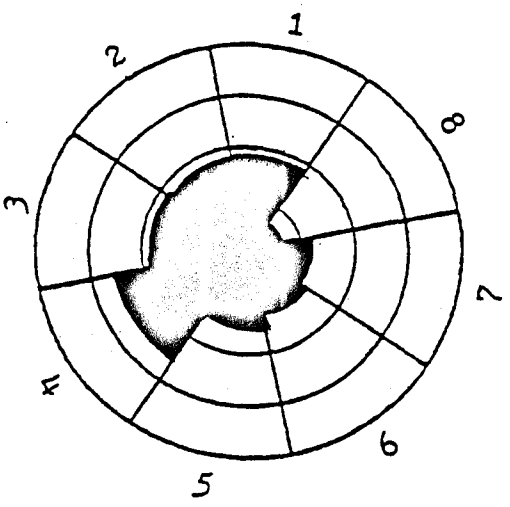


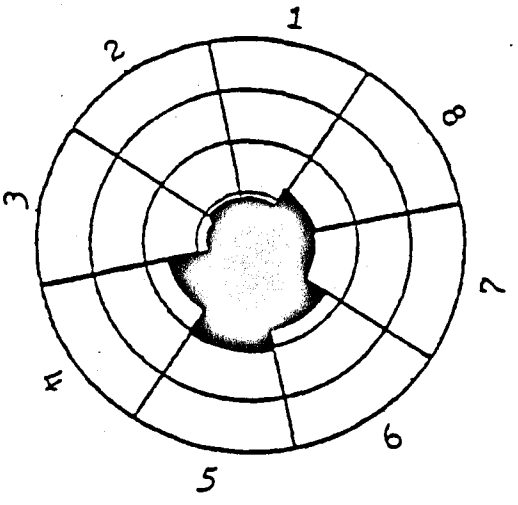
Figure 7. ICL summary points for male patients (N = 20), by subgroup.

With regard to stylistic differences between males and females, a visual inspection of Figures 6 and 7 reveals differences which are relatively less salient than those between HN and LN groups. Generally speaking, both males and females tended to display a wide array of overt interpersonal styles as represented by summary points on the interpersonal circle, although those displayed by men are slightly more evenly distributed across different types of behavior than those displayed by women. Although all behavioral styles had at least one representative among male patients, no female patient displayed an interpersonal style which was overtly "managerial-autocratic" (octant 1) or "responsible-hypernormal" (octant 8). There was also somewhat of a preponderance of "competitive-narcissistic" and "aggressive-sadistic" styles among women, whereas there was no clear preponderance among male patients in any one sector of the interpersonal circle. Despite these apparent dissimilarities between groups, two-way ANOVA tests revealed no significant differences between males and females with respect to either dom-sub or lov-hat dimensions (see Table 11 in Appendix J).

Figure 8 presents a graphic summary of mean ICL octant scores for all 40 patients, by HN and LN group, and by gender. Figure 9 presents a graphic summary of mean ICL octant scores for LNF and LNM subgroups.

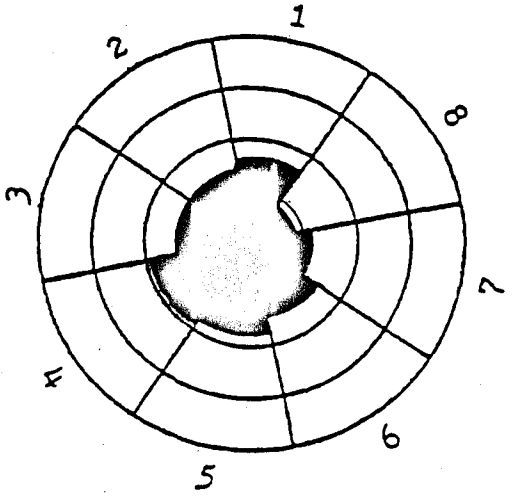


HN Group (N = 20)

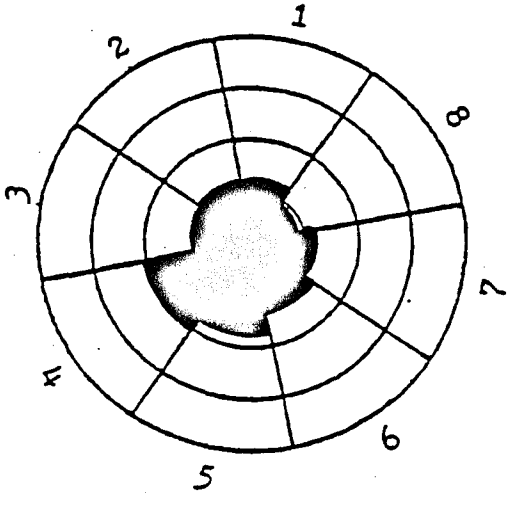


LN Group (N = 20)

(a) HN and LN patient groups.



Females (N = 20)



Males (N = 20)

(b) Female and male patient groups.

Scale: Unit = 4; Center Point = 0

Figure 8. Mean ICL octant scores.

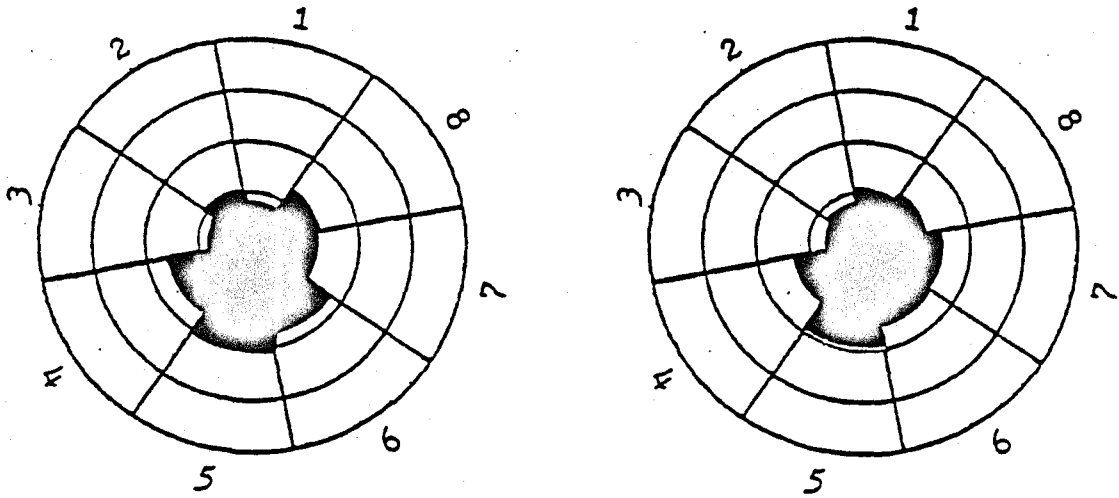


Figure 9. Mean ICL octant scores for LNFs and LNMs.

A visual examination of Figure 8a reveals that in comparison to LN patients, HN patients were described on the ICL as being relatively nonaffiliative, a result which is consistent with summary point data for these HNF and HNM patients cited above. These graphs also suggest that HN patients were viewed by therapists as displaying more overtly dominant behavior than LN patients. Figure 8b shows that overt behavior of male and female patients was very similar to each other. Relatively submissive behavior was most predominant in both groups. LNF and LNM patients were similar to male and female groups in this respect (see Figure 9).

Two-way ANOVA tests of individual octant scores across all groups revealed significant differences between HN and LN groups with respect to octants 1, 2, 3, 4, and 8 (see Table 13 in Appendix J). No significant differences were found between male and female patient groups for individual octants. And, as previously discussed, only a trend toward significant interactive differences between subgroups were found, in octant 1.

These results indicated that with respect to overt interpersonal behavior, HN patients tended to be significantly more "managerial-autocratic," more "competitive-narcissistic," more "aggressive-sadistic," more "rebellious-distrustful," and less "responsible-hypernormal" than LN patients. These differences appeared to reflect the relatively nonaffiliative nature of the HN styles in comparison to LN styles, as discussed above. They also appeared to lend support to the conclusion based upon visual inspection of Figure 7b that, to some extent, HN patients were also viewed by therapists as being more overtly dominating than LN patients.

For male and female patient groups, these ANOVA results indicated that overt interpersonal behavior was not significantly different with respect to behavior represented by any particular octant.

Hypothesis 2b stated that HNFs would tend to display overt interpersonal styles (as measured by therapists' descriptions on the ICL) which fell in the relatively affiliative (and nondominant) octants of the Leary interpersonal circle (octants 5, 6, 7, and 8), while HNMs would tend to display overt styles which fell in relatively nonaffiliative (and dominant) octants (1, 2, 3, and 4).

Figure 10 presents ICL summary points for HNFs and HNMs by interpersonal circle-half defined by octants 1, 2, 3, 4 and by octants 5, 6, 7, 8. The small numbers in parentheses in the lower right hand corners of the squares indicate the number of patients which would be in the cells if all of the data had fit hypothesis 2b perfectly. A visual examination of this figure suggests that, if anything, there was a trend

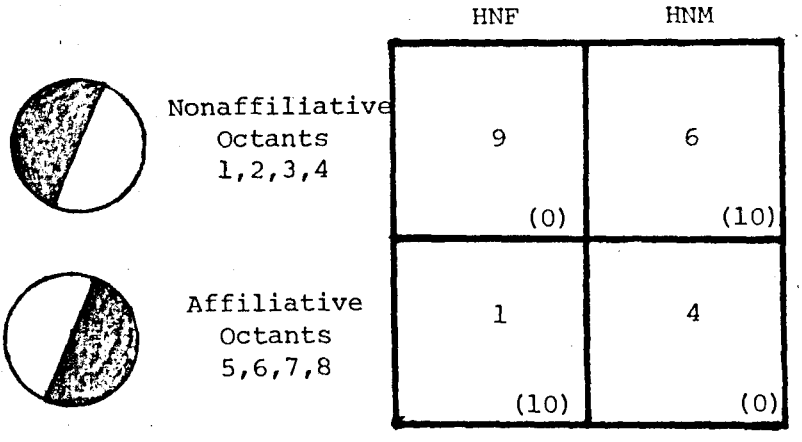


Figure 10. Circle-half locations of ICL summary points for HNFs and HNMs.

toward the opposite outcome. That is, the HNFs tended to display overt interpersonal styles which were relatively nonaffiliative (and dominant) in comparison to the overt interpersonal styles of HNMs. A Fischer's exact test (Sigel, 1956) performed on these data was nonsignificant (probability of distribution = .14).

In summary, data failed to support hypothesis 2b inasmuch as differences between overt interpersonal behavior of HNFs and HNMs were found to be nonsignificant with respect to affiliation (and dominance).

Hypothesis 3a stated that underlying themes regarding self and others among HN patients, as assessed by rated interviews with therapists, would be different from those of LN patients.

Figure 11 presents mean octant ratings of underlying "self" themes for HN and LN groups. The mean scores for Figure 11 are contained in Table 14 in Appendix J.

A visual examination of the HN group data in Figure 11 suggests that at an underlying level, "self" themes tended to be bi-modal, with a preponderance of highly dominant themes (octants 1 and 2) and, although somewhat more widely dispersed, a preponderance of highly submissive themes as well (octants 5, 6, and, to a lesser extent, 4). There were comparatively few underlying "self" themes which fell along

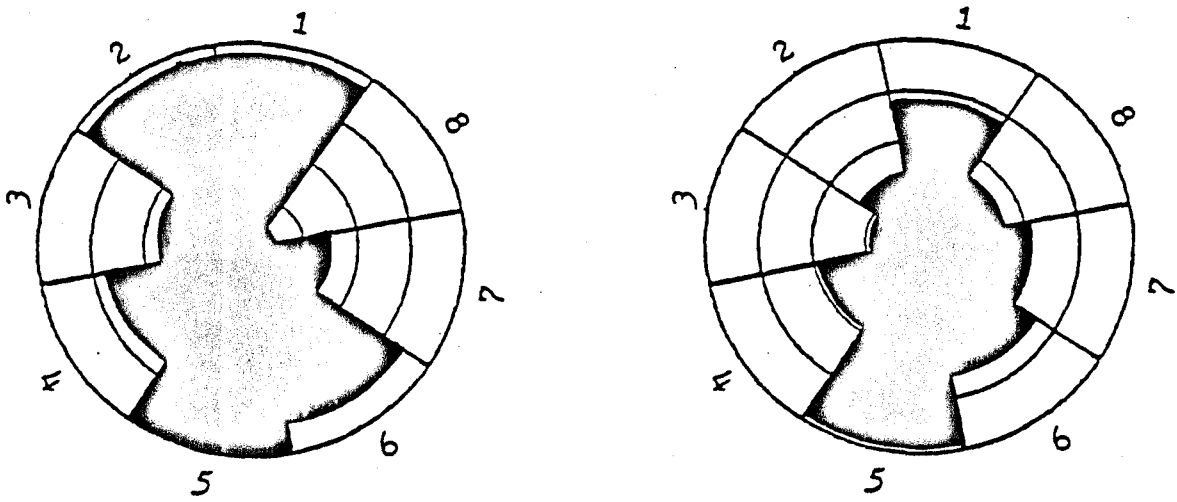


Figure 11. Mean ratings of underlying "self" themes for HN and LN patient groups.

the affiliation/nonaffiliation (i.e., lov-hat) axis. The apparent predominance of underlying self images of and concerns about power and weakness was considered to be generally consistent with the notion discussed earlier in this study that underlying the highly narcissistic individual's overt behavior lies a self which may at the same time be inflated (i.e., powerful) and tenuous (i.e., weak).

Although LN patients also showed a preponderance of underlying "self" themes revolving around weakness, a visual examination of LN group data suggests that these patients were considerably less concerned with power issues than the

HN patients, inasmuch as octant 1, and especially octant 2, were relatively vacant (see Figure 11). In addition, there appear to be more underlying themes having to do with affiliation (octant 7) among LN patients than among HN patients.

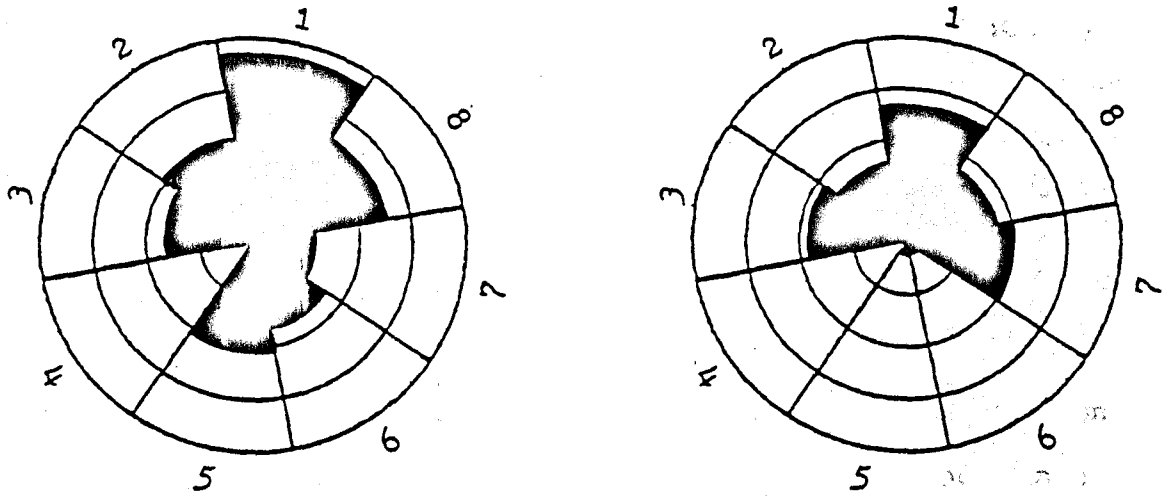
Two-way ANOVA tests performed on underlying 'self' theme ratings for all patients revealed significant differences between HN and LN groups with respect to octants 1, 2, 3, 6, and 7 (see Table 15 in Appendix J for ANOVA results). These results lent support to hypothesis 3a which predicted differences between HN and LN groups. They indicated that with respect to underlying themes regarding self, HN patients tended to be significantly more "managerial-autocratic," more "competitive-narcissistic," and more "aggressive-sadistic" and "docile-dependent" than were LN patients. On the other hand, HN patients were significantly less "cooperative-over-conventional" than LN patients with respect to underlying "self" themes.

The differences described above appeared more specifically to lend support to the notion proposed earlier in this study that the narcissistic mode (with need for mirroring represented by octant 2 and related octants 1 and 3, and need for idealized merger represented by octant 6) underlies the overt behavior of highly narcissistic individuals to a greater degree than that of nonnarcissistic

individuals. These results also supported the related notion that the object loving mode (represented primarily by octant 7) tends to be more predominant for nonnarcissistic individuals than for highly narcissistic individuals.

Figure 12 presents mean octant ratings for underlying "other" themes by HN and LN groups. The mean scores for Figure 12 are contained in Table 16 in Appendix J.

A visual examination of HN group data in Figure 12 shows a preponderance of "other" themes in octant 1 and related octants 2 and 8. This suggests that, at an underlying level, HN patients tended to view others, first of



HN Group (N = 20)

LN Group (N = 20)

Scale: Unit = 1; Center Point = 1

Figure 12. Mean ratings of underlying "other" themes for HN and LN groups.

all, as being very powerful, and secondly as being competitive (octant 2) and/or responsible and giving (octant 8). HN patients also appear to view others as being weak (octant 5).

