Published in final edited form as:
Clin Gerontol. 2011 January ; 34(1): 71–87. doi:10.1080/07317115.2011.524821.

The Presentation of Narcissistic Personality Disorder in an Octogenarian: Converging Evidence from Multiple Sources

STEVE BALSIS, PhD,
Texas A&M University, College Station, Texas, USA

NICHOLAS R. EATON, MA,
University of Minnesota, Minneapolis, Minnesota, USA

LUKE D. COOPER, MA, and
Texas A&M University, College Station, Texas, USA

THOMAS F. OLTMANNS, PhD
Washington University, St. Louis, Missouri, USA

Abstract

Little is known about personality disorders (PDs) in later life. One reason for this dearth of knowledge is that many investigators believe that PDs soften with age. Recent anecdotal and empirical evidence, however, suggests that PDs are still very relevant in later life and may actually have unique presentations and consequences. The DSM-IV PD criteria seem to overlook these possibilities, perhaps because the personalities of older adults were not sufficiently understood when these criteria were written. But without age-appropriate criteria, clinicians and investigators who work with older adults may be unable to measure PDs adequately in their clients and research participants. A starting point for better understanding these disorders in older adults is the presentation of rich, empirical, clinical descriptions of symptoms and related behaviors using data from multiple instruments and sources. To this end, we describe in depth a case of narcissistic PD (NPD) in a woman in her mid 80s. This case study reveals that NPD is indeed relevant in the context of later life and impairs functioning in significant ways.

Keywords

aging; *case study*; *narcissism*; *personality disorder*

Little is known about personality disorders (PDs) in later life. One reason for this dearth of knowledge is that many investigators believe that PDs mellow or soften with age (e.g., Kenan et al., 2000). Despite this widespread belief, several case studies (e.g., Jacobowitz & Newton, 1999) and some limited empirical findings (e.g., Abrams, Spielman, Alexopoulos,

Address correspondence to Steve Balsis, Department of Psychology, Texas A&M University, College Station, TX 77845, USA. balsis@tamu.edu.

& Klausner, 1998; Vine & Steingart, 1994) have indicated that PDs can indeed persist into later life and can have clinically significant, deleterious effects in older adults.

One PD that might be especially problematic in later life is narcissistic PD (NPD). Individuals in later life may find themselves confronting declines in their physical attractiveness, cognitive and intellectual abilities, and health. Although older adults who are psychologically healthy may adjust well to these changes, older adults with NPD may feel threatened by them. Consider an older adult with an inflated self-concept rooted in physical beauty. When younger, this person may have devoted a great deal of energy to the maintenance of a perfect physique. When older, however, he or she may face psychological challenges related to the natural course of physiological aging such as decreased muscle tone and wrinkling skin. Adapting to these natural changes may be difficult for the narcissistic older adult, because these changes may threaten the very foundation of his or her identity/defense structure.

In addition to potential negative consequences for the self, the presence of NPD in later life may have unique interpersonal consequences. As individuals age, for example, they are often forced to rely more on family members for support (Antonucci & Akiyama, 1997). While psychologically healthy older adults might have little problem asking family members for help, narcissistic older adults might experience shame or vulnerability resulting from this threat to their prized autonomy. As a result, older adults with NPD may decide not to ask others for assistance. But by failing to request necessary support, these older adults may experience increased difficulty with necessary daily activities such as cooking, medical needs, and basic hygiene. Even when an older adult with NPD may be willing to request necessary assistance, he or she may do so in an inappropriate way, based on feelings of entitlement to special privileges or status. The potentially abrasive personality features that were present throughout life may also now limit the number of family members available or willing to help. Indeed, relatives may have distanced themselves over the years due to interpersonal conflicts and tensions that frequently accompany NPD.

As these examples suggest, the presentation of NPD in older adults may have unique manifestations and consequences. Unfortunately, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (*DSM-IV*; American Psychiatric Association [APA], 1994) PD system does not closely consider the context of later life (e.g., Balsis, Segal, & Donahue, 2009). To the contrary, the developers of the current and previous *DSM* editions may not have adequately considered later life when creating the diagnostic criteria. Perhaps as a result of this unintentional neglect, many *DSM-IV* PD diagnostic criteria contain age-related measurement bias (Balsis, Woods, Gleason, & Oltmanns, 2007).

The NPD criterion, “is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love” (APA, 1994, p. 661), for example, may measure NPD pathology differently for older and younger adults (Agronin & Maletta, 2000): While younger adults with NPD may have active current or prospective fantasy lives, older adults with NPD may retrospectively dwell on past achievements. As a consequence, younger adults seem more likely than older adults, to endorse this diagnostic criterion even though the criterion may still be present “in spirit” in older adults. Potentially problematic criteria such as this one raise questions about the reasons why some NPD diagnostic criteria may contain measurement bias across age. One likely explanation is simply that the authors of the modern *DSM*s were not familiar with (or particularly concerned about) the manifestation of narcissism in later life. This, of course, is not the fault of those authors. Even now, little is known about NPD in older adults, and its unique presentation and consequences remain inadequately described in the literature. To help address this knowledge gap, it is important to describe clinical cases of NPD (and other PDs) in older adults. Rich, descriptive case

presentations of NPD in later life should help mental health researchers and practitioners better recognize and diagnose this disorder.

