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Shame in patients with narcissistic personality disorder

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ABSTRACT

Shame has been described as a central emotion in narcissistic personality disorder (NPD). However, there is a dearth of empirical data on shame in NPD. Patients with NPD ($N=28$), non-clinical controls ($N=34$) and individuals with borderline personality disorder (BPD, $N=31$) completed self-report measures of state shame, shame-proneness, and guilt-proneness. Furthermore, the Implicit Association Test (IAT) was included as a measure of implicit shame, assessing implicit shame-self associations relative to anxiety-self associations. Participants with NPD reported higher levels of explicit shame than non-clinical controls, but lower levels than patients with BPD. Levels of guilt-proneness did not differ among the three study groups. The implicit shame-self associations (relative to anxiety-self associations) were significantly stronger among patients with NPD compared to nonclinical controls and BPD patients. Our findings indicate that shame is a prominent feature of NPD. Implications for diagnosis and treatment are discussed.

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1. Introduction

Whilst the DSM-IV-TR (APA, 2000) defines narcissistic personality disorder (NPD) foremost by a sense of grandiosity, clinical literature depicts a paradoxical combination of grandiosity and vulnerability (Dickinson and Pincus, 2003; Pincus and Lukowitsky, 2010; Ronningstam, 2010; Miller et al., 2010). A prominent clinical feature of narcissistic vulnerability is the patient's propensity to suffer from feelings of intense shame (Dickinson and Pincus, 2003) which has only been recognized as an associated feature of NPD in the DSM-IV-TR. However, empirical data on shame in NPD are very limited.

In the current manuscript, the term NPD refers to clinical cases as defined by the most up-to-date edition of the DSM available at the time the research was conducted. 'Pathological narcissism' refers to clinical descriptions or constructs that may not overlap completely with the DSM definition and often extend beyond this definition, e.g. by acknowledging grandiose and vulnerable facets or proposing a regulatory etiological model (e.g., Kohut, 1971; Kernberg, 1975, 2009; Horowitz, 2009; Ronningstam, 2010). Throughout the present manuscript, the term 'narcissism' refers to cases from non-clinical samples (mainly assessed with the Narcissistic Personality Inventory, (NPI); Raskin and Terry, 1988) and definitions from social psychology (e.g., Morf and Rhodewalt, 2001; Tracy and Robins, 2004).

Shame encompasses an emotion resulting from a negative evaluation of the stable, global self, elicited by a perceived failure (Lewis, 1971; Tangney and Dearing, 2002). Explicit shame is defined as a deliberative, reflected emotional response towards negative evaluations of the self and is assessed with direct self-report measures (e.g., Lewis, 1971). Implicit shame is an automatic, overlearned, presumably non-conscious emotional response and is assessed with indirect measures (Greenwald and Banaji, 1995; Fazio and Towles-Schwen, 1999; Pelham and Hetts, 1999; Rüsch et al., 2007b). Furthermore, shame is often associated with characteristic bodily postures (e.g., posture that make the body appear smaller), head movements (e.g., head tilting down or to the side), covering the face with the hand and downcast eye-gaze (Keltner and Buswell, 1996).

The initial introduction of NPD in the DSM III was largely influenced by psychoanalytic theories that describe shame as a core emotion in narcissistic psychopathology (e.g., Morrison, 1983). For instance, Kohut (1971, 1977) views shame as a prominent clinical

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feature in pathological narcissism. According to his view, children carry egocentric narcissistic needs that are tempered through empathic, realistic mirroring by their parents. Kohut hypothesized that repeated negative parental evaluations in childhood leads to increased shame reactivity in narcissistic patients. Moreover, due to a lack of empathic parental responses, narcissistic patients never move beyond earlier narcissistic developmental states that are characterized by narcissistic needs (i.e., need to receive excessive attention). According to Kohut's theory, individuals with pathological narcissism avoid frequent experiences of shame by reacting with rage or withdrawal. In line with this theory, Kernberg (1975) hypothesized that narcissistic patients suffer from negative interactions with primary nurturing figures. In contrast to Kohut, Kernberg does not consider pathological narcissism as a normal developmental stage. Instead, he proposes that negative parental interaction fosters narcissistic features that are characterized by unconscious negative self-representations that are strongly connected to the experience of explicit shame. In later life, acquired grandiose self-representations may conflict with implicit feelings of inferiority that are strongly connected to affective experiences of shame. Consequently, narcissistic patients use defense mechanisms that limit feelings of explicit shame in response to failures.

