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The Diagnostic Interview for Narcissistic Patients

John G. Gunderson, MD; Elsa Ronningstam, PhD; Alexander Bodkin, MD

• This report describes the content and development of a semistructured interview, the Diagnostic Interview for Narcissism. The interview evaluates 33 features of pathological narcissism covering five domains of function: grandiosity, interpersonal relations, reactiveness, affects and moods, and social and moral adaptation. Its utility is established by reliability studies and by developing a scoring system from a sample of 24 prototypic narcissistic patients who were compared with 58 others. Because narcissistic personality disorder is a widely used diagnosis whose inclusion in *DSM-III-R* was without reference to an empirical base, this instrument offers a method for doing much-needed research.

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The widespread usage of the term *narcissistic* by clinicians prompted the introduction of the narcissistic personality disorder (NPD) category into *DSM-III*.[1] The *DSM-III* criteria were developed by a committee with reference to the prior, largely psychoanalytic literature, and without the benefit of empirical evaluation. This report describes a semistructured clinical interview, the Diagnostic Interview for Narcissism (DIN). The DIN is designed to examine a range of clinical phenomena, including those in *DSM-III-R*, that are believed to be associated with pathological narcissism, and to develop more scientifically based criteria for NPD.

The rationale for approaching diagnosis by a semistructured interview is that this method helps to develop a consistent and replicable approach to confusing diagnostic problems. This is especially needed for diagnosing narcissistic patients because of the frequent use of this label; its lack of an empirical basis; and the recognition that the term can be used as a category of disorder, as a personality trait more or less present in everyone, as a developmental process, or as a synonym for self-esteem. Future understanding of clinical, research, or theoretical reports about pathological narcissism can be assisted by having a better knowledge about the samples of patients to whom this diagnosis is applied. A better means of defining such samples can be a springboard for future research into etiology and treatment.

Prior efforts to assess narcissism either have involved self-report measures[2-4] or have been embedded within structured interviews used to assess all Axis II disorders.[5-7] Among the self-report measures, the Narcissistic Personality Inventory is perhaps the most developed.[4,8,9] It has been shown to correlate with measures of self-preoccupation and lack of empathy in a college population.[9] Self-report methods have the advantage of easy administration, but their limited validation in clinical populations makes their correspondence with clinical diagnosis uncertain. Our own prior use of self-report measures suggests that they may be particularly problematic for narcissistic disorders. Because self-report instruments tend to be more blunt and direct in identifying narcissistic traits, these traits are more likely than interviews to be perceived as pathological and to evoke defensive responses. Moreover, narcissistic people are particularly unable to view themselves realistically.

Studies that have used structured interviews have assessed *DSM-III* criteria for NPD as part of a broader effort to evaluate all Axis II categories. The Personality Disorder Examination was developed on a sample of 60 subjects, which included only 3 who met criteria for NPD.[5] The Structured Interview for Diagnosing Personality was developed on a sample of 131 subjects, which included only 5 who met *DSM-III* criteria for NPD.[6] The Diagnostic Interview for Personality Disorders was developed on a sample of 97 subjects, which contained 6 who met NPD criteria.[7] None of these instruments have had sufficient samples to evaluate reliability for the NPD criteria or for the diagnosis. Moreover, none have reported whether they generate diagnoses that correlate with clinical judgment. Two recent efforts have indicated that when clinical use of the narcissistic diagnosis is compared with fulfillment of *DSM-III* criteria as assessed by questionnaire[10] or structured interview,[11] the correspondence is very low.

The DIN evolved out of a review of the previous literature from which characterizations of narcissistic persons were identified.[12] It is also based on our clinical experience, including that which resulted from the multiple exposures to narcissistic persons during the 2-year period of this instrument's development. As such, the DIN now reflects the impressions gathered during the course of systematically examining samples of narcissistic patients. In its present form, it is suitable for the examination of narcissism as a pathological dimension of personality (ie, as a trait) and is suitable for diagnosing NPD. This report presents a description of the content, factor structure, mode of scoring and administering, reliability, training requirements, and psychometric features of this interview.

