Chapter 17

Association Between Psychopathy and Narcissism

Theoretical Views and Empirical Evidence

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Research on both psychopathy and narcissism has expanded rapidly during the past two to three decades. For the most part, the two fields have evolved separately, without much coordina-

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tion or cross-fertilization. This is unfortunate, because—as others have noted and as is discussed below—there may be potentially important similarities between the two disorders. In this chapter, theory and research on the association between psychopathy and narcissism are summarized. The authors begin by outlining the traditional clinical construct of psychopathy and by clarifying the difference between psychopathy and antisocial personality disorder. Next, the authors briefly discuss some key clinical-theoretical perspectives on the association between psychopathy and narcissism. This is followed by a review of the relevant empirical literature. They conclude by identifying some unanswered questions and by recommending avenues for future research.

The Nature of Psychopathy

Clinical Features

Psychopathy—also known as sociopathy and dissocial or antisocial personality disorder—is a specific form of personality disorder with a distinctive pattern of interpersonal, affective, and behavioral symptoms. Modern clinical descriptions of the psychopathic person have been extremely consistent over time, beginning with Cleckley's classic text, *The Mask of Sanity* (1941), and continuing to the present (e.g., Buss 1966; Craft 1965; Hare 1970; Karpman 1961; McCord and McCord 1964; Millon 1981). These clinical descriptions are representative of the views of researchers and clinicians, according to content analyses (Albert et al. 1959; Fotheringham 1957) and to opinion polls of mental health professionals, forensic personnel, and even the lay public (Davies and Feldman 1981; Gray and Hutchinson 1964; Livesley 1986; Rogers et al. 1992, 1994; Tennent et al. 1990). The descriptions can be summarized as follows: interpersonally, psychopathic persons are grandiose, arrogant, callous, superficial, and manipulative; affectively, they are short-tempered, unable to form strong emotional bonds with others, and lacking in guilt or anxiety; and behavior-

ally, they are irresponsible, impulsive, and prone to delinquency and criminality.

Diagnostic Issues

Although there is little debate over the key features of psychopathy, in recent years there has been considerable disagreement about how best to diagnose the disorder. There are two major approaches (Hare et al. 1991; Lilienfeld 1994). The first, which can be called the Cleckleyan tradition, argues that an adequate diagnosis must be based on the full range of psychopathic symptomatology. According to this perspective, a focus on behavioral symptoms (e.g., irresponsibility, delinquency) to the exclusion of interpersonal and affective symptoms (e.g., grandiosity, deceitfulness) may lead to the overdiagnosis of psychopathy in criminal populations and to underdiagnosis in noncriminals (Lilienfeld 1994; Widiger and Corbitt 1993). The Cleckleyan tradition was reflected in the first two versions of DSM (American Psychiatric Association 1952, 1968) and currently is reflected in the criteria for dissocial personality disorder in ICD-10 (World Health Organization 1990). It also is reflected in the revised Psychopathy Checklist (PCL-R; Hare 1980, 1991), which forms the basis for much of our research described below.

The second perspective, which can be called the Washington University tradition, is based on a number of influential works published by people who worked or trained at that institution (e.g., Feighner et al. 1972; Robins 1966). One of the fundamental assumptions of this approach is that assessment should focus on publicly observable antisocial behaviors, because clinicians are incapable of reliably assessing interpersonal and affective characteristics (Robins 1978). The Washington University tradition heavily influenced DSM-III, DSM-III-R, and DSM-IV (American Psychiatric Association 1980, 1987, 1994).

Criteria sets based on the two traditions generally show moderate to high levels of diagnostic agreement, even in forensic settings (Hare 1980, 1985; Widiger et al. 1996). However, criteria sets based on the Washington University approach, such as those in

DSM-III, diagnose antisocial personality disorder in the majority (50%–80%) of incarcerated offenders, whereas criteria based on the Cleckleyan tradition, such as the PCL-R, diagnose psychopathy in about 25% of the same offenders (Hare 1983, 1985; Hare et al. 1991). This has led many to criticize severely DSM-III, DSM-III-R, and DSM-IV criteria for confusing psychopathy with criminality (Hare 1985; Hare et al. 1991; Rogers and Dion 1991; Stevens 1994; Wulach 1988). Indeed, DSM-IV acknowledges that the Washington University approach may be inadequate for use in forensic settings. Another problem with criteria based on this approach is that it has poor predictive validity in forensic settings (Hare et al. 1991), unlike Cleckleyan criteria such as the PCL-R (Hare and Hart 1992; Hare et al. 1992, 1993; Hart et al. 1994). For these reasons, the authors prefer the Cleckleyan tradition and focus their discussion on this approach whenever possible.

