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An empirical typology of narcissism and mental health in late adolescence

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Abstract

A two-step cluster analytic strategy was used in two studies to identify an empirically derived typology of narcissism in late adolescence. In Study 1, late adolescents ($N = 204$) responded to the profile of narcissistic dispositions and measures of grandiosity (''superiority'') and idealization (''goal instability'') inspired by Kohut's theory, along with several College Adjustment Scales and a measure of pathology of separation-individuation. Cluster analysis revealed three clusters: covert narcissists ($N = 71$), moderate narcissists ($N = 55$) and overt narcissists ($N = 74$). Moderate narcissists had significantly lower means scores on indices of anxiety, relationship problem, depression, esteem- and family problems and pathology of separation-individuation. The overt and covert clusters showed comparable levels of dysfunction on most indices of adjustment. This general pattern was replicated in Study 2 ($N = 210$). Moderate narcissists showed a uniform profile of good adjustment, whereas covert and overt narcissist clusters showed a pervasive pattern of dysfunction. Results support the claim that narcissism has ''two faces'' and that a moderate degree of narcissism is associated with fewer adjustment problems or psychological symptoms. Directions for future research are discussed.

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Introduction

Narcissism has long been a central category for understanding important aspects of adolescent personality development. Indeed, it is widely believed in both the popular and theoretical literatures that adolescents are particularly susceptible to narcissistic tendencies, and that the management of narcissism may well differentiate normal from dysfunctional adolescent development (Bleiberg, 1994). The source of these narcissistic tendencies has been theoretically linked to the normative developmental task of separation-individuation that requires the adolescent to shed parental dependencies, exercise autonomous agency and become an individuated self but within the context of enduring relational commitments. Narcissistic reactions are said to emerge as a concomitant of this process to ward off the mourning reactions that attend the loss of childhood identifications and to fortify the adolescent against the vulnerabilities common to this developmental transition (Blos, 1962). On this interpretation narcissism serves an adaptive function as the adolescent wrestles with the twin demands of assertion and connectedness.

The possibility of adaptive and healthy narcissism is also evident in Winnicott's (1965) object relational theory and in Kohut's (1977) self-psychology. For Winnicott (1965), self-absorption and a sense of subjective omnipotence can provide the psychological aliments that support self-extension, ambition, creativity and growth. Kohut (1977) argued that normal self-development could follow either a "grandiose" line, characterized by exhibitionism, assertiveness and ambition ("I am perfect, and you admire me") or else an "idealizing" line, characterized by an idealization of figures and goals ("You are perfect, and I am part of you"). Both theorists suggest that narcissistic "illusions" can be used to creatively sustain psychological growth and self-development (Mitchell, 1988). A narcissistic stance may be particularly adaptive for meeting the developmental challenges of late adolescence and emerging adulthood (Wink, 1992a).

Of course, lurking within reach of healthy and adaptive uses of narcissism are its dysfunctional and maladaptive aspects. Kernberg (1975) argued that the grandiose self oscillates between cycles of self-admiration and devaluation of others to protect against dependency and disappointment, and tends more toward dysfunction and pathology than it does healthy adaptation. Moreover, dysfunctional narcissism can take overt and covert forms that reflect either two facets of the same individual (Rhodewalt & Morf, 1995) or else two expressive "types" of narcissism (Wink, 1996). Hence, alongside overt displays of haughty grandiosity, invulnerability and entitlement there could reside covert and hypersensitive feelings of anxiety, inferiority and worthlessness.

Recent research has attempted to document types of narcissism in community samples of emerging and young adults. Wink (1991a) subjected 6 MMPI narcissism scales to a principal components analysis that resulted in two factors, which he labelled Vulnerability-Sensitivity and grandiosity-exhibitionism. Both factors were correlated with certain core features of narcissism, such as conceit, entitlement, self-indulgence, fragile self-esteem, and exploitative interpersonal relationships. But the two factors also appeared to correspond to the distinction between overt (grandiosity-exhibitionism) and covert (vulnerability-sensitivity) narcissism. Hence, on the basis of MMPI descriptors, the overt narcissist was described as a grandiose exhibitionist who is self-indulgent, manipulative, driven by power and by a strong need to be admired. The covert narcissist was described as being insecure, hypersensitive and vulnerable to feelings of inferiority. As Wink (1996, p. 167) put it, "narcissistic fantasies of power and grandeur can equally well lurk

behind a bombastic and exhibitionistic facade as one of shyness, vulnerability and depletion.'' Not surprisingly both forms of narcissism were ''associated with psychological problems and difficulties in effective functioning'' (Wink, 1991, p. 596), although the covert form appears to be more dysfunctional than the overt form (Wink, 1996).

A somewhat different typology emerges when one examines observer-based *Q*-set ratings of the narcissism prototype rather than MMPI-derived factor profiles. Wink (1992a, b) identified three types of narcissism using *Q*-methodology, which he denoted as willful, hypersensitive, and autonomous. When correlated with standard personality inventories the willful narcissist was described as one who is a self-assured, rebellious exhibitionist who displays overt grandiosity, poor impulse control and a strong power orientation. The hypersensitive narcissist was described as one who is overtly inhibited, introverted and lacking in self-confidence, which masks a covert sense of self-importance and entitlement. According to Wink (1992a), the willful and hypersensitive types are strongly congruent with overt and covert forms of narcissism, respectively. Finally, the autonomous narcissist was described as creative, empathic, and achievement oriented, which reflected a ''healthy variant of narcissism'' (Wink, 1992b, p. 51).

These studies document the general clinical-developmental claim that there are different *types* of dysfunctional narcissism that can be usefully described in terms of overt and covert characteristics. Moreover, the overt–covert forms of narcissism are evident even though quite different methodologies (principal components analysis, *Q*-methods) and data sources (MMPI-scales, observer ratings) were used across these studies. The *Q*-set studies also revealed a type of narcissism (''autonomous'') that is compatible with positive adjustment and mental health. This form of narcissism was associated with the self-investment that supports creative achievement, inner-directedness, self-reliance and empathy. While it is customary, then, to speak of the dual nature of narcissism in terms of its overt and covert forms, or, alternatively, in terms of functional and dysfunctional forms, it might be more accurate to say that there are three types of narcissism evident in unselected samples: overt, covert and adaptive.