CONTENT

The content of the interview (Table 1) is divided into five sections: grandiosity, interpersonal relations, reactiveness, affects and mood states, and social and moral adaptation. These divisions are based on our conceptual organization of the 33 descriptive characteristics that we culled from the literature and our experience.

Each of the five sections is evaluated separately in the interview and each has its own time framework (Table 1). These time frameworks have a minimum of 1 year (affects and mood states) and a maximum of 5 years (social and moral adaptation) that were chosen to assure that the scoring is based on the usual patterns in a person's life rather than on potentially misleading current states such as recent depression,[13] anxiety,[14] and substance abuse.[15]

The grandiosity section begins with general questions about the patient's functional history and how he or she would describe himself or herself as a person. It then moves into specific inquiries that are directed at eliciting whether and how the person has unrealistically elevated views of himself or herself in terms of special abilities, invulnerability, self-

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sufficiency, uniqueness, and superiority.

The characteristics in the interpersonal relations section are to a large extent derived from the psychoanalytic/psychotherapeutic literature.[16-22] Issues such as the narcissistic person's tendency to idealize others and to lack empathy draw heavily on writings from Kohut.[20,21] Other characteristics that describe the narcissistic person's putative devaluative, contemptuous, entitled, and exploitative style are more heavily drawn from the descriptions by Kernberg.[18,19] Although psychotherapists primarily wrote about observations within psychotherapy, the interview is directed at eliciting evidence for the presence of such characteristics in the patient's usual interpersonal style with significant others.

The reactiveness section evaluates whether a person has unusually intense reactions to criticism, defeat, or disappointment. Specific inquiries directed at whether a person has felt that such experiences were motivated by envy, and whether they result in feeling deep shame, humiliation, and rage, highlight the narcissistic person's extreme sensitivity and inappropriate exaggerated responses.

The affects and mood states section looks for sustained and deep feelings of emptiness, boredom, meaninglessness, and futility. Sustained feelings of inner badness was included because it is characteristic of borderline patients[23,24] and thus might help with this important differentiation. A high score on it is weighted against the narcissistic diagnosis.

The section of social and moral adaptation is based on the expectation that narcissistic people manage high achievements while maintaining superficial, self-serving values and morals. A distinction is drawn between the narcissistic person who may break laws in a state of anger or for reasons of personal aggrandizement and a person who repeatedly engages in antisocial behavior for monetary or other materialistic gain. The latter pattern is considered typical of the antisocial person and is weighted against the narcissistic diagnosis.

There is reason to expect that some subtle, covert, and atypical forms of narcissistic psychopathology may not be identified by the DIN's content. This reflects both the lack of consensus about such traits and their problems in being assessed. Future research may lead to their inclusion.

SCORING

All five sections are composed of characteristics frequently attributed to narcissistic patients. Each of these characteristics is written in the form of a statement (n = 33). Each statement is scored after a series of discrete probes (n = 105) have been made, which are intended to illuminate and quantify the presence of that characteristic. All probes and statements are scored as 2 (much), 1 (some), or 0 (none). The interviewer is expected to score the probes and then to synthesize the information into a more general impression about the presence or absence of the characteristic that appears in the summary statement. The 105 probes and 33 statements are distributed as follows: 22 probes and 8 statements for grandiosity; 42 probes and 9 statements for interpersonal relations; 25 probes and 5 statements for reactiveness; 5 probes and 5 statements for affects and mood states; and 11 probes and 6 statements for social and moral adaptation. The statements for each section are added to form section total scores.