Further, theories from social-psychology also focus on self-regulatory processes as a core element of narcissism (e.g., Morf and Rhodewalt, 2001). Shame has been hypothesized as the central emotional component in this process (e.g., Tracy and Robins, 2004). According to theory, shame, as well as guilt, is elicited when an individual attributes the cause of a negative event to internal factors (e.g., Lewis, 1971; Tracy and Robins, 2004). Thus, shame and guilt are elicited by a common set of cognitive processes. However, shame involves negative feelings about the dispositional (internal), stable and global self, whereas guilt involves specific, internal attribution patterns in response to failures (Tangney and Dearing, 2002; Tracy and Robins, 2004; Hasson-Ohayon et al., 2012). Thus, according to theory, individuals who tend to frequently engage in internal, *global* attributions when experiencing negative events should be more shame-prone. In contrast, individuals who tend to make more *specific*, internal attributions when experiencing a negative event are said to be more guilt-prone. Tracy and Robins (2004) proposed that the experience of shame (but not guilt) is the central feature of narcissistic individuals. The authors hypothesized that increased shame-proneness in narcissistic individuals is related to self-esteem discrepancies, i.e., verbally expressed grandiose self-views that contradict unconscious feelings of insecurity. In their view, narcissistic individuals are more self-focused and use different regulation strategies to prevent unconscious feelings of low self-esteem from becoming explicit, and thereby, experience explicit shame (e.g., appraise negative events as irrelevant to identity goals or attribute failure externally and become angry or aggressive) (Tracy and Robins, 2004).

Numerous empirical studies demonstrated that shame is in general more maladaptive than guilt (Tangney et al., 1992; Tracy and Robins, 2004). With respect to psychopathology, several studies provide evidence that shame and psychiatric impairment are strongly associated (e.g., depression, Andrews, 1995; posttraumatic stress disorder, Andrews et al., 2000; social phobia, Browning, 2005; borderline personality disorder, Rüsch et al., 2007b; reaction after negative live events, Uji et al., 2012; caregivers' distress, Weisman de Mamani, 2010).

Current clinical conceptualizations of pathological narcissism also propose a regulatory etiological model (e.g., Horowitz, 2009; Kernberg, 2009; Ronningstam, 2010). Grandiose and vulnerable facets in pathological narcissism can be understood as consequences of attempts to regulate self and self-esteem (e.g., Ronningstam, 2010). According to Ronningstam, individuals with pathological narcissism can fluctuate between grandiosity and vulnerability depending on external or internal factors. Intense feelings of explicit shame belong to the vulnerable features of pathological narcissism and occur, for example, as response to negatively perceived events. As individuals with pathological narcissism try to avoid these intense feelings of shame, they engage in various intrapersonal and interpersonal strategies in order to prevent explicit shame (e.g., devaluation of others, responding with anger, and self-enhancement). Further, Ronningstam (2010) emphasizes that perfectionism is a significant feature of self-enhancement that is closely related to shame in pathological narcissism. When perfectionism is not sufficient enough to bridge the gap between real abilities and ideal imaginations about the self, feelings of explicit shame are especially likely to be elicited.

In summary, shame is a central feature of non-clinical and pathological narcissism in several theoretical models that might be relevant for the future definition of NPD. Until the present, there have only been a few studies on shame and narcissism, and these have relied on non-clinical or mixed clinical populations. For instance, explicit shame and narcissism (assessed with the NPI) are negatively correlated in non-clinical individuals (Gramzow and Tangney, 1992; Watson et al., 1996; Pincus et al., 2009). However, a recent study suggests that the NPI measures a grandiose variant of (normal or subclinical) narcissism that strongly overlaps with (high explicit) self-esteem (Vater et al., 2013b). Thus, the NPI is likely not appropriate for assessing pathological narcissism in clinical research on NPD. Another study used a more valid measure to assess pathological narcissism, the Pathological Narcissism Inventory (PNI, Pincus et al., 2009). The authors found a moderately positive correlation between explicit shame and pathological narcissism in a mixed clinical sample (PNI, Pincus et al., 2009). These data emphasize the importance of differentiating non-clinical and pathological narcissism, especially when assessing vulnerable facets of the disorder.

The overall aim of this study was to provide evidence of altered implicit and explicit shame in patients with NPD compared to controls. To our knowledge, this is the only study that assessed shame in a clinical sample of patients with NPD.

The first aim of this study was to assess explicit shame-proneness and state shame in patients with NPD compared to non-clinical controls. Explicit shame-proneness is a conscious, self-reported tendency to react with shame towards external events. Building upon theory and previous empirical findings of shame in pathological narcissism (provided above), we hypothesized that patients with NPD score higher on explicit state shame and explicit shame-proneness compared to non-clinical controls.

Second, existing studies on shame and narcissism exclusively assessed shame with self-report measures. Building upon clinical theories of NPD that propose high levels of not necessarily conscious shameful reactions in patients with NPD (see above), we hypothesized that patients with NPD show higher levels of implicit shame than non-clinical controls.

Third, shame and guilt are the two possible emotional responses in reaction to perceived failures. Several theories indicate that narcissistic individuals are more shame-prone than guilt-prone (e.g., Tracy and Robins, 2004; Martens, 2005). Thus, we hypothesize that patients with NPD do not differ significantly in guilt-proneness from non-clinical controls. By doing so, we aim to provide initial evidence that shame (but not guilt) is a central self-conscious emotion of NPD.

Fourth, and in order to investigate specificity, we included a clinical comparison group of inpatients with borderline personality disorder (BPD). We decided to include this clinical group as shame has previously been described as a prominent clinical feature in BPD (Crowe, 2004; Brown et al., 2009). Moreover, prior empirical data indicate that BPD patients had higher explicit levels of shame-proneness, state shame, and stronger implicit shame-self (relative to anxiety-self) associations in comparison to non-clinical controls (Rüsch et al., 2007b). Furthermore, we used BPD as a

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