Although theoreticians often assert that narcissism is not dysfunctional, per se, and that adaptive forms of narcissism are possible, most of the extant research has focused on dysfunctional narcissism (for an exception, Rose, 2002). Indeed, as Kohut (1986, p. 61) pointed out, ''the contribution of narcissism to health, adaptation and achievement has not been studied extensively.'' Perhaps one reason for the relative absence of studies on the adaptive features of narcissism is the fact that the extant measures of narcissism are derived either from the MMPI or clinical diagnostic criteria of narcissistic personality, or else purport to measure self-pathology. Although one would not expect to find much evidence of adaptive functioning using scales designed to gauge clinical defects in the self, it is of interest to note that at least some of these measures or subscales have been linked with positive adjustment. The subscales of the Narcissistic Personality Inventory, for example, appear to be differentially correlated with indices of mental health (Raskin & Novacek, 1989). Similarly, Robbins and Patton (1985) noted that their measure of Kohut's notion of grandiosity (''superiority scale'') and idealization (''goal instability scale'') might ''actually represent *healthy* forms of narcissism'' (p. 226, emphasis in original) rather than mild forms of self-immaturity. Moreover, a recently designed scale, the Profile of Narcissistic Dispositions (Taylor, 1995), an assessment that purports to measure normal and healthy narcissism, nonetheless includes subscales (e.g. Manipulativeness) that seem to point more toward maladaptation.

In the present studies, we attempted to explore the heterogeneity of narcissism in a novel way. Using cluster analytic techniques, and many of the extant measures of narcissism, we hoped to identify a theoretically useful typology of narcissism. In contrast to previous research that correlates narcissism factor scores or *Q*-set ratings with personality inventories, we attempted to examine the relationship between narcissism clusters and multiple indices of adjustment, such as anxiety, interpersonal problems, depression, self-esteem disturbance, and family problems. We also explored the relationship between the narcissism clusters and pathology of separation-individuation, which is the principal ego developmental process that is thought to invite narcissistic defenses. We anticipated that our analytic strategy would reveal three forms of narcissism suggested by the clinical developmental literature.

Study 1

Method

Participants

Subjects included 204 late adolescents (137 females, 67 males) attending a mid-sized, Midwestern state university. The mean age of the participants was 20.54 years (S.D. = 2.06). Participants were predominately White/Caucasian (91.2%) and Black/African-American (7.4%), a distribution that reflects the ethno-racial composition of this university community. Approximately, 21% of the participants were freshman ($N = 43$); 36% were sophomores ($N = 74$); 20% were juniors ($N = 40$); and 23% were seniors ($N = 47$). Participants were volunteers solicited from developmental and educational psychology classes for nominal course credit.

Instruments and procedure

Narcissism. Participants responded to the profile of narcissistic dispositions (POND) and a measure of grandiosity (''superiority'') and idealization (''goal instability'') inspired by Kohut's theory.

The POND was developed by Taylor (1995) to assess normal manifestations of narcissism. Items are responded to along a six-step Likert-type continuum (1 = *strongly agree* to 6 = *strongly disagree*). The POND consists of five subscales. The *assured leadership* scale ($\alpha = .75$) consists of 12 items that assess the extent to which one perceives the self to have effective leadership qualities. The *manipulativeness* scale ($\alpha = .64$) consists of nine items that reflect approval or admission of tendencies toward interpersonal manipulation. The *public recognition* scale ($\alpha = .68$) consists of nine items that indicate public self-consciousness and the need for favourable notice by others. The *vain exhibition* scale ($\alpha = .69$) consists of 11 items that measure the extent to which one perceives the physical self to be a pleasing stimulus for others. Finally, the *competitive ambition* scale ($\alpha = .57$) consists of 10 items that reflect assertive ambition to the very boundaries of social convention. According to Taylor (1995), the core of POND narcissism is non-pathological, healthy and free of psychosocial distress. The psychometric integrity and construct validity of the POND is demonstrated by several studies reported by Taylor (1995).

The "goal instability" and "superiority" scales were used to assess defects along the idealization and grandiosity lines of development, respectively, as articulated by Kohut's theory. The goal instability scale ($\alpha = \cdot 74$) consists of 10 items that reflect a lack of goal-directedness and failure to idealize adaptive or realistic goals (and hence a defect in idealization). The "superiority" scale ($\alpha = .83$) consists of 10 items that reflect grandiose self-assertion. Research has shown that the goal instability (idealization) scale predicts adjustment to college (Robins & Schwitzer, 1988), academic performance (Scott & Robbins, 1985) and career development (Robbins & Patton, 1985). Robbins (1989) also reported that the superiority (grandiosity) scale was related to social gregariousness, interpersonal exploitation and impulsivity, while the goal instability (idealization) scale was related to a pattern of social withdrawal, depression and lack of ambition or goals.

Adjustment. The College Adjustment Scales (CAS, Anton & Reed, 1991) were used to assess various dimensions of mental health and adjustment. The CAS can be used as a screen for common developmental and psychological problems faced by college students. It consists of nine subscales, only five of which were used in the present study. The *anxiety* scale (12 items, $\alpha = .85$) is a measure of clinical anxiety, focusing on common affective, cognitive and physiological symptoms. The *interpersonal problems* (12 items, $\alpha = .79$) scale measures the extent of problems in one's relational field. The *depression* scale (12 items, $\alpha = .84$) is a measure of depressive symptoms. The *esteem problems* scale (12 items, $\alpha = .81$) is a measure of global self-esteem that taps negative self-evaluations and dissatisfaction with personal achievement. The *family problems* (12 items, $\alpha = .81$) scale taps difficulties experienced in family relationships. Higher scores represent more adjustment problems in each domain. The extensive literature on the construct validity of these scales is summarized by Anton and Reed (1991).

Finally, we included a measure of pathology of separation-individuation ($\alpha = .89$) developed by Christenson and Wilson (1985). This measure is a 39-item Likert-type scale that assesses differentiation issues, splitting, and relational disturbances in one's interpersonal field. Preliminary research shows that the scale has a unitary factor structure and distinguishes clinical subjects from normal controls (Christenson & Wilson, 1985). It is also internally consistent, and differentially predicts secure and insecure adult attachment (Lapsley & Edgerton, 2002), and numerous indices of psychiatric symptomatology and adjustment (Lapsley, Aalsma, & Varshney, 2001). We included this measure as a diagnostic guide to the interpretation of the empirically derived narcissism clusters. Insofar as narcissistic disturbances are theoretically linked to faults in separation-individuation, we expected this measure of pathology of separation-individuation to be strongly related to maladaptive forms of narcissism.