Generally speaking, underlying "other" themes among LN patients appear to be less extreme than underlying "other" themes among HN patients. Power themes were also predominant for the LN group, however, unlike the HN group, themes having to do with others' weaknesses were virtually absent. In addition, LN patients appear to have more affiliative themes than do HN patients.

Two way ANOVA tests performed on underlying "other" theme ratings of all patients revealed significant differences between HN and LN groups with respect to octants 1, 5, 6, 7, and 8 (see Table 17 in Appendix J for ANOVA results). These results also lent support to hypothesis 3a which predicted differences between HN and LN groups at the underlying level. They indicated that with respect to underlying themes regarding others, HN patients tended to be significantly more "managerial-autocratic," more "responsible-hypernormal," more "docile-dependent," and more "self-effacing-masochistic" than were LN patients. They also indicated that there were significantly fewer "other" themes concerning cooperation and conventionality among HN patients than there were among LN patients.

The above differences between HN and LN patients appeared more specifically to lend support to the notion proposed earlier in this study that for highly narcissistic individuals, idealization of others (i.e., others in octants 1 and 8) and devaluation of others (i.e., others in octants 5 and 6) are relatively extreme and predominant in comparison to nonnarcissistic individuals. In this same vein, these results also suggested that concerns about others serving as self "mirrors" (i.e., others in octant 6, and to some extent, octant 8) were significantly greater among HN patients than among LN patients. These findings also lent support to the related notion that the ability to view others as having needs which are separate from one's own (i.e., others in octant 7) is more highly developed among nonnarcissistic individuals than among highly narcissistic individuals.

In summary, results concerning underlying themes appeared to lend support to hypothesis 3a. For both "self" and "other" themes, significant differences were found between HN and LN groups with respect to five out of eight octants. This means that at an underlying level, HN patients did indeed differ from LN patients in a variety of ways. The nature of these differences, moreover, supported the notion proposed earlier in this study that the underlying mode of highly narcissistic individuals is relatively

narcissistic, while the underlying mode of individuals who are not highly narcissistic is relatively object loving.

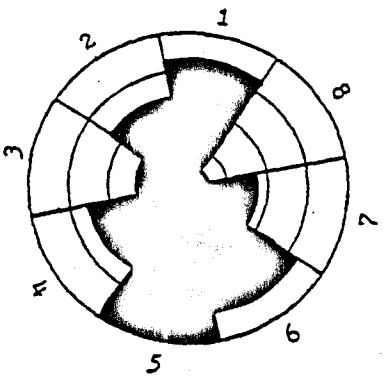
Although not directly pertinent to the testing of hypothesis 3a, data regarding the underlying themes of patient groups other than HN and LN groups were of related interest, and are therefore also presented below.

Figure 13 presents the mean octant ratings of underlying "self" themes for male and female patient groups, and by subgroup.

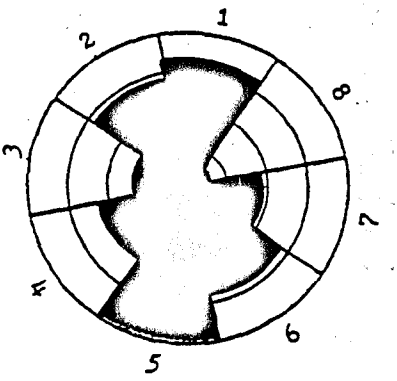
A visual inspection of Figure 13a suggests that underlying "self" themes among male and female patients were very similar overall. In comparison to "self" themes among HN patients (see Figure 11, page 90), male and female patients had themes which appear to be somewhat less extremely dichotomous; in comparison to LN "self" themes, they appear to be somewhat more widely dispersed across octants.

HNF and HNM profiles (see Figure 13b) both appear to reflect the underlying "self" theme pattern which was characteristic of the larger HN group. LN subgroup profiles (i.e., LNFs and LNMs) both appear to reflect the underlying "self" theme pattern which was characteristic of the LN group in general.

Two-way ANOVA tests (see Table 15 in Appendix J) indicated the absence of significant differences between

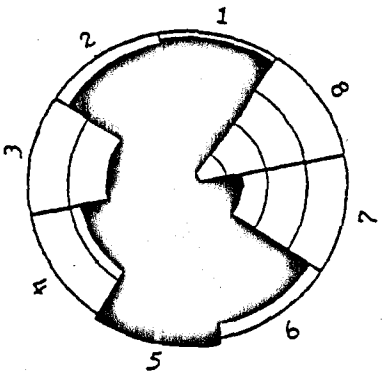


Females (N = 20)

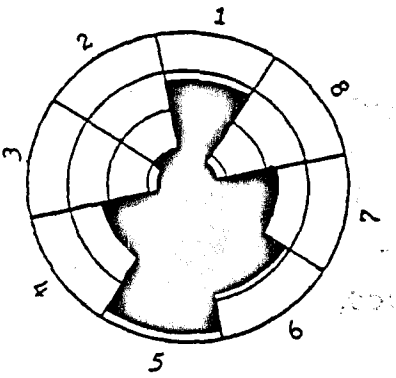


Males (N = 20)

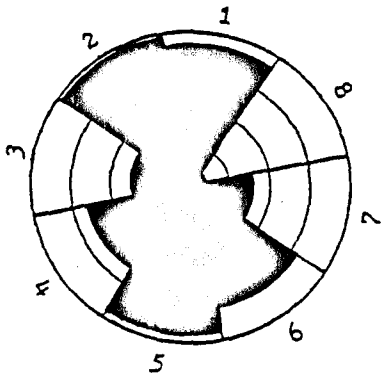
(a) By gender.



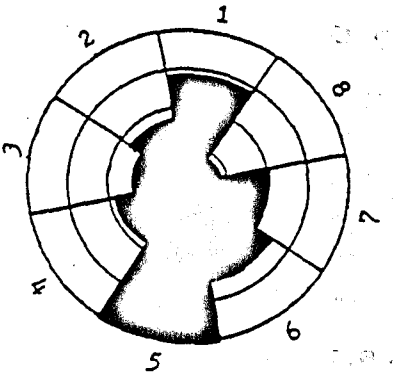
HNF (N = 10)



LNF (N = 10)



HNM (N = 10)



LNF (N = 10)

(b) By subgroup.

Scale: Unit = 1; Center Point = 1

Figure 13. Mean ratings of underlying "self" themes.

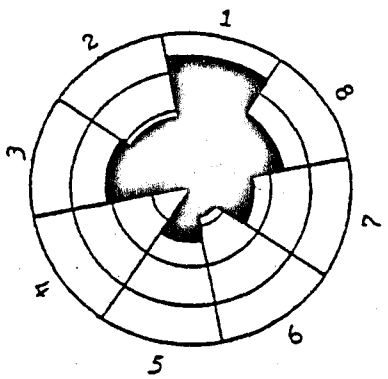
male and female patient groups with respect to underlying "self" themes, although a trend toward a significant difference between these groups was revealed in octant 2. No significant interaction effects were found, a result which indicated the absence of significant differences which were unique to subgroups.

Figure 14 presents the mean octant ratings of underlying "other" themes for male and female patient groups, and by subgroup.

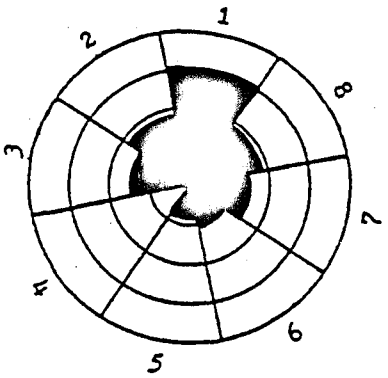
A visual inspection of Figure 14a suggests that underlying "other" themes among female patients tended to be somewhat more extreme overall than "other" themes among male patients, but that they are similar in overall pattern. Both groups show a predominance of power themes.

Generally speaking, subgroup profiles (Figure 14b) appear to mirror the profiles of the larger HN and LN groups respectively. However, HNFs do appear to have more "aggressive-sadistic" (octant 3) "other" themes than do HNMs.

Two-way ANOVA tests (see Table 17 in Appendix J) revealed the absence of significant differences between male and female patient groups. (Differences in octant 3 were at the .1 level only.) No significant interaction effects were found between subgroups.

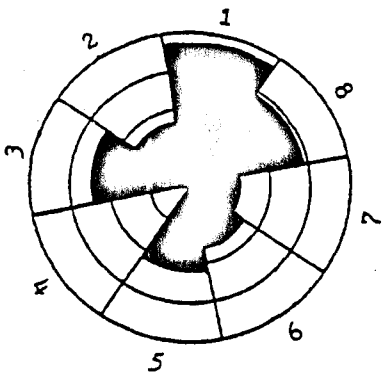


Females (N = 20)

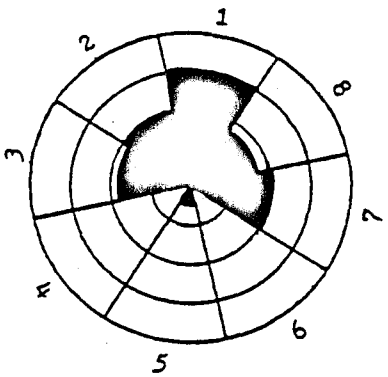


Males (N = 20)

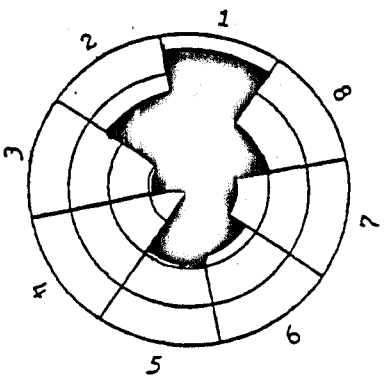
(a) By gender.



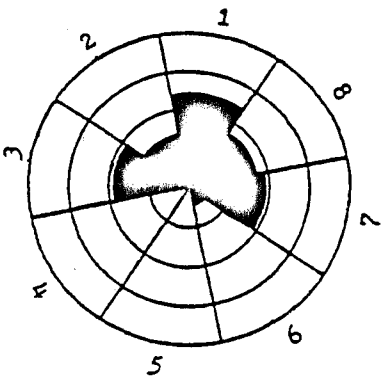
HNF (N = 10)



LNF (N = 10)



HNM (N = 10)



LNM (N = 10)

(b) By subgroup.

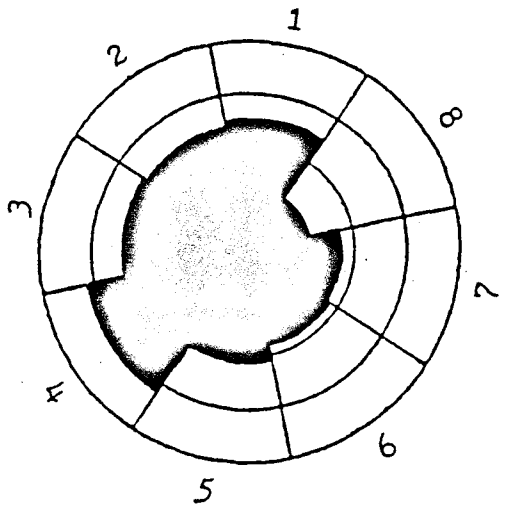
Scale: Unit = 1; Center Point = 1

Figure 14. Mean ratings of underlying "other" themes.

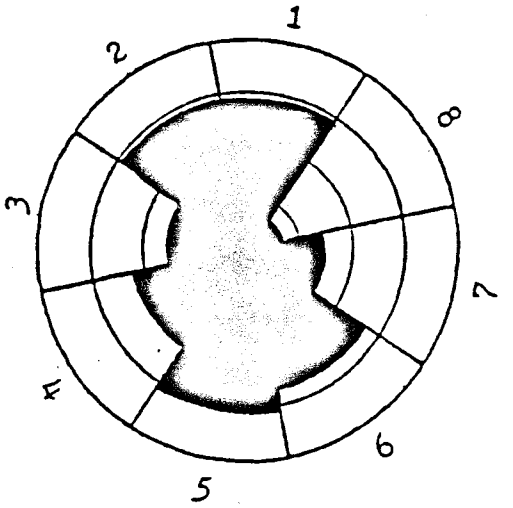
Hypothesis 3b stated that underlying themes regarding "self" and "others" among HN patients, as assessed by rated interviews with therapists, would be more similar to each other than overt interpersonal behavior among these same patients.

Figure 15 is a graphic representation of the mean ICL octant scores, underlying "self" themes, and underlying "other" themes among HN patients. Figure 16 presents these same bi-level data in superimposed form. The conversion of these data to standard scores permitted a direct comparison between Level I (ICL) and Level III (underlying themes). The mean standard scores upon which the graphs in Figure 15 were based are listed in Table 18 in Appendix J.

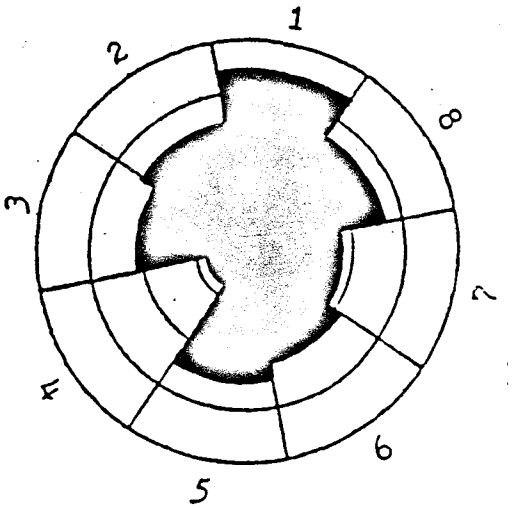
Operationally, hypothesis 3b predicted that whereas ICL scores of HN patients would tend to be widely dispersed around the interpersonal circle, underlying theme ratings would tend to cluster in a relatively limited sector of the circle. Conclusions drawn from visual examination of ICL and "self" theme data in Figure 15 failed to support this hypothesis. These graphs show that, although HN ICL scores were above the overall mean score in five different octants (1, 2, 3, 4, and 5), underlying "self" ratings for these patients were also above the mean in five different octants (1, 2, 4, 5, and 6). That is, although the overall pattern of scores was different at Level III in comparison to



ICL
(Level I)



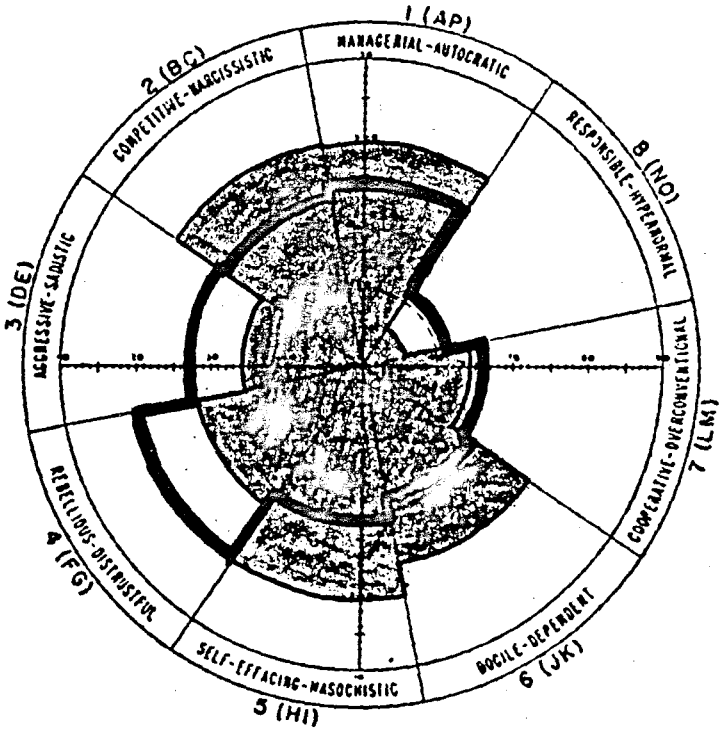
"Self" Themes
(Level III)



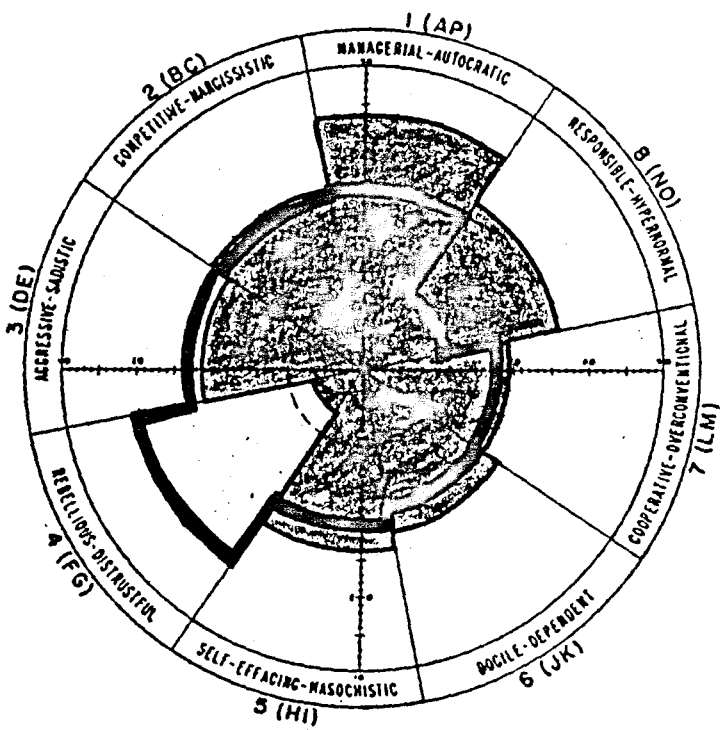
"Other" Themes
(Level III)

Scale: Unit = 10; Center Point = 30

Figure 15. Mean octant scores for ICL and underlying themes of HN patients (standard scores).