To determine whether the DIN could be used to identify patients with NPD, we first established cutoffs for each of the five section total scores that could optimally differentiate a sample of 24 patients given a well-informed clinical diagnosis based on extended knowledge (ie, the "LEAD" [*l*ongitudinal *e*xpert *a*ll *d*ata] standard[25]) of NPD from a sample of 58 others whose non-NDP diagnoses were established by the LEAD standard and verified by instrument-guided diagnoses. All subjects signed an informed consent. Conditional probabili-

Table 1.—Content and Interrater Reliabilities of Diagnostic Interview for Narcissism

Section/Statement	Weighted κ (n = 18)
I. Grandiosity (3-y framework, 22 probes)	
1. The person exaggerates talents, capacity, and achievements in an unrealistic way.*	.56
2. The person believes in his/her invulnerability or does not recognize his/her limitations.	.61
3. The person has grandiose fantasies.*	.80
4. The person believes that he/she does not need other people.	.77
5. The person regards himself/herself as unique or special compared with other people.*	.72
6. The person regards himself/herself as generally superior to other people.	.76
7. The person behaves self-centeredly and/or self-referentially.	.14
8. The person appears or behaves in a boastful or pretentious way.	.73
II. Interpersonal relations (3-y framework, 42 probes)	
9. The person has a strong need for admiring attention.	.62
10. The person unrealistically idealized other people.	.65
11. The person devalues other people, including feelings of contempt.	.59
12. The person has recurrent and/or deep feelings of envy toward other people.*	.80
13. The person reports or behaves entitled, ie, has unreasonable expectations of favors or other special treatment.*	.50
14. The person appears or behaves in a condescending, arrogant, or haughty way.	.45
15. The person is exploitative, ie, takes advantage of or uses other people.*	.56
16. The person lacks empathy (is unable both to understand and to feel for other people's experiences).*	.57
17. The person has been unable to make close, lasting emotional commitments to others.	.59
III. Reactiveness (3-y framework, 25 probes)	
18. The person is hypersensitive.	.75
19. The person has had unusually intense feelings in response to criticism or defeat.*	.61
20. The person has behaved or felt suicidal or self-destructive in response to criticisms or defeat.	.85
21. The person has reacted with inappropriate anger in response to criticism or defeat.	.31
22. The person has had hostile, suspicious reactions in response to the perception of others' envy.	.59
IV. Affects and mood states (1-y framework, 5 probes)	
23. The person has deep, sustained feelings of hollowness.	1.00
24. The person has deep, sustained feelings of boredom.	1.00
25. The person has deep, sustained feelings of meaninglessness.	.96
26. The person has deep, sustained feelings of futility.	1.00
27. The person has deep, sustained feelings of badness.	.85
V. Social and moral adaptation (5-y framework, 11 probes)	
28. The person has been capable of high school/work achievement (academic, employment, creative).	.65
29. The person has superficial and changing values and interests.	.73
30. The person shows a disregard for usual/conventional values or rules of society.	.70
31. The person has broken laws one or a few times under circumstance of being enraged or as a means to avoid defeat.	1.00
32. The person has recurrent antisocial behavior.	.82
33. The person's sexual behavior includes perversions, promiscuity, and/or a lack of inhibitions.	.77

**DSM-III-R* criteria for narcissistic personality disorder.

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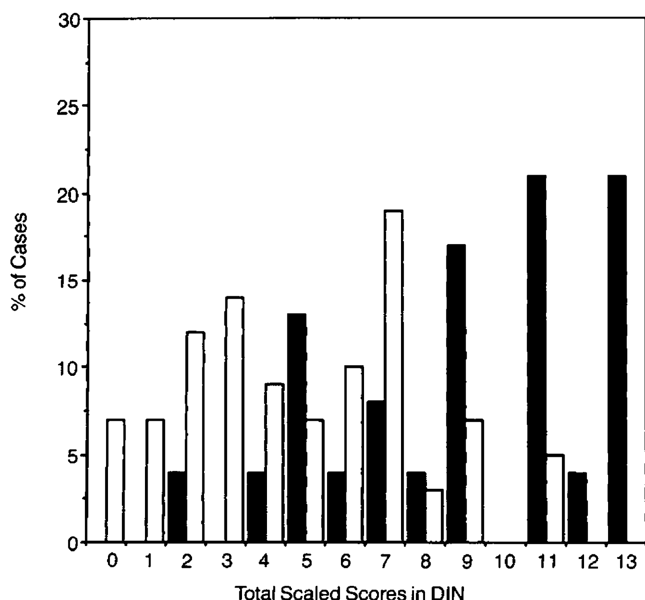

The distribution of Diagnostic Interview for Narcissism (DIN) scaled totals by diagnosis in 24 patients with narcissistic personality disorder (solid bars) and 58 other patients (open bars).

ties for each possible section score were examined and the optimal cutoffs emerged as 10 for section I, 12 for section II, and 6 for sections III, IV, and V.