Results

Correlational analysis

We first examined the pattern of bivariate relationships among the measures used in this study in order to provide an interpretive context for our efforts to derive a typology of narcissism by means of cluster analysis. The correlation among the measures used in this study is reported in Table 1. Given the number of correlations we proceeded conservatively by considering only those correlations statistically significant at $p < .01$. Several patterns are of interest. First, the Kohut measures of idealization (goal instability) and grandiosity (superiority) appear to be representing

Table 1
Correlation between indices of narcissism and adjustment: Study 1

Adjustment measures	Kohut measures[b]		Profile of narcissistic dispositions				
	Idealization	Grandiosity	Leadership	Vain exhibition	Competitive ambition	Manipulative	Assured recognition
Pathology of sep-ind.	−.52	−.26	−.26	−.21	.12	.42	.29
Anxiety[a]	−.43	−.01	−.24	−.28	.01	.20	.19
Relationship problems[a]	−.51	−.10	−.26	−.26	.02	.34	.17
Depression[a]	−.49	−.06	−.22	−.26	.05	.18	.17
Esteem problems[a]	−.38	.09	−.54	−.42	−.27	.24	.11
Family problems[a]	−.41	−.05	−.28	−.17	−.04	.23	.19

Note: Pathology of sep.-ind., pathology of separation-individuation; all correlations at least $r = .17$ are statistically significant ($p < .01$). Correlations among the narcissism sub-scales are available from the first author upon request.

[a]College Adjustment Scales.

[b]Goal Instability and Superiority Scales.

healthy dimensions of narcissism. Both scales are negatively correlated with pathology of separation-individuation, while idealization is negatively correlated with each of the CAS. Second, the dimensions of narcissism measured by POND appear to be differentially related to adjustment. For example, leadership and vain exhibition are negatively correlated with pathology of separation-individuation and the CAS, and positively correlated with the Kohut measures. In contrast, Manipulativeness was positively correlated with pathology of separation-individuation and with each of the CAS. Third, it is of interest to note that pathology of separation-individuation was the strongest correlate of anxiety, relationship problems, depression, esteem problems, and family problems of any variable measured in this study, making it reliable diagnostic guide for the interpretation of empirically derived narcissism clusters.

Cluster analysis

Following the recommendations of Heir, Anderson, Tatham, and Black (1995), we performed a two-step cluster analysis on the standardized narcissism scales. In the first step, a hierarchical procedure determined the number of clusters evident in the data. In the second step, the cluster centers derived from this analysis were then used as the initial seed points for a non-hierarchical cluster analysis. Cluster group differences were then explored by multivariate analysis of variance, with appropriate univariate post hoc procedures controlled for alpha inflation by the Bonferroni method.

The hierarchical cluster analysis, using Ward's agglomerative procedure, revealed three clusters. The cluster centroids from this analysis were then used as initial seed points in a *K*-means (non-hierarchical) cluster analysis that specified three clusters. We proceeded conservatively here by

Table 2
Means and standard deviations of narcissism and adjustment measures by cluster group: Study 1

	Cluster group 1 overt $N = 71$		Cluster group 2 adaptive $N = 55$		Cluster group 3 covert $N = 74$	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
POND						
Leadership	54.60[a]	5.46	50.84[a]	5.57	41.28[b]	5.73
Vain exhibition	46.25[a]	6.67	42.51[b]	5.79	38.50[c]	6.00
Manipulative	30.96[a]	5.42	21.65[c]	4.66	28.76[b]	4.75
Assured recognition	35.95[a]	5.03	26.87[c]	5.39	31.26[b]	5.29
Competitive ambition	39.25[a]	5.78	32.33[b]	5.72	33.17[b]	5.45
Kohut measures						
Idealization	39.05[b]	7.96	46.78[a]	7.27	35.13[c]	8.02
Grandiosity	28.94[c]	5.05	39.58[a]	5.96	36.62[b]	5.90
Pathology of sep-ind	127.42[b]	33.85	80.44[c]	18.65	139.12[a]	37.79
College adjustment						
Anxiety	22.40[b]	6.71	18.33[c]	4.06	24.04[a]	6.81
Relationship problems	20.94[b]	5.20	16.47[c]	3.00	22.71[a]	5.61
Depression	19.05[b]	5.53	15.34[c]	2.56	20.77[a]	5.96
Esteem problems	23.1[b]	5.12	19.78[c]	4.52	27.66[a]	5.78
Family problems	18.13[b]	4.33	15.13[c]	3.50	20.77[a]	6.47

Note: Means with a different superscript are significantly different from each other (Bonferroni contrasts). POND, profile of narcissistic dispositions; pathology of sep-ind, pathology of separation-individuation.

interpreting only statistically significant mean differences. This profile is reported in Table 2. A one-factor Cluster Group MANOVA was calculated on the linear combination of narcissism scales, revealing a significant multivariate effect (Pillai trace = 1.167, $F = 38.45, p < .001, \eta^2 = .584$). Univariate analyses indicated significant cluster group differences for each of the narcissism scales (all $p < .001, \eta^2 = .234$ to .431), and a pervasive pattern of significant contrasts, as indicated in Table 2. The cluster group labels were chosen based on the cluster groupings on the narcissism measure (POND) and "Kohut measures" of grandiosity (superiority) and idealization (goal instability). Additionally, the score on the pathology of separation-individuation measure was utilized for interpretive purposes (where higher scores indicate greater symptomatology).

The first cluster ($N = 71$) was characterized by a pattern of high scores on all of the dimensions of POND, and medium and low scores on idealizaton and grandiosity, respectively, and a medium score on pathology of separation-individuation. It was denoted the overt narcissism group. The third cluster ($N = 74$) reported a profile of low-to-medium scores on all of the narcissism measures but the highest degree of pathology of separation-individuation, and was designated the covert narcissism group. In contrast to these groups the second cluster ($N = 55$) reported a mixture of low, high and medium scores across all of the narcissism measures, and the lowest mean score on pathology of separation-individuation, and was designated the adaptive narcissism group.

Tests of means

In the next analyses, we attempted to show a differential pattern of symptomatology and adjustment among these three cluster groups. A cluster group (3) × gender (2) MANOVA was conducted on pathology of separation-individuation and the CAS. A significant multivariate effect emerged for Cluster Group (Pillai Trace = .46, $F = 9.30, p = .001, \eta^2 = .230$). Univariate ANOVAs revealed significant cluster group effects for anxiety, $F(2, 191) = 10.38, p < .001, \eta^2 = .098$; for relationship problems, $F(2, 191) = 19.26, p < .001, \eta^2 = .168$; for depression, $F(2, 191) = 14.59, p < .001, \eta^2 = .133$; for esteem problems, $F(2, 191) = 30.83, p < .001, \eta^2 = .244$; for family problems, $F(2, 191) = 15.10; p < .001, \eta^2 = .137$; and for pathology of separation-individuation, $F(2, 191) = 44.72, p < .001, \eta^2 = .319$. Post hoc analysis using the Bonferroni procedure revealed the following significant differences among the cluster groups: adaptive narcissists had significantly lower mean scores on indices of anxiety, relationship problems, depression and esteem- and family problems, than did maladaptive (overt and covert) narcissists. Adaptive narcissists also had significantly lower mean scores on pathology of separation-individuation than did maladaptive narcissists. There were no significant differences between covert and overt narcissists on indices of anxiety, relationship problems or depression, or in pathology of separation-individuation. However, covert narcissists indicated significantly more esteem problems and family problems than did overt narcissists. The multivariate Gender and interaction effect were not statistically significant. Means and standard deviations of indices of adjustment by cluster group are also reported in Table 2.