(a) ICL and underlying "self" themes.



(b) ICL and underlying "other" themes.

Scale: Unit = 1; Center Point = 30

Figure 16. Bi-level comparison of mean octant scores for HN patients.

Level I, the dispersion of scores across octants at the underlying level was not smaller than the dispersion of scores at the overt level. The implication of these data is that for HN patients, underlying self images and concerns were as varied as overt interpersonal behavior.

Conclusions based upon visual examination of HN ICL scores and underlying "other" data in Figure 15 likewise failed to support hypothesis 3b, and if anything tended to suggest its inverse. That is, whereas HN ICL scores were dispersed primarily across five different octants (1, 2, 3, 4, and 5--as mentioned above), scores for underlying "other" themes among these same patients were above the overall mean score in six different octants (1, 2, 3, 5, 6, and 8). The implication of these results is that underlying images and concerns about others among HN patients tended to be slightly more widely varied than the types of overt interpersonal behavior displayed by these same individuals.

To summarize: inasmuch as the dispersion of themes at the underlying level among HN patients was found to be similar (or somewhat greater) to theme dispersion at the overt level, data failed to support hypothesis 3b which predicted a relative similarity among underlying themes of HN patients.

Although it was the comparison of the respective dispersions of underlying theme and ICL scores with which

hypothesis 3b was concerned, a bi-level comparison of individual octant scores among HN patients was of related interest, and was therefore also made.

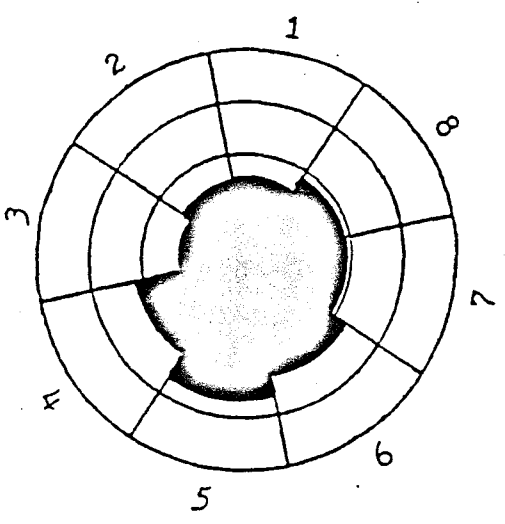
With regard to ICL scores and underlying "self" themes of HN patients, treatment-by-subjects ANOVA tests performed on individual octants revealed significant bi-level differences with respect to octants 1, 2, 3, 4, 5, and 8 (see Table 19 in Appendix J). There was also a trend toward significant differences on octant 1. These results mean that among HN patients, underlying "self" themes tended to be significantly more "competitive-narcissistic," more "self-effacing-masochistic," and more "docile-dependent" than overt behavior, and significantly less "aggressive-sadistic," less "rebellious-distrustful," and less "responsible-hypernormal" than overt behavior. These differences suggested that at the overt level, HN patients tended to be more concerned with distance (and to some extent, closeness) from others than they were at an underlying level where concerns about their own power and/or weakness were relatively predominant.

Treatment-by-subjects ANOVA tests performed on individual octants with respect to ICL scores and underlying "other" themes among HN patients revealed significant differences in octants 1, 4, and 8 only (see Table 20 in Appendix J). These results suggested that in comparison to

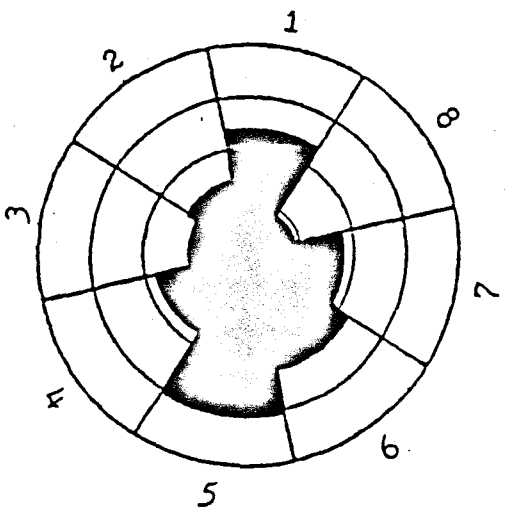
overt interpersonal behavior, underlying "other" themes among HN patients were, on the whole, very similar. The differences which were found indicated that HN patients were significantly more "managerial-autocratic" and "responsible-hypernormal" with respect to their underlying "other" themes than with respect to their overt behavior, and less "rebellious-distrustful." The implication of these differences is that underneath the HN patients' overt cautiousness and interpersonal distance (octant 4) lies a view of others as being relatively powerful and potentially helpful (octants 1 and 8).

Although it was also not directly pertinent to the testing of hypothesis 3b, an analysis of the bi-level data of LN patients was made for the sake of comparison to HN data. Figure 17 is a graphic representation of the mean ICL octant scores, underlying "self" themes, and underlying "other" themes among LN patients. (See Table 21 in Appendix J for a list of bi-level mean octant scores.) A visual comparison of this figure with Figure 15 (page 100) indicates that the underlying themes of LN patients tended to be similar in range to those of HN patients. In comparison to HN patients, LN patients also appear to have greater overall discrepancies between "self" and "other" themes.

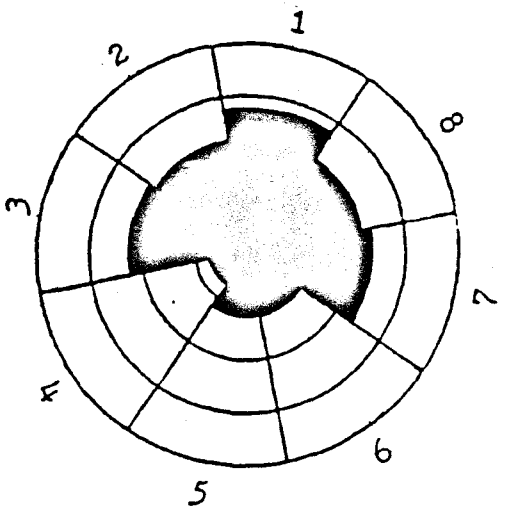
For the purpose of comparison, statistical tests for differences across octants were also performed on ICL scores and underlying theme ratings of LN patients.



ICL
(Level I)



"Self" Themes
(Level III)



"Other" Themes
(Level III)

Scale: Unit = 10; Center Point = 30

Figure 17. Mean octant scores for ICL and underlying themes of LN patients (standard scores).

With regard to LN ICL and underlying "self" theme data, significant differences were found for octants 1, 5, and 8 only (see Table 22 in Appendix J). These data indicated that in comparison to HN patients, LN patients had fewer discrepancies between overt behavior and underlying "self" themes.

Treatment-by-subjects ANOVA tests performed on ICL scores and underlying "other" theme ratings of LN patients revealed significant differences in seven out of eight octants (see Table 23 in Appendix J).

Patients One through Five (Original Proposal)

In addition to the procedures carried out for all 40 patients, the first five patients underwent an interview with the investigator which was rated for overt interpersonal behavior on the ICL by the investigator, and by an independent co-rater. These five patients also reported six early memories which were rated by the interviewer for underlying themes regarding "self" and "others." These additional measures were part of the procedure originally proposed for this project, which was later revised because of insurmountable difficulties in obtaining patient participants. The five "original" patients consisted of three LNFs, and two HNMs.

Summary points for ICL ratings of patients one through five made by therapists, the investigator, and an independent rater are presented in Figure 18. The octant locations of these summary points are summarized in Table 24 in Appendix J. Application of the simple formula proposed by LaForge (1976) for measuring the distance between summary points revealed that in four out of five cases, the independent rater's summary points were closer to those of the investigator than to the ratings of the therapist (see Table 25 in Appendix J). In three out of five cases, the octant in which the independent rater's summary point fell was also closer to that of the investigator than to that of the therapist (however, this did not always represent the closest agreement among all three raters (see Table 24 in Appendix J). Although the sample size was too small to allow meaningful statistical tests for significance of differences, these results tended tentatively to suggest that the therapists' views of these patients' overt interpersonal styles were distinct from the views of these styles held by other raters.

A comparison of these three sets of ICL scores across individual octants lent further support to the trend suggested above. Figure 19 presents the mean scores for this group of five patients by rater, in graphic form. Scores are listed in Table 26 in Appendix J. A visual comparison suggests that the overall pattern of ratings made

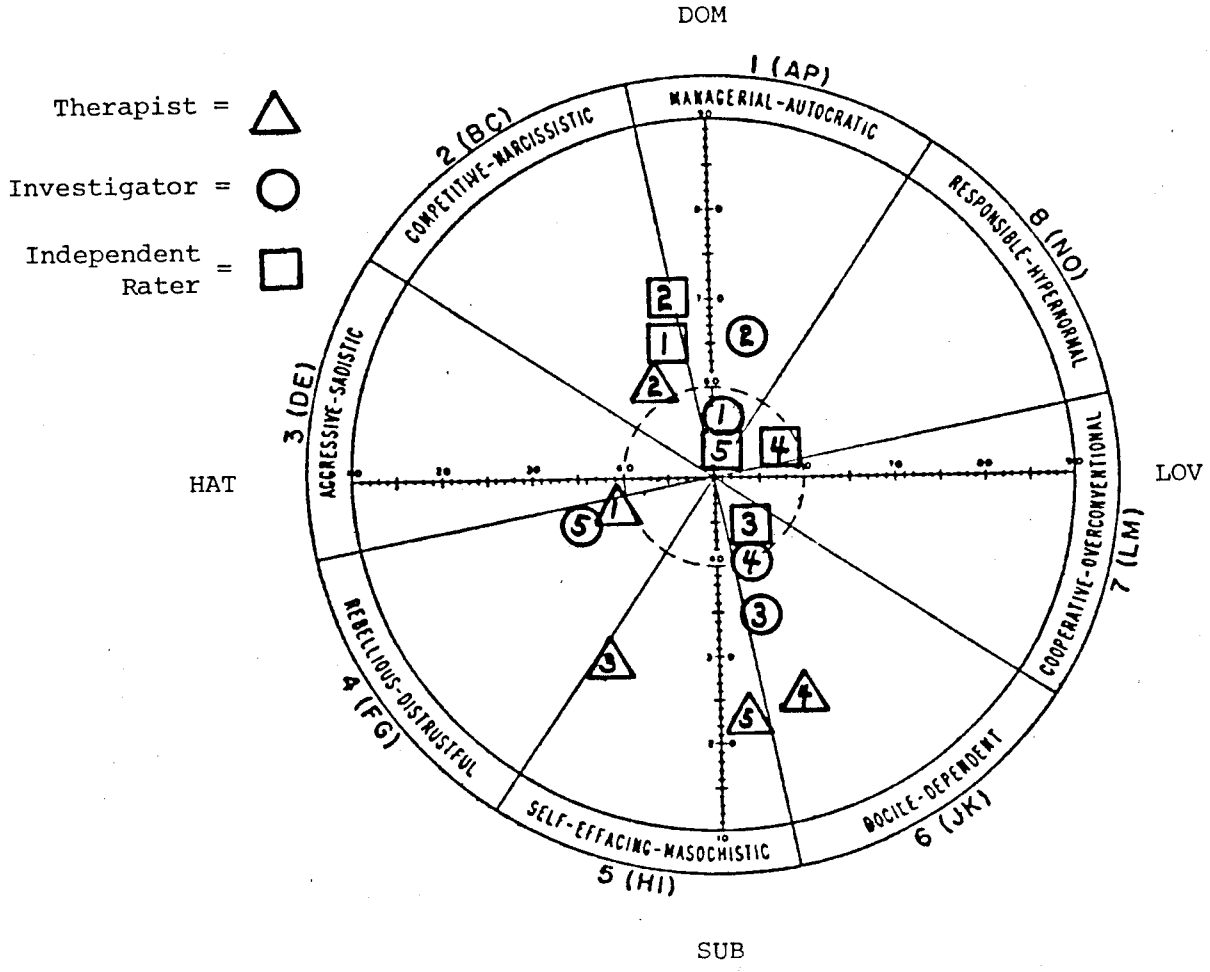
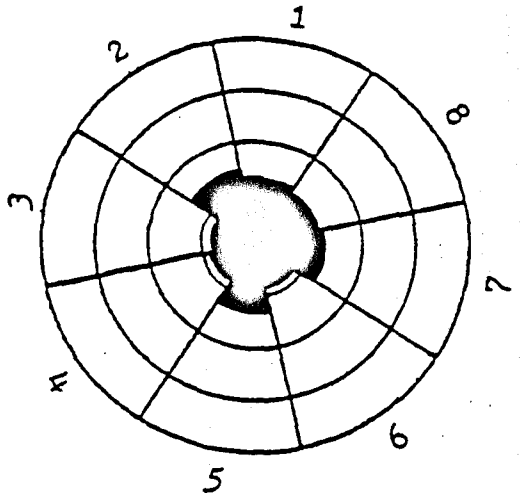
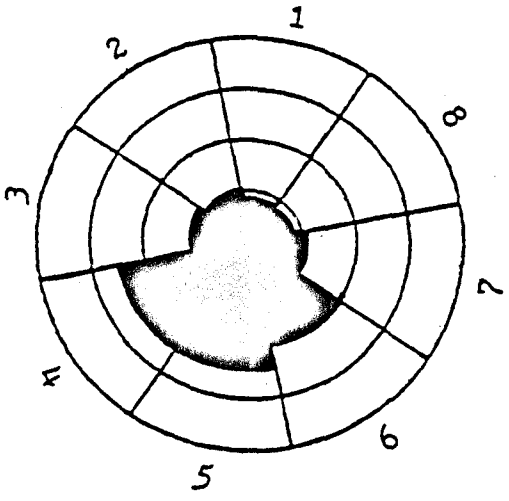


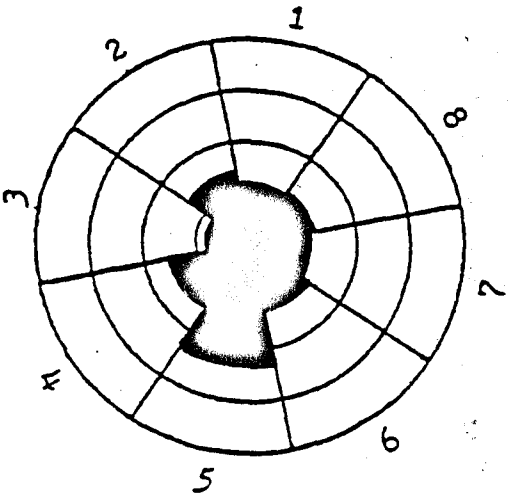
Figure 18. ICL summary points for patients one through five, by rater.



Independent Rater



Therapist



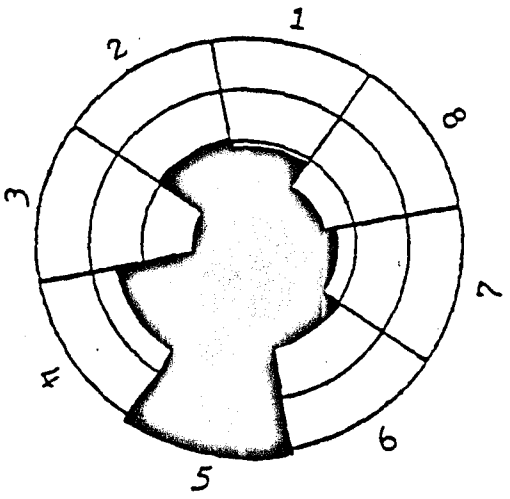
Investigator

Scale: Unit = 4; Center Point = 0

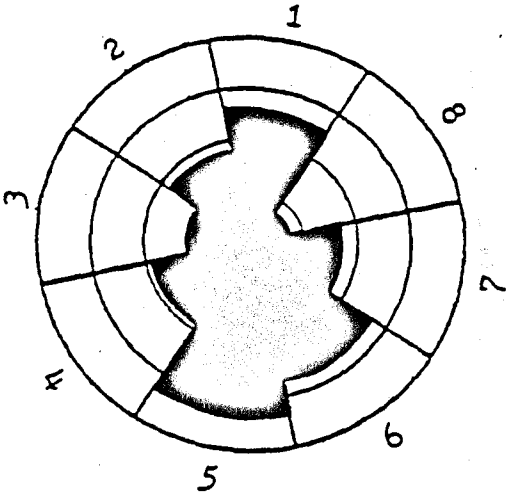
Figure 19. Mean ICL scores for patients one through five, by rater.

by the investigator and by an independent rater were relatively similar to each other, whereas the overall pattern of ratings made by therapists were relatively dissimilar to either of the others. Generally speaking, the therapists appeared to view these five patients as being more overtly rebellious and self-effacing than either of the other two raters. Indeed, a Pearson correlation coefficient computed for investigator and independent co-rater scores was the highest (.60). The correlation coefficient between investigator and therapist scores was next highest (.38), and the correlation coefficient between therapist and independent rater scores was the lowest (.25).