Case studies of NPD require the consideration of several issues. Expecting grandiose individuals who lack insight to provide accurate self-reports of their personalities may be unrealistic (Oltmanns & Turkheimer, 2006), as they may be unable or unwilling to admit the pathological aspects of their personalities. Supplementing self-reported data with information gathered from informants may therefore be a necessary practice to ensure that the data accurately reflect the target individual. Additionally, case studies of *older adults* with NPD provide their own set of challenges. For example, many NPD assessments have been based on the *DSM* PD criteria, which may contain age-related measurement bias. Hence, converging evidence from multiple instruments (e.g., clinical interviews, self-report inventories, etc.) may be needed to meet the challenge of assessing NPD in an individual whose age group was not closely considered when the *DSM* diagnostic criteria were developed. The assessment of PDs in older adults definitely presents a number of important challenges (e.g., Zweig, 2008). However, given what some authors have referred to as the "geriatric crisis" of providing mental health care to the growing population of older adults (Jeste et al., 1999), these challenges must be met. Not until we have detailed descriptions of the presentation of NPD in later life can we develop diagnostic criteria that allow us to identify and diagnose it well. As a step in the process toward a better understanding of NPD in older adults, we present the case of "NAS."

METHODS

Participant

The participant for this case study is a Caucasian, 85-year-old, divorced (twice) woman who has one daughter. To protect her identity, we will refer to her as NAS and have altered minor details of her life. NAS is the youngest of three siblings and has one older brother and one older sister. Her father died when she was a toddler. NAS had regular contact with her mother, but her rearing environment was not stable; by age 18, NAS had lived in 15 houses and attended 20 schools. NAS first married at age 20; this marriage lasted only 1 year. NAS's second marriage (at age 30) lasted 4 years. Her daughter, who NAS gave birth to when she was 32, was sired by her second husband; NAS is in periodic contact with her daughter. NAS holds a Master's degree in the liberal arts, and worked in mostly office settings overseeing clerical employees. NAS is active for her age and is in relatively good physical health.

Procedure

Over the course of three meetings that spanned a period of two months, we administered to NAS a comprehensive battery of instruments and interviews (described subsequently) to assess her present self. On three of the personality-related measures, we also asked her to respond from the perspective of her younger self so that we could analyze the effects of aging on her personality. Specifically, we asked NAS to select a five year span of her life that was clearly demarcated by memorable events. She chose the period between the end of her first marriage and the time of her second marriage (approximately ages 30 to 35 years). By using these two "anchor points" to demarcate a discrete period of her life, we hoped NAS's retrospective reports would be more reliable than if we defined an arbitrary age range, especially given recent evidence that retrospective reports yield marked underestimates of past psychopathology (Moffitt et al., 2010).

NAS provided us with written consent to use all gathered information in an article for publication, and even remarked at one point, "My brother always told me that I'd be a case

study." Her willingness to undergo such extensive testing may have been related to the fact that our inquiries allowed her to explore herself while simultaneously receiving attention from "powerful" others (i.e., researchers).

Measures of Personality

To assess for the presence of personality pathology, we administered the Structured Interview for *DSM-IV* Personality (SIDP-IV; Pfohl, Blum, & Zimmerman, 1997), a widely-used interview for the assessment of personality disorders. With permission from NAS, we collected SIDP-IV informant-reports of current personality functioning from three individuals of her choice. To determine how the manifestations of NPD may have changed with age, we later asked NAS to respond to the SIDP-IV questions as she would have answered them during her previously-chosen five year span.

To obtain additional NPD-related information, we asked NAS to complete two self-report questionnaires: the Narcissism Personality Inventory (NPI; Raskin & Hall, 1979; Raskin & Terry, 1988) and the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). In the current study, we administered the 40-item version of the NPI, which has acceptable psychometric properties (del Rosario & White, 2005). Because levels of self-esteem are positively related to narcissism (e.g., Raskin, Novacek, & Hogan, 1991), NAS's RSES score should provide evidence that would complement her score on the NPI and shed additional light on the ways in which she thinks about herself.

To assess NAS's current and previous general personality, we administered the NEO Personality Inventory Revised (NEO PI-R; Costa & McCrae, 1992), a leading measure of personality that is based on the Five Factor Model, which assumes personality can be understood in terms of five relatively stable factors: Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. As with the NPD items from the SIDP-IV, we also asked NAS to complete the NEO PI-R from the perspective of the five year span she had identified from her younger adult life.

