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BRIEF REPORT

CLINICAL CHARACTERISTICS OF COMORBID NARCISSISTIC PERSONALITY DISORDER IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER

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This study examines psychopathology and clinical characteristics of patients with borderline personality disorder (BPD) and comorbid narcissistic personality disorder (NPD) from two international randomized controlled trials. From a combined sample of 188 patients with BPD, 25 also fulfilled criteria for a comorbid diagnosis of NPD according to *DSM-IV*. The BPD patients with comorbid NPD, compared to the BPD patients without comorbid NPD, showed significantly more BPD criteria ($M = 7.44$ vs. $M = 6.55$, $p < .001$), fulfilled more criteria of comorbid histrionic ($M = 3.84$ vs. $M = 1.98$, $p < .001$), paranoid ($M = 3.12$ vs. $M = 2.27$, $p = .014$), and schizotypal ($M = 1.64$ vs. $M = 1.02$, $p = .018$) personality disorders, and were more likely to meet criteria for full histrionic PD diagnosis (44.0% vs. 14.2%, $p < .001$). The BPD-NPD group also reported significantly fewer psychiatric hospitalizations in the previous year ($M = 0.40$ vs. $M = 0.82$, $p = .019$) and fewer axis I disorders ($M = 2.68$ vs. $M = 3.75$, $p = .033$). No differences could be found in general functioning, self-harming behavior, and suicide attempts.

The comorbidity of narcissistic and borderline pathology has been shown clinically and empirically to be a complicating factor for both an accurate

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diagnosis and psychotherapy (Diamond & Yeomans, 2008; Ellison et al., 2013; Kernberg, 1984; Levy, 2012). Indeed, clinical experience involving the treatment of patients with comorbid borderline and narcissistic personality disorders suggests that this patient population poses specific clinical challenges and may be among the more difficult to treat within the personality disorder spectrum (Kernberg, 2007; Stone, 1990). The current study examines data from patients with borderline personality disorder recruited for participation in two separate randomized clinical trials (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010) and allowed for the study of the characteristics and clinical differences of the subgroup of borderline patients who also fulfill comorbid narcissistic personality pathology (according to criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition [*DSM-IV*; American Psychiatric Association, 1994] and fifth edition [*DSM-5*; American Psychiatric Association, 2013]). The goals of the present study are to examine how BPD patients with a comorbid NPD (referred to as NPD/BPD) differ from BPD patients without comorbid NPD in the context of borderline pathology (referred to as BPD) on the number of axis I and axis II disorders, general functioning, as well as mental health service use, self-harming, and suicidal behavior.

The overt characteristics of NPD as defined in the *DSM-IV*/*-5*, such as grandiosity, a sense of entitlement, exploitativeness of others, inordinate reliance on admiration of others to regulate self-esteem, arrogant haughty behaviors, exhibitionism, and lack of empathy have now been confirmed by research (see Cain, Pincus, & Ansell, 2008; Levy, Reynoso, Wassermann, & Clarkin, 2007, for reviews). However, the ways that NPD manifests itself in the context of borderline pathology have not been well conceptualized or investigated. In previous research, NPD has been shown to be highly comorbid with other *DSM*-diagnosed axis II disorders, particularly those in cluster B (histrionic, borderline, and antisocial). In a previous study, Gunderson and colleagues found that the rate of comorbidity of NPD with other personality disorders exceeded 50% (Gunderson, Ronningstam, & Smith, 1995). Similarly, Morey and colleagues reported the highest rate of comorbidity on axis II of any personality disorders, with 53.1 % of patients with histrionic personality disorder also fulfilling criteria for NPD, 46% of patients with borderline personality disorder, 35.9% of patients with paranoid personality disorder, and 35.9% of patients with avoidant personality disorder (Morey, 1988). In the recent National Epidemiologic Survey on Alcohol and Related Conditions study (NESARC), the prevalence of NPD in a community sample who met criteria for schizotypal personality disorder was 43.2%, for borderline for personality disorder it was 38.9%, and for histrionic personality disorder it was 32.4% (Stinson et al., 2008). Such studies have added to the growing literature that fails to support the *DSM*'s putative structure of six distinct personality disorders.

