# OPTIMAL PSYCHOTHERAPY PROCESS FOR PATHOLOGICAL NARCISSISM: AN EXPLORATION OF CLINICIANS' PERSPECTIVES

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**ABSTRACT**

Pathological narcissism is a syndrome involving distorted self-image and identity dysregulation. Narcissistic pathology is associated with emotional and interpersonal difficulties, functional impairment, and mental disorder; such patients are seen frequently in mental health settings, and tend to be regarded by clinicians as having complex treatment issues. Despite a vast conceptual literature on pathological narcissism, empirical research regarding treatment is extremely limited. This study was designed to explore clinicians' perspectives regarding optimal psychotherapy process in the treatment of pathological narcissism. A Q-methodological approach was used to obtain detailed accounts of therapists' opinions in a manner that would allow for systematic examination. Participants were 34 psychotherapists of various disciplines who responded to email and listserv postings of the recruitment notice. Participants reviewed three clinical vignettes portraying hypothetical patients suffering from grandiose narcissism, vulnerable narcissism, and panic disorder without pathological narcissism. Participants then used the Psychotherapy Process Q-set (PQS), a 100-item Q-sort instrument, to indicate their views regarding optimal therapy process for each hypothetical case. Analysis of therapists' mean PQS responses using ANOVA found several differences in prospective interventions, according to the different psychopathologies featured in the vignettes. Principal components analysis with varimax rotation was conducted on all 102 Q-sorts and revealed four factors. Detailed descriptions of these ideal therapy processes were interpreted. The factors were also analyzed regarding their relationship to established therapy models. The first factor was endorsed across all three patient types, and represented an introspective, relationally-oriented therapy process. This factor was strongly correlated with established psychodynamic treatments. The second factor, most frequently endorsed for the panic disorder vignette, consisted of a

cognitive and alliance-building approach that correlated strongly with expert-rated cognitive-behavioural therapy. The third and fourth factors involved therapy processes focused on the challenging interpersonal behaviours associated with narcissistic vulnerability and grandiosity, respectively, and were endorsed for vignettes presenting these narcissistic subtypes. These factors had fewer and smaller correlations with established treatments. The findings are discussed with respect to implications for the study and treatment of pathological narcissism.

## PREFACE

This dissertation is an original, unpublished work. I designed the research project, collected and analyzed the data, and interpreted the results. The research project was approved by the University of British Columbia's Behavioural Research Ethics Board (certificate #: H12-01821). Dr. John Ogrodniczuk (University of British Columbia, Vancouver) supervised the development and conduct of the research project. The research was supported by a University of British Columbia Humanities and Social Sciences Research Grant (FAS #: F13-01357) awarded to Dr. Ogrodniczuk. Dr. Geoff Goodman (Long Island University, Brookville, NY) provided statistical consultation, and provided the expert-rated PQS psychotherapy prototypes used for comparison analyses in section 5.8.

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# 1 INTRODUCTION

## 1.1 Narcissism in clinical practice

Narcissism has long been the subject of considerable fascination. The ancients recognized the problem of distorted self-image in the myth of Narcissus, a young man whose rejection of love and enthrallment with his own image eventuated in his demise. The term narcissism in contemporary usage also conjures images of superficiality and selfishness, conveying a degree of investment in the self that overrides concern for others. This state of being has been explored across a range of disciplines, including the humanities, political science, sociology, and human services. Narcissism has been considered by clinical disciplines – psychiatry, psychology, social work, and psychoanalysis – as having serious implications for mental health. Indeed, pathological narcissism is a clinically significant phenomenon associated with both personal and social tragedy. A substantial conceptual literature has developed in response to the problem of pathological narcissism, with various theories regarding its phenomenology and etiology, fostering recent empirical contributions. Among such writings, psychotherapy has consistently been proposed as the principal means of remedying pathological narcissism.

Pathological narcissism is a frequently encountered issue in the practice of psychotherapy (Doidge, et al., 2002; Ogrodniczuk, 2013; Pincus, Cain, & Wright, 2014). Efforts at understanding pathological narcissism in the clinical context continue to accrue across mental health disciplines such as psychiatry and clinical psychology (Campbell & Miller, 2011; Ogrodniczuk, 2013; Pincus & Lukowitsky, 2010; Ronningstam, 2005) and social work (Hotchkiss, 2006; Imbesi, 1999; Kealy & Ogrodniczuk; Kealy & Rasmussen, 2012). Recommended psychotherapeutic approaches include variations of psychodynamic therapy

(Kernberg, 2010; Lachmann, 2008;), cognitive therapy (Freeman & Fox, 2013; Rasmussen, 2005), and integrative models (Behary & Dieckmann, 2013; Dimaggio & Attina, 2012); consensus among these perspectives is that treatment tends to be challenging. Given the prevalence of narcissism in clinical practice, the difficulties associated with it, and the conceptual variation in the field, the dearth of empirical inquiry into the psychotherapy of narcissistic pathology is a serious concern. The present study was developed in response to this concern, as an attempt to discover ideal therapy processes in the treatment of pathological narcissism.