Measures of Axis I Psychopathology and Cognitive Functioning

Three well-validated instruments were used to assess NAS for Axis I psychopathology: the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-IV; First, Spitzer, Gibbon, & Williams, 1995), Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), and Beck Anxiety Inventory (BAI; see Beck, Epstein, Brown, & Steer, 1988). Given that NAS is well into older adulthood, we also administered the Short Blessed Orientation-Memory-Concentration Test (BOMC; Katzman et al., 1983) to assess NAS for cognitive impairment, which she passed.

Measure of Social Structure

Interpersonal impairments are both a consequence and defining feature of PDs. To assess the dynamics of her social relationships, we asked NAS to construct her Social Convoys (Antonucci & Akiyama, 1987), an instrument that can be used to assess the objective and subjective aspects of an older adult's social network. We administered the Social Convoys to NAS on two different occasions during her two-month assessment period.

Supplemental Information

We conducted the Clinical Diagnostic Interview (CDI; Westen, 2002) to obtain additional information regarding NAS's background and life history. The CDI is a semi-structured clinical interview designed to elicit rich, descriptive, clinical information about numerous areas of an individual's life, childhood experiences, relationships, work history, and personal identity. NAS also generously volunteered to provide the research team with fascinating

journal entries that she had written during her chosen five-year span (between the ages of 30 and 35) so that we could better understand that period in her life. She wrote an entry at the end of each month to recap the previous month's personal, social, occupational, and medical events. The data gathered from the CDI and her journal entries were used to help inform diagnostic impressions and to identify areas of impairment.

RESULTS

Assessment of Present and Past Personality

SIDP-IV—The results of NAS's present SIDP-IV indicated that she satisfied the *DSM-IV* PD diagnostic requirements for only one personality disorder: NPD. NAS met five (of the nine) *DSM-IV* NPD criteria: “has a grandiose sense of self-importance,” “has a sense of entitlement,” “is interpersonally exploitative . . .,” “lacks empathy . . .,” and “is often envious of others or believes that others are envious of him or her” (APA, 1994, p. 661). Her response style to the SIPD-IV NPD items can be inferred from her answer to the following question. When asked, “Would you describe yourself as someone who has or will accomplish great things—accomplishments that will set you apart from your equals?” (Pfohl et al., 1997, p. 20) NAS answered, “In *every* way: Intelligence, education, diet, exercise . . . We're not talking about the average person here—we're talking about *me*.” NAS stated that her lack of empathy caused her significant distress and/or impairment; specifically, that she finds it “impossible” to understand what others are going through.

NAS did not meet diagnostic requirements for any other PDs, but she did meet some other notable PD criteria. For example, NAS met three schizoid PD criteria. She said she often chooses solitary activities; and, like the majority of older adult women in our larger study, has little interest in sexual activities. Of most interest, however, was NAS's claim that she is indifferent to praise or criticism; NAS said that she appreciates praise, but that she tends to brush aside criticism as a result of the other party's ignorance. Although NAS met schizoid criteria, it seems that she met two of them (chooses solitary activities and is indifferent to criticism) for reasons related to her narcissism rather than because of a schizoid style (e.g., she probably chose solitary activities because her social activities typically did not go well; her abrasiveness, callousness, and self-focus tend to turn people away). She likely met the third criterion (lack of interest in sex) for reasons associated with typical aging. NAS also met three histrionic criteria: Her interactions with others tend to be marked by sexually seductive behavior, she uses her physical appearance to draw attention to herself on a consistent basis (NAS was wearing bright pink lipstick, a revealing top, and a jaunty hat with a feather at the time of this interview), and she frequently considers relationships to be more serious than they truly are. We believe that NAS used the behaviors that these criteria assess to fuel her narcissistic self-concept.

Information gathered from NAS's informants generally confirmed her self-reported descriptions. They did not introduce significant new data. People with NPD typically describe themselves in more positive terms than their informants use (Clifton, Turkheimer, & Oltmanns, 2004); but they do seem to be aware of what others think of them (Carlson, Vazire, & Oltmanns, 2010; Oltmanns, Gleason, Klonsky, & Turkheimer, 2005), and they can often answer questions about others’ impressions accurately if they are asked directly for that information. NAS was clearly aware of the ways in which other people tended to view her behavior, but she was unaffected by their negative opinions. As Morf and Rhodewalt (2001) have noted, “when narcissists have to choose between being liked or admired, they go for admiration” (p. 182). NAS's informants confirmed her descriptions of her narcissistic characteristics, and they also provided additional and sometimes less tactful confirmation of the ways in which she had alienated other people over the years.

In a retrospective account of her personality (ages 30 to 35), NAS met six NPD criteria at a clinically significant level. She met all but one (feelings of envy and jealousy or being the target thereof) of her presently-reported NPD criteria and met two additional criteria that were present in the past but were no longer characteristic of her: "requires excessive admiration" and "shows arrogant, haughty behaviors or attitudes" (APA, 1994, p. 661). NAS did not endorse any subjective distress or impairment resulting from NPD symptoms at this earlier point in her life, but additional information (described subsequently) did indicate marked interpersonal problems. Hence, we also feel confident about a past diagnosis of NPD.