However, in a recent study Sharp and colleagues (2015), using a bifactor model to investigate personality disorder (PD) pathology, evaluated the general factors that account for both common variance shared across PD diagnoses and the specific, unique sources of variance that may represent more specific forms of personality disorder pathology in a sample of inpatients.

Interestingly, while BPD items loaded most strongly on the general factor, narcissistic PD's average loading on the general factor was relatively weak, but quite strong on the factors specific to NPD, such as grandiosity and arrogance. These findings suggest that while there is an overlap between the two disorders reflected in the high rates of comorbidity, they are by no means synonymous. Such studies call for more research on the extent to which NPD may be a discrete and separate personality disorder that may affect the presentation and treatment course of personality pathology.

In addition, recently there has been increasing attention to narcissistic pathology as a dimensional disorder with varying degrees of pathology in self and object relations (American Psychiatric Association [APA], 2013; Ronningstam, 2011; Skodol, Bender, & Morey, 2014). This is also reflected in the *DSM-5*, which retains the diagnostic category of NPD unchanged, but in section III also allows for different levels of severity of narcissistic pathology, as personality disorders in this section are characterized by impairments in self and interpersonal functioning, identity, goal direction, and pathological personality traits (APA, 2013). Thus, it is increasingly recognized that pathological narcissism has been found at various levels of pathology, and encompasses impairments across a number of dimensions. In Kernberg's model (Kernberg, 1975; 1997; 2010), pathological narcissism spans a spectrum of pathology from higher functioning (neurotic) to lower functioning (borderline) levels of personality organization. Higher functioning narcissists show an excessive need for admiration from others, attitudes of entitlement, and exploitativeness toward others, as well as lack of empathy and excessive envy, but they may have made a good superficial adjustment based on achieving admiration from others and self-esteem regulation from a relatively stable grandiose self. By contrast, those with narcissistic pathology organized at a borderline level include individuals who show the typical manifestations of narcissistic personality disorder (Kernberg, 1997; 2007) but also present with unstable and unintegrated sense of self that is evident in general identity diffusion, lack of anxiety tolerance, and impulse control, as well as more drastic fluctuations in self-esteem and affect regulation, despite the defensive functions of the grandiose self.

Contributing to the idea that narcissistic pathology may manifest itself differently depending on the individual's level of organization are the investigations, both clinical and empirical, that have identified a broad variation of subtypes of pathological narcissism and of the phenotypic expression of narcissism. These subtypes or phenotypes range from the grandiose type, characterized by unbridled grandiosity, the ruthless exploitation of others, and pervasive arrogance (also referred to as "grandiose or overt narcissism") to the vulnerable type, characterized by chronic feelings of rejection and humiliation and deflated self-concept in the context of preoccupation with hidden grandiose fantasies (often referred to as "vulnerable or covert narcissism") (Akhtar, 2003; Bursten, 1973; Cain et al., 2008; Cooper, 1998; Gabbard, 1989; Gersten, 1991; Levy et al., 2007, 2009; Ronningstam, 2005; Rosenfeld, 1987; Wink, 1991). However, the connection between these two phenotypic descriptions of NPD and particular personality disorders, such as borderline personality disorder, has not been systematically investigated.

Some speculations have been made that the vulnerable narcissistic type is more likely to characterize NPD/BPD patients, since in some presentations narcissism appears to be associated with measures of psychopathology (e.g., neuroticism) and service utilization (Ellison et al., 2013; Pincus et al., 2009; Rathvon & Holmstrom, 1996), and in other positions, it seems most associated with measures of distress (Levy, 2012). These investigations have dovetailed with clinical observations that the dimensions of vulnerability and grandiosity may actually represent not distinct categories or subtypes of NPD, but phenotypic expressions that may provide indices of the level of severity of narcissistic disorders. More recent research has focused on how these two dimensions may coexist and oscillate in different patterns within the individual (Diamond & Yeomans, 2008; Ellison et al., 2013; Levy, 2012; Pincus et al., 2009). A number of researchers have defined grandiosity, including interpersonal exploitativeness, self-aggrandizing behaviors, and fantasies, as the core defining trait of the disorder (Bender, Morey & Skodol, 2011; Miller et al., 2013, 2014, 2016; Perry, 2014) since vulnerability is more likely to be associated with general personality impairment. In any case, it is recognized that individuals with NPD are more likely to present for treatment when in a vulnerable state of mind.