Assessment Issues

Although highly structured methods that rely on self-reports of behavior and attitudes may be useful for the assessment of many aspects of normal and pathological personality, such methods are inappropriate for the assessment of psychopathy (Hare and Hart 1992; Hare et al. 1989, 1991, 1993; Lilienfeld 1994). Several reasons account for this. For example, deceitfulness (e.g., lying, manipulation) is a key clinical feature of the disorder. There is every reason to expect that psychopathic individuals will attempt to minimize or deny their antisocial behavior. For example, Hare (1985) described in a previous report one psychopathic person who, while incarcerated in a federal prison, managed to obtain copies of a major psychological test and its scoring key. This inmate ran a successful and lucrative consulting business for some time, coaching other prisoners on how to respond to the test, which was administered as part of routine correctional and pre-parole assessments. In light of such gross deceitfulness, it is difficult to put much faith in an individual's response to common interview and self-report questions such as, "As an adult, have you lied a lot?" or "As an

adult, have you on several or more occasions committed acts for which, if you had been caught, you could have been arrested?"

There are other reasons for mistrusting the self-reports of psychopathic persons, even apart from the matter of conscious deceitfulness. First, the grandiosity and superficiality of psychopathic individuals give them a strong tendency to present themselves in an unrealistically positive light. This tendency may be "unconscious," that is, habitual or otherwise outside the realm of normal awareness. Second, psychopathic individuals, because of their shallow affect and lack of empathy, may have a poor understanding of how they impress and have an effect on others. They may truly believe that others perceive them to be "nice guys" or "responsible employees," in spite of a history of callous and irresponsible behavior. Third, recent research suggests that psychopathic individuals may have a major disturbance of affective and linguistic processing (Hare et al. 1988). This may impair their comprehension and communication of emotionally toned language. These same problems may also hamper the assessment of narcissism by self-report (Gunderson et al. 1990).

Research supports our mistrust of self-report assessments of psychopathy. Several studies that used popular psychological tests—such as the Minnesota Multiphasic Personality Inventory (Butcher et al. 1989; Hathaway and McKinley 1940), the Millon Clinical Multiaxial Inventory (MCMI; Millon 1983, 1987), and the California Psychological Inventory (Gough 1957, 1987)—found low to moderate correlations between various psychopathy-related scales and clinical diagnoses made using PCL-R and DSM criteria (Hare 1985; Hart et al. 1991, 1994). The results are not simply the result of method variance, because the correlations among self-reports were as low as the correlations between self-reports and clinical diagnoses. Another important finding is that self-reports tend to be biased in their assessment of psychopathy, measuring some symptoms much better than others (e.g., Harpur et al. 1989; Hart et al. 1991).

Ironically, the most appropriate use of self-report measures of psychopathy may be in research on "normal" (i.e., nonpatient) populations. For example, Levenson et al. (1995) developed a

self-report inventory that attempted to capture faithfully the Cleckleyan concept of psychopathy using an "antisocial desirability" manipulation that allows the respondent to report psychopathic traits while maintaining the impression of positive self-presentation. That is, psychopathic traits are presented as thought-out, "philosophical" positions. This scale was associated with self-reported antisocial behavior in a population of university students and was correlated with self-report measures of personality constructs that are conceptually related to psychopathy.

The Psychopathy Checklist

For reasons discussed above, our view is that psychopathy should be assessed with expert observer (i.e., clinical) ratings. The ratings should be based on a review of case history materials, such as interviews with family members and employers and examination of criminal and psychiatric records, and supplemented with interviews or behavioral observations whenever possible (Hare 1991; Hart et al. 1992, 1994). The authors have spent considerable effort during the past 15 years developing and validating rating scales of psychopathy in the Cleckleyan tradition based on this approach.