In her retrospective account, the only schizoid PD criterion NAS met was "lacks close friends or confidants other than first-degree relatives" (APA, 1994, p. 641). Once again, this endorsement probably reflected the consequences of her inability to maintain significant interpersonal relationships as a result of her narcissism; it did not reflect a schizoid-like insular style. She met the same three histrionic PD criteria noted in the previous section. When describing herself as a young adult, NAS retrospectively met two antisocial PD criteria: "deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure" and "lack of remorse, as indicated by being indifferent to, or rationalizing having hurt, mistreated, or stolen from another (APA, 1994, p 650). Both of these characteristics were related to her love life and her relationships with men. She admitted to leading men on while using them for their money. NAS said that dating had been "a game" for her, but the men she dated did not see it that way. She claimed that several men left her house in tears after she rejected their marriage proposals; presumably, they viewed their relationship much differently than she did. Although she had clearly upset them, NAS said she felt no remorse for this, as it was "all part of the game." These antisocial criteria characterize again her interpersonally exploitative narcissistic tendencies.

NPI—On the NPI, NAS endorsed 23 (57.5%) of the 40 items. As a basis of comparison, one study found that 1,018 subjects (479 men, 529 women, ages 17 to 49) endorsed a mean of 15.5 (*SD* = 6.66) items; no meaningful age effects were found (Raskin & Terry, 1988). A different sample, one of elite college students, had a mean of 14.66 (*SD* = 6.11; del Rosario & White, 2005). NAS's responses indicate that she is roughly 1.25 *SD*s above the mean (or at about the 90th percentile) in narcissism as measured by the NPI. A selection of some of her responses on the NPI include the following endorsements: "Modesty doesn't become me," "I know that I am a good person because everybody keeps telling me so," "If I ruled the world it would be a better place," "I find it easy to manipulate people," "I like to show off my body," "I always know what I am doing," "I like to look at myself in the mirror," "I really like to be the center of attention," "People always seem to recognize my authority," "I wish someone would write my biography," and "I am an extraordinary person."

NAS's retrospective NPI score was a 28, 5-points higher than her present score (23). Most (33 of 40, 83%) of her NPI responses were consistent across her present and retrospective accounts. Among the seven items that were inconsistent between her two accounts, NAS endorsed the more narcissistic response six times and the less narcissistic response one time. Two of the responses that NAS selected to be more descriptive of her previous self than present self were: "I am going to be a great person" and "I am more capable than other people." Interestingly, both of these items seem to contain age bias. The first item looks to the future, which is a perspective younger adults may take more often than older adults (who spend more time reflecting); the second item does not specify whether one should exclude physical limitations (of which older adults frequently have many). NAS's failure to endorse items such as these in the present may reflect context-specific aspects of normal aging, not because of real changes in her personality.

RSES—On the RSES, NAS scored a 30—the maximum score possible. As high scores indicate higher levels of explicit self-esteem, a score of 30 indicated that NAS could not have a more positive self-concept, at least as measured by the RSES. We interpreted NAS's maximum RSES score as further evidence of her grandiose self-perceptions.

NEO PI-R—We submitted NAS's NEO PI-R responses to its publisher, Psychological Assessment Resources, to use its Professional Report Service. Our first impression of NAS's present profile was the extremity of her scores, which were often ± 2 *SD*s from the norm (i.e., below the third percentile or above the 97th percentile). Indeed, NAS responded Strongly Agree or Strongly Disagree to 73% and Neutral to only 6% of the NEO PI-R items, possibly reflecting a tendency to think or behave in extremes. NAS's retrospective profile also showed numerous personality extremes. NAS's general personality at the factor-level remained relatively stable between her present and retrospective reports; her score levels (e.g., Very High, High, etc.) were unchanged in four of the five factors. NAS's overall Agreeableness score increased one level from Low (retrospective) to Average (present). Overall, the correlation between her 35 (5 domains, 30 facets) present and retrospective *T* scores was high ($r = .91$, df = 33, $p < .001$).