A number of studies have indicated that the inflated but unstable self-esteem and vacillations between grandiosity and vulnerability may predispose those with NPD toward axis I disorders. Rates of substance abuse, affective disorders, and/or anxiety disorders were 40%, 29%, and 40%, respectively, among respondents with lifetime NPD in the recent NESARC study (Stinson et al., 2008). In a study comparing patients with NPD to NPD/BPD patients and to patients with BPD only, NPD patients showed the lowest rates of co-occurring axis I and II disorders compared to the other two groups (Ritter et al., 2010). Recent studies have investigated the association between depressive temperament and both narcissistic vulnerability and grandiosity (Kealy, Tsai, & Ogrodniczuk, 2012; Tritt, Ryder, Ring, & Pincus, 2010). However, it has also been suggested that while vulnerable narcissistic traits may function as risk factors for the development of comorbid axis I disorders (Miller, Widiger & Campbell, 2014; Tritt et al., 2010), grandiose traits may also function as a protective factor (Simonsen & Simonsen, 2011). Indeed, Ellison and colleagues (2013) found a negative association between grandiose narcissism and different forms of treatment utilization (e.g., crisis hotline, psychiatric hospitalization). In an outpatient sample, Hilsenroth and colleagues (1998) found that compared to patients with other personality disorders, NPD patients had the largest percentage of dropout from treatment (64%). For example, the subgroup of individuals with NPD who do not suffer from comorbid depressive disorders might not see the need for treatment as often as individuals with comorbid axis I pathology and thus may seek therapy less frequently. We therefore might expect lower treatment utilization in NPD/BPD patients than in BPD patients without NPD.

The infrequency of treatment utilization noted in previous research on individuals with NPD has led us to investigate in this study whether co-occurrence of NPD in the context of BPD mitigates the levels of self-injurious and suicidal behaviors. Some studies have shown differences in suicidal be-

haviors in patients with NPD from patients with other personality disorders. In a study examining suicidal behavior of NPD patients in comparison to other cluster B personality disorders, NPD patients who attempted suicide had higher expected lethality than those without NPD, even while the impulsivity in NPD patients did not differ from the impulsivity in patients without NPD. In contrast, patients with histrionic PD, antisocial PD, and BPD showed significantly more impulsivity than individuals without these diagnoses attempting suicide (Blasco-Fontecilla et al., 2009). It is assumed that suicidality may serve a self-regulatory function in patients with NPD (Ronningstam & Weinberg, 2013). In a small clinical sample, Pincus and colleagues (2009) established positive correlations between narcissism, as assessed by the Pathological Narcissism Inventory (PNI), and suicide attempts and parasuicidal behaviors. However, further investigation of how suicidal and parasuicidal behavior manifests itself in individuals with comorbid NPD/BPD is warranted.

HYPOTHESES

Consistent with studies reviewed above which emphasize the comorbidity of NPD with a number of other personality disorders, we expected that compared with BPD patients without NPD, NPD/BPD patients would be more likely to meet criteria for additional comorbid personality disorders, in particular more comorbidity with cluster B than with clusters A and C disorders. In addition, although the comorbidity of NPD with disorders formerly on axis I has been documented as discussed above, some studies indicate that patients with NPD may experience or report fewer symptoms of axis I disorders (Ritter et al., 2010); thus, we expected less axis I comorbidity in the NPD/BPD group compared with the BPD group. Finally, based on the studies showing a negative association between NPD and treatment use, we expected less mental health service use and less suicidality and self-harming behavior compared to the BPD patients without comorbid NPD.