Discussion

In this study, we identified three clusters of narcissists that were differentially related to indices of symptomatology and pathology of separation-individuation. Participants in the adaptive cluster reported significantly lower scores on measures of anxiety, relationship problems, depression, esteem problems and family problems than did participants in the two maladaptive clusters, and fewer symptoms of pathology of separation-individuation. Hence, late adolescents who show a mixed narcissism profile that is marked by pronounced idealization and grandiosity and moderate aspirations to exhibit leadership, but lower tendencies to achieve recognition through competitive manipulation, reported the better profile of adjustment than did covert and overt narcissists. The two maladaptive clusters were statistically equivalent in reported pathology of separation-individuation, anxiety, relationship problems and depression, although the covert pattern reported more esteem problems and more family problems than the overt pattern. Hence, although the covert and overt patterns are both associated with significant dysfunctional and maladaptive symptomatology, the covert pattern appeared to show a more pervasive profile of poor adjustment than the overt pattern, a finding that is also reported elsewhere in the literature (Wink, 1996).

Study 2

One limitation of the first study was that it did not include the highly regarded Narcissistic Personality Inventory. Hence, one purpose of the second study was to replicate the derived

typology by including the narcissistic personality inventory (NPI) as one of the extant measures of narcissism. In addition, we wanted to assess the mental health implications of the derived clusters of narcissism using a broader array of indices than in Study 1. Hence, in addition to the CAS and the measure of pathology of separation-individuation, we also included the Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) in order to more adequately assess the pattern of symptomatology and adjustment associated with the typology of adolescent narcissism. We also included an alternative measure of grandiosity and idealization, in order to cast a broader nomological net over the narcissism construct. As in Study 1, we expected to identify three clusters of narcissists, with one cluster indicating a pervasive association with positive mental health, while the remaining clusters indicating a pervasive relationship with adjustment difficulties and symptomatology.

Method

Participants

Subjects included 210 late adolescents (mean age = 21.27; 143 females, 67 males) who attended a large regional university in the American Midwest. Five participants were freshmen, 88 were sophomores, 42 were juniors, 70 were seniors, and 5 participants indicated "other." Participants were predominately White/Caucasian (88.6%) and Black/African–American (8.1%). The mean age was 21.27 years (S.D. = 4.57).

Instruments and procedure

Narcissism. Participants responded to standard assessments of narcissism, including the NPI, the POND, and new measures of grandiosity ("Pseudo-autonomy") and idealization ("peer group dependence") inspired by Kohut's theory.

The NPI is designed to measure individual differences in narcissism as it is expressed in non-clinic populations. It consists of 40-items that were developed in accordance with DSM-III criteria for narcissistic personality disorder. The NPI consists of the following factors: *authority* (dominance, assertiveness, leadership, self-confidence, $\alpha = .71$); *exhibitionism* (exhibitionism, sensation-seeking; lack of impulse control, $\alpha = .67$); *superiority* (capacity for status, social presence, self-confidence, $\alpha = .46$); *exploitativeness* (rebelliousness, nonconformity, hostility, lack of tolerance or consideration of others, $\alpha = .50$); *vanity* (regarding the self, and being judged by others, as physically attractive, $\alpha = .63$); *self-sufficiency* (assertiveness, independence, self-confidence, need-for-achievement, $\alpha = .37$); and *entitlement* (ambitiousness, need-for power, dominance, hostility, lack of self-control and tolerance for others, $\alpha = .37$). The reliability of the total NPI was $\alpha = .81$. Although a few subscales have rather low internal consistency (perhaps because of fewer items, see Raskin & Terry, 1988), the NPI otherwise appears to have strong psychometric properties (Raskin & Terry, 1988). A rich nomological network of relationships with external criteria of narcissism and related constructs have been established (Emmons, 1984; Rhodewalt & Morf, 1995; Watson, Grisham, Trotter, & Biderman, 1984).

The internal consistency of the POND scales was as follows: *assured leadership* ($\alpha = .77$); *manipulativeness* ($\alpha = .76$); *public recognition* ($\alpha = .79$); *vain exhibition* ($\alpha = .69$); and *competitive ambition* ($\alpha = .64$). We used alternative measures of grandiosity ("pseudo-autonomy") and idealization ("peer-group dependence") developed by Lapan and Patton (1986). These measures,

also derived from Kohut's self-psychology, assess "different and more serious forms of narcissistic vulnerability" (p. 138) than the scales that were used in Study 1. The Grandiosity ("pseudo-autonomy") scale included items reflecting antisocial attitudes and a sense of independence, arrogance, entitlement and defensive anger. The Idealization scale ("peer-group dependence") emphasizes conformity, fear of separation from admired others, and the desire to be recognized by admired others. Lapan and Patton (1986) report satisfactory internal consistency for the grandiosity (KR-20 = .88) and idealization (KR-20 = .86) scales. The scales appear to be factorially distinct, and able to discriminate hospitalized from non-hospitalized adolescents. Internal consistency of the two scales in the present study was adequate for idealization ($\alpha = .78$.) but modest for grandiosity ($\alpha = .44$), which will set an upper limit on the magnitude of its observed correlation with other variables.

Mental health. The Hopkins Symptom Checklist (HSCL; Derogatis et al., 1974) requires participants to report the extent to which they have experienced each of 58 symptoms "in the past several days" along a four-step continuum (*not at all* to *extremely*). Higher scores indicate more psychiatric symptomatology. Scale items (symptoms) form several subscales, as follows: *somatization* (complaints of distress arising from perceptions of bodily dysfunction, $\alpha = .81$); *obsessive–compulsion* (reports of unremitting thoughts, concerns, impulses, behaviors, $\alpha = .85$); *anxiety* (restlessness and nervous tension, $\alpha = .77$); *depression* (dysphoria, hopelessness, lack of interest and motivation, $\alpha = .88$) and *interpersonal sensitivity* (feelings of personal inadequacy and inferiority, $\alpha = .80$). Strong evidence of factorial invariance and construct validity is reported by Derogatis et al. (1974).