The original Psychopathy Checklist (PCL; Hare 1980) was a 22-item rating scale, later revised and shortened to 20 items (Hare 1985, 1991). The PCL and PCL-R were designed for use in forensic populations. Items are scored on a 3-point scale (0 = item does not apply, 1 = item applies somewhat, 2 = item definitely applies). Because the two scales are highly correlated (see Hare et al. 1990), the authors focus below on the PCL-R. Table 17–1 lists the PCL-R items, which are defined in detail in the test manual. Total scores can range from 0 to 40; scores of 30 or higher are diagnostic of psychopathy. There is a considerable body of evidence supporting the validity of the PCL and PCL-R, including laboratory research suggesting that psychopathic individuals have unusual patterns of cognitive and psychophysiological response to aversive, emotional, and linguistic stimuli (Hare et al. 1988; Harpur and Hare 1990; Newman and Wallace 1993) and forensic research suggesting that psychopathic individuals have criminal careers

Table 17–1. Items in the Hare Psychopathy Checklist—Revised (PCL-R)

Item	Description	Loads on factor
1.	Glibness/superficial charm	1
2.	Grandiose sense of self-worth	1
3.	Need for stimulation/proneness to boredom	2
4.	Pathological lying	1
5.	Conning/manipulative	1
6.	Lack of remorse or guilt	1
7.	Shallow affect	1
8.	Callous/lack of empathy	1
9.	Parasitic lifestyle	2
10.	Poor behavioral controls	2
11.	Promiscuous sexual behavior	—
12.	Early behavioral problems	2
13.	Lack of realistic, long-term goals	2
14.	Impulsivity	2
15.	Irresponsibility	2
16.	Failure to accept responsibility for own actions	1
17.	Many short-term marital relationships	—
18.	Juvenile delinquency	2
19.	Revocation of conditional release	2
20.	Criminal versatility	—

Note. — = Item does not load on either factor.

Source. Reprinted from Hare RD: *The Hare Psychopathy Checklist—Revised.* Toronto, Ontario, Multi-Health Systems, 1991. Copyright 1991, Multi-Health Systems Inc., 908 Niagara Falls Boulevard, North Tonawanda, NY 14120-2060 (800-456-3003). Used with permission.

characterized by early-onset delinquency, high-density offending, and instrumental violence (Forth et al. 1990; Hare et al. 1992, 1993; Hart et al. 1994).

The second scale is the screening version of the PCL-R (PCL:SV; Hart et al. 1995). It is a brief, easy-to-administer, 12-item scale (see Table 17–2) based directly on the PCL-R but intended for use in nonforensic populations and as a screening test for psychopathy in forensic populations. The PCL:SV is scored in the same

Table 17–2. Items in the Screening Version of the Psychopathy Checklist (PCL:SV)

Part 1	Part 2
1. Superficial	7. Impulsive
2. Grandiose	8. Poor behavior controls
3. Deceitful	9. Lacks goals
4. Lacks remorse	10. Irresponsible
5. Lacks empathy	11. Adolescent antisocial behavior
6. Doesn't accept responsibility	12. Adult antisocial behavior

Source. Reprinted from Hart SD, Cox DN, Hare RD: *Manual for the Psychopathy Checklist: Screening Version (PCL:SV).* Toronto, Ontario, Multi-Health Systems, 1995. Copyright, Multi-Health Systems Inc., 908 Niagara Falls Boulevard, North Tonawanda, NY 14120-2060 (800-456-3003). Used with permission.

manner as the PCL-R, yielding total scores that can range from 0 to 24. The two scales are highly correlated ($r = .80$; see Hart et al. 1995).

The Association Between Psychopathy and Narcissism

Theoretical Views

Many writers have commented on the overlap between psychopathy and narcissism at a descriptive or phenotypical level (Bursten 1973, 1989; MacKay 1986; McGlashan and Heinssen 1989; Wulach 1988). The point is made perhaps most eloquently by Stone (1993, p. 292): "All commentators on psychopathy . . . allude to the attribute of (pathological) narcissism—whether under the rubric of egocentricity, self-indulgence, or some similar term. In effect, all psychopathic persons are at the same time narcissistic persons." The nature of the association between the two disorders has been discussed at length by Kernberg (1970, 1989; see also Chapter 2, this volume) and Meloy (1988). Both work within an

object relations framework; however, Kernberg's primary emphasis is narcissism, whereas Meloy's is psychopathy.

The parallels between psychopathy and Kernberg's conceptualization and description of the manifestations of narcissistic personality are clear; indeed, Kernberg noted that the two disorders "present the same general constellation of traits" and that "the antisocial personality may be considered a subgroup of the narcissistic personality" (1970, p. 5). Even closer conceptually to psychopathy is what Kernberg calls "malignant narcissism," a form of narcissistic personality disorder with severe superego pathology (Kernberg, Chapter 2, this volume).