With regard to underlying "self" and "other" themes, a graphic comparison of ratings derived from patients' early memories on the one hand, and from interviews with therapists, on the other hand, reveals surprising similarities in overall pattern of scores (see Figure 20). The mean standard scores upon which Figure 20 was based appear in Table 27 in Appendix J. Although there are also obvious differences, both sets of "self" ratings show most themes falling along the dom-sub axis rather than the lov-hat axis, with a relative preponderance of themes on the submissive end of this axis. Both sets of "other" ratings, on the other hand, show a predominance of themes in the upper half of the circle, although it appears that early memories tended in

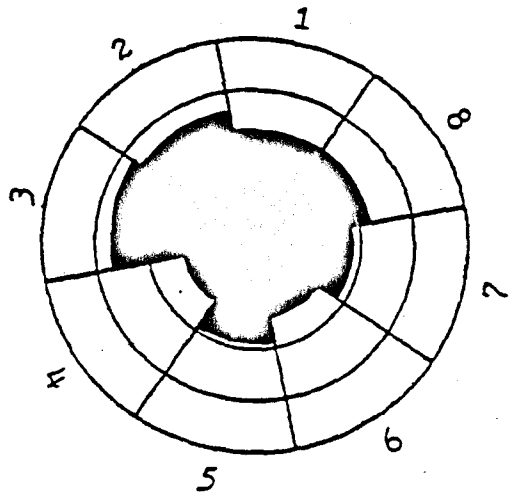


Early Memories

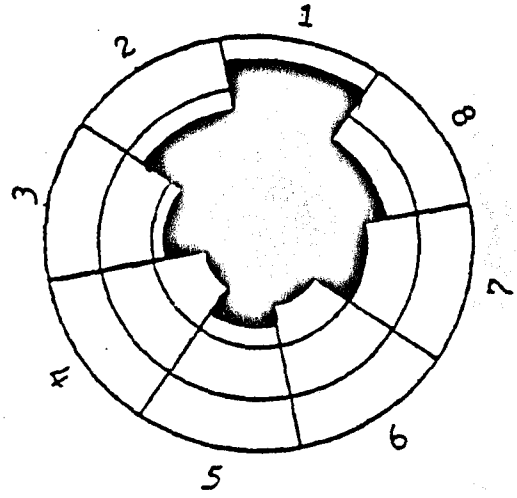


Therapist Interviews

(a) "Self" themes.



Early Memories



Therapist Interviews

(b) "Other" themes.

Scale: Unit = 10; Center Point = 50

Figure 20. Mean ratings of underlying themes for patients one through five, from two different sources.

some measure to elicit "other" themes which were relatively aggressive and nonaffiliative in comparison to those obtained from therapists. These general similarities between patterns of scores obtained from early memories and those obtained from therapist interviews were considered to be very tentative support of the validity of the latter method for measuring "underlying operations." It should be noted, however, that Pearson correlation coefficients computed on this very small sample of patients were small (.47 for "self" themes) or negligible (.13 for "other" themes).

In summary, comparison of data from patients one through five, obtained by original and by revised procedures, revealed that therapists' ICL descriptions of patients' overt interpersonal behavior were relatively distinct from ICL descriptions made by both the investigator and by an independent rater. A tentative conclusion to be drawn from these results is that therapists' descriptions of overt style were relatively inaccurate. This comparison also revealed a general similarity in pattern between underlying themes obtained from patients' early memories, and those obtained from interviews with therapists. The latter results lent very tentative support to the validity of the underlying themes obtained from therapist interviews.

V. DISCUSSION

Hypothesis 1 Results

In terms of the "narcissistic styles" proposed by Fenichel (1945), Bursten (1973), and Kohut and Wolf (1978), the majority of narcissistic individuals studied in this project (those HN patients whose ICL summary points fell in octants 2 and 3; see Figure 2, page 73) appeared to correspond most closely to the Aggressive Type (Fenichel, 1945), the Phallic Type (Bursten, 1973), or the Mirror-hungry Type (Kohut & Wolf, 1978). Generally speaking, these types constitute the "traditional" narcissistic style, a style in which arrogant, competitive, and exhibitionistic behavior is relatively overt, and upon which the literature on narcissistic personalities (NPs) has primarily focused. With regard to less overtly narcissistic styles among HN patients studied, those patients whose summary points fell in octant 5 would presumably correspond more closely to the Masochistic Type (Fenichel, 1945), or the Craving Type (Bursten, 1973), and the HN patient in octant 4 would presumably correspond to the Paranoid Type (Bursten, 1973). In addition, the HN patient whose ICL summary point fell in octant 6 might fit the Craving Type (Bursten, 1973), or the Ideal-hungry Type (Kohut & Wolf, 1978). From his verbal description ("very

shy, lacks self confidence and social grace, 'mousy'") he might also correspond to the Contact-shunning Type (Kohut & Wolf, 1978).

The most obvious inference to be made from these results is that, contrary to the notions proposed in this study regarding the existence of an array of narcissistic styles, narcissistic individuals tend to have interpersonal styles which are on the whole overtly narcissistic. Another conclusion that could be drawn, however, is that these data did not constitute a representative sampling of narcissistic styles, but instead reflected a population sample which was disproportionately skewed toward the most obvious narcissistic types. In support of the latter conclusion (which the investigator believes to be the more probable of the two), it can be argued that at least two factors tended to decrease the number of nontraditional narcissistic styles found among HN patients in this study.

1. Limitations of sampling methodology. Part of the difficulty in devising a methodology by which narcissistic individuals with nontraditional styles could be identified and provided as subjects was the very fact of their relative covertness. Toward the end of eliciting these types of patients in addition to the more traditional narcissistic types, criteria for HN patients given to therapists were made to include explicit suggestions that narcissistic

characteristics "may or may not be overt and immediately apparent." In spite of these statements however, therapists often appeared to have selected individuals who were among their most obviously narcissistic patients. Indeed, informal comments made by therapists about HN patients were often to this effect (e.g., "Boy, this is the most narcissistic guy you've ever seen!"). The issue of suitable methodology for a study of this sort, in fact, is in some measure reminiscent of a "catch-22" dilemma: nonovert NPs are not recognized because they are not written about, and they are not written about because they are not recognized. In summary, although efforts were made by the investigator to elicit HN patients with an array of overt interpersonal styles, the actual methodology, although it did not exclude less overtly narcissistic styles, may have failed to counteract sufficiently the current tendency among mental health professionals to identify as "narcissistic" only those individuals whose overt behavior is obviously arrogant, competitive, and/or exhibitionistic.

2. Possible inaccuracy of therapists' assessments of overt interpersonal style. From the relative discrepancies found between therapists' descriptions of patients one through five and the descriptions of these patients made by the investigator and an independent rater, either of at least two conclusions can be tentatively drawn:

a. Unlike therapists, the investigator and independent rater had insufficient data from which to make accurate assessments of overt interpersonal behavior, and therefore could not describe overt style as accurately as therapists could.

b. Unlike the investigator and independent rater who were relatively objective observers, therapists were relatively unable to "see" and describe accurately the surface behavior of their patients.

The most obvious explanation for the latter conclusion would be that the therapists' relatively greater emotional involvement and knowledge of underlying dynamics made it difficult or impossible for them to achieve the distance from patients which would enable them to make accurate appraisals of their overt behavior. In addition, the unique nature of the psychotherapy situation (as opposed, even, to a research interview) may in itself have constituted a context which was so atypical that, within it, typical overt behavior could not be readily observed, or even inferred.

An informal comparison of therapist's verbal descriptions of HN patients (Table 9, Appendix J) to ICL assessments of overt interpersonal style made by these same therapists (see Figure 2, page 73) lent some tentative support to the conclusion that therapists' ICL descriptions may have been relatively inaccurate, the conclusion which the investigator

believes to be the more probable of the two listed above. Whereas verbal descriptions of at least eight HN patients contained adjectives which were overtly affiliative (e.g., "socially polished," "social butterfly," "outgoing," "charming," etc.), descriptions of overt styles on the ICL were, as previously discussed, almost exclusively nonaffiliative. From this discrepancy one can speculate that, seeing and experiencing the essentially non-"object-loving" intentions beneath behavior which was overtly affiliative in nature, therapists tended to describe this overt behavior in terms of its underlying intentions rather than its surface appearance. If, in fact, therapists were relatively unable to separate underlying issues from overt behavior, then the predominance of overtly narcissistic styles among HN patients used in this study may be due, in part, to the predominance of underlying narcissistic issues among these patients rather than the actual absence of nontraditional narcissistic styles. Such a tendency among therapists generally might also explain the relative absence of detailed descriptions of overt behavior in the literature on NPs, in comparison to descriptions of underlying dynamics of these same patients.

Hypothesis 2 Results

Except for possible differences with respect to "managerial-autocratic" behavior (octant 1), no significant

differences were found between HNFs and HNMs. The implication of these findings is that, contrary to notions proposed in this study, highly narcissistic females tend to have overt interpersonal styles which are very similar to those of highly narcissistic men. The fact that no significant differences in overt behavior were found between the larger female and male patient groups generally, however, tends to diminish the significance of these results regarding HN patients. It also brings up the question of whether or not the population sample for this study was representative of men and women generally. Inasmuch as research on sex differences suggests the presence of significant differences in overt interpersonal behavior among men and women generally (Hoyenga & Hoyenga, 1979; Maccoby & Jacklin, 1974; Garai & Scheinfeld, 1968; Kagan, 1964), the absence of sex differences among patients studied suggests that the sample was not representative. The most likely explanation for this circumstance is that gender similarities were due to common membership in the group "psychotherapy patients," and that similarities stemming from patient status tended to supercede gender differences which might otherwise be apparent among a heterogeneous group of men and women. The fact that both male and female patients were seen generally by therapists as displaying overt behavior which was predominantly nondominant (see Figure 8b, page 85) lends tentative support

to this explanation. Whereas a predominance of overtly submissive behavior would not be expected among a heterogeneous group of men and women generally, it would be expected among a group of psychotherapy patients with respect to their therapists inasmuch as the assumption of a one-down, help seeking, relatively submissive stance is perhaps the most salient interpersonal feature of the patient role. The fact that there were disproportional numbers of underlying "other" themes having to do with power and authority among both male and female patients (see Figure 14a, page 98) also lends support to the notion that behavior was overly determined by patient status, inasmuch as "looking up to an authority" is an attitude which is inherent in the patient role, and one which would therefore naturally be salient among a group of psychotherapy patients.

Notwithstanding the lack of significant differences found between HNFs and HNMs, a visual examination of individual summary point locations tends to suggest a trend toward HNFs being more overtly narcissistic than HNMs (see Figures 6 and 10, pages 82 and 88). Whereas at least four HNMs could be described as having styles which were not overtly narcissistic (i.e., patients with summary points in octants 4, 5, and 6), only one HNF could be readily classified as such (HNF in octant 5). In addition, t tests for individual octants indicated that HNFs were in fact more

overtly "managerial-autocratic" than HNMs. Findings represented in Figure 10 also suggested a (nonsignificant) trend toward HNFs being more "aggressive-sadistic" than HNMs, again in the direction of HNFs being more overtly narcissistic than HNMs. This overall trend was in the opposite direction of the outcome suggested by research on sex differences generally, and contrary to the outcome predicted by hypothesis 2b. In the investigator's view, at least two factors may be pertinent to these (tentative) findings.

1. All HNFs except for one had careers. As cited earlier, Eichler's (1973) study implies that in comparison to women without careers, women with careers tend to have overt interpersonal styles which are relatively similar to those of men. In light of this, the failure to exclude patients with careers from the sample of HNFs may have inadvertantly contributed to the selection of relatively "masculine" appearing women (i.e., women who tended to be overtly narcissistic).

2. As discussed earlier, the sampling method used in this study may have failed to correct sufficiently for the general bias toward viewing as narcissistic only those styles which are overtly arrogant, competitive, and/or exhibitionistic, with the result that therapists tended to select only those patients, male and female, who fit this description. Paradoxically, the fact that this appeared to

have occurred even more frequently with respect to HNFs than with respect to HNMs can in a way be interpreted as constituting indirect support for the notion that narcissism is recognized less readily in women than in men: whereas the underlying narcissistic mode tended to be recognized in women only among those who were relatively overtly narcissistic, men were more often recognized as being highly narcissistic even when their overt interpersonal behavior was relatively nonnarcissistic. Since this conclusion is based upon trends which were statistically nonsignificant, however, it is speculative only.

With respect to differences between the overt interpersonal behavior of HN and LN patients, the former were found to display a more restricted range of interpersonal styles than the latter. In addition, HN patients tended to be considerably less affiliative than LN patients at the overt level, and somewhat more dominant. The obvious inference to be drawn is that these differences were due to the relative predominance of the underlying narcissistic mode among HN patients versus the relative predominance of the object loving mode among LN patients, a notion proposed earlier in this study to which hypothesis 3 results lent support. That is, the underlying predominance of (frustrated) narcissistic needs appears to have served to restrict the range of overt interpersonal behavior among HN patients,

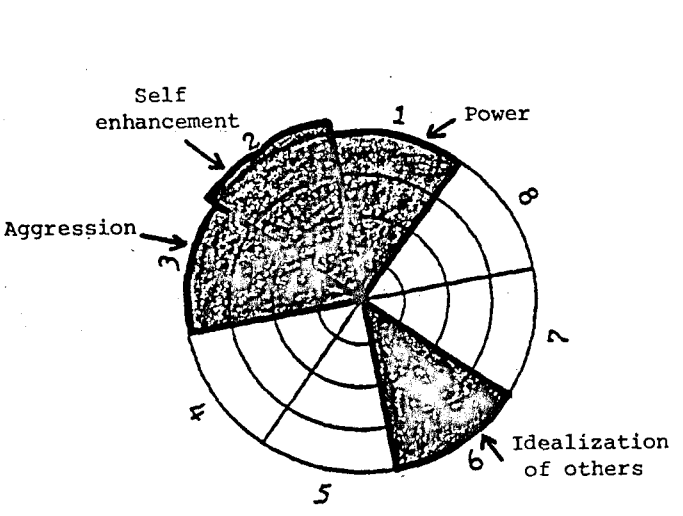
and to have necessitated the assumption of overt roles which were relatively nonaffiliative and dominating. If therapists were in fact unable to differentiate overt behavior from the underlying mode in their ICL descriptions of patients, however, then these differences may to some extent have reflected the therapists' respective reactions to the underlying narcissistic and object loving modes rather than actual differences in overt behavior. That is, given the underlying predominance of the narcissistic mode among HN patients, interpersonal behavior was most likely experienced as being narrow, unfriendly, and demanding (i.e., restricted in range, nonaffiliative, relatively dominating) regardless of its surface appearance, and therefore labeled as such by therapists on the ICL. The overt behavior of LN patients, on the other hand, underlain predominantly by the object loving mode rather than the narcissistic mode, was most likely experienced as being relatively flexible, cooperative, and respectful (i.e., not restricted to a narrow range, affiliative, relatively nondominating), and therefore described in this fashion.

Hypothesis 3 Results

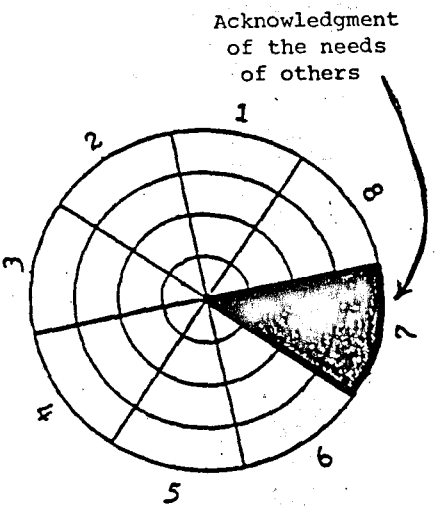
The array of differences found between the underlying themes of HN patients and the underlying themes of LN patients lent strong support to hypothesis 3. In addition,

the overall pattern of differences at this level appeared specifically to support the narcissistic-object loving mode distinction between these two groups as proposed earlier in this study, but not contained in hypothesis 3. Figure 21 provides a graphic summary of the octant locations in which significant differences were found between HN and LN groups with respect to underlying themes regarding self and others.

With regard to "self" themes, differences between HN and LN groups were by far the greatest for "competitive-narcissistic" (i.e., self-enhancing) themes. (In octant 2, $\underline{F} = 81.01$, $p = .001$. The next highest $\underline{F}$ value was 11.34 in octant 1, with $\underline{p} = .005$. See Table 15, Appendix J.) That is, in comparison to those of LN patients, underlying themes of HN patients reflected a relative predominance of the issues most pertinent to the narcissistic mode. HN patients also had significantly more "self" themes having to do with power (octant 1) and aggression (octant 3), issues which are also clearly related to self enhancement specifically (especially frustrated self enhancement), and to the narcissistic mode generally. Together, octants 2, 1, and 3 describe the frustrated exhibitionism of the "grandiose self" and what Kohut describes as the intensified need for "mirroring," a feature which is viewed in this study as being one of two prominent components of the narcissistic mode.