As in Study 1, several of the College Adjustment Scales (CAS, Anton & Reed, 1991) were also used to assess various dimensions of mental health and adjustment. These scales included *anxiety* ($\alpha = .88$); *interpersonal problems* ($\alpha = .82$); *depression* ($\alpha = .85$); *esteem problems* ($\alpha = .88$); and *family problems* ($\alpha = .74$). Similarly, as in Study 1, the measure of pathology of separation-individuation ($\alpha = .92$) was included in order to assess the relational dysfunction that is theoretically associated with narcissistic disturbance, and to provide a reliable diagnostic marker for the interpretation of empirically derived narcissism clusters.

Results

Correlational analysis

The correlation between indices of narcissism and adjustment are reported in Table 3. As can be seen, the various narcissism scales were differentially correlated with the indices of adjustment and psychiatric symptomatology. As in Study 1, the leadership and vain exhibition dimensions of POND, for example, were significantly and negatively correlated with every measure of dysfunction and symptomatology, except somatization. The leadership scale was also negatively correlated with pathology of separation-individuation. In contrast, as in Study 1, the manipulative and assured recognition dimensions of POND were positively associated with PATHSEP and with most indices of dysfunctional adjustment. Similarly, as in Study 1, the competitive ambition dimension was largely unrelated to indices of mental health and adjustment, with the exception of PATHSEP although it did counterindicate esteem problems as expected, the idealizing and grandiosity scales were significantly and positively correlated with pathology of

Table 3
Correlation between indices of narcissism and adjustment: Study 2

Adjustment measures	NPI	Kohut measures[c]		Profile of narcissistic dispositions				
	Total score	Idealization	Grandiosity	Leadership	Vain exhibition	Competitive ambition	Manipulative	Assured recognition
Pathology of sep-ind	−.01	.41	.26	−.29	−.01	.17	.35	.31
Anxiety[a]	−.12	.40	.19	−.27	−.25	.01	.20	.24
Relationship problems[a]	−.03	.30	.29	−.27	−.17	.02	.34	.15
Depression[a]	−.09	.39	.27	−.28	−.24	.01	.22	.21
Esteem problems[a]	−.40	.58	.09	−.59	−.49	−.27	.12	.14
Family problems[a]	−.10	.21	.13	−.17	−.15	−.04	.13	.13
Somatization[b]	.02	.12	.21	−.01	.01	.07	.08	.14
Obsessive–compulsion[b]	−.06	.32	.25	−.25	−.15	.12	.25	.24
Sensitivity[b]	−.19	.47	.17	−.33	−.27	−.10	.22	.23
Depression[b]	−.16	.39	.18	−.28	−.24	−.09	.16	.22
Anxiety[b]	−.03	.36	.21	−.26	−.17	.06	.17	.20

Note: Pathology of sep-ind, pathology of separation-individuation; all correlations at least $r = .17$ are statistically significant ($p < .01$). Correlation among the narcissism scales are available from the first author upon request.

[a]College Adjustment Scales.

[b]Hopkins Symptom Checklist.

[c]Pseudo-autonomy and Peer Group Dependence.

separation-individuation and most indices of dysfunctional adjustment, although the pattern of correlations was stronger and more pervasive for idealization (perhaps reflecting its stronger internal consistency). This pattern was expected given that these scales were constructed to measure more serious vulnerabilities of the self. Finally, the narcissistic personality inventory (NPI total score) was negatively correlated with esteem problems and with sensitivity, but it was uncorrelated with other indices of adjustment Table 4.

Cluster analysis

A hierarchical cluster analysis, using Ward's agglomerative method, was performed on standardized narcissism scales. Three clusters were evident. The cluster centers from this analysis were then used as initial seeds in a *K*-means (non-hierarchical) cluster analysis, specifying three clusters. A one-factor (Cluster group) MANOVA was calculated on the linear combination of narcissism scales, revealing a significant multivariate effect (Pillai trace = 1.267, $F = 22.09, p < .001, \eta^2 = .633$). Univariate analyses indicated significant cluster group differences for each of the narcissism scales (all $p < .001$), and a pervasive pattern of significant contrasts, as indicated in Table 5. As in Study 1, the interpretation of the resulting cluster groups was guided by an internal analysis of the profile of significant differences among narcissism clusters, as well as by the diagnostic marker constructs (e.g. pathology of separation-individuation, NPI total score). The cluster group scores of the total NPI scale and pathology of separation-individuation, and narcissism scale effect sizes, are also noted in Table 5.

As can be seen, cluster group 1 reported significantly lower scores than the other cluster groups on all 7 NPI subscales and on 2 of 5 POND subscales (leadership, vain exhibition). However, cluster group 1 also reported the highest scores on idealization; and moderate scores for grandiosity and manipulativeness. Cluster group 3, in contrast, reported the highest scores on all of the NPI scales, the highest score on grandiosity, and the highest scores on 5 of the 6 POND scales. As in Study 1 the first and third cluster groups are mirror opposites, and were designated covert and overt narcissism clusters, respectively. In contrast, cluster group 2 reported a moderate score on the NPI scales; statistically higher scores than group 1 on 6 scales, and statistically lower scores than group 3 on 10 scales. Cluster group 2 also reported the lowest score on pathology of separation-individuation. Consequently, we designated group 2 the "adaptive narcissist" cluster.

Test of means

A gender (2) × cluster (3) MANOVA explored group differences on indices of CAS. A second gender × cluster MANOVA was performed on a linear combination of the HSCL subscales, using the narcissism clusters as the grouping variable. A one-way ANOVA explored cluster group differences on the measure of pathology of separation-individuation.

A significant multivariate effect was observed for the cluster group analysis of college adjustment scales (Pillai trace = .31, $F = 6.46, p < .001, \eta^2 = .15$) Post hoc ANOVA on CAS scales revealed significant cluster group effects for anxiety, $F(2, 185) = 8.43, p < .01, \eta^2 = .085$; for relationship problems, $F(2, 185) = 9.12, p < .01, \eta^2 = .091$; for depression, $F(2, 185) = 8.48, p < .01, \eta^2 = .085$; for esteem problems, $F(2, 185) = 22.21, p < .01, \eta^2 = .196$; and for family problems, $F(2, 185) = 8.36, p < .01, \eta^2 = .084$. The analysis of cluster group means using the Bonferroni procedure indicated that the adaptive cluster group reported significantly less anxiety, less relationship problems and less depressive symptoms than did the covert and overt narcissist

Table 4
Means, standard deviations and effect sizes of narcissism scales, by cluster group: Study 2

