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Journal of Adolescence ■ (■■■■) ■■■-■■■

Journal of
Adolescence

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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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1 Introduction

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

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

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

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

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

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

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

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

1 In the present studies, we attempted to explore the heterogeneity of narcissism in a novel way.
2 Using cluster analytic techniques, and many of the extant measures of narcissism, we hoped to
3 identify a theoretically useful typology of narcissism. In contrast to previous research that
4 correlates narcissism factor scores or *Q*-set ratings with personality inventories, we attempted to
5 examine the relationship between narcissism clusters and multiple indices of adjustment, such as
6 anxiety, interpersonal problems, depression, self-esteem disturbance, and family problems. We
7 also explored the relationship between the narcissism clusters and pathology of separation-
8 individuation, which is the principal ego developmental process that is thought to invite
9 narcissistic defenses. We anticipated that our analytic strategy would reveal three forms of
10 narcissism suggested by the clinical developmental literature.
11

13 Study 1

15 Method

17 Participants

19 Subjects included 204 late adolescents (137 females, 67 males) attending a mid-sized,
20 Midwestern state university. The mean age of the participants was 20.54 years (s.d. = 2.06).
21 Participants were predominately White/Caucasian (91.2%) and Black/African-American (7.4%),
22 a distribution that reflects the ethno-racial composition of this university community.
23 Approximately, 21% of the participants were freshman ($N = 43$); 36% were sophomores
24 ($N = 74$); 20% were juniors ($N = 40$); and 23% were seniors ($N = 47$). Participants were
25 volunteers solicited from developmental and educational psychology classes for nominal course
26 credit.
27

27 Instruments and procedure

29 *Narcissism.* Participants responded to the profile of narcissistic dispositions (POND) and a
30 measure of grandiosity (“superiority”) and idealization (“goal instability”) inspired by Kohut’s
31 theory.

32 The POND was developed by Taylor (1995) to assess normal manifestations of narcissism.
33 Items are responded to along a six-step Likert-type continuum (1 = *strongly agree* to 6 = *strongly*
34 *disagree*). The POND consists of five subscales. The *assured leadership* scale ($\alpha = .75$) consists of
35 12 items that assess the extent to which one perceives the self to have effective leadership qualities.
36 The *manipulativeness* scale ($\alpha = .64$) consists of nine items that reflect approval or admission of
37 tendencies toward interpersonal manipulation. The *public recognition* scale ($\alpha = .68$) consists of
38 nine items that indicate public self-consciousness and the need for favourable notice by others.
39 The *vain exhibition* scale ($\alpha = .69$) consists of 11 items that measure the extent to which one
40 perceives the physical self to be a pleasing stimulus for others. Finally, the *competitive ambition*
41 scale ($\alpha = .57$) consists of 10 items that reflect assertive ambition to the very boundaries of social
42 convention. According to Taylor (1995), the core of POND narcissism is non-pathological,
43 healthy and free of psychosocial distress. The psychometric integrity and construct validity of the
POND is demonstrated by several studies reported by Taylor (1995).

1 The “goal instability” and “superiority” scales were used to assess defects along the idealization
2 and grandiosity lines of development, respectively, as articulated by Kohut’s theory. The goal
3 instability scale ($\alpha = .74$) consists of 10 items that reflect a lack of goal-directedness and failure to
4 idealize adaptive or realistic goals (and hence a defect in idealization). The “superiority” scale
5 ($\alpha = .83$) consists of 10 items that reflect grandiose self-assertion. Research has shown that the
6 goal instability (idealization) scale predicts adjustment to college (Robbins & Schwitzer, 1988),
7 academic performance (Scott & Robbins, 1985) and career development (Robbins & Patton,
8 1985). Robbins (1989) also reported that the superiority (grandiosity) scale was related to social
9 gregariousness, interpersonal exploitation and impulsivity, while the goal instability (idealization)
10 scale was related to a pattern of social withdrawal, depression and lack of ambition or goals.