### 1.2 Normal narcissism

The widespread colloquial use of the term, combined with varied theoretical discourse has resulted in confusion about the meaning of narcissism (Britton, 2004). Even within psychoanalysis, where discussions of narcissism have a long history, the term has been used to refer to developmental issues, sexual behaviour, interpersonal relatedness, and as a form of self-esteem functioning (Pulver, 1970). Contemporary usage generally associates narcissism with issues pertaining to self-image or self-esteem and interpersonal functioning. Often narcissism refers to a relative degree of self-absorption and diminished concern for others. There is, however, a concept of normal narcissism (Stone, 1998). Normal narcissism refers to an essential and healthy degree of self-investment that consists of the ability to adaptively and sustainably achieve positive self-regard. As an important aspect of mature personality functioning, normal narcissism entails a realistic appraisal of one's personal attributes and abilities, coupled with a capacity for empathy towards others (Stone, 1998). Narcissistic functioning is involved in the development of personal agency, the pursuit of ambitions, and the restoration of self-esteem following personal defeat. Healthy narcissism, including a realistic sense of deservedness, is

also thought to be important in the development and maintenance of positive interpersonal relationships (Stone, 1998). Stolorow (1975) emphasized that the concept of narcissism is most usefully defined functionally, in reference to the maintenance of the self. Narcissism is thus conceived of as any mental activity that serves to "maintain the structural cohesiveness, temporal stability, and positive affective coloring of the self-representation" (Stolorow, 1975). Implicit in this view is the notion of narcissism as a phenomenon of varying degrees, from healthy and adaptive at one end of the spectrum, to pathological and severely maladaptive at the other.

### 1.3 Pathological narcissism

Pathological narcissism involves a distortion of self-regard and a failure to adaptively maintain a positive sense of self. Individuals with pathological narcissism lack the appropriate means for healthy self-esteem regulation. For many individuals, this can manifest as arrogance, fantasies of brilliance, and social dominance – features of narcissism that are commonly referenced in public discourse. These features are recognized in clinical nosology as Narcissistic Personality Disorder (NPD; American Psychiatric Association, 2013; World Health Organization, 2010), indicating patterns of extreme grandiosity, entitlement, and diminished empathy for others. As maladaptive self-enhancement strategies, the purpose of such features is to raise the individual's self-image, even at the expense of relations with others. It is not self-inflation per se, however, that defines narcissistic dysfunction. The key issue is a relative deficiency in healthy self-regulation (Kealy & Rasmussen, 2012; Ronningstam, 2011a). Pathological narcissism is thus most usefully defined as the presence of "significant regulatory deficits and maladaptive strategies to cope with disappointments and threats to a positive self-image" (Pincus & Lukowitsky, 2010, p. 426). Accordingly, contemporary clinical discourse

regarding pathological narcissism focuses on deficits in identity and self-regulation, and on maladaptive mechanisms of self-enhancement (Ronningstam, 2011a).

### 1.4 Epidemiology and associated features

It has long been recognized – and recently empirically confirmed – that pathological narcissism causes significant impairment and distress (Miller, Campbell, & Pilkonis, 2007). A number of accompanying psychiatric, emotional, and social problems have also been observed, thereby further confirming the impairment connected with pathological narcissism. In a large epidemiological study, Stinson and colleagues (2008) found that NPD tends to be comorbid with substance use, mood, and anxiety disorders. Narcissism has also been found to correlate with post-traumatic stress disorder (Bachar, Hadar, & Shalev, 2005), eating disorder symptoms (Gordon & Dombeck, 2010), and problem gambling (Lakey, Rose, Campbell, & Goodie, 2008). NPD is reported by mental health clinicians to be clinically prevalent, estimated at between 8 – 20% of patients in outpatient psychotherapy (Doidge et al., 2002; Westen & Arkowitz-Westen, 1998), despite general population prevalence estimates of about one percent (Dhawan, Kunik, Oldham, & Coverdale, 2010). Patients with narcissistic pathology are regarded as having a higher than average risk for suicide (Ronningstam, Weinberg, & Maltsberger, 2008), with more deliberate and lethal suicidality compared with other personality disorders (Blasco-Fontecilla et al., 2009). A retrospective chart review found that pathological narcissism was positively associated with the number of reported suicide attempts (Pincus et al., 2009). Individuals with pathological narcissism are considered to be particularly susceptible to later-life despair and impairment as their capacity for self-enhancement erodes over the life course (Cramer, 2011; Goldstein, 1995). Indeed, Heisel and colleagues (2007) found significantly higher levels of suicidal vulnerability among geriatric patients with narcissistic pathology.

Pathological narcissism has been found to be associated with interpersonal problems (Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009; Dickinson & Pincus, 2003) and with poor occupational functioning (Campbell, Hoffman, Campbell, & Marchisio, 2011). Narcissistic dysfunction has also been widely considered as an impediment to love relations (Akhtar, 2009; Rosegrant, 2012; Solomon, 1994), and indeed as an obstruction in the capacity to give and receive love (Kealy & Ogrodniczuk, 2014). Associations have also been found between narcissism and disagreeable post-separation parenting arrangements (Ehrenberg, Hunter, & Elterman, 1996), as well as perpetration of child abuse (Wiehe, 2003). In sum, there is a substantive body of evidence of significant impairment associated with pathological narcissism, and thus compelling need for clinical efforts to ameliorate it.

### 1.5 Narcissism and self-enhancement

Self-enhancement has been a focal issue in the study of narcissism in the field of social psychology, where empirical research on narcissism as a personality trait has helped to clarify mechanisms through which self-image may be bolstered. Self-enhancement strategies can broadly be categorized as (1) intrapsychic, the use of internal psychological mechanisms, and (2) interpersonal, the use of interactions with others (Campbell & Baumeister, 2006). Examples of intrapsychic mechanisms include fantasizing about one's own brilliance, inordinately praising one's successes, and attributing all blame for setbacks to external circumstances. These mechanisms may well be aspects of normal narcissism that, when utilized in a measured and appropriate fashion, serve to support positive self-regard. When held to a pathological degree, these attitudes may include a sense of being above the usual conventions and norms that bind society, or an entitlement to success and recognition without having expended the necessary efforts to achieve it, often contributing to lack of investment in education, work, or relationships.