METHOD

PARTICIPANTS

The designs of the studies are described in detail elsewhere (Clarkin et al., 2001; 2007; Doering et al., 2010). All participants from both studies were clinically referred outpatients. In both studies, inclusion and exclusion criteria were very similar, with the exception of the upper age range included (Cornell-NY sample: up to age 50, Vienna-Munich (V-M) group: 45 years), that the V-M sample excluded those with antisocial personality disorder, and differences in the inclusion of mood disorders. The Cornell-NY study excluded those with bipolar I but included bipolar II, whereas the V-M group excluded only those with bipolar I and II if they had had a manic, hypomanic, or major depressive episode in the last six months. Combined demographics are as follows: In the current study, 188 patients from the total of 194 patients from both RCTs were examined (n = 90 from the Cornell-NY

study and n = 104 from the V-M study), due to missing data from one patient and the exclusion of five men from the Cornell-NY study (for a more homogeneous sample of only women). In this study, 100% of participants were women who all fulfilled the criteria of *DSM-IV* borderline personality disorder, with age ranging from 18 to 51 (mean = 28.8, SD = 7.6). Of the participants, 39.9% were in a relationship, 3.7% were divorced, and 56.4% were single; 53.2% of participants were employed, 22.3% were enrolled in school or a training program, and 24.5% had no employment. Of the 188 participants, 25 met criteria for NPD/BPD (13.3% of the sample) while 163 met criteria for BPD only (86.7%). In the Cornell-NY RCT, 15 of 84 patients (17.9%) met criteria for NPD/BPD, while in the V-M RCT, 10 of 104 patients (9.6%) met criteria for both diagnoses. No significant differences in the likelihood of meeting NPD criteria were found ($\chi^2(1) = 2.74$, $p < .10$).

MEASURES

In the Cornell-NY sample, axis I pathology was assessed using the Structured Clinical Interview for DSM-IV (SCID-I; First, Gibbon,Spitzer, & Williams, 1996) and axis II pathology using the International Personality Disorders Examination (IPDE; Loranger, 1999). In the V-M sample, the German versions of the Structured Clinical Interviews for DSM-IV (SCID-I and -II; Fydrich, Renneberg, Schimitz, & Wittchen, 1997; Wittchen, Wunderlich, Gruschwitz, & Zaudig, 1997) were employed. The assessment of personality disorders both in IPDE and SCID-II follows the *DSM-IV* approach. Reliability was established prior to beginning the study and monitored throughout. For more detail regarding diagnostic interviewers, interviewer credentials and training, and reliability procedures, see Critchfield, Levy, and Clarkin (2007) for the Cornell-NY study and Doering and colleagues (2010) for the V-M sample. Global Assessment of Functioning (GAF) is a clinician-rated scale (0 through 100) assessing the social, occupational, and psychological functioning of individuals. It is presented and described in the *DSM-5* system (APA, 2013). In the Cornell-NY study, self-harming and suicidal behavior was assessed by the Cornell Interview for Suicidal and Self-Harming Behavior – Self Report (CISSB; Levy, Meehan & Clarkin, 1998a), adapted from the Parasuicidal History Interview (PHI; Linehan, Wagner & Cox, 1989), and service use by the Cornell Revised Treatment History Inventory (CRTHI; Levy, Meehan & Clarkin, 1998b). In the V-M study, self-harming and suicidal behaviors were assessed by the German version of the CISSB (Levy, Meehan, & Clarkin, 1998a), and service use by the German version of the CRTHI (Levy, Meehan, & Clarkin, 1998b).

STATISTICAL ANALYSIS

Before the use of parametric tests, Levene's tests to assess homogeneity of variance were performed. Mean differences between the NPD/BPD and BPD groups were analyzed by independent samples t-tests; for data without homogeneity of variances, Mann-Whitney U tests were performed. All categor-