Despite their similarities, though, Kernberg still differentiates psychopathy and narcissism (including malignant narcissism). One major difference is that psychopathic persons have a total incapacity for loyalty, remorse, and concern for others. Another is that psychopathic individuals are unable to see a moral dimension in others. They do not have a good sense of time and are unable to make realistic plans for the future. Finally, Kernberg noted that the antisocial behavior of narcissistic individuals tends to be of the "passive-parasitic" variety, whereas psychopathic persons are more overtly aggressive.

Meloy (1988) views psychopathy as a "deviant developmental process" (p. 311) with a core feature that is "the coexistence of a benign detachment and aggressively pursued, sadistically toned attempts to bond" (p. 59). He also recognized the close link between psychopathy and narcissism, stating that "the weight of clinical research supports the hypothesis that psychopathic personality organization is one subtype of narcissistic personality disorder, albeit an extreme and dangerous variant" (p. 7). His conclusion is based in part on clinical observations of apparent similarities in the Rorschach protocols of psychopathic and narcissistic patients (Meloy 1988; see also Gacono and Meloy 1994; Gacono et al. 1990). Like Kernberg, though, Meloy differentiated between the two disorders along several lines, noting that psychopathy is characterized by, among other things, prominent aggression, sadism, a "malignant ego ideal," and a tendency toward paranoid ideation (rather than depression) when under stress (pp. 19–20).

Empirical Evidence

Conceptual overlap. One important line of evidence comes from studies that focus on the internal structure of psychopathic traits. It appears that whenever a reasonably comprehensive set of symptoms is examined, two clusters emerge: one comprising interpersonal and affective symptoms such as grandiosity, superficiality, and remorselessness; and the other comprising behavioral symptoms such as irresponsibility and antisociality. The first cluster is, conceptually, very similar to narcissism, perhaps lending support to clinical views that all psychopathic individuals are narcissistic.

Harpur et al. (1988) factor-analyzed the 22 items of the PCL and attempted to identify a factor structure that was stable across samples, sites, and investigators. They had PCL ratings from six samples, with a total sample size of 1,119. For each sample, they extracted between two and eight factors and then subjected the factors to a variety of orthogonal and oblique rotations. The stability of various solutions both within and across samples was determined using split-half cross-validation and congruence. The results strongly supported an oblique two-factor solution. Factor 1, labeled the "selfish, callous and remorseless use of others," comprised items tapping egocentricity; superficiality; deceitfulness; callousness; and a lack of remorse, empathy, and anxiety. On the other hand, Factor 2, labeled a "chronically unstable and antisocial lifestyle" or "social deviance," comprised items tapping impulsivity, sensation-seeking, irresponsibility, aggressiveness, and criminality. The two factors were correlated at about $r = .50$. Identical factor structures have been reported for the PCL-R (Hare et al. 1990) and the PCL:SV (Hart et al. 1995) (see Tables 17–1 and 17–2). The two factors are differentially correlated with important external variables, such as violence, substance use, and personality variables (Hare 1991; Harpur et al. 1989; Hart et al. 1995).

The two-factor structure found with the PCL and related measures is also found in analyses based on other assessment procedures. Livesley et al. (1989, 1992) developed self-report scales to measure a wide range of personality disorder symptoms

described in the clinical literature (i.e., not limited to the domain of traits found in DSM-III-R). They conducted factor analyses of the scales in both patient and nonpatient samples. With respect to the prototypical symptoms of psychopathy, they found a two-factor structure isomorphic to that reported by Hare et al. (1990); they labeled the factors "interpersonal disesteem" and "conduct problems." Livesley and Schroeder (1991) replicated these findings when they reanalyzed only those symptoms contained in DSM-III-R criteria for antisocial personality disorder. One interesting finding was that interpersonal disesteem also emerged as a primary factor underlying traits of narcissistic personality disorder.

Harpur et al. (1990) conducted a factor analysis of DSM-III Cluster 2 (dramatic–erratic–emotional) personality disorder symptoms—including symptoms of antisocial and narcissistic personality disorder—in a large sample of community residents (relatives of psychiatric patients and a control group consisting of relatives of nonpatients). All subjects were assessed with the Structured Interview for DSM-III Personality (SIDP; Stangl et al. 1985), a reliable and well-validated instrument. Several factors emerged, including two that comprised symptoms of antisocial and narcissistic personality disorder and that were isomorphic to the PCL factors.