11 *Adjustment.* The College Adjustment Scales (CAS, Anton & Reed, 1991) were used to assess
12 various dimensions of mental health and adjustment. The CAS can be used as a screen for
13 common developmental and psychological problems faced by college students. It consists of nine
14 subscales, only five of which were used in the present study. The *anxiety* scale (12 items, $\alpha = .85$) is
15 a measure of clinical anxiety, focusing on common affective, cognitive and physiological
16 symptoms. The *interpersonal problems* (12 items, $\alpha = .79$) scale measures the extent of problems in
17 one’s relational field. The *depression* scale (12 items, $\alpha = .84$) is a measure of depressive symptoms.
18 The *esteem problems* scale (12 items, $\alpha = .81$) is a measure of global self-esteem that taps negative
19 self-evaluations and dissatisfaction with personal achievement. The *family problems* (12 items,
20 $\alpha = .81$) scale taps difficulties experienced in family relationships. Higher scores represent more
21 adjustment problems in each domain. The extensive literature on the construct validity of these
22 scales is summarized by Anton and Reed (1991).

23 Finally, we included a measure of pathology of separation-individuation ($\alpha = .89$) developed by
24 Christenson and Wilson (1985). This measure is a 39-item Likert-type scale that assesses
25 differentiation issues, splitting, and relational disturbances in one’s interpersonal field.
26 Preliminary research shows that the scale has a unitary factor structure and distinguishes clinical
27 subjects from normal controls (Christenson & Wilson, 1985). It is also internally consistent, and
28 differentially predicts secure and insecure adult attachment (Lapsley & Edgerton, 2002), and
29 numerous indices of psychiatric symptomatology and adjustment (Lapsley, Aalsma, & Varshney,
30 2001). We included this measure as a diagnostic guide to the interpretation of the empirically
31 derived narcissism clusters. Insofar as narcissistic disturbances are theoretically linked to faults in
32 separation-individuation, we expected this measure of pathology of separation-individuation to
33 be strongly related to maladaptive forms of narcissism.

35 *Results*

37 *Correlational analysis*

39 We first examined the pattern of bivariate relationships among the measures used in this study
40 in order to provide an interpretive context for our efforts to derive a typology of narcissism by
41 means of cluster analysis. The correlation among the measures used in this study is reported in
42 Table 1. Given the number of correlations we proceeded conservatively by considering only those
43 correlations statistically significant at $p < .01$. Several patterns are of interest. First, the Kohut
44 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.

^aCollege Adjustment Scales.

^bGoal 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.
<i>POND</i>						
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
<i>Kohut measures</i>						
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
<i>Pathology of sep-ind</i>	127.42 ^b	33.85	80.44 ^c	18.65	139.12 ^a	37.79
<i>College adjustment</i>						
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 idealization 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.

1 Tests of means

3 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
5 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
7 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, $F(2, 191) =$
9 $14.59, p < .001, \eta^2 = .133$; 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,
11 $F(2, 191) = 44.72, p < .001, \eta^2 = .319$. Post hoc analysis using the Bonferroni procedure revealed
the following significant differences among the cluster groups: adaptive narcissists had
13 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
15 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
17 separation-individuation. However, covert narcissists indicated significantly more esteem
problems and family problems than did overt narcissists. The multivariate Gender and interaction
19 effect were not statistically significant. Means and standard deviations of indices of adjustment by
cluster group are also reported in Table 2.

21

23 Discussion

23

In this study, we identified three clusters of narcissists that were differentially related to indices
25 of symptomatology and pathology of separation-individuation. Participants in the adaptive
cluster reported significantly lower scores on measures of anxiety, relationship problems,
27 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
29 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
31 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
33 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,
35 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
37 poor adjustment than the overt pattern, a finding that is also reported elsewhere in the literature
(Wink, 1996).

39

41 Study 2

43 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

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

13 Method

15 Participants

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

21 Instruments and procedure

22 *Narcissism.* Participants responded to standard assessments of narcissism, including the NPI,
23 the POND, and new measures of grandiosity (“Pseudo-autonomy”) and idealization (“peer group
24 dependence”) inspired by Kohut’s theory.