Axis I Psychopathology

SCID-IV, BDI-II, and BAI—The results of NAS's SCID-IV revealed that she meets the *DSM-IV* diagnostic requirements for alcohol abuse. NAS also reported experiencing some difficult events (e.g., her father died during her early childhood and she was sexually abused as an adolescent), but there was no evidence for clinically significant posttraumatic stress disorder. On the BDI-II, NAS received a score of 2; she reported having less energy than in the past and having somewhat less appetite. Her very low score indicated essentially no self-reported depression. NAS scored a 7 on the BAI, which indicated a low level of anxiety. The items she endorsed were somatic items, including sweating, having a racing heart, experiencing dizziness, and feeling numbness/tingling sensations. Given that NAS is in her mid 80s, she may have endorsed these items because of physiological rather than psychological disturbances. In fact, NAS explicitly stated that two of these symptoms were due to medical conditions. For reasons such as this, Morin et al. (1999) recommended that somatic symptoms should be weighted less than cognitive or behavioral symptoms when interpreting BAI responses from an older adult. Hence, with the exception of her alcohol abuse, NAS reported little Axis I symptomatology of note. We must note, however, that her lack of self-reported symptomatology could also have been due to a defensive denial resulting from her narcissistic need to maintain a positive self-concept.

Social Structure and Supplemental Information

Social convoys: Time 1—Compared to the other individuals participating in our larger study of older adults, NAS reported a somewhat large social network (*N* 11). The four people in her innermost social circle—individuals that she could not live without—were her brother, her daughter, and two friends (she had known one for three years and the other for 50). Each of the three people in her next social level—individuals to whom she felt very close—were friends she had known for two, 10, and 25 years. She identified four people in her outermost social level—individuals she thought needed to be included to give an accurate depiction of her social network. When asked about the amount of confiding in the relationships between her and each person in her social network, NAS reported that she confided in two members (50%) of her innermost circle, one member (33%) of her middle social circle, and two members (50%) of her outermost social circle. She thus had a confiding relationship with five of the 11 (45%) individuals she identified as composing her social network.

Social convoys: Time 2—During second Social Convoys administration, which occurred two months after the first administration, NAS reported a larger (N = 15), but rather different social network. Of the four people in her innermost circle, now all were family members. Two of these individuals were the family members reported at Time 1 (brother and daughter) but two were new additions (a niece and a nephew). The two individuals from Time 1 not included in her Time 2 innermost social circle (who were previously included as friends she could not live without) had been demoted to her middle circle, which now contained six people. Only one member appeared in her middle circle on both Times 1 and 2. Of the three remaining middle circle members, one was a friend who had been promoted from her Time 1 outer circle and two were friends who were not identified at Time 1. NAS identified five individuals (all friends) in her outer circle, *none* of whom appeared anywhere in her Time 1 circle. NAS reported she confided in two members (50%) of her innermost circle, three members (50%) of her middle circle, and two members (40%) of her outer circle. She therefore had a confiding relationship with seven of the 15 (approximately 47%) individuals she had identified in her Time 2 social network.

Social convoys: Stability and change—Many notable changes occurred in NAS's social networks. Five of the 11 (45%) individuals she reported in her Time 1 social network did not appear in her Time 2 network and 9 of the 15 (60%) individuals she reported in her Time 2 social network did not appear in her Time 1 network. Thus, of the 20 total individuals NAS reported across both time points, only six (30%) of the individuals appeared in both networks. And of these six individuals, NAS listed three (15%) of them in circles different than the ones where they originally appeared. In short, NAS consistently placed only three of the 20 individuals across administrations. We interpret these results to suggest that NAS's social network is very unstable, even across the relatively short, two month time period.

Supplemental information—Data from her clinical interviews and journal entries revealed additional aspects of her personality, interpersonal relationships, and thought processes. At a time in life when many other women would focus on aspects of their lives such as their children (i.e., ages 30 to 35 years), NAS's monthly journal summaries talked mostly of dating, social gatherings, and cars. Like the instability of her present social network, NAS's journal entries revealed a constantly rotating cast of individuals, most of whom were men. Dating 3 to 5 men at once was not uncommon for her during this period. And although some men appeared in entries spanning a few months, the majority of her romantic relationships seemed to have been somewhat superficial and largely transient.

As part of her intake, we also asked NAS to list the major milestones and accomplishments in her life beginning with her youth. Both the information she did and did not report was interesting. For example, while NAS explicitly reported that “parenting wasn't very significant”—a rather unusual thing to note in our experience—there was no mention of her two marriages and divorces, or the birth of her child. Instead, NAS listed accomplishments such as “caring for pets” and being “brave enough to comment on scientific research.” This self-focused style is classically narcissistic. She seemed to have been most concerned with maintaining a positive image of herself, and thus may have tended to omit or minimize events that contradicted or failed to confirm her grandiose self-perceptions.

Dysfunction and Impairment

NAS's case and presentation was noteworthy for many reasons, one of which was her lack of self-reported mood- and anxiety-related distress (BDI-II = 2, BAI = 7). She did abuse alcohol; otherwise, however, there was little self-report data that suggested NAS was impaired by her narcissism. If asked, NAS would likely say that she has a wonderful life.

But when looking beyond her self-reports and combining information gathered from multiple sources, evidence of past and present dysfunction and impairment emerged.