Self-enhancement can also be obtained interpersonally. Mature and reciprocal relationships, for example, normatively involve positive affirmation of the self through occasional praise and recognition. In extreme form, however, interpersonal strategies may involve the constant seeking of admiration from others or a preoccupation with competitively triumphing over perceived rivals. Consequently, narcissistic interpersonal relationships may be shallow and one-sided, with more concern for the self-enhancing properties of the relationship than for mutuality and reciprocity (Kealy & Ogrodniczuk, 2011).

Narcissistic self-enhancement has been likened to an addiction process whereby cravings for admiration and self-inflation are never truly satisfied (Baumeister & Vohs, 2001). According to this view, tolerance to the effects of self-aggrandizement and admiration leads to the constant seeking of newer and more powerful sources of self-enhancement. An absence of admiration, or an experience that diminishes the individual's self-image results in an intolerable state of withdrawal that impels further addictive self-enhancement activity. An alternative view emphasizes the lack of interpersonal concern associated with narcissism in contributing to ongoing self-enhancement efforts (Morf & Rhodewalt, 2001). Although external affirmation may be constantly sought to enhance a fragile self-concept, the devaluation of other people prevents their usefulness as reliable supports to the individual's sense of self. This state of affairs is thus thought to propel a cycle of ongoing self-enhancement efforts.

Campbell & Campbell (2009) proposed a contextual reinforcement model whereby self-enhancement strategies are rewarded for their short-term social advantages, but are experienced as costly in the long run. According to this view, superficiality and self-inflation is advantageous for both the narcissistic individual and for others in some social contexts (Paulhus, 1998). These advantages reinforce self-enhancement mechanisms until the costs of narcissism are met in the

area of compromised interpersonal relations over the long term (Campbell & Campbell, 2009). This burning of bridges, so to speak, confronts the individual with the option of either modifying their narcissistic features or redoubling their self-enhancement efforts.

A critical issue regarding the aforementioned social psychology research is the degree to which the narcissism investigated corresponds to the narcissistic pathology encountered in clinical settings. First of all, much of this research relies on self-report measures, which in the case of narcissism may be less reliable because of social desirability bias. Secondly, the overwhelming majority of narcissism research is based on non-clinical samples of college undergraduates, a population that may be quite different in many respects from patients with narcissistic problems who seek treatment for psychiatric distress. Another limitation concerns the principal measure used to investigate narcissism in non-clinical samples. The Narcissistic Personality Inventory (NPI; Raskin & Terry, 1988) has been critiqued as not adequately capturing characteristics of narcissistic pathology, and that it instead measures some aspects of adaptive functioning (Ackerman et al., 2011; Pincus & Lukowitsky, 2010; Trzesniewski, Donnellan, & Robins, 2008; Vater, et al., 2013). Indeed, the NPI has been referred to as containing "a confusing mix of adaptive and maladaptive content" (Cain, Pincus, & Ansell, 2008, p. 643). Furthermore, research findings have overall been inconclusive with respect to the question of whether narcissistic self-enhancement masks underlying poor self-esteem (Bosson, et al., 2008), a predominant clinical opinion.

In sum, while social psychology research on trait narcissism has provided valuable insight regarding self-enhancement, further developments are required to integrate these findings with clinical perspectives on narcissistic pathology. A clinically relevant measure of narcissism – the Pathological Narcissism Inventory (PNI; Pincus, 2013) – has recently been developed and

may contribute to efforts at bridging social psychology and clinical research. Recent studies have also examined narcissism in clinical samples (Ellison, Levy, Cain, Ansell, & Pincus, 2013; Kealy, Tsai, & Ogrodniczuk, 2012). Integration and consolidation of narcissism research across these fields would strengthen understanding of pathological narcissism and ultimately contribute to improved treatment of this psychopathology (Cain, Pincus, & Ansell, 2008; Pincus & Lukowitsky, 2010).

### 1.6 Narcissistic personality disorder

Progress in the understanding of pathological narcissism has also been limited within clinical psychology and psychiatry, in particular by the official diagnostic criteria for narcissistic personality disorder (NPD). The diagnosis of NPD should represent a clinically significant and impairing personality constellation organized around narcissistic dysfunction. In a dimensional view of pathological narcissism, NPD would represent individuals with relatively high levels of narcissistic pathology. The criteria for NPD in DSM-5 (APA, 2013) only partially accomplish this, emphasizing the presence of grandiosity and entitlement, fantasies of brilliance and success, intense envy, and lack of empathy and sensitivity towards others. Although these are indeed important aspects of narcissistic dysfunction, the DSM criteria have been criticized for omitting other aspects of distorted self-image and maladaptive self-regulation (Pincus, 2011; Ronningstam, 2011b). A proposed revised criteria set for DSM-5 would have incorporated features such as distorted or fluctuating identity, goals and values based on inflated or entitled self-appraisal, and limited empathic functioning based on self-regulatory concerns (Skodol, Bender, & Morey, 2014). Ultimately, amidst much controversy, the proposed revision of the personality disorders section was not included in DSM-5, leaving a diagnostic category for NPD that has been widely regarded as unsatisfactory, not least because of suspected under-reporting of

NPD (based on DSM criteria) in prevalence studies (Dhawan, Kunik, Oldham, & Coverdale, 2010).

Another problem concerning NPD is the issue of whether pathological narcissism should even be represented as a category of personality disorder. An earlier proposed revision of DSM had actually eliminated NPD as a distinct category, recommending instead the scoring of dimensional personality traits such as antagonism. The question had been raised as to whether pathological narcissism is better understood as an underlying common element of personality dysfunction (Skodol, Bender, & Morey, 2014). Several of the main features of pathological narcissism, such as distorted identity and impaired empathic functioning, are found across virtually all personality disorder categories (Morey & Stagner, 2012).