	Cluster group 1 covert $N = 75$		Cluster group 2 adaptive $N = 64$		Cluster group 3 overt $N = 55$		Effect size
	Mean	S.D.	Mean	S.D.	Mean	S.D.	η^2
POND							
Leadership	43.85[c]	.62	53.34[b]	.67	54.13[a]	.72	.451
Vain exhibition	36.41[c]	.79	43.29[b]	.85	48.40[a]	.92	.347
Competitive ambition	31.73[c]	.69	32.81[b]	.75	41.33[a]	.81	.324
Manipulative	25.92[b]	.63	20.75[c]	.68	30.40[a]	.74	.326
Assured recognition	27.63	.76	25.22[a]	.82	30.34[a]	.89	.085
Kohut measures							
Idealization	12.07[a]	.19	10.42[b]	.21	10.82[b]	.23	.154
Grandiosity	7.56[b]	.09	7.25[b]	.10	8.40[a]	.11	.248
NPI							
Authority	10.78[c]	.18	13.12[b]	.19	14.13[a]	.21	.464
Exhibitionism	7.99[b]	.16	8.09 [b]	.18	10.07[a]	.19	.299
Superiority	6.32[b]	.13	7.73[a]	.14	7.93[a]	.15	.313
Entitlement	6.73[b]	.10	7.02[b]	.11	8.44[a]	.12	.389
Exploitativeness	5.96[b]	.11	6.00[b]	.12	7.25[a]	.13	.253
Self-sufficiency	7.91[b]	.15	9.05[a]	.16	8.87[a]	.17	.147
Vanity	3.57[c]	.10	3.98[b]	.11	4.85[a]	.12	.253
NPI total score	49.52[c]	.48	55.38[b]	.46	61.78[a]	.49	.656

Note: Means with a different superscript are significantly different from each other (Bonferroni contrasts). NPI, Narcissistic Personality Inventory.

Table 5
Means and standard deviations of mental health variables, by cluster group: Study 2

	Cluster group 1 covert $N = 75$		Cluster group 2 adaptive $N = 64$		Cluster group 3 overt $N = 55$		Effect size
	Mean	S.D.	Mean	S.D.	Mean	S.D.	η^2
Pathology of sep-ind	137.98	41.19	98.71	36.25	143.32	48.59	.184
NPI total score	49.52	3.32	55.38	3.31	61.78	4.21	.656
College Adjustment Scales							
Anxiety	22.87[a]	7.36	17.72[b]	5.07	21.15[a]	6.91	.085
Relationship problems	21.65[a]	5.86	17.34[b]	5.17	21.30[a]	5.98	.091
Depression	20.17[a]	5.87	16.00[b]	3.77	19.13[a]	6.30	.085
Esteem problems	26.88[a]	5.99	19.56[b]	4.82	20.98[b]	6.07	.196
Family problems	18.43[a]	4.71	15.68[b]	3.95	17.61	4.01	.084
Hopkins Symptom Checklist							
Somatization	18.01	4.91	16.79[b]	4.26	18.98[a]	5.69	.046
Obsessive–compulsive	14.76[a]	4.77	11.03[b]	3.44	14.46[a]	4.80	.108
Interpersonal sensitivity	13.73[a]	4.56	10.12[b]	3.53	11.74[b]	4.42	.065
Depression	19.98[a]	6.89	15.03[b]	4.55	17.65	9.15	.067
Anxiety	8.91[a]	2.83	7.47[b]	1.85	9.15[a]	3.48	.066

Note: Means with a different superscript are significantly different from each other (Bonferroni contrasts). NPI, Narcissistic Personality Inventory; pathology of sep-ind, pathology of separation-individuation.

clusters, and less family problems than the covert narcissist group. In contrast, the covert and overt narcissist groups reported statistically equivalent levels of anxiety, relationship problems and depression, although the covert narcissist group did report significantly more esteem problems than the overt narcissist cluster. Means and standard deviations for these comparisons are reported in Table 5. The multivariate gender and gender × cluster Group interaction term were not statistically significant.

The analysis of the linear combination of Hopkins Symptom Checklist subscales revealed a significant multivariate effect for Cluster Group (Pillai trace = .155, $F = 3.09, p < .001, \eta^2 = .077$). Post hoc ANOVA on these scales revealed significant effects for somatization, $F(2, 187) = 4.55, p < .01, \eta^2 = .046$; obsessive–compulsion, $F(2, 187) = 11.35, p < .001, \eta^2 = .108$; for interpersonal sensitivity, $F(2, 190) = 6.50, p < .001, \eta^2 = .065$; for depression, $F(2, 190) = 6.74, p < .001, \eta^2 = .067$; and for anxiety, $F(2, 190) = 6.59, p < .01, \eta^2 = .066$. The analysis of cluster means using the Bonferroni procedure showed that both the overt and covert narcissist groups reported significantly more obsessive–compulsion and anxiety, compared to the adaptive narcissist group. Moreover, the covert narcissist group reported more interpersonal sensitivity and more depressive symptoms than did the overt narcissist group. The overt narcissist group reported significantly more somatization concerns than did the adaptive narcissist group. In contrast, the covert and overt narcissist groups were statistically equivalent on all of these scales except for interpersonal sensitivity, where the covert narcissist group reported more symptoms than the overt narcissist group. Means and standard deviations for these comparisons are reported in Table 5.

The multivariate gender effect was also statistically significant (Pillai trace = .07, $F = 2.83, p < .05, \eta^2 = .072$). Univariate analyses revealed significant gender mean differences for somatization, $F(1, 187) = 8.43, p < .01$; for interpersonal sensitivity, $F(1, 187) = 9.19, p < .01$; for depression, $F(1, 187) = 6.74, p < .05$; and for anxiety, $F(1, 187) = 6.59, p < .01$. In all cases females reported significantly higher scores than males.

A cluster group (3) × gender (2) ANOVA was calculated to determine group differences on pathology of separation-individuation. A significant cluster group effect was observed, $F(2, 186) = 20.67, p. < .000, \eta^2 = .184$. Post hoc comparisons using the Bonferroni procedure showed that covert and overt narcissists reported more pathology of separation-individuation than the adaptive narcissist group. The gender and interaction effects were not statistically significant.

As a manipulation check we also conducted a one-way ANOVA on the total NPI score using the narcissism clusters as the grouping variable. As expected, a significant main effect emerged, $F(2, 190) = 180.94, p. < .001, \eta^2 = .656$. Post hoc comparisons showed the overt, covert and adaptive narcissism clusters were significantly different from each other. Means and standard deviations for the indices of mental health by cluster group are reported in Table 5.