NAS evidenced a lifelong history of significant impairments in her self-other representations and interpersonal functioning (two of the four areas which PDs often affect; see APA, 1994, p. 633). These two areas were intimately related; in fact, there was probably a causal relationship between the two, with her skewed self-other representations impairing her ability to develop and maintain close relationships. NAS's self-focus, sense of entitlement, lack of empathy, and inability to perceive another person's point of view probably made it difficult for others to connect with her. For example, during one interview, she wondered aloud whether World War II was meant to "put Hitler in his place, or to set me free?" from her first marriage, which ended due to her husband being drafted. This question shows the extent of NAS's narcissistic perceptions. Not only did she identify herself as the possible reason for a major global conflict (grandiosity), but, in so doing, she also disregarded the victims of this tragic occurrence (lack of empathy). Even during our relatively short interviews, NAS's overwhelmingly overt narcissism made it difficult to develop a mutual rapport—a crucial building block for the beginning of any interpersonal relationship.

From her journal entries, we gathered that many of NAS's previous relationships were transient and superficial (which is consistent with the results of her present Social Convoys). This quote from her journal exemplifies the nature of her interpersonal relationships (all names and locations changed to protect confidentiality):

> Peter is still around, but I know I couldn't get along with him. Ray said the other night that we should pack up his trailer and head for South Carolina. I think I could get along with him, but I really don't care for him. Jacob wants me to make my mind up by Valentine's Day. With him I would certainly have security, plus everything my little heart desires. Jim said I could go to Oregon with him. I told him I haven't tired of him yet. On the other hand, I haven't seen as much of him as the others yet.

The contents of this quotation illustrate NAS's self-focus and exploitative nature. Her focus is not on these men as individuals, but rather on herself and their desire to have a relationship with her. NAS enjoyed their admiration, seemed to revel in the control that she had over them, and was not at all concerned with how her behavior may have affected them. As NAS stated during an interview, "I was never in love with anyone as much as myself." Instead of experiencing and reciprocating feelings, NAS used (and uses) interpersonal relationships to fuel her narcissism. With the possible exceptions of the relationships with her daughter and brother, none of her past or present relationships seemed to be meaningful at all. From our data, which we gathered using many methods, instruments, and informants, we feel confident concluding that NAS has experienced serious, lifelong interpersonal impairment as a result of her pathological narcissism.

NAS's dysfunction across her lifespan can be understood through a developmental theory of personality (e.g., Erikson, 1950). Beginning in her adolescence (and perhaps earlier), NAS failed to proceed through pivotal life stages as evidenced by her inability to develop a stable, non-contingent identity; engage in mutually beneficial intimate relationships; meaningfully engage her role as a parent; and cultivate a personal integrity. Her narcissistic tendencies seemed to have hindered her ability to navigate these challenges effectively. Now as an older adult, NAS's life is largely empty, without many (any?) significant mutually supportive relationships. Despite this emptiness, NAS has been able to maintain her narcissistic perceptions in part by clinging to and reflecting on what a "great" life that she has had. However, these perceptions are not fully based in reality, as NAS has had no significant, long-lasting, meaningful relationships; has made no significant contributions

beyond those typically made by other people, and has continuously created havoc for those who have entered her life.

DISCUSSION

Recognizing our inability to generalize too far from the results of a single case study, we will highlight what we view are the most important findings. First, the obvious: NAS, an older adult, met the *DSM-IV* diagnostic requirements for NPD. Hence, even if personality and personality pathology soften with age, PDs can persist into, and be associated with marked impairment, in later life. Second, NAS, who in our collective opinion is one of the most narcissistic people we have ever encountered, met only five NPD diagnostic criteria (the diagnostic threshold for NPD is five); the *DSM-IV* criteria and threshold were only just able to identify her presentation as a case of NPD. Therefore, as previous literature suggests, the current criteria may not adequately capture the manifestations of NPD well in later life. Third, convergent evidence from multiple sources may be helpful when assessing PDs in older adults (e.g., Grove & Tellegen, 1991); not only may individuals with PDs be inaccurate self-reporters, but many *DSM-IV* PD diagnostic criteria as well as other instruments may also contain age-related measurement bias. While the SIDP-IV was able to assess the diagnostic features of NPD, the supplemental information from the NPI, the RSES, clinical interviews, her Social Convoys, and her journal entries provided additional descriptive information that we used to help determine the manifestations and especially the consequences of her personality pathology. Fourth, consistent with previous research (Miller, Campbell, & Pilkonis, 2007), NAS's NPD-related impairment was most pronounced in her interpersonal relationships. Her grandiosity, entitlement, lack of empathy, and exploitativeness, especially, likely prevented her from maintaining social, romantic, and marital relationships and have left her relatively isolated in later life. And fifth, NAS's trait personality profile was relatively stable across her present and retrospective accounts, indicating that when personality remains stable, the NEO PI-R is able to reflect that stability, even across multiple decades.