Rogers and colleagues asked 331 forensic psychiatrists (Rogers et al. 1994) and 250 members of the lay public (Rogers et al. 1992) to rate the prototypicality of a long list of psychopathy-related symptoms. They performed a factor analysis of the ratings and retained four factors for extraction. Although there were some relatively minor differences, in both samples the first two factors were isomorphic to the PCL factors: the first reflected impulsive and irresponsible behavior (i.e., Factor 2 of the PCL), and the second reflected manipulation and lack of guilt (i.e., Factor 1 of the PCL). The remaining two factors reflected violent and nonviolent delinquency, respectively.

Finally, the authors note that the two-factor structure of psychopathic symptoms is apparent in several self-report measures of psychopathy (Hare 1991; Levenson et al. 1995; Rogers and Bagby 1995).

Diagnostic overlap. Let us turn now from studies of the internal structure of psychopathic traits to studies of the association between measures of psychopathy and narcissism. If, as was suggested in previous sections, narcissism is a basic factor underlying about half of all psychopathic symptoms, the two disorders should have high rates of comorbidity, and their traits should be highly correlated.

Numerous studies have examined the overlap among DSM-III or DSM-III-R personality disorders, including narcissistic and antisocial personality disorders. Rather than discuss them individually, the authors discuss a review by Widiger et al. (1991). Summarizing the findings of four studies ($N = 568$), Widiger et al. (1991) found that, on average, the co-occurrence of antisocial and narcissistic personality disorder was about 16%. That is, of all patients with a diagnosis of either antisocial or narcissistic personality disorder, 16% had both disorders. Although quite high in absolute terms, this co-occurrence rate was lower than that for some other disorders. For example, antisocial personality had co-occurrence rates of 26% with borderline personality disorder and 18% with passive-aggressive personality disorder; and narcissistic personality disorder had a 17% co-occurrence rate with histrionic personality disorder. When the investigators analyzed various dimensional measures (e.g., symptom counts) rather than categorical diagnoses, they found an average correlation between narcissistic and antisocial personality disorder of .33 across nine studies. Once again, antisocial personality disorder was more strongly related to borderline personality disorder and passive-aggressive personality disorder ($r = .37$ and .35, respectively) than to narcissistic personality disorder; and narcissistic personality disorder was more strongly related to histrionic personality disorder ($r = .35$) than to antisocial personality disorder.

One problem with the studies summarized by Widiger et al. (1991) concerns the assessment of personality disorder: most of the studies used structured interviews or self-report inventories, which may have been susceptible to the effects of deceitfulness on the part of psychopathic individuals. A second problem is that the studies all used DSM criteria for antisocial personality disorder

rather than a measure of psychopathy in the Cleckleyan tradition. A third problem is that participants in most of the studies were civil psychiatric patients, a population with a relatively low base rate of psychopathy relative to forensic populations (e.g., Hart et al. 1994; Widiger and Corbitt 1993). As a result of these problems, the Widiger et al. (1991) analyses may underestimate the association between narcissistic personality disorder and measures of Cleckleyan psychopathy, such as the PCL-R.

Only a few studies have examined the association between narcissism and the PCL-R. Hart and Hare (1989) studied 80 men remanded to a forensic hospital for pretrial psychiatric evaluation. Patients' conditions were assessed with the PCL-R and diagnosed with DSM-III Axis I and II criteria. They were also given prototypicality ratings on each personality disorder using a 10-point scale (1 = low, 10 = high). The correlation between PCL-R total scores and ratings of narcissistic personality disorder was moderate (r = .39) and second in magnitude only to the correlation with antisocial personality disorder (r = .71). Not surprisingly, scores on Factor 1 of the PCL-R correlated more highly with ratings of narcissism (r = .49) than with ratings of any other personality disorder; in contrast, scores on Factor 2 of the PCL-R correlated most highly with ratings of antisocial personality disorder (r = .71) and much lower with ratings of narcissistic personality disorder (r = .39).

Hart et al. (1991) studied the correlation between the PCL-R and measures of personality disorder on the MCMI-II (Millon 1987) in a sample of 119 adult male prisoners. In that study, the correlation between PCL-R total scores and MCMI-II base rate scores on narcissistic personality disorder was .31; the correlations with Factor 1 and 2 scores were r = .24 and .28, respectively. As one would expect, the PCL-R correlated more highly with antisocial personality disorder; otherwise, the correlations with narcissistic personality disorder were higher than those with any other disorders except for aggressive-sadistic and paranoid personality disorder.