Section I, grandiosity, and section II, interpersonal relations, contained a majority of the features attributed to pathological narcissism from the literature, seemed conceptually more central to this diagnosis, and had the best performance in differentiating the narcissistic sample. Hence, these two sections are given heavier weighting by scaled scoring of the section totals. The scaled section score for section I has a maximum of 4, and for section II the scaled section score has a maximum of 3. The other three sections have a maximum scaled score of 2. Thus, the possible range of the total scaled interview score is 0 to 13. This sum provides a rough index of how prototypic the patient's narcissism is. At the same time it corresponds to a quantitative estimate of narcissism as a dimensional personality trait, as opposed to the use of a cutoff by which to define narcissism as a categorical diagnostic entity.

The total scaled interview score was used to establish the optimal diagnostic cutoff for the DIN. The Figure shows the frequency distribution for the scaled total score of the narcissistic sample compared with the others. The two best scaled total interview cutoffs were 9 or 10; both resulted in correct classification of 80% of the sample as either narcissistic or not (Table 2). The κ with a cutoff of 9 or more is .52, and with a cutoff above 10 fell to .46. A cutoff of 9 thus is the standard by which the DIN should be used to identify NPD, but the cutoff of 10 may be preferable for eliminating questionable (ie, false-positive) patients from research samples.

ADMINISTERING THE INTERVIEW

The interview is semistructured, meaning that the interviewer is expected to add probes in areas where he or she is confused or dissatisfied with the patient's response and to rely on judgments and impressions that may come from the patient's behavior or from unsolicited, volunteered information. Under no circumstances can an item be scored as present without some confirmation by the patient.

The interview takes about 45 minutes. Patients find it understandable and generally relevant to their problems.

Table 2.—Comparison of Clinical vs DIN Diagnostic Assignment*

	Cutoff at 9		Cutoff at 10	
	Clinical NPD	Clinical Non-NPD	Clinical NPD	Clinical Non-NPD
DIN NPD	15	7	11	3
DIN non-NPD	9	51	13	55
κ	0.52		0.46	
Concordance	0.80		0.80	
Sensitivity	0.63		0.46	
Specificity	0.88		0.95	
Positive predictive power	0.68		0.79	
Negative predictive power	0.85		0.81	

*DIN indicates Diagnostic Interview for Narcissism; NPD, narcissistic personality disorder.

Table 3.—Interrater Reliability (Intraclass *R*) on Section Scores and Total Score (*P*>.000)

Section	Trial (n = 18)
I	.87
II	.80
III	.74
IV	.96
V	.84
Total	.88

Because the interview often probes into inherently sensitive issues, a concerned and interested interviewer is important to avoid aggravating the patient's defenses and/or resulting in negative interview reactions. Thus far, no patients have left the interview out of anger or found the interview offensive. Interviewers find the interview clinically rich and easy to get involved with despite repetitions. Its use is rarely restricted by patient psychopathology. It is our impression, however, that very disorganized patients may lack the self-observing capacity to give meaningful responses, and that healthy but self-conscious individuals are more likely to discern the narcissistic themes and to react more defensively.

The grandiosity section is addressed first because experience has shown that narcissistic people are more apt to respond openly to these inquiries early in an interview and may become more defensive about these issues if they perceive the overall themes of the interview. Narcissistic people are frequently sufficiently pleased with their achievements and interpersonal style that they lack self-consciousness and offer more information about themselves than they realize when talking with a sympathetic and interested interviewer/audience.

RELIABILITY

Interrater reliability was assessed on samples that included both outpatients and inpatients. Because about one third of the samples had clear narcissism and most of the other patients had other types of personality disorder, a sterner test of reliability was offered (than when distant diagnoses are used, which lead to many nonrelevant inquiries and fewer issues in interviewer judgment). Interviews were done during an initial evaluation in which a clear clinical diagnosis had not yet been established, but often in instances where the referral was generated because of knowledge of our interest in studying pathological narcissism.