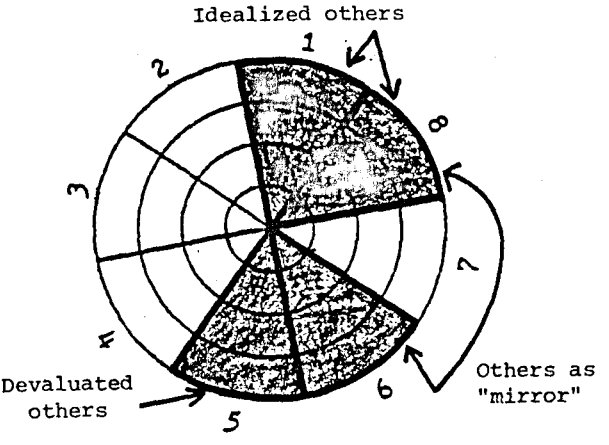


HN Group
(More than LN Group)

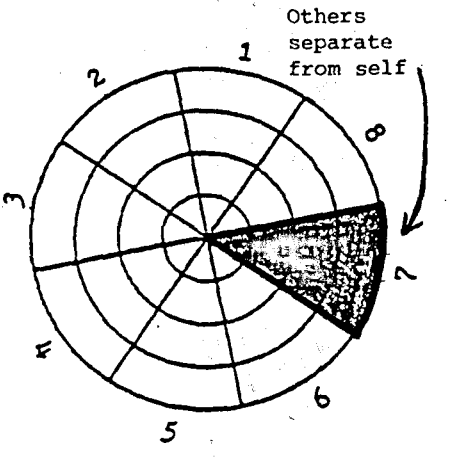


LN Group
(More than HN Group)

(a) Self.



HN Group
(More than LN Group)



LN Group
(More than HN Group)

(b) Others.

Figure 21. Octant locations of significant differences between HN and LN patients.

The other prominent feature of the narcissistic mode is the relatively intense need for idealized merger with others, a "self" theme which is represented on the interpersonal circle by octant 6. Figure 21a shows that, in addition to "mirroring" themes, HN patients had significantly more "self" themes in octant 6, the basis for which was undoubtedly their relatively preponderant concerns with and about idealized merger. Structurally, Kohut describes these concerns as the "idealized Parental imago," as discussed earlier.

In comparison to those of HN patients, the underlying "self" ratings of LN patients, on the other hand, reflected a relative predominance of themes having to do with cooperation and conventionality (octant 7), issues which are clearly more pertinent to the object loving mode than to the narcissistic mode in that they are predominantly other-oriented. (Octant 7 represents the most highly other-oriented behavior on the interpersonal circle.)

It is noteworthy that although aggression (i.e., octant 3 themes) was significantly more important among HN "self" themes than among LN "self" themes, with respect to most other underlying "self" themes among HN patients, it was relatively unimportant (see Figure 11, page 90). This result can be viewed as providing tentative support for Kohut's viewpoint that aggression in the NP is secondary to

the frustration of narcissistic needs, rather than primary as Kernberg (1975) suggests. If Kernberg's view regarding aggression were accurate, one would expect octant 3 "self" themes to be relatively predominant among the HN patients in this study. Instead, they were among the least prevalent for this group.

Results regarding underlying "other" themes suggested that, as compared to LN patients, HN patients tended to view others as being significantly more powerful (octant 1) and giving (octant 8). This view of others is consistent with the view of others which is implied by the structural presence (in the NP) of the "idealized parental imago" (Kohut, 1971). The relative predominance of these concerns among HN patients appears again to lend support to the notion that among highly narcissistic individuals, there exists a relatively intense and salient need for idealized merger with others. HN patients also tended more than LN patients to view others as being self-effacing (i.e., submissive, compliant--octant 6). These themes, in conjunction with "giving" themes in octant 8, constitute a description of the underlying narcissistic need for others to serve merely as compliant self-reflectors, a need which is viewed theoretically as stemming from the structural presence (in the NP) of the "grandiose self," and which has been earlier described in this study as being characteristic of the

narcissistic mode of relating to others. The relative predominance of weakness themes (octant 5) among "other" themes of HN patients furthermore appears to reflect the relatively extreme tendency among highly narcissistic individuals toward devaluation of others, a tendency which is also mentioned by Kohut (1971).

Put in slightly different terms, these data suggested that HN patients tended more than LN patients to view others from what Wolman (1967) called a "personally functional" viewpoint. That is, HN patients tended to view others primarily as givers of power (others in octants 1 and 8), or as potential sources of exhibitionistic gratification (others in octant 6, and to some extent octants 8 and 5 as well) rather than as individuals in their own right. The fact that LN patients had significantly more "other" themes which were straightforwardly cooperative and affiliative (octant 7) suggested that LN patients more than HN patients tended to relate to others less exclusively in terms of others' potential function to them personally, and were more able to recognize others as having needs and initiatives which were separate from their own. (Indeed, the word "cooperative" implies a mutual agreement based upon the unique needs of separate individuals.) The latter qualities are descriptive of the object loving mode as opposed to the narcissistic mode. These conclusions lend further support

to the theoretical notions proposed in this study, and are also consistent with Wolman's findings (1967) that the extent to which others are viewed from a personally functional viewpoint depends upon the degree of narcissism.

The fact that differences between HN and LN groups were apparent at the underlying level only in the narcissistic and object loving mode-related octants served to emphasize the paramount significance of the narcissistic mode as the distinguishing feature of the HN patients.

Hypothesis 3b stemmed from the belief that underneath an array of overt interpersonal styles among HN patients would lie relatively few narcissistic issues. The failure of the data to support this hypothesis was due most likely to the fact that underlying narcissistic issues were represented on the interpersonal circle by a variety of octants rather than by a limited sector of the circle as originally anticipated. Narcissistic "self" themes related to self-aggrandizement and "mirroring," for example, fell in octants 2 and 1, while "self" themes regarding idealization fell in octant 6, and aggression fell in octant 3. Narcissistic issues regarding others likewise fell in a number of different octants, including 1 and 8 (idealized others), 6 and 8 (others as self reflectors), and 5 (devaluated others).

A notion related to hypothesis 3b which was not explicitly hypothesized was that in comparison to HN patients,

LN patients would tend to have a wide array of underlying themes since, unlike those of HN patients, their themes would not be limited to narcissistic issues. Contrary to this notion, however, underlying "self" and "other" themes among LN patients, although different, tended to be similar in range to those of HN patients. If anything, LN themes were somewhat less varied than HN themes (see Figures 15 and 17, pages 100 and 105, and related Tables 18 and 21, pages 192 and 193). Rather than refute the notion that underlying narcissistic issues were more predominant among HN patients than among LN patients (which other results strongly support), these results merely suggested that although different in quality, narcissistic and object loving issues were not different in quantity. Although these conclusions do not directly support Kohut's (1971) theoretical position that the differences between narcissistic and object loving modes are qualitative rather than quantitative, they are in some measure reminiscent of the quality versus quantity distinction which was made earlier in this project.

It is interesting to note that in comparison to HN patients, LN patients showed more overall discrepancies between self and other themes (see Figures 15 and 17). These results can be interpreted as reflecting the greater ability of nonnarcissistic individuals to discriminate between self and others, and to acknowledge the separateness

of others. The fact that underlying "self" themes among LN patients were relatively exclusively nondominant in comparison to "self" themes among HN patients (who had many dominant themes as well as nondominant themes) may be seen as reflecting the absence of a "grandiose self" among LN patients. This finding also suggests that low self esteem among LN patients was relatively stable, whereas for HN patients self esteem tended to fluctuate widely.

It is also interesting to note that, with respect to HN patients, LN ICL scores and underlying "self" theme ratings were relatively congruent (see Figures 15 and 17). Statistically there were significant differences in six of eight octants for HN patients, whereas there were significant differences in only three of eight octants for LN patients (see Table 23 in Appendix J). These results suggested that underlying issues were more readily apparent among LN patients than among HN patients. Further speculation in this vein would be that LN patients tended less than HN patients to hide behind a social facade. This conclusion would be consistent with the notion that the "self" of the NP is based upon the needs of others rather than upon the unique underlying needs and abilities of the individual himself (Rinsley, 1980; Brodey, 1965; Lomas, 1962).

Results of Original Procedure

The discrepancies between therapists' ICL ratings of patients and those of the investigator and independent rater were discussed previously. The similarities in patterns of underlying themes from early memories and those from therapist interviews have also been noted previously. With regard to dissimilarities between the latter two sets of data, it can be speculated that the relatively affiliative, nonaggressive nature of "other" themes obtained from therapist interviews reflected a reluctance of the therapists' parts to acknowledge aspects of the patients' negative feelings toward them, possibly in an attempt to protect themselves from the intense anger of these patients.

Methodology

In the absence of other valid tools for measuring narcissism, the investigator chose to rely upon the clinical judgment of trained clinicians, aided by a list of criteria for HN patients, as a means of obtaining highly narcissistic and nonnarcissistic individuals. Inasmuch as it is the quality of the therapeutic relationship which is in Kohut's view the diagnostic sine qua non of NPs, this method in any case had the advantage over paper and pencil measures of narcissism of being based, in part at least upon the impressions which therapists had of the therapy relationships.

Although it may have failed to elicit a wide array of NP styles, it was the investigator's impression that those individuals who were selected by this method were in fact highly narcissistic on the one hand, and nonnarcissistic on the other hand. In only one or two cases did the investigator have strong reservations about whether or not patients actually fit the applicable criteria.

The failure to obtain qualifying patients for interviews in accordance with the procedure which was originally proposed appeared to be due to a number of factors. First of all, many therapists were unwilling even to try and provide subjects due to concerns about breaking confidentiality and potential disruption to treatment which they considered to be prohibitive. This appeared to be especially true for psychoanalyst M.D.s. Secondly, many of those therapists who were willing to approach qualifying patients with the option of participating in a research interview were reportedly unable to obtain patient cooperation. At least 12 different HN patients, for example, when approached by their therapists in this regard reportedly declined to participate in this research project. It was this investigator's impression (corroborated later by at least one therapist) that ambivalence among participating therapists about providing their patients as subjects in a research project was also a factor in the failure to obtain

the cooperation of patients. In all probability, this ambivalence was subliminally communicated to patients when the subject of their participation in research was broached, tending to diminish the chances that patients would agree to participate.

The method of obtaining underlying themes regarding self and others from interviews with therapists rather than from patients' projective materials, although much easier to accomplish than interviews with patients, was considered by this investigator to be a 'second best' method made necessary by the lack of feasibility of the 'best' method. A primary drawback of this indirect method in terms of the present study was that patients' underlying themes necessarily passed through the filter of the therapists' personalities and therapeutic orientations, and were inevitably colored in the process. Similarities in the descriptions and formulations of underlying dynamics made by the same therapists about different patients were often striking, and presumably contained projective material from the therapists in addition to information about patients' underlying dynamics. On the other hand, the investigator was repeatedly struck by the essential similarity in the many formulations of underlying narcissistic issues, a similarity which was apparent in spite of the wide variation of ways in which these issues were described by different therapists. The surprising

overall similarity in pattern of underlying themes for patients one through five obtained from early memories and from interviews with therapists, moreover, provided tentative but nonetheless encouraging evidence for the validity of therapist interviews as a means of eliciting Level III material about patients.

Further Research

It is this investigator's view that further basic research is needed in the area of narcissistic styles toward the end of increasing our awareness of covertly narcissistic individuals, and improving our ability to recognize and treat these nontraditional narcissistic types in addition to the more overtly narcissistic types.

A sampling methodology which excluded traditional narcissistic styles from the sample of highly narcissistic individuals would probably be the most effective way of obtaining the more covert types of NPs. In terms of the procedure used in this study, the suggestions on the Criteria for HN Patients that characteristics "must not be overt or immediately apparent." Given the apparent problems in obtaining accurate descriptions of surface behavior from therapists, it is also recommended that future research on NPs which distinguishes overt and underlying levels rely upon assessments made by observers who are relatively

uninvolved emotionally and therapeutically with the individuals being described. With regard to therapy patients, of course, this is difficult to accomplish unless the investigator is able to make direct contact with the patients themselves. One possible method would be for objective observers to rate verbal descriptions of surface behavior made by therapists rather than to have therapists make the ratings themselves. Another possibility would be to have descriptions of surface behavior made by individuals, other than therapists, who know the individual in question (e.g., friends, colleagues, receptionists, etc.), although the logistics of such a procedure would admittedly be challenging.

In addition, continued efforts need to be made toward developing an effective tool, other than mere clinical judgment, for measuring narcissism. Exner (1973), Raskin and Hall (1980), and Ashby (1978) have already begun this type of research. In light of the fact that the relative predominance of the underlying narcissistic mode appears to be a meaningful factor in the identification of highly narcissistic individuals, there is a need for measuring tools to be constructed which are sensitive to the underlying narcissistic mode as distinguished from the object loving mode. The results of the present study with regard to Level III differences between HN and LN patients suggest

that the Leary system might be effectively adapted in this regard. Individuals could be administered measures to elicit Level III material (TAT stories, early memories, interviews with therapists, etc.) which could then be identified in terms of narcissistic or nonnarcissistic pattern configurations. Another possible means of measuring the underlying narcissistic mode among therapy patients would be to construct a detailed checklist of interpersonal experiences which are common (countertransference) reactions to the underlying narcissistic mode, and which therapists might be able to identify even with respect to those patients who were not overtly narcissistic.

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APPENDICES

APPENDIX A

CRITERIA FOR HIGH NARCISSISM PATIENTS

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1. Grandiose sense of self importance, uniqueness, or power, e.g., tends to exaggerate achievements and talents, even those that are ostensibly quite minor, or to focus on how special his/her problems are. This may or may not be overt and immediately apparent.

2. A. Exhibitionistic: tends to constantly seek attention, admiration, or praise. This may or may not be overt and immediately apparent, e.g., may exhibitionistically talk about what he/she does for others.

   AND/OR

   B. Tends to intensely idealize others, attributing to them great power and importance. Extreme idealization may vacillate or coexist with extreme devaluation of others.

3. At least two of the following:

   A. Entitlement: tends to expect special favors without assuming reciprocal responsibilities, e.g., may be surprised and angry that others won't do what he/she wants. This may or may not be overt and immediately apparent.

   B. Responds to criticism, indifference of others, or defeat with either cool indifference, or with marked feelings of rage, inferiority, shame, humiliation, or emptiness.

C. Lack of empathy: tends to be unable to recognize how others feel, e.g., cannot appreciate the distress of someone who is seriously ill. This may or may not be overt and immediately apparent.

D. Interpersonal exploitiveness: in relationships, tends to act in a self aggrandizing manner, and to indulge own desires while disregarding the personal integrity and needs of others. This may or may not be overt and immediately apparent, especially, for example, in relationships between parents and children.

4. At least one of the following:

A. Has marked problems regulating self esteem.

B. Tends to demand a great deal of you emotionally and to leave you feeling drained.

C. Presented him or herself with feelings of emptiness and boredom.

D. Is extremely embarrassed by social blunders (FAUX PAUS).

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*Criteria 1, 2, and 3 are derived from DSM III criteria for Narcissistic Personality Disorder. For the purposes of this study, DSM III criteria were modified and made more inclusive so as to be more consistent with Heinz Kohut's (1971) broad view of narcissism. Their priority was changed somewhat in order to emphasize (following Kohut) the diagnostic primacy of grandiosity, exhibitionism, and/or intense idealization in relationships. DSM III criteria were also made somewhat less stringent since subjects for this study are to be highly narcissistic individuals, but not necessarily Narcissistic Personality Disorders. Criterion 4 is derived from Ashby's (1978) eight criteria for Narcissistic Personality Disorder.

APPENDIX B

LETTERS TO PARTICIPATING THERAPISTS

2715 Barbara Lane
Houston, Texas 77005
Phone: (713) 661-1263

For my doctoral research in clinical psychology, I am examining stylistic differences between narcissistic men and narcissistic women, and also between narcissistic and nonnarcissistic individuals. I am particularly interested in the interpersonal styles of narcissistic women, since the literature tends to focus primarily on men. I believe this to be an important area of investigation for reasons of diagnostic, theoretical, and therapeutic advancement. Curiously, there have been few systematic attempts made to compare or contrast overt differences among highly narcissistic individuals, especially between men and women.

As a means of trying to study these individuals, I am planning to talk with therapists about patients who are highly narcissistic (and nonnarcissistic). The patients themselves need not be contacted, and can remain completely anonymous. I am wondering whether you would be willing to participate in this research project.

More specifically, the patients that I am attempting to (indirectly) study are nonpsychotic men and women, aged 20 and above, who are currently (or were very recently) in psychotherapy with you. Patients in the high narcissism group should be those individuals who are in your judgment highly narcissistic. Although they need not necessarily be diagnosable as Narcissistic Personality Disorders, they do need to meet the criteria described on the enclosed pages which are based primarily upon DSM III criteria for this diagnosis. Patients in the low narcissism group are those individuals who in your judgment have few if any narcissistic features. Although their diagnoses may vary widely, they must not meet any of the major criteria for high narcissism subjects. If possible, I would like for you to choose a low narcissism patient for each high narcissism patient, however this is not essential.