Hart et al. (1994; see also Hart et al. 1995) examined the correlations between the PCL:SV and various measures of personality disorder. In one sample of 40 adult male prisoners who completed

the MCMI-II, base rate scores for narcissistic personality disorder were correlated at $r = .44$ with PCL:SV total scores, .48 with scores on Part 1 (comparable to Factor 1 of the PCL-R), and .30 with scores on Part 2 (comparable to Factor 2 of the PCL-R). Although substantial, these correlations were smaller than those between the PCL-R and several disorders other than antisocial personality, including borderline, schizotypal, passive-aggressive, and aggressive-sadistic personality disorder.

In a second sample of 38 civil psychiatric patients, Hart et al. (1994) examined correlations between the PCL:SV and dimensional ratings of personality disorder based on the Personality Disorder Examination (PDE; Loranger 1988), a structured interview for DSM-III-R Axis II. The PCL:SV and PDE ratings were completely independent, made by different raters on the basis of different interviews. Aside from the expected correlations between the PCL:SV and antisocial personality disorder, the highest correlations were between PCL:SV total scores and narcissistic personality disorder ($r = .58$). Part 1 scores correlated more highly with narcissistic personality disorder than did Part 2 scores ($r = .63$ and .41, respectively). Indeed, narcissistic personality disorder was the single strongest correlate of Part 1 scores.

The authors know of only one study that has examined the association between psychopathy and narcissism as a normal personality dynamic. The PCL-R manual presents correlations with the Narcissistic Personality Inventory (NPI; Raskin and Hall 1979; Raskin and Terry 1988) in a sample of 100 adult male prisoners. The correlations between the NPI total score and the PCL-R total, Factor 1, and Factor 2 scores were $r = .34, .33$, and .34, respectively. Looking at the NPI subscales, the highest correlations were with authority and exploitativeness ($r = .40$ and .29, respectively, with PCL-R total scores).

Conclusion

The available empirical evidence appears to support the theoretical view that a strong association exists between psychopathy and

narcissism. There are some important qualifiers to this conclusion, however. First, the association between the disorders is not sufficiently large in magnitude to suggest that psychopathy is simply a "subgroup" or "subtype" of narcissistic personality disorder. The diagnostic overlap is far from complete, and many psychopathic individuals do not have symptoms that meet the criteria for narcissistic personality disorder. Second, narcissism is associated primarily with one of the two major facets of psychopathic symptomatology. In other words, narcissism is related to only one-half of the construct of psychopathy. Third, both psychopathy and narcissistic personality disorder are as strongly related to other personality disorders as they are to each other. In light of these comments, psychopathy can be viewed as a higher-order construct with two distinct, albeit related, facets, one of which is very similar to the clinical concept of narcissism; this two-facet conceptualization of psychopathy is illustrated in Figure 17–1.

Despite these qualifications, the association between psychopathy and narcissism would seem to be a fruitful avenue for further research. It raises many questions. What is the exact extent and nature of the association between the disorders? Is it simply descriptive, or is there a common diathesis—say, temperamental, genetic, or neurocognitive? Does the association remain consistent across various modes of functioning (e.g., behavioral, cognitive, interpersonal)? What is the difference between the disorders with respect to family history, course, and treatment response?

In our view, future research should begin by conducting a series of studies focused specifically on the psychopathy-narcissism association in various populations. For reasons described earlier in this chapter, the authors recommend that researchers avoid relying solely on self-report inventories. They also recommend avoiding omnibus-structured interviews of personality disorder, which sacrifice depth of assessment for breadth of coverage. Instead, researchers should consider using clinical rating scales such as the PCL-R (in forensic settings) or PCL:SV (in other settings) and the Diagnostic Interview for Narcissism (DIN; Gunderson et al. 1990). Although these scales require considerable time