General discussion

In Study 2, we successfully identified three clusters of narcissism that were differentially related to indices of adjustment, symptomatology and pathology of separation-individuation. Participants in the overt and covert narcissist clusters reported significantly more college adjustment problems than did adaptive narcissists, and more pathology of separation individuation Overt

and covert narcissists reported more anxiety and more obsessive–compulsion than did adaptive narcissists. In addition the overt cluster reported more somatic complaints, and the covert cluster more symptoms of interpersonal sensitivity and depression, than did the adaptive narcissists. Although overt and covert narcissists were not statistically distinguishable on most measures of symptomatology, there was a tendency for covert narcissists to report a somewhat poorer profile of adjustment, a finding also noted in Study 1.

There is an interesting pattern of convergence across the two studies. Both studies show that a moderate degree of narcissism is associated with positive mental health. Hence, narcissistic tendencies in late adolescence are not invariably evidence of vulnerability or immaturity. Indeed, these data support an emerging consensus that "the presence of narcissistic tendencies in the personality actively serve to enhance psychological well-being and to promote good feelings about the self" (Davis, Claridge & Brewer, 1996, p. 163).

Moreover both studies were each able to demonstrate a typology of narcissism that reflects the expected theoretical complexity of the construct. The clinical developmental literature has long suggested the possibility of adaptive and maladaptive forms of narcissism, and that maladaptive narcissism can be manifested in overt or covert ways. The first suggestion is clearly demonstrated by the present data. The two studies each show that alongside adaptive narcissism there exist two types of dysfunctional narcissism. Moreover, the two studies also support the theoretical distinction between covert and overt forms of narcissism. In both studies, the overt narcissist cluster reported a pervasive pattern of high scores on most dimensions of narcissism, particularly those dimensions that might be expected to result in public display of narcissistic traits. In turn the covert pattern showed a pervasive pattern of low scores on many dimensions of narcissism but elevated scores on other dimensions.

In Study 1, for example, the covert narcissist cluster reported the lowest scores on the POND scales (leadership, vain exhibition, competitive ambition, manipulation, and assured recognition), but the highest scores on grandiosity and idealization. In Study 2, the covert cluster reported the lowest scores on 8 narcissism scales, but the highest score on idealization, and elevated scores on several others. One does get the sense, here, of narcissistic grandiosity and entitlement lurking behind a façade of personal inadequacy, inferiority and vulnerability. Of particular interest here is the strong tendency towards dysfunctional idealization revealed in both studies exhibited by covert narcissists, characterized by conformity, a desire to be recognized and admired by others and a fear of being separated from them. These separation anxiety features of covert narcissism perhaps explains why it accounts for twice the amount of variation in pathology of separation-individuation ($r = .41$) than does the dysfunctional grandiosity construct ($r = .26$), and why covert narcissism shows a relatively poorer profile of adjustment than does overt narcissism.

Finally, the two studies converge on the fact that overt and covert narcissism are significantly correlated with pathology of separation-individuation. The clinical-developmental literature has posited a theoretical linkage between separation-individuation and self-related functioning. Blos (1962) and others (Josselson, 1980) have argued that adolescents resort to narcissistic self-inflation to ward off the mourning reactions that attend separation-individuation. Moreover, narcissistic disorders are assumed to result when narcissistic tendencies are not successfully transmuted into creative lines of positive development (Kohut, 1986), or else have their developmental origins in patterns of separation-individuation that have gone awry (Lapsley & Rice, 1988). Hence, there is a clear theoretical expectation for dysfunctional narcissism to be significantly associated with

pathology of separation-individuation, as was demonstrated here. Moreover, both studies showed that although the overt and covert narcissism profile are both significantly related to a range of dysfunctional symptoms, the covert pattern shows a poorer profile of adjustment, a finding that replicates findings reported by Wink (1996).

The present data are congruent with three somewhat different theoretical traditions. It is congruent, first of all, with the strand of psychodynamic theory that suggests that narcissistic illusions represent the cutting edge of the growing, creative self (Mitchell, 1988). It was Winnicott's view, for example, that occasional dalliance with states of "subjective omnipotence" was critical for creative, healthy self-development. It is congruent, second of all, with social cognitive developmental claims that certain kinds of "personal fables," such as a sense of omnipotence and invulnerability, are associated with positive adjustment in adolescence (Lapsley, 1993). It is congruent, thirdly, with a social psychological claim that certain kinds of "positive illusions" are fundamental to adaptive mental health. Taylor and Brown (1988) argued, for example, that illusory over-valuation of the self, excessive optimism about one's personal future and illusions of personal control, serve to buffer stress, protect against depressive affect, and otherwise contribute to resilience in the face of disappointment, challenge and crisis. There is now an emerging consensus that these illusions might reflect adaptive forms of narcissism (Watson, Hickman, Morris, Milliron, & Whiting, 1994).

Indeed, it is interesting to note that a number of developmental assets identified by the Search Institute (Scales & Leffert, 1999) as being critical to positive youth development may also trade on these aspects of healthy narcissism. The perception of personal power or agentic influence over events (Asset 37), high self-esteem (Asset 38) and a positive view of one's personal future (Asset 40) are perhaps the sort of adaptive cognitions that derive from a healthy sense of narcissism. Hence, the narcissism construct holds much promise for integrative accounts of adolescent development across a number of theoretical traditions.

It is true that the characteristics of any empirically derived typology will vary depending on the assessments used in the cluster analysis. Firm conclusions about empirical typologies are warranted only after casting a wide nomological net and by replication, which was the general strategy used here. Although there is some inevitable warble in the results from Study 1 to Study 2, the two studies nonetheless demonstrate an impressive degree of convergence on some central findings. Narcissism can take adaptive and maladaptive forms, and maladaptive narcissism can be overt or covert, with the latter posing a somewhat larger risk of maladjustment.

The present studies would seem to raise an interesting question regarding the incidence of narcissistic tendencies and the prevalence of mental health in emerging young adults. For example, it would appear that nearly two-thirds of the university students sampled in these studies were exhibiting forms of narcissism that are clearly dysfunctional, resulting in maladaptive patterns of adjustment. Although university counseling centers are reporting an increase in the number of student clients who present with serious psychopathological symptoms (e.g. Robbins, May, & Corrazzini, 1985), the present data would not support the conclusion that most of the participants in these studies were demonstrating clinically significant psychopathology. This is evident when one notes that the narcissism typology accounts for nearly twice the amount of variation in the linear combination of college "adjustment" scales ($\eta^2 = .155$) than it accounts for in the linear combination of "psychiatric symptomatology" scales ($\eta^2 = .077$).

There are several limitations that should be noted. First, although the general typology of narcissism is broadly replicated across two samples, these samples are, nonetheless, highly similar with respect to participant characteristics. Replicating patterns of relationship among variables is certainly desirable, and this is an important feature of the present studies, but it should not be mistaken for generalizability. Similarly, although the ethno-racial composition of the two samples was broadly representative of the university population from which they were drawn, only additional research can determine whether the empirical typology observed here will generalize to more diverse samples. Third, although the internal consistency of most of the measures used in these studies was satisfactory for our purposes (see, e.g. Schmitt, 1996), the reliability of some scales, particularly two subscales of the Narcissistic Personality Inventory, was modest.