Your participation in this project as a therapist would involve only the following:

1. Completion of an adjective checklist (the Interpersonal Check List) with regard to each patient that you have determined to fit the specified criteria for high

or low narcissism groups. This will take about 10 or 15 minutes per patient. I will also ask you to fill out a brief Patient Information Sheet.

2. Participation in a fairly brief, semistructured interview with me in which you will be asked to describe the underlying motives and interpersonal attitudes of each qualifying patient as you view them (see enclosed Interview Format). This interview will be tape recorded (so that it can be rated), and should take less than thirty minutes per patient. It can be scheduled at your convenience, not necessarily during regular working hours or all at once.

Be assured that your name would not be linked in any way with the information given about patients, nor would it appear in any record of this research project. I would appreciate your letting me know by the enclosed card whether or not you would be willing to participate in this project as described above, and if so how many qualifying patients you would be willing to discuss with me.

Thank you. Please let me know if you have any questions.

Sincerely,

Douglas L. Dunlap
Ph.D. Candidate
Clinical Psychology
The University of Tennessee

2715 Barbara Lane
Houston, Texas
Phone: (713) 661-1263

Since I last contacted you regarding my doctoral research on narcissistic styles, I have made a basic revision in methodology so that direct participation of patients is no longer necessary. Instead, I plan to talk with therapists about those patients whom they have determined to fit the criteria for either high or low narcissism groups. Patients themselves need not be contacted, and can remain completely anonymous. Your participation as a therapist in this project would now involve only the following:

1. Completion of an adjective checklist (the Interpersonal Check List) with regard to each patient that you have determined to fit the specified criteria for high or low narcissism groups. This will take about 10 or 15 minutes per patient. I will also ask you to fill out a brief Patient Information Sheet.

2. Participation in a brief, semistructured interview with me in which you will be asked to describe the underlying motives and interpersonal attitudes of each qualifying patient as you view them (see enclosed Interview Format). This interview will be tape recorded (so that it can be rated), and should take less than thirty minutes per patient. It can be scheduled at your convenience, not necessarily during regular working hours or all at once.

As before, the patients that I am attempting to study (indirectly) are nonpsychotic men and women aged 20 and above who are currently (or were very recently) in psychotherapy with you. High narcissism patients should be individuals who are in your judgment highly narcissistic. Although they need not necessarily be diagnosable as Narcissistic Personality Disorder, they do need to meet the criteria described on the attached pages. Low narcissism patients should be those individuals who in your judgment have few if any narcissistic features. Although their diagnoses may vary, they must not meet any of the major criteria for high narcissism subjects.

If possible, I would like for you to choose a low narcissism patient for each high narcissism patient, however this is not essential.

2715 Barbara Lane
Houston, Texas
Phone: (713) 661-1263

Since I last contacted you regarding my doctoral research on narcissistic styles, I have made a basic revision in methodology so that direct participation of patients is no longer necessary. Instead, I plan to talk with therapists about those patients whom they have determined to fit the criteria for either high or low narcissism groups. Patients themselves need not be contacted, and can remain completely anonymous. Your participation as a therapist in this project would now involve only the following:

1. Completion of an adjective checklist (the Interpersonal Check List) with regard to each patient that you have determined to fit the specified criteria for high or low narcissism groups. This will take about 10 or 15 minutes per patient. I will also ask you to fill out a brief Patient Information Sheet.

2. Participation in a brief, semistructured interview with me in which you will be asked to describe the underlying motives and interpersonal attitudes of each qualifying patient as you view them (see enclosed Interview Format). This interview will be tape recorded (so that it can be rated), and should take less than thirty minutes per patient. It can be scheduled at your convenience, not necessarily during regular working hours or all at once.

As before, the patients that I am attempting to study (indirectly) are nonpsychotic men and women aged 20 and above who are currently (or were very recently) in psychotherapy with you. High narcissism patients should be individuals who are in your judgment highly narcissistic. Although they need not necessarily be diagnosable as Narcissistic Personality Disorder, they do need to meet the criteria described on the attached pages. Low narcissism patients should be those individuals who in your judgment have few if any narcissistic features. Although their diagnoses may vary, they must not meet any of the major criteria for high narcissism subjects.

If possible, I would like for you to choose a low narcissism patient for each high narcissism patient, however this is not essential.

Be assured that your name will not be linked with the information given about patients, nor will it appear in any record of this research. I will plan to call you in the near future to see if you would be willing to participate.

Thank you. Please let me know if you have any questions.

Sincerely,

Douglas L. Dunlap
Ph.D. Candidate
Clinical Psychology
The University of Tennessee

APPENDIX C

INTERVIEW FORMAT FOR THERAPISTS

INTERVIEW FORMAT FOR THERAPISTS

With regard to the patient under consideration:

a) What are his underlying views about himself and others? About you?

b) At an underlying level, what does he want, need, and expect from himself, and from others? From you?

c) What are his relationships with others like? With you?

d) What are his most important, recurrent fantasies and/or dreams?

e) How would you describe his basic outlook on life, e.g., basic goals, primary motivating factors. (Summary sentence if possible.)

f) How does he manifest underlying needs, i.e., how would you describe his overt interpersonal style?

g) How do you think of this patient diagnostically?

h) Other follow up questions.

APPENDIX D

CONSENT FORMS

CONSENT FORM FOR THERAPISTS

Your participation in my doctoral research, entitled A Study of Interpersonal Styles of Narcissistic Men and Women, will involve the following:

1. Completion of an adjective checklist (the Interpersonal Checklist) with regard to each patient which you have determined to fit the specified criteria for high or low narcissism groups. This will take about 10 to 15 minutes per patient.

2. A tape recorded, semistructured interview with me in which you will be asked to describe the underlying motives and interpersonal attitudes of each patient as you view them. This interview should take less than thirty minutes per patient. The tape recording of the interview may be rated by one or two research assistants.

At no time during your participation, or afterward, will you be asked to reveal the names of the patients being described, or any other information which might reveal their identities. Your name will not be linked with patient information in any written account of this study, nor will it even appear in these accounts. Tape recordings of interviews will be erased immediately after they have been rated.

You are free at any time to withdraw your consent, or to discontinue participation in this study. I will be glad to answer any questions that you have about this research, or about what your participation in it will entail.

Douglas L. Dunlap
Ph.D. Candidate
Clinical Psychology
The University of Tennessee

Address: 2715 Barbara Lane
Houston, Texas 77005

Phone: (713) 661-1263

I have read the above statements and agree to participate in Douglas L. Dunlap's doctoral research as described therein. I give my consent for the interview with Mr. Dunlap to be tape recorded.

Signed:_____ Date:_____

Witnessed by:_____

INFORMED CONSENT 'SHORT FORM'

I have been verbally informed by Douglas Dunlap about the nature of the procedures in which I have agreed to take part as a participant in his doctoral research project. I have also been informed of my rights as a 'subject', and assured that my participation will be on an anonymous basis.

Signed:_____ Date:_____

Witnessed by: _____

Project Director: Douglas L. Dunlap
Ph.D. Candidate in Clinical Psychology
The University of Tennessee

Address: 2515 Barbara Lane
Houston, Texas

Phone: (713) 661-1263

APPENDIX E

INTERPERSONAL CHECK LIST

The Interpersonal Check List

Patient #: _____

SCORE:

AP 1) _____ HI 5) _____

BC 2) _____ JK 6) _____

DE 3) _____ LM 7) _____

FG 4) _____ NO 8) _____

DIRECTIONS: This checklist contains a list of descriptive words and phrases to be used in describing the specified high or low narcissism patient. Please read the items quickly and fill in the first circle in front of each item you consider to be generally descriptive of this patient. Leave the answer blank when an item does not apply to this patient. Please use column 1 only. The example below indicates that item A is true and item B is false as applied to the individual under consideration:

Item

1 2 3 4 5 6 7 8

A ●○○○○○○○ well-behaved

1 2 3 4 5 6 7 8

B ○○○○○○○○ suspicious

In describing this patient, please try and focus as much as possible on behavior which is overt, salient, and immediately apparent, rather than on underlying motives or covert attitudes. Your first impression is generally the best, so work quickly and don't be concerned about duplications, contradictions, or being exact. If you feel much doubt about whether an item applies, leave it blank.

This booklet has been prepared by Timothy Leary, Ph.D., and published by the Psychological Consultation Service, 1230 Queens Road, Berkeley 8, California. The Interpersonal Check List was developed by Rolfe LaForge, Ph.D., and Robert Suczek, Ph.D., and other staff members of the Kaiser Foundation Research Project in Psychology.

Column 1 PATIENT

SAMPLE:

	1	2	3	4	5	6	7	8	
A	●	O	●	O	●	●	O	O	0 well thought of

	1	2	3	4	5	6	7	8	
P	O	O	O	O	O	O	O	O	1 well thought of
P	O	O	O	O	O	O	O	O	2 makes a good impression
A	O	O	O	O	O	O	O	O	3 able to give orders
A	O	O	O	O	O	O	O	O	4 forceful
B	O	O	O	O	O	O	O	O	5 self-respecting
B	O	O	O	O	O	O	O	O	6 independent
C	O	O	O	O	O	O	O	O	7 able to take care of self
C	O	O	O	O	O	O	O	O	8 can be indifferent to others
D	O	O	O	O	O	O	O	O	9 can be strict if necessary
D	O	O	O	O	O	O	O	O	10 firm but just
E	O	O	O	O	O	O	O	O	11 can be frank and honest
E	O	O	O	O	O	O	O	O	12 critical of others
F	O	O	O	O	O	O	O	O	13 can complain if necessary
F	O	O	O	O	O	O	O	O	14 often gloomy
G	O	O	O	O	O	O	O	O	15 able to doubt others
G	O	O	O	O	O	O	O	O	16 frequently disappointed
H	O	O	O	O	O	O	O	O	17 able to criticize self
H	O	O	O	O	O	O	O	O	18 apologetic
I	O	O	O	O	O	O	O	O	19 can be obedient
I	O	O	O	O	O	O	O	O	20 usually gives in
J	O	O	O	O	O	O	O	O	21 grateful
J	O	O	O	O	O	O	O	O	22 admires and imitates others
K	O	O	O	O	O	O	O	O	23 appreciative
K	O	O	O	O	O	O	O	O	24 very anxious to be approved of
L	O	O	O	O	O	O	O	O	25 cooperative
L	O	O	O	O	O	O	O	O	26 eager to get along with others
M	O	O	O	O	O	O	O	O	27 friendly
M	O	O	O	O	O	O	O	O	28 affectionate and understanding
N	O	O	O	O	O	O	O	O	29 considerate
N	O	O	O	O	O	O	O	O	30 encourages others
O	O	O	O	O	O	O	O	O	31 helpful
O	O	O	O	O	O	O	O	O	32 big-hearted and unselfish
O	O	O	O	O	O	O	O	O	33 often admired
O	O	O	O	O	O	O	O	O	34 respected by others
O	O	O	O	O	O	O	O	O	35 good leader
O	O	O	O	O	O	O	O	O	36 likes responsibility
O	O	O	O	O	O	O	O	O	37 self-confident
O	O	O	O	O	O	O	O	O	38 self-reliant and assertive
O	O	O	O	O	O	O	O	O	39 businesslike
O	O	O	O	O	O	O	O	O	40 likes to compete with others
O	O	O	O	O	O	O	O	O	41 hard-boiled when necessary
O	O	O	O	O	O	O	O	O	42 stern but fair
O	O	O	O	O	O	O	O	O	43 irritable
O	O	O	O	O	O	O	O	O	44 straightforward and direct
O	O	O	O	O	O	O	O	O	45 resents being bossed
O	O	O	O	O	O	O	O	O	46 skeptical
O	O	O	O	O	O	O	O	O	47 hard to impress
O	O	O	O	O	O	O	O	O	48 touchy and easily hurt
O	O	O	O	O	O	O	O	O	49 easily embarrassed
O	O	O	O	O	O	O	O	O	50 lacks self-confidence
O	O	O	O	O	O	O	O	O	51 easily led
O	O	O	O	O	O	O	O	O	52 modest
O	O	O	O	O	O	O	O	O	53 often helped by others
O	O	O	O	O	O	O	O	O	54 very respectful to authority
O	O	O	O	O	O	O	O	O	55 accepts advice readily
O	O	O	O	O	O	O	O	O	56 trusting and eager to please
O	O	O	O	O	O	O	O	O	57 always pleasant and agreeable
O	O	O	O	O	O	O	O	O	58 wants everyone to like him
O	O	O	O	O	O	O	O	O	59 sociable and neighborly
O	O	O	O	O	O	O	O	O	60 warm
O	O	O	O	O	O	O	O	O	61 kind and reassuring
O	O	O	O	O	O	O	O	O	62 tender and soft-hearted
O	O	O	O	O	O	O	O	O	63 enjoys taking care of others
O	O	O	O	O	O	O	O	O	64 gives freely to self

1 2 3 4 5 6 7 8 65
O O O O O O O O always giving advice

1 2 3 4 5 6 7 8 66
O O O O O O O O acts important

1 2 3 4 5 6 7 8 67
O O O O O O O O bossy

1 2 3 4 5 6 7 8 68
O O O O O O O O dominating

1 2 3 4 5 6 7 8 69
O O O O O O O O boastful

1 2 3 4 5 6 7 8 70
O O O O O O O O proud and self-satisfied

1 2 3 4 5 6 7 8 71
O O O O O O O O thinks only of himself

1 2 3 4 5 6 7 8 72
O O O O O O O O shrewd and calculating

1 2 3 4 5 6 7 8 73
O O O O O O O O impatient with others' mistakes

1 2 3 4 5 6 7 8 74
O O O O O O O O self-seeking

1 2 3 4 5 6 7 8 75
O O O O O O O O outspoken

1 2 3 4 5 6 7 8 76
O O O O O O O O often unfriendly

1 2 3 4 5 6 7 8 77
O O O O O O O O bitter

1 2 3 4 5 6 7 8 78
O O O O O O O O complaining

1 2 3 4 5 6 7 8 79
O O O O O O O O jealous

1 2 3 4 5 6 7 8 80
O O O O O O O O slow to forgive a wrong

1 2 3 4 5 6 7 8 81
O O O O O O O O self-punishing

1 2 3 4 5 6 7 8 82
O O O O O O O O shy

1 2 3 4 5 6 7 8 83
O O O O O O O O passive and unaggressive

1 2 3 4 5 6 7 8 84
O O O O O O O O meek

1 2 3 4 5 6 7 8 85
O O O O O O O O dependent

1 2 3 4 5 6 7 8 86
O O O O O O O O wants to be led

1 2 3 4 5 6 7 8 87
O O O O O O O O lets others make decisions

1 2 3 4 5 6 7 8 88
O O O O O O O O easily fooled

1 2 3 4 5 6 7 8 89
O O O O O O O O too easily influenced by friends

1 2 3 4 5 6 7 8 90
O O O O O O O O will confide in anyone

1 2 3 4 5 6 7 8 91
O O O O O O O O fond of everyone

1 2 3 4 5 6 7 8 92
O O O O O O O O likes everybody

1 2 3 4 5 6 7 8 93
O O O O O O O O forgives anything

1 2 3 4 5 6 7 8 94
O O O O O O O O oversympathetic

1 2 3 4 5 6 7 8 95
O O O O O O O O generous to a fault

1 2 3 4 5 6 7 8 96
O O O O O O O O overprotective of others

1 2 3 4 5 6 7 8 97
O O O O O O O O tries to be too successful P

1 2 3 4 5 6 7 8 98
O O O O O O O O expects everyone to admire him P

1 2 3 4 5 6 7 8 99
O O O O O O O O manages others A

1 2 3 4 5 6 7 8 100
O O O O O O O O dictatorial A

1 2 3 4 5 6 7 8 101
O O O O O O O O somewhat snobbish B

1 2 3 4 5 6 7 8 102
O O O O O O O O egotistical and conceited B

1 2 3 4 5 6 7 8 103
O O O O O O O O selfish C

1 2 3 4 5 6 7 8 104
O O O O O O O O cold and unfeeling C

1 2 3 5 6 7 8 105
O O O O O O O O sarcastic D

1 2 3 4 5 6 7 8 106
O O O O O O O O cruel and unkind D

1 2 3 4 5 6 7 8 107
O O O O O O O O frequently angry E

1 2 3 4 5 6 7 8 108
O O O O O O O O hard-hearted E

1 2 3 4 5 6 7 8 109
O O O O O O O O resentful F

1 2 3 4 5 6 7 8 110
O O O O O O O O rebels against everything F

1 2 3 4 5 6 7 8 111
O O O O O O O O stubborn G

1 2 3 4 5 6 7 8 112
O O O O O O O O distrusts everybody G

1 2 3 4 5 6 7 8 113
O O O O O O O O timid H

1 2 3 4 5 6 7 8 114
O O O O O O O O always ashamed of self H

1 2 3 4 5 6 7 8 115
O O O O O O O O obeys too willingly I

1 2 3 4 5 6 7 8 116
O O O O O O O O spineless I

1 2 3 4 5 6 7 8 117
O O O O O O O O hardly ever talks back J

1 2 3 4 5 6 7 8 118
O O O O O O O O clinging vine J

1 2 3 4 5 6 7 8 119
O O O O O O O O likes to be taken care of K

1 2 3 4 5 6 7 8 120
O O O O O O O O will believe anyone K

1 2 3 4 5 6 7 8 121
O O O O O O O O wants everyone's love L

1 2 3 4 5 6 7 8 122
O O O O O O O O agrees with everyone L

1 2 3 4 5 6 7 8 123
O O O O O O O O friendly all the time M

1 2 3 4 5 6 7 8 124
O O O O O O O O loves everyone M

1 2 3 4 5 6 7 8 125
O O O O O O O O too lenient with others N

1 2 3 4 5 6 7 8 126
O O O O O O O O tries to comfort everyone N

1 2 3 4 5 6 7 8 127
O O O O O O O O too willing to give to others O

1 2 3 4 5 6 7 8 128
O O O O O O O O spoils people with kindness O

APPENDIX F

PATIENT INFORMATION SHEET

Patient #: _____
(To be assigned by investigator)

1. Sex: M F

2. Fits criteria for:

   a. High narcissism group ____

   b. Low narcissism group ____

3. Age: _____

4. Marital Status: S M D W Sep

   a. If married, number of years: _____

   b. Previously married? YES NO

   c. If so, how many times? _____

   d. Children (number, gender, age): _____

5. Number of siblings: _____

6. Birth order (e.g., of suggested notation: M_2 (F) 6F = female patient with brother 2 years older and sister 6 years younger):

_____

7. Education (and degrees): _____

8. Occupation: _____

9. Occupations of parents: _____

10. Length of time in therapy:

    a. With you: _____

    b. With others (previously): _____

11. Other important information (e.g., very obese, has physical handicap, grew up in France, lives with mother, etc.):

APPENDIX G

RATING MANUAL

MANUAL FOR RATING THERAPIST INTERVIEWS

Tape recordings of interviews with therapists about High and Low Narcissism patients are to be rated for underlying themes with regard to "self" and "others." Initially, themes corresponding to sixteenths of the Leary interpersonal circle (see Guide) are rated with respect to their relative importance and/or intensity for each patient on a scale of 0 to 3 (0, 1, 2, 2.5, or 3--see Scale). To obtain the final scores, sixteenth ratings are combined into octant ratings with a range of 0 to 6 points. Each patient receives separate octant scores for underlying "self" themes, and for underlying "other" themes. Each tape should be listened to twice.