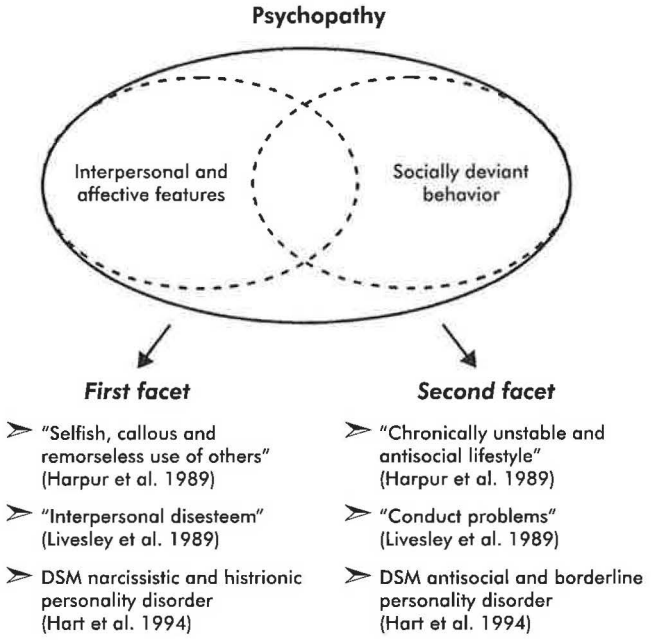

Figure 17–1. A two-facet conceptualization of psychopathy.

and expertise to administer (at least relative to self-reports), they provide detailed and reliable information. They can also provide a variety of dimensional measures in addition to categorical diagnoses.

Regardless of the assessment techniques used, researchers should consider using samples from several different populations. In particular, it will be important to determine whether the association between the disorders is similar across forensic populations, in which the base rate of psychopathy is relatively high but in which little information is available about the base rate of narcissistic personality disorder; in psychiatric populations, in which the base rate of narcissistic personality disorder is relatively high and the base rate of psychopathy generally is quite low; and in the community, wherein both disorders are rare.

References

Albert RS, Brigante TR, Chase M: The psychopathic personality: a content analysis of the concept. J Gen Psychol 60:17–28, 1959

American Psychiatric Association: Diagnostic and Statistical Manual: Mental Disorders. Washington, DC, American Psychiatric Association, 1952

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2nd Edition. Washington, DC, American Psychiatric Association, 1968

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. Washington, DC, American Psychiatric Association, 1980

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised. Washington, DC, American Psychiatric Association, 1987

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

Bursten B: The Manipulator. New Haven, CT, Yale University Press, 1973

Bursten B: The relationship between narcissistic and antisocial personalities. Psychiatr Clin North Am 12:571–584, 1989

Buss AH: Psychopathology. New York, Wiley, 1966

Butcher JN, Dahlstrom WG, Graham JR, et al: Minnesota Multiphasic Personality Inventory (MMPI-2): Manual for Administration and Scoring. Minneapolis, MN, University of Minnesota Press, 1989

Cleckley H: The Mask of Sanity. St. Louis, MO, Mosby, 1941

Craft MJ: Ten Studies Into Psychopathic Personality. Bristol, England, John Wright, 1965

Davies W, Feldman P: The diagnosis of psychopathy by forensic specialists. Br J Psychiatry 138:329–331, 1981

Feighner JP, Robins E, Guze SB, et al: Diagnostic criteria for use in psychiatric research. Arch Gen Psychiatry 26:57–63, 1972

Forth AE, Hart SD, Hare RD: Assessment of psychopathy in male young offenders. Psychological Assessment: A Journal of Consulting and Clinical Psychology 2:342–344, 1990

Fotheringham JB: Psychopathic personality: a review. Canadian Psychiatric Association Journal 2:52–74, 1957

Hathaway SR, McKinley JC: A multiphasic personality schedule (Minnesota), I: construction of the schedule. J Psychol 10:249–254, 1940

Karpman B: The structure of neurosis: with special differentials between neurosis, psychosis, homosexuality, alcoholism, psychopathy, and criminality. Archives of Criminal Psychodynamics 4:599–646, 1961

Kernberg OF: Factors in the treatment of narcissistic personalities. J Am Psychoanal Assoc 18:51–85, 1970

Kernberg OF: The narcissistic personality disorder and the differential diagnosis of antisocial behavior. Psychiatr Clin North Am 12:553–570, 1989

Levenson MR, Kiehl KA, Fitzpatrick CM: Assessing psychopathic attributes in a noninstitutionalized population. J Pers Soc Psychol 68: 151–158, 1995

Lilienfeld SO: Conceptual problems in the assessment of psychopathy. Clinical Psychology Review 14:17–38, 1994

Livesley WJ: Trait and behavioral prototypes of personality disorder. Am J Psychiatry 143:728–732, 1986

Livesley WJ, Schroeder M: Dimensions of personality disorder: the DSM-III-R cluster B diagnoses. J Nerv Ment Dis 179:320–328, 1991