Although there are no instruments perfectly suited to measure PDs in later life, we can offer a couple of suggestions for clinicians who wish to identify these disorders in their older clients. First, we suggest using a battery of tests (instead of just one). Because there are no perfect instruments, using several can help reduce the influence of measurement imprecision and allow the clinician to arrive at a more accurate diagnosis than if he/she were to use a single instrument. In particular, we suggest using at least one PD measure and at least one trait measure; in our experience, trait measures are more resistant to erroneous results when used with older adults than are PD measures. When working with measures that have known item problems, identifying items that might contain measurement bias and making a clinical judgment based on adapting the item to fit the later life context may be useful (although less than ideal). Also, enlisting informants (peers and/or family members) is fundamental to PD assessment. Multiple informants should be used for a more thorough assessment; at least one should be used for a briefer assessment. On a related note, we also recommend focusing on dysfunction in social relationships, which is a key correlate of PDs (as previously described). And finally, it may be useful for clinicians to rely partly on their own reactions; however, clinicians would certainly want to avoid putting too much weight on personal reactions that can be idiosyncratic and misleading at times. As with all clients, and especially with older adult clients, the safest PD diagnosis can be made when information gathered from multiple sources and multiple instruments converge.

Although this case study addresses several key unresolved questions in the PD literature, it also raises as many questions as it addresses. For example: What are the optimal criteria for capturing NPD in later life? Do we need separate diagnostic criteria for assessing NPD in

older adults, or can criteria without age biases be developed? Are there also unique treatment considerations for older adults with PDs? Do differences in present and retrospective accounts of personality reflect item bias, personality change, or inaccurate recollection? Might the procedure we implemented of using anchor points 30 or 40 years apart be used on a wider scale (e.g., in DSM-5) to help identify those PD features that tend to be invariant over time and those that seem to change? We must leave these questions for future analysis. What is clear, however, is that NPD does exist in older adults and is associated with significant impairment. We hope that these findings will stimulate additional studies on the presentation, assessment, and consequences of NPD and other PDs in older adults.

REFERENCES

Abrams RC, Spielman LA, Alexopoulos GS, Klausner E. Personality disorder symptoms and functioning in elderly depressed patients. American Journal of Geriatric Psychiatry. 1998; 6:24–30. [PubMed: 9469211]

Agronin ME, Maletta G. Personality disorders in late life: Understanding and overcoming the gap in research. American Journal of Geriatric Psychiatry. 2000; 8:4–18. [PubMed: 10648290]

American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed.. Author; Washington, DC: 1994.

Antonucci TC, Akiyama H. Social networks in adult life and a preliminary examination of the convoy model. Journal of Gerontology. 1987; 42:519–527. [PubMed: 3624811]

Antonucci, TC.; Akiyama, H. Social support and the maintenance of competence.. In: Willis, SL.; Schaie, KW.; Hayward, M., editors. Social mechanisms for maintaining competence in old age. Springer; New York, NY: 1997. p. 182-231.

Balsis S, Carpenter BD, Storandt M. Personality change precedes clinical diagnosis of dementia of the Alzheimer type. The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences. 2005; 60:98–101.

Balsis S, Segal DL, Donahue C. Revising the personality disorder diagnostic criteria for the Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition (*DSM-V*): Consider the later life context. American Journal of Orthopsychiatry. 2009; 79:452–460. [PubMed: 20099936]

Balsis S, Woods CM, Gleason MEJ, Oltmanns TF. Overdiagnosis and underdiagnosis of personality disorders in older adults. American Journal of Geriatric Psychiatry. 2007; 15:742–753. [PubMed: 17804828]

Beck AT, Epstein N, Brown G, Steer RA. An inventory for measuring clinical anxiety: Psychometric properties. Journal of Consulting and Clinical Psychology. 1988; 56:893–897. [PubMed: 3204199]

Beck, AT.; Steer, RA.; Brown, GK. Manual for Beck Depression Inventory II (BDI-II). Psychological Corporation; San Antonio, TX: 1996.

Carlson, EN.; Vazire, S.; Oltmanns, TF. You probably think this paper's about you: Social perceptions of a narcissist. 2010. Manuscript submitted for publication

Clifton A, Turkheimer E, Oltmanns TF. Contrasting perspectives on personality problems: Descriptions from the self and others. Personality and Individual Differences. 2004; 36:1499–1514.

Costa, PT., Jr.; McCrae, RR. Revised NEO Personality Inventory (NEO PI-R) and NEO Five-Factor Inventory (NEO-FFI) professional manual. Psychological Assessment Resources; Odessa, FL: 1992.

Costa PT Jr. Herbst JH, McCrae RR, Siegler IC. Personality at midlife: Stability, intrinsic maturation, and response to life events. Assessment. 2000; 7:365–378. [PubMed: 11151962]

del Rosario PM, White RM. The Narcissistic Personality Inventory: Test-retest stability and internal consistency. Personality and Individual Differences. 2005; 39:1075–1081. doi: 10.1016/j.paid.2005.08.001.