Regardless of whether pathological narcissism is designated categorically (i.e. as NPD), the construct should represent narcissistic personality phenomena as encountered in clinical contexts. In contrast to individuals with trait narcissism (i.e. as assessed by the NPI), individuals with clinically significant narcissistic pathology – patients who present for clinical help – are seldom observed to be in the throes of relentless self-enhancement. Individuals suffering from pathological narcissism are more likely to seek treatment upon the failure of self-enhancement mechanisms, where the exposure of unstable identity brings forth a torrent of dysphoria that may resemble other psychiatric disorders. It is this state in which patients with narcissistic problems are more likely to seek help, though their narcissistic features may be obscured due to an absence of overt grandiose features.

### 1.7 Presentations of pathological narcissism

Clinical theorists have long observed narcissistic self-regulatory problems to encompass much more than persistent self-enhancement. Indeed, the literature on narcissism contains many

references to fragile self-representations, feelings of worthlessness, and even overtly avoidant and helpless behaviour. Such observations have evolved a notion of "subtypes" of pathological narcissism and narcissistic personality disorder (Levy, 2012a; PDM Task Force, 2006). In a thorough review of the narcissism literature, Cain and colleagues (Cain, Pincus, & Ansell, 2008) distilled a multitude of various descriptions of narcissism into two fundamental themes: (1) grandiosity, and (2) vulnerability. Regarded as non-orthogonal (i.e., not mutually exclusive), these expressions of pathological narcissism have been supported by empirical research (Pincus et al., 2009; Russ, Shedler, Bradley, & Westen, 2008; Wink, 1991; Zeigler-Hill, Clark, & Pickard, 2008). Grandiose narcissism encompasses parallel terms such as exhibitionistic, oblivious, phallic, manipulative, and extroverted. This presentation involves self-inflation, callousness, and fantasies of superiority. Narcissistic grandiosity also includes self-regulatory disavowal of negative self-views, and exhibitionistic behaviour designed to obtain admiration (Cain, Pincus, & Ansell, 2008). Grandiose narcissism is depicted in the DSM-5 criteria for NPD (APA, 2013). The vulnerable theme, on the other hand, refers to feelings of helplessness, suffering, and anxiety regarding threats to the self, and reflecting inner feelings of inadequacy, emptiness, and shame. Narcissistic vulnerability involves hypervigilance to insult, and excessive shyness or interpersonal avoidance in order to retreat from perceived threats to self-esteem. This vulnerable theme of narcissism is not represented in official diagnostic nomenclature, despite being widely discussed in the clinical literature (it is represented as a subtype in the Psychodynamic Diagnostic Manual; PDM Task Force, 2006).

Narcissistic grandiosity and vulnerability may each be either overtly or covertly expressed. For example, themes of fragility and depletion may be predominant and overtly expressed, yet grandiose fantasies may hover covertly in the background. Likewise, overt

arrogance can mask covert feelings of inadequacy (Pincus & Lukowitsky, 2010). Although many patients might evince one or the other theme much of the time, the contrasting theme remains psychologically salient, albeit unexpressed and perhaps inaccessible to the patient's awareness. Some degree of fluctuation between grandiosity and vulnerability is thought to be likely for most narcissistic patients (Levy, 2012a; Ronningstam, 2005). From this perspective, a patient who presents primarily with grandiose narcissism may at some level experience aspects of narcissistic vulnerability, such as deeply-held feelings of shame or inadequacy (Morrison, 1983; Reich, 1960; Ronningstam, 2005). Indeed, the presence of overt grandiosity for such a patient may reflect his or her considerable effort at defending against or compensating for such experience. Such observations – found throughout the clinical and conceptual literature on narcissistic pathology – are consistent with the "mask model" of narcissism that has received inconsistent support in non-clinical personality research (Bosson, et al., 2008).

The problematic self-enhancement strategies that define grandiose narcissism are thus regarded as serving to protect against the emergence of vulnerable self-states. In this way, vulnerable self-experience is an important driving force in narcissistic pathology. Hence the contemporary clinical view that "the self-regulatory deficit of pathological narcissism is not the grandiosity itself, but a secret fragile core that must be warded off from conscious awareness and prevented from discovery by others – and indeed from the self" (Kealy & Rasmussen, 2012, p. 358). When grandiose self-regulatory efforts reach their limits or fail, this fragility is exposed in an overt expression of narcissistic vulnerability.

In contrast to individuals with predominantly grandiose presentations, those who mainly present with overt vulnerable narcissism have sometimes been referred to as "failed narcissists", indicating the perspective that overt vulnerability may reflect an inability to develop or sustain

self-enhancement strategies (Campbell & Baumeister, 2006). In other words, individuals with overt narcissistic vulnerability would be grandiose, if only they had the ability or opportunity to do so. This perspective is consistent with observations of treatment seeking among patients with pathological narcissism. Patients are more likely to avail themselves of clinical intervention in dysphoric affect states, when overtly grandiose self-enhancement methods are no longer viable. Observations of primary narcissistic vulnerability – with limited overt expression of grandiosity – have been well-documented in the clinical literature under labels such as hypervigilant narcissism (Gabbard, 1998), closet narcissism (Masterson, 1993), and shy narcissism (Ronningstam, 2005). Patients with these presentations are widely considered to harbour secret grandiose fantasies that remain largely hidden behind overtly vulnerable attitudes and behaviours. These covert intrapsychic self-regulatory mechanisms are thought to operate largely beyond conscious awareness, and may only become accessible when the individual is under the threat of severe psychological injury, or following successful treatment interventions.