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

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

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

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

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

31 *Results*

33 *Correlational analysis*

34 The correlation between indices of narcissism and adjustment are reported in Table 3. As can be
 35 seen, the various narcissism scales were differentially correlated with the indices of adjustment and
 36 psychiatric symptomatology. As in Study 1, the leadership and vain exhibition dimensions of
 37 POND, for example, were significantly and negatively correlated with every measure of
 38 dysfunction and symptomatology, except somatization. The leadership scale was also negatively
 39 correlated with pathology of separation-individuation. In contrast, as in Study 1, the
 40 manipulative and assured recognition dimensions of POND were positively associated with
 41 PATHSEP and with most indices of dysfunctional adjustment. Similarly, as in Study 1, the
 42 competitive ambition dimension was largely unrelated to indices of mental health and adjustment,
 43 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.

^aCollege Adjustment Scales.

^bHopkins Symptom Checklist.

^cPseudo-autonomy and Peer Group Dependence.

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

7 *Cluster analysis*

8 A hierarchical cluster analysis, using Ward's agglomerative method, was performed on
 9 standardized narcissism scales. Three clusters were evident. The cluster centers from this analysis
 10 were then used as initial seeds in a *K*-means (non-hierarchical) cluster analysis, specifying three
 11 clusters. A one-factor (Cluster group) MANOVA was calculated on the linear combination of
 12 narcissism scales, revealing a significant multivariate effect (Pillai trace = 1.267,
 13 $F = 22.09, p < .001, \eta^2 = .633$). Univariate analyses indicated significant cluster group differences
 14 for each of the narcissism scales (all $p < .001$), and a pervasive pattern of significant contrasts, as
 15 indicated in Table 5. As in Study 1, the interpretation of the resulting cluster groups was guided by
 16 an internal analysis of the profile of significant differences among narcissism clusters, as well as by
 17 the diagnostic marker constructs (e.g. pathology of separation-individuation, NPI total score).
 18 The cluster group scores of the total NPI scale and pathology of separation-individuation, and
 19 narcissism scale effect sizes, are also noted in Table 5.

20 As can be seen, cluster group 1 reported significantly lower scores than the other cluster groups
 21 on all 7 NPI subscales and on 2 of 5 POND subscales (leadership, vain exhibition). However,
 22 cluster group 1 also reported the highest scores on idealization; and moderate scores for
 23 grandiosity and manipulateness. Cluster group 3, in contrast, reported the highest scores on all
 24 of the NPI scales, the highest score on grandiosity, and the highest scores on 5 of the 6 POND
 25 scales. As in Study 1 the first and third cluster groups are mirror opposites, and were designated
 26 covert and overt narcissism clusters, respectively. In contrast, cluster group 2 reported a moderate
 27 score on the NPI scales; statistically higher scores than group 1 on 6 scales, and statistically lower
 28 scores than group 3 on 10 scales. Cluster group 2 also reported the lowest score on pathology of
 29 separation-individuation. Consequently, we designated group 2 the "adaptive narcissist" cluster.
 30

31 *Test of means*

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

36 A significant multivariate effect was observed for the cluster group analysis of college
 37 adjustment scales (Pillai trace = .31, $F = 6.46, p < .001, \eta^2 = .15$) Post hoc ANOVA on CAS scales
 38 revealed significant cluster group effects for anxiety, $F(2, 185) = 8.43, p < .01, \eta^2 = .085$; for
 39 relationship problems, $F(2, 185) = 9.12, p < .01, \eta^2 = .091$; for depression, $F(2, 185) =$
 40 $8.48, p < .01, \eta^2 = .085$; for esteem problems, $F(2, 185) = 22.21, p < .01, \eta^2 = .196$; and for family
 41 problems, $F(2, 185) = 8.36, p < .01, \eta^2 = .084$. The analysis of cluster group means using the
 42 Bonferroni procedure indicated that the adaptive cluster group reported significantly less anxiety,
 43 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 <i>N</i> = 75		Cluster group 2 adaptive <i>N</i> = 64		Cluster group 3 overt <i>N</i> = 55		Effect size η^2
	Mean	s.D.	Mean	s.D.	Mean	s.D.	
<i>POND</i>							
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
<i>Kohut measures</i>							
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
<i>NPI</i>							
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
<i>NPI total score</i>	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.