Erikson, EH. Childhood and society. W. W. Norton; New York, NY: 1950.

First, MB.; Spitzer, RL.; Gibbon, M.; Williams, JBW. Structured clinical interview for Axis I DSM-IV Disorders—Patient edition (SCID-I/P, Version 2.0). New York State Psychiatric Institute, Biometrics Research Department; New York, NY: 1995.

Grove WM, Tellegen A. Problems in the classification of personality disorders. Journal of Personality Disorders. 1991; 5:31–41.

Jacobowitz, J.; Newton, NA. Dynamics and treatment of narcissism in later life.. In: Duffy, M., editor. Handbook of counseling and psychotherapy with older adults. John Wiley & Sons; Hoboken, NJ: 1999. p. 453-469.

Jeste DV, Alexopoulos GS, Bartels SJ, Cummings JL, Gallo JJ, Gottlieb GL, Lebowitz BD. Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. Archives of General Psychiatry. 1999; 56:848–853. [PubMed: 12884891]

Katzman R, Brown T, Fuld P, Peck A, Schechter R, Schimmel H. Validation of a short orientation-memory-concentration test of cognitive impairment. American Journal of Psychiatry. 1983; 140:734–739. [PubMed: 6846631]

Kenan MM, Kendjelic EM, Molinari VA, Williams W, Norris M, Kunik ME. Age-related differences in the frequency of personality disorders among inpatient veterans. International Journal of Geriatric Psychiatry. 2000; 15:831–837. [PubMed: 10984730]

Miller JD, Campbell WK, Pilkonis PA. Narcissistic personality disorder: Relations with distress and functional impairment. Comprehensive Psychiatry. 2007; 48:170–177. [PubMed: 17292708]

Moffitt TE, Caspi A, Taylor A, Kokaua J, Milne BJ, Polanczyk G, Poulton R. How common are common mental disorders? Evidence that lifetime prevalence rates are doubled by prospective *versus* retrospective ascertainment. Psychological Medicine. 2010; 40:899–909. [PubMed: 19719899]

Morf CC, Rhodewalt F. Unraveling the paradoxes of narcissism: A dynamic self-regulatory processing model. Psychological Inquiry. 2001; 12:177–196.

Morin CM, Landreville P, Colecchi C, McDonald K, Stone J, Ling W. The Beck Anxiety Inventory: Psychometric properties with older adults. Journal of Clinical Geropsychology. 1999; 5:19–29.

Oltmanns TF, Gleason MEJ, Klonsky ED, Turkheimer E. Meta-perception for pathological personality traits: Do we know when others think that we are difficult? Consciousness and Cognition. 2005; 14:739–751. [PubMed: 16256371]

Oltmanns, TF.; Turkheimer, E. Perceptions of self and others regarding pathological personality traits.. In: Krueger, RF.; Tackett, JL., editors. Personality and psychopathology. Guilford Press; New York, NY: 2006. p. 71-111.

Pfohl, B.; Blum, N.; Zimmerman, M. Structured Interview for DSM-IV Personality. American Psychiatric Press; Washington, DC: 1997.

Raskin RN, Hall CS. A narcissistic personality inventory. Psychological Reports. 1979; 45:590. [PubMed: 538183]

Raskin R, Novacek J, Hogan R. Narcissism, self-esteem, and defensive self-enhancement. Journal of Personality. 1991; 59:19–38. [PubMed: 2037962]

Raskin R, Terry H. A principal-components analysis of the Narcissistic Personality Inventory and further evidence of its construct validity. Journal of Personality and Social Psychology. 1988; 54:890–902. [PubMed: 3379585]

Rosenberg, M. Society and the adolescent self-image. Princeton University Press; Princeton, NJ: 1965.

Segal DL, Coolidge FL, Cahill BS, O'Riley AA. Psychometric properties of the Beck Depression Inventory–II (BDI-II) among community-dwelling older adults. Behavior Modification. 2008; 32:3–20. [PubMed: 18096969]

Segal, DL.; Coolidge, FL.; Rosowsky, E. Personality disorders and older adults: Diagnosis, assessment, and treatment. John Wiley & Sons; Hoboken, NJ: 2006.

Terracciano A, McCrae RR, Brant LJ, Costa PT Jr. Hierarchical linear modeling analyses of the NEO-PI-R scales in the Baltimore Longitudinal Study of Aging. Psychology and Aging. 2005; 20:493–506. [PubMed: 16248708]

Vine RG, Steingart AB. Personality disorders in the elderly depressed. Canadian Journal of Psychiatry. 1994; 39:392–398.

Westen, D. Clinical diagnostic interview manual. 2002. Retrieved from http://www.psychsystems.net/manuals/cdi.doc

Zweig RA. Personality disorder in older adults: Assessment challenges and strategies. Professional Psychology: Research and Practice. 2008; 39:298–305.