Another perspective suggests that overt vulnerable narcissism, expressed through themes of failure and defeat, may in itself reflect a primary form of self-enhancement. Cooper (1988; 2009) proposed that attitudes of being hard-done-by, unappreciated, or rejected may serve important narcissistic functions. Lurking beneath a chronic sense of injustice may be a covert sense of superiority associated with suffering wrongdoings and receiving little from life. According to this view, a covert self-enhancement process underlies repetitive patterns of self-defeating behaviour, in that the individual maintains a sense of autonomy and control over one's own suffering. Repeated self-defeating patterns, accompanied by resentment and disappointment, thus help to avert even more painful feelings of shame and inadequacy that might ensue from genuinely hoping for, but not receiving, love or success. Overt vulnerability

may even disguise a somewhat grandiose sense of pride in suffering; such patients have been referred to as "injustice collectors" (Cooper, 1988).

Differences between patients with primarily grandiose versus vulnerable expressions of narcissism have been the subject of recent empirical investigations. Grandiosity has been found to be associated with positive affect, gambling, criminality (Miller, et al., 2010), and with dominant, vindictive, and intrusive interpersonal problems (Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009). Narcissistic vulnerability has been associated with anxiety, depression, paranoid ideation, and hostility and interpersonal sensitivity, as well as insecure attachment and histories of childhood abuse (Miller, et al., 2010). In a clinical sample, grandiosity was found to be correlated with violence and manic symptoms, while vulnerability was associated with depression, sleep problems, and psychosis (Ellison, Levy, Cain, Ansell, & Pincus, 2013). In a study of psychiatric outpatients, narcissistic grandiosity was positively associated with dependency-related depressive experiences, and vulnerability was positively associated with self-critical themes of depression (Kealy, Tsai, & Ogrodniczuk, 2012).

### 1.8 Etiology and contributing factors

Etiological factors contributing to the development of grandiosity and vulnerability are not clearly understood. Improvements in construct definition, assessment, and research integration will hopefully provide empirical clarification of contributing factors. Broad social forces have been suggested as contributing to the development of narcissistic problems. Lasch's popular *Culture of narcissism* (1979) critiqued modern society, especially in North America, for the promotion of narcissistic values, including the norming of exhibitionism and self-aggrandizement. The high valuation of celebrity status, material wealth, and physical appearance in contemporary society seems to lend itself well to such an interpretation.

Consumerism may in particular contribute to narcissistic difficulties, by promoting a cultural axiom of "you are what you buy" rather than valuing the development of the self within a greater relational social matrix. Erich Fromm (1964; 1976) argued that contemporary Western social and economic values tend to suppress optimal self-development and contribute to narcissism. He suggested that consumerist ideals are corrosive to healthy self-regulation and social relatedness, in that individuals are valued for what they produce or "having" things rather than for "being" who they are. According to this view, admiration needs and self-enhancement efforts may be informed by culturally and corporately determined values about what it means to be a person in Western society. This perspective has been advanced in connection with data suggesting that narcissism is on the rise in contemporary Western society (Twenge and Campbell, 2009; Twenge, Konrath, Foster, Campbell, & Bushman, 2008), though such findings and conclusions have been disputed (Trzesniewski, Donellan, & Robins, 2008).

Clinical theorists have espoused a number of perspectives regarding the origins of pathological narcissism that have developed from clinical experience and that are used to inform treatment models. These contributions tend to implicate early interactions with caregivers in the development of narcissistic pathology (Kernberg, 1970; 1974; Kohut, 1968; 1971; Masterson, 1993). This includes the perspective that parental narcissism promotes the development of distorted self-image and admiration needs. Parents with healthy self-esteem and empathic abilities are more likely to foster these capacities in their children. By contrast, a parent with a fragile self or profound self-enhancement concerns may not be able to reliably affirm the child's unfolding self-image, resulting in inadequate self-regulatory development. Variations on this perspective – focusing on traumatic childhood experiences – comprise the majority of psychodynamic theorizing on pathological narcissism. An alternate view, however, suggests that

excessive praise and indulgence by parents may contribute to a child being unable to develop realistic appraisal of efforts and achievements, resulting in inordinate reliance on admiration and self-inflation (Twenge & Campbell, 2009; Millon, Grossman, Millon, Meagher, & Ramnath, 2004). These perspectives need not be mutually exclusive; a combination of deprivation and overindulgence could also contribute to narcissistic personality configurations. The common thread between these different views is the influence of problematic interactions with caregivers in the development of identity and self-regulation functioning.

# 2 THEORIES OF PATHOGENESIS AND TREATMENT

## 2.1 The nuances of narcissism theorizing

Theorizing about the development of narcissistic pathology has largely taken place in conjunction with clinical observations and recommendations. The majority of such discourse has occurred within psychodynamic theory. There are nonetheless several conceptual variations between these schools of thought, along with areas of overlap and agreement. This literature is vast and in some respects perplexing, due to differing terminology and theoretical complexity. Adding to this confusion is the fact that several of these theories do not explicitly reference narcissism, despite speaking directly to the problem of narcissistic pathology. Recent conceptual models such as attachment theory and cognitive therapy have added breadth to such theorizing by attempting to integrate findings from different approaches and other disciplines. Furthermore, there is debate regarding the positioning and distinctness of some theories in relation to others. Although it is beyond the scope of this dissertation to tease apart all of these nuances, several major schools of thought will be discussed in an effort to provide a concise overview of significant contributions to the understanding and treatment of pathological narcissism.