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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
<i>College Adjustment Scales</i>							
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
<i>Hopkins Symptom Checklist</i>							
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.

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

7 The analysis of the linear combination of Hopkins Symptom Checklist subscales revealed a
8 significant multivariate effect for Cluster Group (Pillai trace = .155, $F = 3.09, p < .001, \eta^2 = .077$).
9 Post hoc ANOVA on these scales revealed significant effects for somatization, $F(2, 187) =$
10 $4.55, p < .01, \eta^2 = .046$; obsessive-compulsion, $F(2, 187) = 11.35, p < .001, \eta^2 = .108$; for interper-
11 sonal sensitivity, $F(2, 190) = 6.50, p < .001, \eta^2 = .065$; for depression, $F(2, 190) =$
12 $6.74, p < .001, \eta^2 = .067$; and for anxiety, $F(2, 190) = 6.59, p < .01, \eta^2 = .066$. The analysis of
13 cluster means using the Bonferroni procedure showed that both the overt and covert narcissist
14 groups reported significantly more obsessive-compulsion and anxiety, compared to the adaptive
15 narcissist group. Moreover, the covert narcissist group reported more interpersonal sensitivity and
16 more depressive symptoms than did the overt narcissist group. The overt narcissist group reported
17 significantly more somatization concerns than did the adaptive narcissist group. In contrast, the
18 covert and overt narcissist groups were statistically equivalent on all of these scales except for
19 interpersonal sensitivity, where the covert narcissist group reported more symptoms than the
20 overt narcissist group. Means and standard deviations for these comparisons are reported in
21 Table 5.

22 The multivariate gender effect was also statistically significant (Pillai trace = .07,
23 $F = 2.83, p < .05, \eta^2 = .072$). Univariate analyses revealed significant gender mean differences
24 for somatization, $F(1, 187) = 8.43, p < .01$; for interpersonal sensitivity, $F(1, 187) = 9.19, p < .01$;
25 for depression, $F(1, 187) = 6.74, p < .05$; and for anxiety, $F(1, 187) = 6.59, p < .01$. In all cases
26 females reported significantly higher scores than males.

27 A cluster group (3) \times gender (2) ANOVA was calculated to determine group differences on
28 pathology of separation-individuation. A significant cluster group effect was observed,
29 $F(2, 186) = 20.67, p < .000, \eta^2 = .184$. Post hoc comparisons using the Bonferroni procedure
30 showed that covert and overt narcissists reported more pathology of separation-individuation
31 than the adaptive narcissist group. The gender and interaction effects were not statistically
32 significant.

33 As a manipulation check we also conducted a one-way ANOVA on the total NPI score using
34 the narcissism clusters as the grouping variable. As expected, a significant main effect emerged,
35 $F(2, 190) = 180.94, p < .001, \eta^2 = .656$. Post hoc comparisons showed the overt, covert and
36 adaptive narcissism clusters were significantly different from each other. Means and standard
37 deviations for the indices of mental health by cluster group are reported in Table 5.

39 General discussion

40 In Study 2, we successfully identified three clusters of narcissism that were differentially related
41 to indices of adjustment, symptomatology and pathology of separation-individuation. Partici-
42 pants in the overt and covert narcissist clusters reported significantly more college adjustment

1 problems than did adaptive narcissists, and more pathology of separation individuation Overt
2 and covert narcissists reported more anxiety and more obsessive-compulsion than did adaptive
3 narcissists. In addition the overt cluster reported more somatic complaints, and the covert cluster
4 more symptoms of interpersonal sensitivity and depression, than did the adaptive narcissists.
5 Although overt and covert narcissists were not statistically distinguishable on most measures of
6 symptomatology, there was a tendency for covert narcissists to report a somewhat poorer profile
7 of adjustment, a finding also noted in Study 1.