TABLE 1. Differences Between NPD/BPD Patients and BPD/Non-NPD Patients

	NPD/BPD (n = 25)		BPD/non-NPD (n = 163)				
	M	*SD*	*M*	*SD*	t (df = 186)	p	d
Axis I pathology: no. of diagnoses	2.68	2.16	3.75	2.33	2.15	.033	–0.48
Axis II pathology: no. of diagnoses	3.72	1.02	2.20	1.03	–6.89	< .001	1.48
Borderline PD no. fulfilled criteria	7.44	1.16	6.55	1.25	–3.33	< .001	0.74
Histrionic PD no. fulfilled criteria	3.84	2.21	1.98	1.89	–4.46	< .001	0.90
Antisocial PD no. fulfilled criteria	3.88	3.85	2.36	2.81	–1.89	.069	0.44
Paranoid PD no. fulfilled criteria	3.12	1.59	2.27	1.60	–2.47	.014	0.53
Schizoid PD no. fulfilled criteria	0.48	0.77	0.64	0.97	0.81	.422	–0.18
Schizotypal PD no. fulfilled criteria	1.64	1.52	1.02	1.15	–2.38	.018	0.46
Avoidant PD no. fulfilled criteria	2.00	1.71	2.44	1.83	1.12	.266	–0.25
Dependent PD no. fulfilled criteria	2.16	1.57	2.11	1.61	-0.14	.886	0.03
Obsessive-Compulsive PD no. fulfilled criteria	2.12	1.79	1.76	1.37	-0.96	.344	0.23
Mental Health Service Use							
No. of hospitalizations past year[a]	0.40	0.50	0.82	1.28	2.41	.019	–0.43
Days hospitalized past year[a]	10.16	22.48	37.56	73.19	2.86	.006	–0.50
Self-Harming Behavior							
No. of self-mutilations[a]	17.76	32.39	49.56	177.57	0.78	.437	–0.25
No. of suicide attempts[a]	0.44	0.77	0.79	1.47	1.20	.231	–0.30
GAF	50.08	8.80	51.99	8.23	1.07	.287	–0.22

Note. d = Cohen's d, GAF: Global Assessment of Functioning Scale. [a]For ease of interpretation, means and standard deviations are reported for the non-transformed data; however, the t statistic and p values are reported for post-transformation analyses for these variables.

ical analyses employed chi-square tests of association, and Fisher's exact test p values were calculated due to the relatively small cell sizes. All analyses were two-tailed and the alpha level was set at $p < 0.05$. Cohen's d is reported for all t-tests as an estimate of effect size (0.20 = small, 0.50 = medium, 0.80 = large).

RESULTS

No significant differences between the NPD/BPD group and the BPD group were found on the sociodemographic variables of age (29.52 vs. 28.63 years; $p = 0.59$, $t = –.544$, $df = 186$), relationship status ($\chi^2(2) = 0.23$, $p = .89$), or work ($\chi^2(2) = 1.13$, $p = .57$). As shown in Table 1, across both samples, NPD/BPD patients who met criteria both for BPD and NPD differed on a number of clinical variables from the patients with BPD who did not meet criteria for NPD. NPD/BPD patients reported significantly fewer axis I disorders. When analyzing the axis I disorders individually, a group difference could only be found in panic disorder; 0% in the NPD/BPD group and 13.5% in the BPD group were diagnosed with this disorder ($\chi^2(1) = 3.80$, Fisher's exact $p = .05$). As can be seen in the first four columns of Table 1, the NPD/BPD group showed a larger total number of axis II disorders and also fulfilled

significantly more criteria of several axis II disorders. In line with previous research (Fossati et al., 2005; e.g., Zimmerman, Rothschild, & Chelminski, 2005), comorbid NPD/BPD was associated with more criteria of BPD, histrionic PD, paranoid PD, and schizotypal PD. A trend towards significance can be seen in the case of antisocial PD. No differences between the groups were found in the personality disorders of *DSM-IV* cluster C. When inspecting differences in terms of fulfilled diagnoses, 44.0% of the NPD/BPD group also met criteria for histrionic PD, compared to only 14.2% in the BPD group ($\chi^2(1) = 12.93$, Fisher's exact $p = .001$).

The lower part of Table 1 shows group differences in mental health service use, self-harming behavior, and general functioning. The data for hospitalizations in the past year, days hospitalized in the past year, number of self-mutilations, and number of suicide attempts were positively skewed. Thus, we followed the guidelines of Tabachnick and Fidell (2012) and performed square-root transformations on these variables before running the analyses. When comparing the two groups in terms of number of hospitalizations and days hospitalized in the previous year, the NPD/BPD) group reported significantly fewer hospitalizations and fewer days in the hospital than the BPD patients, in line with the findings by Ellison and colleagues (2013). The difference between the two groups on self-harming behavior does not reach statistical significance, although it can be seen in Table 1 that NPD/BPD patients report fewer self-mutilations and suicide attempts. The GAF scale as a measure of overall functioning also did not differ significantly between the two groups (Table 1).