## 2.2 Drive theory and ego psychology

Although he wrote only one paper specifically pertaining to narcissism, Freud (1914) brought the term and concept into clinical and psychoanalytic discourse with a descriptively rich treatise that preceded his structural theory (delineating the mental structures of the id, ego, and superego). In "On narcissism: an introduction" Freud discussed narcissism in terms of the focal distribution of psychic energy – the derivative of instinctual libidinal drive. Freud suggested that all individuals begin life in a state of primary narcissism, essentially absorbed in the fulfillment of bodily requirements and unaware of such gratifications being provided by a distinct and

separate other. This experience – a state of omnipotent wish fulfillment – must be given up as it gradually dawns on the infant that the mother (as well as other caregivers) is a separate person who does not automatically gratify all wishes. This gradual relinquishment of primary narcissism allows for libidinal energy to be invested in relationships with others, who may be experienced as truly separate people. Freud suggested, however, that when the encroachment of reality upon infantile omnipotence is too frustrating, primary narcissism is only partially given up. Secondary narcissism is the ensuing revival of the individual's attempt to recapture the original state of self-absorbed wish-fulfillment. Manifesting as a focal investment of psychic energy toward the ego (self), secondary narcissism is essentially a compensatory reaction to the frustration and loss of infantile omnipotence. In Freud's model of libidinal distribution, secondary narcissism focuses the psychic energy that could be devoted to interpersonal relations onto the self. Freud's theoretical model at that time – though pushed to the brink of expansion by his observations of narcissism – contained the notion of finite quantities of psychic energy; when investment is narcissistically focused on self-gratification and omnipotent fantasy, there is a corresponding removal of psychic energy from interpersonal relatedness.

Although Freud wrote about severe narcissistic disturbance, he also noted that attenuated forms of secondary narcissism are within the range of normal functioning, and described the normative self-regulatory role of the ego-ideal. Although he did not use the term "self-representation", Freud developed the concept of the ego-ideal to outline the process by which one has "set up an ideal in himself" to serve as a psychological reservoir of lost perfection and a wished-for version of the self. Freud also posited the influence of secondary narcissism on object choice: relationship partners may be unconsciously chosen according to ways in which they represent the subject's actual or imagined self, rather than for the partner's unique and

differentiated qualities. In other words, engagement in a relationship with another person has the potential to function primarily as a form of self-regulation, in that a lost or wished-for sense of self may be obtained through the relational association.

A drive-based conceptualization of narcissism was extended through the development of psychoanalytic ego psychology, which saw a greater emphasis on adaptation and defense. Anticipating contemporary views, Annie Reich (1960) conceived of narcissism as a normal system of self-esteem regulation that becomes distorted and pathological in response to excessive frustration or to the demands of a severe ego-ideal. She viewed grandiosity as a regressive retreat from both physical and psychological threats, including anxieties bodily intactness and self-esteem. Under severe threat, the capacity for reality testing and the maintenance of self-other boundaries are compromised. Reich postulated that an extreme withdrawal of investment in relations with others may thus become necessary (i.e. is perceived by the ego to be adaptively required) in order to preserve ego function. Reich emphasized the oscillating nature of pathological narcissism, pointing out that the investment of psychic energy toward the self – manifest as self-absorption and grandiosity – tends to alternate with and defend against states of dysphoria and inadequacy.

Psychoanalytic technique at the time of Freud's early writing, and through the development of ego psychology, emphasized the therapist's efforts at bringing unconscious material to the patient's awareness. With regards to narcissism, however, treatment recommendations from the classical and ego psychological perspectives were relatively sparse. Patients with severe narcissistic pathology were generally regarded as unsuitable for psychoanalysis. Reich's contribution, though limited in offering clinical advice, suggested that interpretation of the patient's narcissistic fluctuations would help the patient relinquish

"infantile" self-interest. The technical emphasis on interpretation – regarding shifts between grandiosity and vulnerability – was later emphasized in Kernberg's (2010) contemporary transference-focused psychotherapy, though his model links these oscillations with object relations (see below). Indeed, the various object relations theories arose partly in response to the need for theorizing to guide the treatment of patients who were considered "unanalyzable" from a traditional psychoanalytic standpoint, many of whom suffered from narcissistic disturbances.

### 2.3 Kleinian object relations theory

Melanie Klein's focus on primitive mental states, in both adult patients and in children and infants, stimulated considerable development within psychoanalytic theory. Although Klein did not directly use the terminology of narcissism, her emphasis on primary affects of love and hate have informed subsequent narcissism theorists (most notably Otto Kernberg), and several Kleinian constructs pertain directly to narcissistic psychopathology. Klein (1946) looked beyond the ego psychological framework of oedipal dynamics to the early inner world of the infant. She postulated the infant's alternating experiences of love / hate, contentment / deprivation, and envy / gratitude led to the formation of conflicts and anxieties that are never fully resolved, resurfacing in adult experience. Narcissistic pathology reflects a particular configuration of primitive defenses employed to deal with such anxieties.

Psychological development in Kleinian theory is oriented around "positions" rather than stages that are passed through and resolved sequentially (Ogden, 1986; Segal, 1973). These positions are negotiated such that one may achieve a relative degree of resolution, but ultimately individuals' experience oscillates between them to varying degrees throughout life. The paranoid-schizoid position is the earliest and most primitive, representing the infant's experience of a chaotic world – at times blissful (as in after a satisfying feeding) and at times savagely

depriving (as in the state of hunger or discomfort). These states are not felt by the infant as being associated with the same maternal figure; the infant splits the experience so that, for instance, the nurturing breast is not simultaneously the same object that only moments earlier evoked the baby's desperate hunger. Essentially the infant experiences a "good breast" and a "bad breast". Klein's use of these terms conveys the paranoid-schizoid experience of others as "part objects" that gratify needs or wishes rather than as independent selves (Ogden, 1986). As in Freud's notion of gradually relinquished primary narcissism, the paranoid-schizoid mode eventually recedes to make way for the capacity to appreciate the wholeness of others and to tolerate the comingling of both good and bad experiences. This new level of experience, referred to as the depressive position, involves the achievement of a capacity for concern as the child gradually develops some guilt feelings regarding the aggression that predominates in paranoid-schizoid functioning. "Depressive" refers to such guilt and concern, and the prospect of mourning for a separate person (that one might inflict damage upon) rather than a "part object" (Klein, 1946; Ogden, 1986). The depressive position may be a somewhat precarious achievement, in that one remains susceptible to slipping into the paranoid-schizoid position – the defensive splitting of difficult affective experiences – throughout the lifespan.