Although the present studies showed that narcissism was indeed related to pathology of separation-individuation, this question will need to be further addressed in samples of younger adolescents. Moreover, little is known about the presence of narcissism types in early adolescence, or whether narcissism shows a developmental trajectory from early to later adolescence, or has differential implications for mental health (Aalsma & Lapsley, 1999), or even if the extant assessments of narcissism are construct-valid for early adolescents. A sustained exploration of these topics will pay important dividends for understanding the dynamics of adolescent personality development.

References

Aalsma, M. C., & Lapsley, D. K. (1999). Religiosity and adolescent narcissism: implications for values counseling. *Counseling and Values*, *44*, 17–29.

Anton, W. D., & Reed, J. R. (1991). *College adjustment scales*. Psychological Resources Inc.

Bleiberg, E. (1994). Normal and pathological narcissism in adolescence. *American Journal of Psychotherapy*, *48*, 30–55.

Blos, P. (1962). *On adolescence*. New York: Free Press.

Christenson, R. M., & Wilson, W. P. (1985). Assessing pathology in the separation-individuation process by an inventory. *Journal of Nervous and Mental Disease*, *173*, 561–565.

Davis, C., Claridge, G., & Brewer, H. (1996). The two faces of narcissism: personality dynamics of body esteem. *Journal of Social and Clinical Psychology*, *15*, 153–166.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The Hopkins symptom checklist (HSCL): a self-report inventory. *Behavioral Science*, *19*, 1–15.

Emmons, R. A. (1984). Factor analysis and construct validity of the Narcissistic Personality Inventory. *Journal of Personality Assessment*, *48*, 291–300.

Heir, J. F., Anderson, R. E., Tatham, R. L., & Black, W. L. (1995). *Multivariate data analysis*. New Jersey: Prentice-Hall.

Josselson, R. (1980). Ego development in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology* (pp. 188–210). New York: Wiley.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York: Jason Aronson.

Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.

Kohut, H. (1986). Forms and transformations of narcissism. In A. P. Morrison (Ed.), *Essential papers on narcissism* (pp. 61–87). New York: New York University Press.

Lapan, R., & Patton, M. J. (1986). Self psychology and the adolescent process: measures of pseudo-autonomy and peer-group dependence. *Journal of Counseling Psychology*, *33*, 236–241.

Lapsley, D. K. (1993). Towards an integrated theory of adolescent ego development: the new look at adolescent egocentrism. *American Journal of Orthopsychiatry*, *63*, 562–571.

Lapsley, D. K., Aalsma, M., & Varshney, N. (2001). A factor analytic and psychometric examination of pathology of separation-individuation. *Journal of Clinical Psychology*, *57*, 915–932.

Lapsley, D. K., & Edgerton, J. (2002). Separation-individuation, adult attachment style and college adjustment. *Journal of Counseling and Development*, *80*, 485–493.

Lapsley, D. K., & Rice, K. G. (1988). The New Look at the imaginary audience and personal fable: toward a general model of adolescent ego development. In D. K. Lapsley, & F. Clark Power (Eds.), *Self, ego, identity: integrative approaches* (pp. 109–129). New York: Springer.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: an integration*. Cambridge, MA: Harvard University Press.

Raskin, R., & Terry, H. (1988). A principal components analysis of the Narcissistic Personality Inventory and further evidence of its construct validity. *Journal of Personality and Social Psychology*, *54*, 890–902.

Raskin, R., & Novacek, J. (1989). An MMPI description of the narcissistic personality. *Journal of Personality Assessment*, *53*, 66–80.

Rhodewalt, F., & Morf, C. C. (1995). Self and interpersonal correlates of the Narcissistic Personality Inventory: a review and new findings. *Journal of Research in Personality*, *29*, 1–23.

Robbins, S. B. (1989). Validity of the superiority and goal instability scales as measures of defects in the self. *Journal of Personality Assessment*, *53*, 122–132.

Robbins, S. B., May, T. M., & Corrazzini, J. G. (1985). Perceptions of client needs and counseling center staff roles and functions. *Journal of Counseling Psychology*, *32*, 641–664.

Robbins, S. B., & Patton, M. (1985). Self psychology and career development: construction of the superiority and goal instability scales. *Journal of Counseling Psychology*, *32*, 221–231.

Robins, S. B., & Schwitzer, A. (1988). A validity study of the superiority and goal instability scales as predictors of women's adjustment to college life. *Measurement and Evaluation in Counseling and Development*, *21*, 117–123.

Rose, P. (2002). The happy and unhappy faces of narcissism. *Personality and Individual Differences*, *33*, 379–391.

Scales, P. C., & Leffert, N. (1999). *Developmental assets: a synthesis of the scientific research on adolescent development*. Minneapolis: Search Institute.

Schmitt, N. (1996). Uses and abuses of coefficient alpha. *Psychological Assessment*, *8*, 350–353.

Scott, K., & Robbins, S. (1985). Goal instability: implications for academic performance among students in learning skills classes. *Journal of College Student Personnel*, *23*, 378–383.

Taylor, C.M. (1995). *The profile of narcissistic dispositions (POND)*. Unpublished Doctoral Dissertation, University of British Columbia.

Taylor, S., & Brown, J. D. (1988). Illusion and well-being: a social-psychological perspective on mental health. *Psychological Bulletin*, *103*, 193–210.

Watson, P. J., Grisham, S. O., Trotter, M. V., & Biderman, M. D. (1984). Narcissism and empathy: validity evidence for the Narcissistic Personality Inventory. *Journal of Personality Assessment*, *48*, 301–305.

Watson, P. J., Hickman, S. E., Morris, R. J., Milliron, J. T., & Whiting, L. (1994). Narcissism, self-esteem, and parental nurturance. *The Journal of Psychology*, *129*, 61–73.

Wink, P. (1991). Two faces of narcissism. *Journal of Personality and Social Psychology*, *61*, 590–597.

Wink, P. (1992a). Three types of narcissism in women from college to mid-life. *Journal of Personality*, *60*, 7–30.

Wink, P. (1992b). Three narcissism scales for the California Q-set. *Journal of Personality Assessment*, *58*, 51–66.

Wink, P. (1996). Narcissism. In C. G. Costello (Ed.), *Personality characteristics of the personality disordered* (pp. 146–172). New York: Wiley.

Winnicott, D. W. (1965). *The maturational process and the facilitating environment*. New York: International Universities Press.