Boundaries between 'overt' and 'underlying' themes as expressed by therapists are often unclear. On these tapes, if the therapist refers to an overt or surface trait in explicit or implicit opposition to an underlying trait, then the surface trait is NOT scored. All other ratable statements are scored, however, even if they do not explicitly refer to the underlying level. Traits which are not explicitly 'underlying' should be scored only at level 1 unless further corroborated as being underlying and important (in which case, they may merit scores of 2 or more).

Themes may establish themselves as being more than minimally present (i.e., as higher than level 1) because of their recurrence in the interview, or because of the emphasis placed upon them by the therapist, or both. In other words, themes may be scored at the 2, 2.5, or 3 level due to predominance, or due merely to intensity (even if not predominant). Typically, important underlying themes will be both recurrent and relatively intense, but not always.

Therapists' narratives of specific incidents involving the patient are always scored for underlying themes (as a TAT story would be scored for themes). Narratives of more general "reports," however (e.g., "The patient used to fall down a lot") are not necessarily scored, unless corroborated by other material. Information given by therapists about overt interpersonal style and diagnosis (usually at the end of the interview) is not rated.

Inferential Scores:

Thematic inferences at the 1 level about "others" should be made when corresponding themes inherent in the patient's behavior become clear. For example, if the therapist states that "the patient assumed a dominant, teaching role with others" ("self" score: theme P, level 1 and possibly level 2), "others" is inferentially scored at level 1 for theme J (being a student--see Guide). If the therapist states that "the patient takes care of others" ("self" score: theme 0, level 1), "others" would be scored inferentially at the 1 level in K (dependence). "Others" may be scored in additional areas as well, of course, if these are specified. Inferred level 1 themes should not be raised to the 2 level without further, more explicit corroboration as to their existence. Themes which are based solely upon such inferences will be given no more than 1 point, even if similar inferences have been made two or more times.

References to characteristic interpersonal behavior on a parent's part inferentially merit an "others" score in the appropriate area (e.g., "Her mother was critical of her achievements" is scored for theme E (criticism) in "others." Reference to spouse's or friend's behavior with respect to the patient does not necessarily merit such an inference (although it might, for example if such behavior on the part of others seems to predominate in more than one of the patient's relationships), and should not be scored without further corroboration of the fact that the patient does tend to experience others in this fashion. If the therapist explicitly states that the patient "experiences" others in a certain way, an appropriate "others" theme is scored no matter who the others are.

Automatic Scores:

References on the therapist's part to reasonably good, long standing, or fairly stable relationships with others (or a definite interest in establishing such relationships) automatically merits a level 1 score in L (adjustment) and M (affiliation) for both "self" and "others." More references to these themes are needed before they may be raised to level 2. A statement such as "fairly well adjusted" also merits automatic scores for both L and M themes in "self" and "others." When a reference to a cooperative and/or reasonably productive therapy relationship is made, L theme (cooperation) for both "self" and "others" is automatically scored (at the appropriate level).

"Grandiosity," "inflated self image," etc.: score "self" at level 2 in P (achievement) and A (power). May go up to 2.5 or 3 level with further data about intensity and/or predominance.

"Idealized other" (unspecified): score "others" at level 2 for P and A themes, and score "self" at level 2 in J (idealizing). If idealized other is described as "ideal parent," then "others" is additionally scored at the 2 level in N (support) and O (nurturant), and "self" is additionally scored at the 2 level in K (dependence).

"Positive transference" (unspecified): score "others" at level 1 for P and A themes, and "self" at level 1 in J. Score "others" for N and O themes, and "self" in K only if specified.

Self or others as "bad," "devaluated," "depreciated," etc. (unspecified: score H (incompetence) and I (weakness) themes at level 2.

"Need for admiration," "need for others to serve a self-reflector," etc. ("self" in C): score "others" in J (reflector) and N (supportive) at level 2. "Others" may also be scored in O (giving) if specified.

"Self confidence," "feeling good about self"--even if only fleeting or in circumscribed areas: automatically merits "self" score for B themes at level 1. A and P themes may also be scored if specified.

"Competitive," etc. ("self" in B): score "others" automatically in B also.

Themes Which Are Often, Although Not Always, Scored Together:

C (uses others for self-aggrandizement) and
J (needs others to feel whole)

K (wanting to please) and
O (compulsive doing for others)

P (compulsivity, high self-expectations) and
I (obsessive worry)

Suggested Notation for Rating Form (bottom section, using P as e.g.):

✓ = regular, explicit themes

(✓) = inferred themes

X = fantasy and dream themes (which--informally--carry slightly more weight)

Ⓟ = level 3

P = level 2.5

+P = level 2 due to intensity

②P = automatic 2 level (e.g., "idealized")

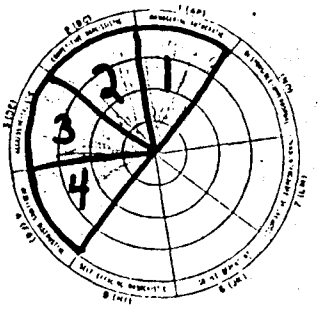
①P = automatic 1 level (e.g., "positive transference")

1P = 1 level only (even if mentioned more than once)

If not otherwise marked, themes will receive a score of 1 when followed (in bottom section of Rating Form) by only one ✓ , and a score of 2 when followed by more than one ✓ (even if there is only a (✓) in addition to the ✓).

GUIDE FOR CLASSIFICATION OF UNDERLYING THEMES REGARDING SELF AND OTHERS

(Based on Leary, 1956)



1 Idealized other; Grandiosity

P) SUCCESS: Heroism, Popularity, Acclaim, Achievement, Wisdom, Teaching, Explaining

Compulsivity ("I must do"), High self-expectations

A) POWER: Leadership, Command, Direction, Authority

Self-control, In control, Managing

2

B) NARCISSISM: Independence, Self-expression, Power struggle

Self confidence, Need to impress others, Wanting to "look good", Self absorption, Emotional unavailability, Competition, Performing

C) EXPLOITATION: Seduction, Rape, Rejection, Depriving, Selfishness, Keeping away from, Keeping Children to self

"Using" others for self aggradizement, Difficulty in/refusal to acknowledge separateness of others, "Using" other as self-reflector, Need for admiration, Demanding excessive attention, Haughtiness

3

D) PUNITIVE HOSTILITY: Punishment, Coercion, Brutality, Quarelling Threat, Sarcasm

E) ALL FORMS OF PURE HOSTILITY: Disaffiliation, Murder, Anger, Fighting, Criticism

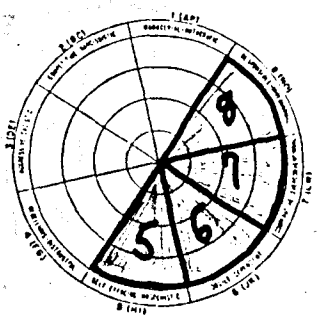
4

F) UNCONVENTIONAL ACTIVITY: Passive resistence, Rebellion, Generic crimes vs. authority, Pure jealousy, Drunkenness, Stealing covertl Offended, Bitterness

Slighted, Envy

G) DEPRIVATION: Distrust, Disappointment, Rejectedness, Suspicion, Bad things are done to one

Paranoia, Over-sensitivity to implied rejection or slights



8
- O) GENEROSITY: Help, Curing someone, Taking care of someone, Giving, Nurturant
  Compulsivity ("I must do for others")
- N) TENDERNESS: Support, Kindness, Encouragement, Solace, Pity
  Acceptance

7 Successful intimate relationship
- M) ALL FORMS OF PURE LOVE: Affiliation, Marriage, Friendship
- L) COLLABORATION AND AGREEABILITY: Congeniality, Cooperation, "Generic happy ending" caused by people working things out, Adjustment in general
  Need to be liked, Play

6
- K) TRUST: Good things come to one, Good luck, Being taken care of, Dependence, Gratitude
  Need for approval (wanting to please)
- J) CONFORMITY: Accepting advice, Provoking advice, Being a student Docility, Followership, Positive Passivity
  Admires others, Idealizing others, Serving as "reflector" or "object" to others, Needing others to feel whole, Need for self confirmation

5 Devaluated self or other
- I) WEAKNESS: Obediance, Submission, Unconsciousness, Indecision, Ambivalence, Immobilization, Illness, Passivity
  Lack of control, Obsessive worry, (Homosexuality)
- H) MASOCHISM: Grief, Sucide, Withdrawal, Guilt, Provoking Punishment, Self-punishment, Fear, Anxiety, Insanity (unspecified), Loneliness, Running Away
  Loss, Depression, Shame, Embarrassment, Lack of Confidence, Incompetence

SCALE FOR SCORING UNDERLYING THEMES

LEVEL 3) Very intensely felt, and/or
Clearly predominate, and/or
Virtually ever-present.

LEVEL 2.5) LEVEL 2 themes which stand out as being more important than other LEVEL 2 themes, but which are not clearly at LEVEL 3.

LEVEL 2) Important, recurrent, and/or
Strongly felt.

LEVEL 1) Present, but not pronounced

LEVEL 0) Absent

RATING FORM FOR UNDERLYING THEMES

Patient _____

SELF	OTHERS
Octant Scores:	Octant Scores:
AP 1) _____ HI 5) _____	AP 1) _____ HI 5) _____
BC 2) _____ JK 6) _____	BC 2) _____ JK 6) _____
DE 3) _____ LM 7) _____	DE 3) _____ LM 7) _____
FG 4) _____ NO 8) _____	FG 4) _____ NO 8) _____
3) _____	3) _____
2.5) _____	2.5) _____
2) _____	2) _____
1) _____	1) _____
P 0 A N B M C L D K E J F I G H	P 0 A N B M C L D K E J F I G H

Comments:

APPENDIX H

ORIGINAL INTERVIEW

ORIGINAL INTERVIEW FORMAT FOR PATIENTS

1) Introduction:

I would like to find out about what you are like when you are with other people - how you typically interact with others, and how others see you. After getting some brief background information about you, I will first of all ask some fairly broad questions about how you behave in different situations, and then ask more specific questions about what you are like with people. As a means of getting some added information about you, I will end up by asking you to recall and describe six of your earliest memories from childhood. If there are any questions that you would prefer not to answer, please feel free to say so. You will be under no pressure to say things here which might make you feel uncomfortable.

Any questions?

I'd like to start by getting a little background information about you.

2) Background Information To Be Gathered:

a) Age
b) Marital status, history, information about children if any
c) Education
d) Occupation: at present, history
e) Information about parents and siblings
f) Place of residence: history
g) Length of time in psychotherapy
h) Favorite leisure activities
i) Future plans

3) Interpersonal Behavior: General

What are you typically like:

a) At home?
b) With spouse, intimate companion?
c) At work?
d) With colleagues/fellow workers?
e) With friends?

f) With parents?
g) With children?
h) With strangers?
i) When you relax?
j) When you are anxious?

4) Interpersonal Behavior: Specific

1*	a) Do you teach or advise others? b) Do you try to win the respect of others? c) Do you take the lead with others? d) Do you tell others what to do?
2	e) Do you act confidently with others? f) Do you show off to others? g) Do you act assertively with others? h) Do you "use" others for your own purposes?
3	i) Do you act aggressively toward others? j) Do you punish others? k) Are you frank and honest with others? l) Do you attack others?
4	m) Do you complain to others? Do you act unconventionally? n) Do you act rebelliously toward others? o) Are you realistically wary of others? p) Are you suspicious of others?
5	q) Do you act modestly with others? r) Do you put yourself down to others? s) Do you obey rules and do your duty? t) Do you do what others want you to do?
6	u) Do you look up to others? v) Do you conform to what others around you are doing? w) Do you ask for and accept help from others? x) Do you depend upon others?
7	y) Do you cooperate with others? z) Do you compromise with others? a. Are you friendly toward others? b. Do you try and get others to like you?
8	c. Do you treat others gently and considerately? d. Do you feel sorry for others? e. Do you help others? f. Do you take on a lot of responsibility?

*Leary octant.

(Typical follow up questions:
Please tell me more, explain further, give an example.
How much, how often do you do this? Is it typical
or rare?)

4) Early Memories:

I'd like you now to think back as far as you can to when you were a small child. What is the earliest memory that you have? Please think of a specific incident or situation, visualize it in your mind's eye, and then describe it to me in detail as though you were describing a picture or a movie. After you have described your earliest memory, I'd like for you to recall and describe five other early memories if possible.

APPENDIX I

BACKGROUND INFORMATION ABOUT PATIENTS STUDIED

Table 4

Educational Level of Patients Studied
(Highest Degree Achieved)

	H.S.	B.A./B.S.	M.A./M.S.	Ph.D./M.D./J.D.	Unfinished degree
			(a) By Group		
HN group	6	9	2	3	8
LN group	6	6	4	4	2
Females	7	7	4	2	6
Males	5	8	2	5	4
			(b) By Subgroup		
HNF	4	3	1	2	4
HNM	2	6	1	1	4
LNF	3	4	3	0	2
LNM	3	2	1	4	0

Table 5

Time Spent in Therapy by Patients Studied.