From a Kleinian perspective, pathological narcissism represents a limited or faulty achievement of the depressive position. In other words, the narcissistic individual is prone to experiencing others as "part objects": for the potential gratification of the individual's needs or wishes rather than as "both significant and separate" (Britton, 2004, p. 478). Impaired empathic functioning and limited capacity for guilt and concern – key features of pathological narcissism – are aspects of the earlier and more primitive paranoid-schizoid position. In Klein's view, unwanted affects such as anxiety and envy are split off, often with an accompanying fantasy of

depositing such experiences into the psyche of another person. Pathological narcissism may be understood as a predominance of such splitting and projective defenses, and the aversion of experiencing others as whole selves who may be hurt, envied, lost, and mourned. While Klein emphasized the child's innate aggression in determining developmental progress, subsequent Kleinian theorists such as Wilfred Bion elaborated the role of caregivers in containing and gradually transforming primitive emotional experience into the more mature, reflective abilities associated with the depressive position. Accordingly, Klein's technical approach emphasized the development of insight regarding split-off and projected experience, including attempts at directly interpreting primitive unconscious fantasy. Bion, however, extended Kleinian technique to include the therapist's relational function in containing and processing the patient's intolerable, projected affect states (1962). This contribution has fostered integration between Kleinian and other psychodynamic schools of thought (Ogden, 1986; Kernberg, 1984).

### 2.4 Interpersonal theory

Like Kleinian theory, the interpersonal conceptualization of personality also emphasizes the structuring of the self around the management of primitive and pervasive anxieties. Interpersonal theory, however, situates this issue within an ongoing and pervasive matrix of interpersonal relations. This school of thought originated in the work of Harry Stack Sullivan (1953) and has evolved into a prominent contemporary model of personality (Pincus, 2005), informing clinical intervention models and a large body of empirical research. Indeed the sophisticated research that has emerged from interpersonal theory, such as the interpersonal circumplex (Wiggins, 1996) or the Structural Analysis of Social Behaviour (Benjamin, 1974), cannot be discussed here due to space limitations.

Interpersonal theory embeds personality development entirely within an interactional field. Sullivan observed fundamental "integrating tendencies" that bring people together throughout the lifespan. For example, when an infant cries in a particular way, her mother feels a corresponding urge to feed her (including a bio-physical preparedness to do so); a successful coming-together in this scenario produces good feelings in both. Imbalanced integrating tendencies (i.e. failed responsiveness) lead to disintegrating experiences, a preponderance of which will flood the self with anxiety. Sullivan (1953) regarded anxiety as a universal threat to interpersonal relations, potentially upending integrating tendencies and contagiously suffusing one or both participants with intolerable dysphoria. Childhood experiences of repeated anxiety-ridden interactions can infuse one's personality with lasting negative self concepts known as "bad me" or "not me" experiences. In this way, interpersonal theory is concerned with internal psychological structure, as developed and subsequently reinforced or modified in the context of interpersonal relations. Sullivan observed the use of "security operations" to manage anxiety. These psychological safety features are functionally similar to defense mechanisms, though protective against perceived interactional and self-representational endangerment rather than drive-derivatives. Once mobilized, security operations may be reinforced through further interactions, becoming embedded as characterological distortions of the interpersonal field.

Security operations in the context of pathological narcissism may consist of grandiose illusions that serve to ward off "bad me" representations, and to immobilize others who could evoke anxiety or vulnerability. Narcissistic "illusionary me-you patterns" (Bacal & Newman, 1990, p. 34) might involve an illusion of others as irrelevant, protecting the individual from anxiety concerning normative relational needs and their accompanying risks. At the same time, others may be superficially quite important for their function in bolstering grandiose illusions.

Bromberg describes this paradox as living "between the mirror and the mask" (Bromberg, 1983, p. 360) in that the individual constantly searches for affirmation from others (the "mirror") yet in a way that reveals little of an inner life (the "mask"). Although illusionary patterns conceal the narcissistic individual's dreaded dysphoric core, they exist at the expense of generative relationships with others, ultimately constricting the development of genuine identity and self-esteem (Mitchell, 1986).

An interpersonal understanding of pathological narcissism suggests the emergence of illusionary patterns within the treatment relationship itself. The patient may function for a long time with the therapist kept at bay as a relatively unimportant figure. Efforts by the therapist to confront and interpret this scenario may evoke anxiety in the patient and prompt humiliation, rage, or unilateral termination – or may be met simply by the patient's disavowal and movement on to the next topic (Bromberg, 1983). From this perspective, the patient's security operations may need to be respected and tolerated, while the therapist attempts to maintain an appropriate gradient of anxiety throughout the treatment. Addressing narcissistic illusions would nonetheless be done directly, through the delivery of interpretations that induce a manageable level of anxiety while illuminating interactive patterns. This would gradually help the patient move from an illusionary mode into a psychologically curious and reflective stance where the therapist can be regarded as a valued – rather than a threatening or irrelevant – figure for the patient (Bromberg, 1983). An associated outcome would be the patient's capacity to interact more freely with others, and to experience concomitant changes in self-concept. A further aim of therapy would be the transformation of illusion from constricting security operation into a source of creativity that can co-exist with consensual reality (Mitchell, 1986).