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

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

25 In Study 1, for example, the covert narcissist cluster reported the lowest scores on the POND
26 scales (leadership, vain exhibition, competitive ambition, manipulation, and assured recognition),
27 but the highest scores on grandiosity and idealization. In Study 2, the covert cluster reported the
28 lowest scores on 8 narcissism scales, but the highest score on idealization, and elevated scores on
29 several others. One does get the sense, here, of narcissistic grandiosity and entitlement lurking
30 behind a façade of personal inadequacy, inferiority and vulnerability. Of particular interest here is
31 the strong tendency towards dysfunctional idealization revealed in both studies exhibited by
32 covert narcissists, characterized by conformity, a desire to be recognized and admired by others
33 and a fear of being separated from them. These separation anxiety features of covert narcissism
34 perhaps explains why it accounts for twice the amount of variation in pathology of separation-
35 individuation ($r = .46$) than does the dysfunctional grandiosity construct ($r = .21$), and why
36 covert narcissism shows a relatively poorer profile of adjustment than does overt narcissism.

37 Finally, the two studies converge on the fact that overt and covert narcissism are significantly
38 correlated with pathology of separation-individuation. The clinical-developmental literature has
39 posited a theoretical linkage between separation-individuation and self-related functioning. Blos
40 (1962) and others (Josselson, 1980) have argued that adolescents resort to narcissistic self-inflation
41 to ward off the mourning reactions that attend separation-individuation. Moreover, narcissistic
42 disorders are assumed to result when narcissistic tendencies are not successfully transmuted into
43 creative lines of positive development (Kohut, 1986), or else have their developmental origins in
44 patterns of separation-individuation that have gone awry (Lapsley & Rice, 1988). Hence, there is a

1 clear theoretical expectation for dysfunctional narcissism to be significantly associated with
2 pathology of separation-individuation, as was demonstrated here. Moreover, both studies showed
3 that although the overt and covert narcissism profile are both significantly related to a range of
4 dysfunctional symptoms, the covert pattern shows a poorer profile of adjustment, a finding that
5 replicates findings reported by Wink (1996).

6 The present data are congruent with three somewhat different theoretical traditions. It is
7 congruent, first of all, with the strand of psychodynamic theory that suggests that narcissistic
8 illusions represent the cutting edge of the growing, creative self (Mitchell, 1988). It was
9 Winnicott's view, for example, that occasional dalliance with states of "subjective omnipotence"
10 was critical for creative, healthy self-development. It is congruent, second of all, with social
11 cognitive developmental claims that certain kinds of "personal fables," such as a sense of
12 omnipotence and invulnerability, are associated with positive adjustment in adolescence (Lapsley,
13 1992). It is congruent, thirdly, with a social psychological claim that certain kinds of "positive
14 illusions" are fundamental to adaptive mental health. Taylor and Brown (1988) argued, for
15 example, that illusory over-valuation of the self, excessive optimism about one's personal future
16 and illusions of personal control, serve to buffer stress, protect against depressive affect, and
17 otherwise contribute to resilience in the face of disappointment, challenge and crisis. There is now
18 an emerging consensus that these illusions might reflect adaptive forms of narcissism (Watson,
19 Hickman, Morris, Milliron, & Whiting, 1994).

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

27 It is true that the characteristics of any empirically derived typology will vary depending on the
28 assessments used in the cluster analysis. Firm conclusions about empirical typologies are
29 warranted only after casting a wide nomological net and by replication, which was the general
30 strategy used here. Although there is some inevitable warble in the results from Study 1 to Study
31 2, the two studies nonetheless demonstrate an impressive degree of convergence on some central
32 findings. Narcissism can take adaptive and maladaptive forms, and maladaptive narcissism can be
33 overt or covert, with the latter posing a somewhat larger risk of maladjustment.

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

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

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

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23 Wink (1991b).

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