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Table 4.—α Values (Correlation Coefficient) for Sections and Total Score (TS)

Section	α
I. Grandiosity	.76
II. Interpersonal relations	.60
III. Reactiveness	.44
IV. Affect/moods	.65
V. Social/moral adaptation	.49
TS, sections	.66
TS, statements	.81

Interrater reliabilities were calculated on all statements using the weighted κ coefficient. The 0, 1, 2 scale on which each statement was scored was converted to an 0, 2, 3 scale, reflecting our judgment that probable and yes are qualitatively closer to each other than they are to no. Using κ = .4 as a cutoff level,[26] Table 1 indicates that satisfactory reliability was achieved for 31 of the 33 statements. One of the two problematic statements involved ratings of the subject's observed behaviors (No. 7, self-centered/self-referential). The relative unreliability of interviewer observations (ie, signs) compared with patient reports has previously been noted with other diagnostic interviews.[27-29] The other statement with weak reliability (No. 21, angry reactions) we thought had insufficient or unfocused probes and ambiguous wording in the statement. Efforts have been made to correct these.

Table 3 shows that the intraclass reliabilities for the diagnostically important section and total interview scores were uniformly high (*P*<.000). The very high reliabilities obtained on these summary scores are especially desirable since cutoffs on the scaled section scores establish the total scaled interview score, which in turn is the basis for diagnosis. Notably, the reliabilities on the DIN's section totals and total interview score (intraclass *R* from .74 to .96) are even higher than those reported on the Diagnostic Interview for Borderlines,[27,30] which has a similar scoring system and where reliability has been well established.[31-33]

Reliability training involved two trials, one with an experienced social worker and the second with a psychiatric resident. At their conclusion, both achieved reliabilities similar to those noted above. We would not infer from this that inexperienced or nonprofessional raters can employ the instrument since, in our opinion, considerable clinical judgment is often involved (especially around the issues of whether a person's self-perceptions are realistic) and because interviewer sensitivity is required to minimize defensive responses.

The format for training raters to become reliable is similar to that developed with the Diagnostic Interview for Borderlines.[27,34] The experienced reliable interviewer conducts the first two of the four training interviews and discusses areas of disagreement after each. These first two patients preferably display considerable narcissism. If the reliability after two interviews is poor (>10 disagreements on statements), it is best to have the experienced rater conduct a third interview as well. If reliability appears good after two interviews, the trainee can conduct the interview on the third and fourth patients while the supervising rater observes.

INTERNAL CONSISTENCY AND CONSTRUCT VALIDITY

Three tests of internal consistency were done. Table 4 shows that the correlation of the 33 statements with the total score (using the same sample of 82 patients used for developing cutoffs) revealed good consistency (α = .81). The correlation of the statements with their corresponding section scores also revealed acceptable, albeit weaker, internal consistency: α≥.60 was observed for sections I, II, and IV. The lower α correlations found in section III, reactiveness (.44), and section V, social/moral adaptation (.49), may be explained both by the smaller number of statements and by the wider range of content within those sections. The examination of the correlation of section scores with the interview total revealed acceptable overall consistency (α = .66). However, section IV showed a sufficiently poor correlation (α = .07) to suggest that it does not contribute greatly to the overall content of the interview. This may have been affected by there being eight members of the narcissistic sample who had concurrent major depression.