	With current therapists		Previously	
	Avg. # years	Range	Avg. # years	Range
		(a) By Group		
HN group	1.9	.5-4	2.0	0-15
LN group	1.3	.3-3.5	1.4	0-9
Females	2.0	.5-4	1.2	0-5
Males	1.2	.3-3.5	2.2	0-15
		(b) By Subgroup		
HNF	2.5	.8-4	1.1	0-4.5
HNM	1.2	.5-3	2.9	0-15
LNF	1.5	.5-3.5	1.2	0-5
LNM	1.1	.3-1.8	1.5	0-9

Table 6

Occupations of Patients Studied, by Subgroup

HNF	LNF
Executive Secretary	Mental Health Professional (Social Worker)
Secretary/Research Asst.	Mental Health Professional (Social Worker)
Administrative Secretary	University Language Professor
Businessperson (owns own business)	Housewife/Volunteer Librarian
Socialite Housewife	Bus Driver
Photographer	Administrative Secretary
Mental Health Professional	Secretary/Journalist
Phone Salesperson	Secretary
Executive	Retired Factory Worker
Lawyer	Unemployed (former Orthodontist's Asst.)
HNM	**LNM**
Computer Programer	Computer Analyst
Computer Analyst	Business Consultant
Charicature Artist	Physician
Artist for advertising sign co.	Physician's Assistant
Business Executive	Graphic Design Specialist
Salesperson (retail)	Research Chemist
Teacher/Truant Officer	Retired Guard/Part-time Construction Worker
Geology Asst. for oil co.	Factory Worker
Lawyer	Carpenter
Graduate Student (former School Teacher)	Machinist

Table 7

Sibling Configurations of Patients Studied

	Avg. # sibs	Oldest child	Youngest child	Mid. child	Only child
		(a) By Group			
HN group	1.9	7	6	3	2
LN group	2.1	4	7	7	2
Females	1.9	4	9	4	1
Males	2.1	7	4	6	3
		(b) By Subgroup			
HNF	1.5	0	3	4	1
HNM	2.1	2	4	2	2
LNF	2.2	1	1	5	3
LNM	2.0	1	3	2	4

Table 8

Diagnoses of Patients Studied, by Subgroup
(DSM III, Approximate)

	HNF	HNM
1)	I. Phobias	I. Anxiety Neurotic Features
	II. Narcissistic Personality Disorder (NPD)	II. NPD Avoidant Personality Disorder (with Obsessive-Compulsive Personality Features)
2)	II. NPD (with Hysterical Personality Features)	II. NPD (with Obsessive-Compulsive Personality Features)
3)	II. NPD Paranoid Personality Disorder (with Compulsive Personality Features)	I. Exhibitionism II. NPD
4)	I. Major Depression II. NPD Borderline Personality Disorder (BPD)	II. NPD (with Cyclothymic Personality Features)
5)	II. NPD BPD (with Paranoid Personality and Quasi-histrionic Personality Features)	I. Transvestism II. NPD
6)	I. Hypomanic Features Psychosomatic Features (blushing) II. NPD BPD (with Obsessive-Compulsive Personality Features) (Homosexual)	II. NPD BPD
7)	I. Drug Abuse II. BPD	II. BPD (with Obsessive Personality Features)
8)	II. BPD (with Depressive Features)	II. BPD (with NP and Histrionic Personality Features) (Homosexual)
9)	II. BPD (with NP Features)	II. Obsessive-Compulsive Personality Disorder (with NP Features) (Homosexual)
10)	I. Adjustment Disorder with Depressed Mood II. Borderline Personality Features	I. Dysthymic Disorder II. NP and Borderline Personality Features (Homosexual)

Table 8 (continued)

	LNF		LNM
1)	II. Obsessive-Compulsive Personality Disorder (O-C PD)	1)	II. Compulsive Personality Disorder
2)	II. O-C PD	2)	I. Adjustment Disorder with Depressed Mood
3)	I. Dysthymic Disorder (Depressive Neurosis)		II. O-C PD
	II. O-C Personality Features	3)	I. O-C Disorder
4)	I. Dysthymic Disorder (Depressive Neurosis)		II. O-C Personality Features
	Psychosomatic Features (nausea, dizziness)	4)	I. O-C Disorder
5)	I. Atypical Somatoform Disorder (Psychophysiological Disorder--severe arthritis)		II. Passive-Dependent Personality Features
	Dysthymic Disorder (Depressive Neurosis)	5)	I. Generalized Anxiety Disorder Features (phobias)
6)	I. Generalized Anxiety Disorder		II. Paranoid Personality Disorder
	II. O-C Personality Features	6)	II. Paranoid Personality Disorder (with Depressive and O-C Personality Features)
7)	I. Generalized Anxiety Disorder (Anxiety Neurotic)	7)	II. Passive-Dependent Personality Disorder (with Masochistic, Obsessive, Passive-Aggressive, and Paranoid Personality Features)
8)	I. Psychosomatic Features (high blood pressure)	8)	II. Passive-Dependent Personality Disorder (paraplegic)
	II. Passive-Dependent Personality Disorder	9)	I. Adjustment Disorder with Depressed Mood
	Depressive Personality Disorder		II. Inadequate Personality Disorder
9)	II. BPD (with Histrionic Personality Features)	10)	I. Adjustment Disorder with Depressed Mood
10)	I. Identity Disorder		
	II. O-C Personality Features		

APPENDIX J

OTHER TABLES

Table 9

Verbal Descriptions of HN Patients Made by Therapists (Summarized)

	HNF
A.	Self confident, self important
B.	Selfish, wary, demanding of self
C.	Social butterfly, bouncy, tends to be submissive and compliant
D.	Socially polished, quick witted, energetic
E.	Seductive, outgoing, introspective
F.	Haughty, quick-witted, tough but vulnerable
G.	Affectively stiff, brisk but well mannered, compulsive
H.	Prim and proper, aloof, carries herself well
I.	Perfectionistic, charming, energetic
J.	Seductive, charming, wants to impress others
	HNM
K.	Very shy, lacks self confidence and social grace, 'mousy'
L.*	Touchy and easily hurt, lacks self confidence, very anxious to be approved of
M.	Snobbish, perfectionistic, competitive, like a British dandy
N.	Depressed, demanding, wrapped up in own feelings
O.	Macho, impatient, chip on his shoulder
P.	Dramatic, verbally facile, seductive
Q.	Dramatic, verbally facile, intellectualized
R.	Tends to be cocky and arrogant, can be outgoing, intellectualizing
S.	Eager to do the 'right' thing, constricted, confident
T.	Charming, affable, elegant

*These items were taken from the therapist's ICL descriptions because pertinent descriptive adjectives were not obtained verbally.

Table 10

Mean ICL DOM and LOV (Raw) Scores

	DOM-SUB		LOV-HAT	
	(a) By Group			
HN group	-2.46		-8.61	
LN group	-7.07		3.42	
Females	-3.60		-4.16	
Males	-5.92		1.04	
	(b) By Subgroup			
	F	M	F	M
HNG	.50	-5.41	-11.14	-6.08
LNG	-7.70	-6.43	2.82	4.01

Table 11

ICL Summary Points: Two-Way ANOVA Results for All Patients on DOM and LOV Dimensions

Source	df	MS	F	p
		DOM-SUB		
Narcissism	1	212.521	1.58	n.s.*
Sex	1	53.827	.40	n.s.
Narcissism x sex	1	128.878	.958	n.s.
Error	36	134.497		
		LOV-HAT		
Narcissism	1	1446.0	16.491	<.001
Sex	1	97.66	1.114	n.s.
Narcissism x sex	1	37.449	.427	n.s.
Error	36	87.685		

*Nonsignificant.

Table 12

Mean ICL Octant Scores

	1	2	3	4	5	6	7	8
				(a) By Group				
HN group	7.3	6.7	6.9	9.9	5.8	4.7	4.3	2.2
LN group	3.7	3.6	2.8	6.0	8.0	6.5	5.2	5.0
Females	6.1	5.6	5.5	7.8	6.6	5.7	4.4	3.5
Males	4.9	4.7	4.2	8.0	7.2	5.6	5.1	3.6

(b) By Subgroup

	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
HNG	9.0	5.6	7.1	6.2	8.0	5.7	9.2	10.5	5.0	6.5	4.4	5.0	4.0	4.5	1.8	2.4
LNG	3.2	4.1	4.1	3.0	2.9	2.6	6.4	5.5	8.1	7.8	6.9	6.1	4.7	5.7	5.2	4.7

Table 13

ICL Octant Scores: Two-Way ANOVA Results for All Patients

Source	df	MS	F	p	MS	F	p
			1			2	
Narcissism	1	133.22	11.79	<.005	99.22	7.54	<.025
Sex	1	15.62	1.38	n.s.	9.02	.69	n.s.
Narcissism x sex	1	46.23	4.09	.05 < p < .1	.23	.02	n.s.
Error	36	11.30			13.16		
			3			4	
Narcissism	1	168.1	17.83	<.001	152.1	11.01	<.005
Sex	1	16.9	1.79	n.s.	.4	.03	n.s.
Narcissism x sex	1	10.0	1.06	n.s.	12.1	.88	n.s.
Error	36	9.43			13.81		
			5			6	
Narcissism	1	48.4	2.49	n.s.	32.4	2.76	n.s.
Sex	1	3.6	.19	n.s.	.1	.01	n.s.
Narcissism x sex	1	8.1	.42	n.s.	4.9	.42	n.s.
Error	36	19.42			11.73		
			7			8	
Narcissism	1	9.02	.9	n.s.	81.22	7.0	<.025
Sex	1	5.62	.56	n.s.	.02	.001	n.s.
Narcissism x sex	1	.63	.06	n.s.	3.03	.26	n.s.
Error	36	10.01			11.6		

Table 14

Mean Octant Ratings of Underlying "Self" Themes

	1	2	3	4	5	6	7	8
				(a) By Group				
HN group	4.75	4.79	2.69	3.69	4.95	4.4	2.45	1.18
LN group	3.84	2.33	1.96	2.95	4.88	3.62	3.1	1.69
Females	4.31	3.3	2.32	3.48	4.93	4.25	2.73	1.39
Males	4.27	3.82	2.33	3.21	4.9	3.78	2.83	1.48

(b) By Subgroup

	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
HNG	4.86	4.63	4.64	4.94	3.0	2.38	3.76	3.61	5.11	4.79	4.71	4.09	2.3	2.6	1.15	1.2
LNG	3.76	3.91	1.95	2.7	1.63	2.28	3.19	2.81	4.75	5.01	3.78	3.46	3.15	3.05	1.63	1.75

Table 15

Underlying "Self" Octant Ratings: Two-Way ANOVA Results for All Patients

Source	df	MS	F	p	MS	F	p
			1			2	
Narcissism	1	8.28	11.34	<.005	60.76	81.01	<.001
Sex	1	.02	.03	n.s.	2.76	3.68	.05 < p < .1
Narcissism x sex	1	.36	.49	n.s.	.51	.68	n.s.
Error	36	.73			.75		
			3			4	
Narcissism	1	6.16	4.34	<.05	4.69	3.61	n.s.
Sex	1	4.62	3.25	n.s.	.70	.54	n.s.
Narcissism x sex	1	3.28	2.31	n.s.	.14	.11	n.s.
Error	36	1.42			1.3		
			5			6	
Narcissism	1	.05	.13	n.s.	6.09	8.83	<.005
Sex	1	.01	.03	n.s.	2.21	3.20	n.s.
Narcissism x sex	1	.85	2.18	n.s.	.03	.04	n.s.
Error	36	.39			.69		
			7			8	
Narcissism	1	4.22	4.1	<.05	2.65	1.59	n.s.
Sex	1	.09	.09	n.s.	.07	.04	n.s.
Narcissism x sex	1	.41	.4	n.s.	.02	.01	n.s.
Error	36	1.03			1.67		

Table 16

Mean Octant Ratings of Underlying "Other" Themes

	1	2	3	4	5	6	7	8
				(a) By Group				
HN group	4.68	3.05	2.65	0.3	3.05	2.67	2.18	3.48
LN group	3.7	2.64	2.84	0.28	1.08	1.05	3.0	2.7
Females	4.38	2.85	3.09	0.18	2.28	1.73	2.6	3.33
Males	4.0	2.84	2.39	0.4	1.85	1.99	2.53	2.86

(b) By Subgroup

	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
HNG	4.75	4.6	2.71	3.38	3.39	1.9	0.0	0.6	3.15	2.95	2.65	2.68	2.2	2.15	3.95	3.0
LNG	4.0	3.4	2.98	2.29	2.79	2.88	0.35	0.2	1.4	0.75	0.8	1.3	3.0	2.9	2.7	2.71

Table 17

Underlying "Other" Octant Ratings: Two-Way ANOVA Results for All Patients

Source	df	MS	F	p	MS	F	p
			1			2	
Narcissism	1	9.51	14.86	<.001	1.68	1.23	n.s.
Sex	1	1.41	2.20	n.s.	0.0	0.0	n.s.
Narcissism x sex	1	.51	.80	n.s.	4.63	3.38	n.s.
Error	36	.64			1.37		
			3			4	
Narcissism	1	.33	.16	n.s.	0.0	0.0	n.s.
Sex	1	4.9	2.34	n.s.	.51	.91	n.s.
Narcissism x sex	1	6.28	3.0	n.s.	1.42	2.54	n.s.
Error	36	2.09			.56		
			5			6	
Narcissism	1	39.0	22.94	<.001	26.08	17.62	<.001
Sex	1	1.8	1.06	n.s.	.7	.47	n.s.
Narcissism x sex	1	.52	.31	n.s.	.56	.38	n.s.
Error	36	1.7			1.48		
			7			8	
Narcissism	1	6.0	5.77	<.025	5.93	6.05	<.025
Sex	1	.05	.05	n.s.	2.21	2.26	n.s.
Narcissism x sex	1	.02	.02	n.s.	2.31	2.36	n.s.
Error	36	1.04			.98		

Table 18

Mean Octant Scores for ICL and Underlying Themes among HN Patients (Standard Scores)

Octant	ICL	Self	Others
1	54.55	59.27	63.79
2	53.04	59.54	53.69
3	53.42	45.81	51.21
4	61.02	52.31	36.66
5	50.64	60.59	53.71
6	47.98	56.98	51.33
7	46.84	44.25	48.25
8	41.40	35.89	56.35

Table 19

ICL and Underlying "Self" Octant Scores: Treatment-by-Subjects ANOVA Results for HN Patients

Octant	(df = 1) MS_{rx}	(df = 19) MS_{error}	F	p
1	219.962	53.698	4.096	.05 < p < .1
2	421.84	60.71	6.948	<.025
3	558.367	62.358	9.275	<.01
4	757.78	51.24	14.79	<.005
5	991.02	62.29	15.91	<.005
6	810.0	9.396	86.2	<.001
7	67.34	37.45	1.789	n.s.
8	303.05	35.92	8.436	<.01

Table 20

ICL and Underlying "Other" Octant Scores: Treatment-by-Subjects ANOVA Results for HN Patients

Octant	(df = 1) MS_{rx}	(df = 19) MS_{error}	F	p
1	852.852	61.773	13.806	<.005
2	4.16	66.111	.063	n.s.
3	48.841	32.415	1.507	n.s.
4	5931.66	33.15	178.927	<.001
5	94.556	88.69	1.066	n.s.
6	111.89	62.946	1.778	n.s.
7	20.88	33.855	.617	n.s.
8	2235.025	36.985	60.43	<.001

Table 21

Mean Octant Scores for ICL and Underlying Themes among LN Patients (Standard Scores)

Octant	ICL	Self	Others
1	45.33	53.29	57.74
2	45.05	43.43	51.15
3	43.05	40.69	52.39
4	51.14	47.83	36.51
5	56.21	60.12	41.47
6	52.53	51.90	41.31
7	49.24	48.49	53.09
8	48.61	39.30	51.58

Table 22

ICL and Underlying "Self" Octant Scores: Treatment-by-Subjects ANOVA Results for LN Patients

Octant	(df = 1) MS_{rx}	(df = 19) MS_{error}	F	p
1	633.616	28.63	22.129	<.001
2	26.732	41.043	.651	n.s.
3	55.69	26.141	2.13	n.s.
4	109.561	45.268	2.42	n.s.
5	152.49	28.648	5.323	<.05
6	4.032	48.946	.08	n.s.
7	5.7	34.17	.167	n.s.
8	866.761	10.22	84.798	<.001

Table 23

ICL and Underlying "Other" Octant Scores: Treatment-by-Subjects ANOVA Results for LN Patients

Octant	(df = 1) MS_{rx}	(df = 19) MS_{error}	F	p
1	1541.322	30.81	50.027	<.001
2	370.272	31.235	11.854	<.005
3	872.356	82.715	10.547	<.005
4	2141.832	43.425	49.322	<.001
5	2174.15	66.39	32.747	<.001
6	1258.884	74.122	16.984	<.001
7	148.225	30.49	4.861	<.05
8	87.912	90.366	.973	n.s.

Table 24

Octant Locations of ICL Summary Points for Patients One through Five

Patient	Therapist	Rater	Investigator
1	4	2	1
2	2	2	1
3	5	6	6
4	6	8	6
5	5	1	4

Table 25

Relative Distances between ICL Summary Points among Three Raters for Patients One through Five ($\underline{R}$ Values*)

	1	2	3	4	5
Therapist-Investigator	12.34	9.53	16.35	13.28	24.07
Therapist-Rater	15.05	6.99	19.21	22.26	24.1
Investigator-Rater	9.60	8.17	7.84	10.69	13.73

*Formula: $R_1 = \sqrt{(DOM_1 - DOM_2)^2 + (LOV_1 - LOV_2)^2}$

Table 26

Mean ICL Octant Scores for Patients One through Five, by Rater

	1	2	3	4	5	6	7	8
Therapist	3.6	4.0	4.6	9.6	9.6	8.0	4.2	3.4
Rater	5.4	5.8	3.0	3.2	5.6	3.6	5.2	5.0
Investigator	4.8	5.4	3.4	4.8	9.4	5.4	4.6	5.0

Table 27

Mean Octant Ratings of Underlying Themes for Patients One through Five, by Source (Standard Scores)

	1	2	3	4	5	6	7	8
				(a) Self				
Early memories	49	50	40	55	71	50	46	44
Therapist interviews	56	48	42	49	64	57	47	37
				(b) Others				
Early memories	52	56	57	43	49	44	48	52
Therapist interviews	65	56	48	40	46	42	50	54

VITA

Douglas L. Dunlap was born in Rochester, Minnesota, on June 6, 1951. He attended public schools in Amsterdam, New York, through the fifth grade, the Lahore American School in Lahore, Pakistan, from sixth through tenth grades, and was graduated from Mr. Hermon School in Massachusetts in June 1969. Following a year of travel, he entered Kalamazoo College in September 1970 and received a Bachelor of Arts degree in psychology in June 1974.

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