DISCUSSION

This study has three main findings, which together contribute to our understanding of the characteristics of borderline patients with a comorbid narcissistic personality (NPD/BPD disorder. First, in our sample, NPD/BPD patients presented with significantly fewer axis I comorbid disorders than those with BPD only. The only axis I disorder–specific difference between the NPD/BPD and BPD groups was that fewer NPD/BPD patients fulfilled criteria for panic disorder than did the BPD patients. This finding could be interpreted as an indication that narcissistic pathology, particularly high levels of grandiosity (which characterized this sample of NPD/BPD patients who were assessed by *DSM-IV*/*-5* NPD criteria), may have a stabilizing function and increases the capacity to tolerate or defend against anxiety. This finding corresponds to the research investigations of Tritt and colleagues (2010), who found a relationship between anxious temperament and individuals high on narcissistic vulnerability but not on grandiosity. Our findings suggest that those with NPD/BPD show a nonspecific decrement of axis I comorbidity rather than specific patterns of comorbidity. This reduced level of comorbidity might be a result of the stabilizing effect of the grandiose self (Ronningstam & Gunderson, 1990), possibly explained by inflated positive ideal aspects of the self that are rigidly sequestered in the self and inflate self-

esteem—while at the same time, negative aspects of the self are relentlessly projected onto others.

In addition, NPD/BPD patients may tend to experience and under-report axis I symptoms (Simonsen & Simonsen, 2011), reflected by the finding of fewer hospitalizations. This hypothesis is in line with the findings of Ellison and colleagues (2013), who reported fewer hospitalizations and crisis hotline calls for patients with higher levels of narcissistic grandiosity. As the *DSM-IV* measures employed in this study privilege grandiosity, our findings can be seen as confirmation of Ellison's findings.

Second, in contrast to the reduced number of axis I disorders, NPD/BPD patients in our sample met more criteria for comorbid axis II diagnoses than those with BPD only. In particular, those BPD patients with comorbid NPD met more criteria for BPD, histrionic, paranoid, and schizotypal PD traits. These findings are consistent with previous research that also found a strong link of NPD to cluster B pathology (Fossati et al., 2005; Zimmerman et al., 2005) as well as with the work of Stinson and colleagues (2008), who in an epidemiological sample found that NPD was associated with comorbid schizotypal disorder. As expected, cluster C disorders (avoidant, dependent, and obsessive-compulsive personality disorders), which are thought to be characteristic of higher functioning PD patients (Caligor, Kernberg, & Clarkin, 2007), were not distinctive of the NPD/BPD patients, speaking to the fact that the patients in our sample were organized at a more disturbed, borderline level of personality (Gunderson & Ronningstam, 2001). The strong link between narcissism and cluster B personality disorders also speaks to this point. The increased association between BPD/NPD with paranoid personality traits has also been found in a number of previous studies (Flick et al., 1993; Joiner, Petty, Perez, Sachs-Ericsson, & Rudd, 2008) and can be understood as the narcissistic patients' tendency to react with negative affect and even extreme hostility when the grandiose sense of self is challenged by the negative valuation of others, who are then perceived as threatening, malevolent, and/or ruthlessly disparaging. Previous research has confirmed this association between grandiosity and the development of paranoid attitudes, involving mistrust and aggression towards others when the inflated sense of self is under threat (Baumeister, Smart, & Boden, 1996; Rhodewalt & Morf, 1998). In terms of schizotypal features, those with NPD tend to reconstruct reality to preserve their grandiose sense of self, leading at times to rigid distortions of reality testing. These findings help to illuminate the clinical observation of the often drastic distortions of reality testing involving perceptions of self or self in relation to others, particularly in situations where self-esteem is threatened, that may occur with NPD patients whose reality testing is otherwise intact (Kernberg, 2007; Ronningstam, 2009).

In sum, the findings suggest that NPD/BPD patients are characterized by a particular patterning of comorbidity involving low axis I, but strong axis II comorbidity that helps us to further define the characteristics of a prevalent, difficult to treat, but under-researched group of patients. Most importantly, the association of NPD with BPD, paranoid, schizotypal, histrionic personality disorders, and antisocial personality disorder traits suggests that this group of patients is defined by a core of general personality impairment—the

so-called general factor of personality pathology (Sharp et al., 2015)—but also by a core-specific dysfunction of grandiosity that predisposes them to respond with antagonism/hostility and reduced reality testing when the grandiose self is threatened.