Livesley WJ, Jackson DN, Schroeder M: A study of the factorial structure of personality pathology. Journal of Personality Disorders 3:292–306, 1989

Livesley WJ, Jackson DN, Schroeder M: Factorial structure of traits delineating personality disorders in clinical and general population samples. J Abnorm Psychol 101:432–440, 1992

Loranger AW: Personality Disorder Examination (PDE) Manual. Yonkers, NY, DV Communications, 1988

MacKay JR: Psychopathy and pathological narcissism: a descriptive and psychodynamic formulation on the antisocial personality disorder. Journal of Offender Counseling, Services, and Rehabilitation 11:77–93, 1986

McCord W, McCord J: The Psychopath: An Essay on the Criminal Mind. Princeton, NJ, Van Nostrand, 1964

McGlashan TH, Heinssen RK: Narcissistic, antisocial, and noncomorbid subgroups of borderline disorder—are they distinct entities by long-term clinical profile? Psychiatr Clin North Am 12:653–670, 1989

Meloy JR: The Psychopathic Mind. Northvale, NJ, Jason Aronson, 1988

Millon T: Disorders of Personality: DSM-III Axis II. New York, Wiley, 1981

Millon T: Millon Clinical Multiaxial Inventory Manual, 3rd Edition. Minneapolis, MN, National Computer Systems, 1983

Millon T: Manual for the Millon Clinical Multiaxial Inventory-II, 2nd Edition. Minneapolis, MN, National Computer Systems, 1987

Newman JP, Wallace JF: Psychopathy and cognition, in Psychopathology and Cognition. Edited by Kendall P, Dobson K. New York, Academic Press, 1993, pp 293–349

Raskin R, Hall CS: A narcissistic personality inventory. Psychol Rep 45:590, 1979

Raskin R, Terry H: A principal-components analysis of the narcissistic personality inventory and further evidence of its construct validity. J Pers Soc Psychol 54:890–902, 1988

Robins LN: Deviant Children Grown Up. Baltimore, MD, Williams & Wilkins, 1966

Robins LN: Aetiological implications in studies of childhood histories relating to antisocial personality, in Psychopathic Behavior: Approaches to Research. Edited by Hare RD, Schalling D. Chichester, England, Wiley, 1978, pp 255–271

Rogers R, Bagby M: Dimensions of psychopathy: a factor analytic study of the MMPI Antisocial Personality Disorder scale. International Journal of Offender Therapy and Comparative Criminology 38:297–308, 1995

Rogers R, Dion K: Rethinking the DSM-III-R diagnosis of antisocial personality disorder. Bull Am Acad Psychiatry Law 19:21–31, 1991

Rogers R, Dion K, Lynett E: Diagnostic validity of antisocial personality disorder: a prototypical analysis. Law and Human Behavior 16:677–689, 1992

Rogers R, Duncan J, Lynett E, et al: Prototypical analysis of antisocial personality disorder: DSM-IV and beyond. Law and Human Behavior 18:471–484, 1994

Stangl D, Pfohl B, Zimmerman M, et al: A structured interview for the DSM-III personality disorders: a preliminary report. Arch Gen Psychiatry 42:591–596, 1985

Stevens GF: Prison clinicians' perceptions of antisocial personality disorder as a formal diagnosis. Journal of Offender Rehabilitation 20:159–185, 1994

Stone M: Abnormalities of Personality: Within and Beyond the Realm of Treatment. New York, WW Norton, 1993

Tennent G, Tennent D, Prins H, et al: Psychopathic disorder: a useful clinical concept? Med Sci Law 30:38–44, 1990

Widiger TA, Corbitt E: Antisocial personality disorder: proposals for DSM-IV. Journal of Personality Disorders 7:63–77, 1993

Widiger TA, Frances AJ, Harris M, et al: Comorbidity among Axis II disorders, in Personality Disorders: New Perspectives on Diagnostic Validity. Edited by Oldham JM. Washington, DC, American Psychiatric Press, 1991, pp 163–194

Widiger TA, Cadoret R, Hare RD, et al: DSM-IV antisocial personality disorder field trial. J Abnorm Psychol 105:3–16, 1996

World Health Organization: International Classification of Diseases and Related Health Problems, 10th Edition. Geneva, Switzerland, World Health Organization, 1990

Wulach JS: The criminal personality as DSM-III-R antisocial, narcissistic, borderline, and histrionic personality disorder. International Journal of Offender Therapy and Comparative Criminology 32:185–199, 1988