Table 5.—Unrotated Principal Component Factor Analysis for Whole Sample*

Statement†	Factor Loading	DIN Section
Factor 1 (18.4% variance)		
2 Belief in invulnerability	.589	I
3 Grandiose fantasies	.716	I
5 Uniqueness	.532	I
6 Superiority	.680	I
7 Self-centered/self-referential	.519	I
8 Boastful/pretentious	.564	I
9 Needs attention/admiration	.653	II
10 Idealization	.549	II
13 Entitlement	.595	II
15 Exploitiveness	.486	II
21 Angry reactions	.499	III
29 Superficial values	.534	V
30 Disregard for values/rules	.666	V
Factor 2 (10.4% variance)		
23 Hollowness	.566	IV
25 Meaninglessness	.605	IV
26 Futility	.635	IV
Factor 3 (6.8% variance)		
16 Lacks empathy	.696	II
17 Uncommitted to anyone	.470	II
32 One or a few crimes	.473	V
Factor 4 (6.3% variance)		
31 Antisocial pattern (−)	.659	V

*DIN indicates Diagnostic Interview for Narcissism.
†See Table 1 for expansion of statement number designators.

An unrotated principal component factor analysis was done on the sample of 82 patients to investigate whether the conceptual structure of the whole interview and of the five sections are reflected in the intercorrelations among the 33 statements. Table 5 shows that most of section I and much of section II loaded on the same first factor. This suggests that those two sections are tapping a common single dimension of narcissism. The second factor was composed of the reasonably well-intercorrelated components of section IV of the DIN. Section V statements were distributed widely, which suggests that it lacks an internal conceptual coherence. Section III did not load very heavily on any of the four factors. It does not seem to tap dimensions that are statistically correlated much with the interviews' scoring and function.

Overall, both the analysis of internal consistency and the factor analysis confirm the construct validity of the first two sections, while raising questions about the value of section IV and the conceptual integrity of sections III and V.

COMMENT

The DIN is the first instrument that has been developed from and applied to clinically diagnosed narcissistic patients.

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It was designed to determine whether patients diagnosed as narcissistic have in actuality the characteristics attributed to them in the previous literature. This effort is based on the belief that there are clinically discernible signs that make narcissistic disturbances identifiable to a sophisticated interviewer. This contrasts with Kohut's view that narcissistic disturbances can only be identified by transference developments.[20,21] Because this interview focuses on observable or reportable information, it may well be that more subtle forms of pathological narcissism will be missed without recourse to a transference relationship. Despite this limitation, we have found that most but not all of the characteristics attributed to pathological narcissism in the literature are found in patients identified by clinicians as narcissistic. Such results yield information that can evaluate *DSM-III-R* criteria and can help establish an empirical basis for the criteria used to define NPD in *DSM-IV.* More important is that it confirms the utility of the DIN as a measure by which samples of narcissistic patients can be reliably defined to assess the validity of the disorder.

This study established a scoring system by which the DIN can be expected to agree with informed clinical judgments. The use of the latter as the standard-bearer for evaluating the instrument is a critical step for the development of the NPD diagnosis, a category developed from clinicians' accounts and justified because of clinician usage. The concordance (80%) is slightly higher than that observed initially with the Diagnostic Interview for Borderlines (77%) when a similar κ of .52 was obtained. This is particularly satisfactory considering that the original Diagnostic Interview for Borderlines studies used less-affiliated comparison groups (depressive and schizophrenic samples) and has subsequently needed revisions to sharpen its ability to distinguish borderline samples from samples with other personality disorders.[33] The fact that a similar level of concordance was reached herein while using what we consider a closer and thus more demanding contrast group (ie, more than half borderline or antisocial) provides evidence that the DIN can provide a useful research role.

The present report also identifies limitations of the DIN that future research should address. Improving interrater reliability in four statements is under way, and the very satisfactory diagnostic reliability noted in the report still needs to be supplemented by test-retest reliability testing. Moreover, the tests of the structure and internal coherence of the interview raise questions about the value of the contributions from several sections. Despite these limitations, we believe that all five sections and all 33 statements should remain in the DIN until such findings are confirmed in other studies.

The present report provides support for the potential usefulness of the DIN as a standardized method for undertaking empirical studies of a group of patients who have been widely discussed but rarely researched. Other studies show which characteristics from the DIN are most useful in discriminating narcissistic patients from those with other diagnoses.[35,36] Such studies can help refine the set of criteria by which narcissistic personality disturbances are diagnosed. As such, the DIN may stimulate much-needed research into issues such as the pathogenesis, course, and treatability of narcissism.

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