The third finding of our study—fewer hospitalizations and days in the hospital in the NPD/BPD group—raises the question of whether comorbid narcissistic pathology can be seen as a protective factor. It could be hypothesized that the grandiose self-concept, although inherently unstable in that it is not totally self-sustaining or grounded in reality, provides some stability that helps to contain crises leading to hospitalization. Perhaps those patients who are stabilized by their narcissistic defenses (omnipotence, projection, autistic fantasy, devaluation, idealization) (Clemence, Perry, & Plakun, 2009; Kernberg, 1975; 1984) might consider it too humiliating to be hospitalized despite their often-drastic regression in functioning, and opt for outpatient treatment instead. Interestingly, despite the finding by Ellison and colleagues (2013) of a negative relationship between grandiose narcissism and service utilization altogether, the fact that those with comorbid NPD may benefit from and be stabilized by outpatient therapy is suggested by previous findings from the Cornell–NY RCT that there were fewer dropouts from individual psychotherapy in the NPD/BPD group than were recorded in the BPD group (Diamond et al., 2012, 2014).

In addition, the presence of fewer axis I disorders provides an indication that NPD is not only a risk factor for personality pathology but also a protective factor for severe pathology that could require hospitalization or exacerbate self-destructive symptoms. In other words, narcissistic pathology in the context of borderline diagnosis could be considered a protective factor from the behavioral manifestations of personality disorders (Simonsen & Simonsen, 2011).

However, the findings from this study suggest that beyond axis II comorbidity, in the context of BPD, NPD may co-occur with more malignant features: paranoia, antisocial personality features and behaviors, and distortions of reality (schizotypal personality disorder features), which approximates Kernberg's definition of malignant narcissism (Kernberg, 1975, 1997, 2007). It appears that consistent with the *DSM-5* emphasis on assessing the levels of severity of personality pathology dimensionally as well as categorically, NPD can co-occur at various levels of pathology. Hence, these findings suggest that narcissistic pathology needs to be carefully assessed at different structural levels, and that patterns of comorbidity may help to illuminate the level of severity. The study results call for further investigation of the characteristics of NPD/BPD patients, particularly how they may differ in their clinical presentation from BPD patients without NPD, and how these comorbid personality features might have an effect on treatment. Given the prevalence of narcissistic pathology and the clinical challenges these patients pose, more research using samples of NPD patients and patients with comorbid NPD is necessary (Simonsen & Simonsen, 2011).

Although this study is unique in that it draws on a large clinical study group of BPD patients recruited across two samples, the findings and their interpretation should be considered in the light of several limitations. First,

the assessment of narcissistic pathology was based on IPDE/SCID-II criteria, which are based on the *DSM-IV/-5* categorical approach. Measures such as the IPDE and SCID-II, which in many ways are state of the art, can be limited by their face validity (see Levy et al. 2007). Additionally, we used a categorical approach for assessing BPD and NPD pathology and not a dimensional approach that is often suggested (e.g., Widiger & Simonsen, 2005), which may have implications for our findings, particularly given the limitation of how NPD is assessed (presently in favor of narcissistic grandiosity in the *DSM-IV/-5* categorical approach). Our findings suggest that both a dimensional approach that emphasizes severity and a categorical approach that emphasizes traits and characteristics are useful for assessing and understanding narcissistic pathology. Second, the small sample size and female gender limit the generalizability of the findings. As the NPD/BPD group is fairly small ($n = 25$), the means of the axis I and axis II variables are likely to be less robust or stable. Importantly, these findings are based on a disturbed group of NPD patients, that is, NPD patients with comorbid BPD, so they cannot readily be generalized to patients with NPD only. Future research should replicate this study in other samples that also include male patients. Third, the lack of an NPD–only comparison group makes it difficult to definitively state whether the results are due primarily to factors related to NPD or to some interaction between NPD and BPD. Future studies should include an NPD–only comparison group. Finally, the unequal group sizes limit power to detect differences between the groups, and multiple independent testing of null hypotheses might have increased the possibility of Type I errors. Despite these limitations, our findings contribute to an understanding of important differences in both the psychopathology and the treatment course for those BPD patients with comorbid NPD, both protective and vulnerability factors of which clinicians should be aware. Future investigations should not only replicate our findings in additional samples but also examine the effects of comorbid NPD/BPD on treatment process and outcome.

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