## 2.5 Object relations: Fairbairn and Winnicott

Relational psychodynamic theorists and clinicians often integrate interpersonal theory with British object relations theories, several of which deal with narcissistic phenomena. The object relations theory of W. R. D. Fairbairn (1952), developed in his work with schizoid patients, has been particularly influential in understanding personality pathology and narcissistic pathology (Celani, 2014; Masterson, 1981; Rinsley, 1989). Fairbairn observed his patients' overvalued ideas, self-absorption, and concomitant convictions of badness and unworthiness. These patients had great difficulty establishing close relationships and oscillated between experiences of others as either exciting or rejecting. Fairbairn described such presentations as schizoid phenomena, though his description closely resembles the dynamics associated with the contemporary vulnerable narcissism construct.

Fairbairn regarded the establishment of loving and responsive relationships during infancy and childhood as crucial to the development of internal object relations – the implicit mental models of self and others. He suggested that early relatedness with caregivers would be psychologically preserved at all costs, even at the expense of self-esteem and real relatedness (Fairbairn, 1952). When early relationships are fraught with turmoil or trauma the child finds a way to maintain a cleansed version of the objects of such relationships. This is accomplished by accepting responsibility for maltreatment; the child preserves an inner tie to "good" parents by concluding that she is bad and undeserving of love. Dissatisfying early relations are internalized as "bad objects," that continually haunt the individual with feelings of shame and badness, remaining tenaciously embedded within the personality structure. This bleak internal world – where a bad object is preferable to none at all – is accompanied by ameliorative efforts to withdraw from real relationships and engage in omnipotent fantasy (Fairbairn, 1952). To

complicate matters, these internal object relations are subsequently imposed upon new interpersonal relationships. The individuality of others is blurred or obscured; others tend to be experienced as screens onto which the individual projects internalized objects (Ogden, 2010). This could take the form of the other as an exciting yet forbidden tantalizer, or as someone likely to reject and humiliate. Indeed, Fairbairn described an "internal saboteur" representation, evolving in response to frustrating early relations and continuing as a source of scorn and derision from within the individual's psyche – and hence also projected onto others. This closed internal system is resolutely adhered to as a grim preference over exposing oneself to the vulnerability of real intimacy, and the associated risks of becoming overwhelmed or dejected in the course of real relatedness (Fairbairn, 1952; Ogden, 2010). Furthermore, the relinquishment of bad objects that real relatedness could offer would threaten the individual with an overwhelming sense of bleak emptiness (Grotstein, 1993). Fairbairn's emphasis on experiencing others in almost exclusive accordance with one's inner world, along with the entrenched predominance of aggressive internal objects, is highly consistent with the contemporary conceptualization of pathological narcissism.

Winnicott (1971) also outlined the role of inimical early experiences in the development of identity problems that parallel contemporary descriptions of pathological narcissism. Winnicott's concept of the holding environment refers to the quality of environmental provision required for the optimal development of a child's incipient self. The caregiver's adequate "holding" of the infant – both physically and metaphorically / psychologically – is considered the cornerstone element in helping the infant to feel secure, alive, and integrated. A vital aspect of holding is the mother or father's sense of the infant as a subjective self, involving the parents' suspension of their own needs in order to provide for the infant's nascent experience of being

and aliveness (Ogden, 2004). This process requires the parents' tolerance of negative features of infant care and the inevitable ruptures in the caregiver-infant relationship (Winnicott, 1965).

Caregivers' responsiveness – attendance to intense affects, needs, and even infantile aggression – crucially shape the nature of the child's experience of self. Repeated faulty responses or an inadequate holding environment impinge on the child's natural development; the child's "true self" retreats under the imposition of the parents' demands (Winnicott, 1956). In other words, a self evolves out of compliance with a faulty environment rather than in harmony with a responsive caregiving milieu. Consequently the frustrated true self is protectively encased within a compliance-oriented "false self". Winnicott's true self / false self configuration corresponds to pathological narcissism as a syndrome of self-regulation; a superimposed layer of personality engages the external world while shielding a thwarted, vulnerable core. Although the false self protects the true self from further impingement, the individual pays the price of diminished personality integration, subjective feelings of emptiness, and reduced capacity for creativity and intimacy (Winnicott, 1956; 1971). Affects associated with tenderness, dependence, and loss – potentially induced through interpersonal relationships – are consequently deflected as threats rather than embraced as aspects of true self experience.

From the object relations perspective elaborated by Fairbairn and Winnicott, psychotherapeutic treatment of a narcissistically compromised self is thought to require a new, mutative experience within the therapeutic relationship itself. Winnicott suggested that the therapist treating a patient with a "false self disorder" must expect to provide a therapeutic holding environment in the form of a psychosocial milieu of unobstrusiveness and facilitation of the patient's gradual expression of the vulnerabilities associated with true self experience. The therapist essentially maintains a steadfast sense of the patient's needs, including the patient's

sense of time and therapeutic process (Kealy & Lee, 2014; Ogden, 2004). Confrontational or even interpretive interventions may be experienced by the patient as impingements to the process of "becoming", provoking narcissistic retreat or acting out rather than encouraging the gradual emergence of the true self. Winnicott (1971) suggested that an effective holding environment awakens the patient's capacity for relatedness, and for the kind of creative fantasy involved in play and self-reflection, phenomena that are often stunted in pathological narcissism. The patient may thus develop the capacity to imaginatively "create" the functions of the holding environment (i.e. the therapist's mutative responsiveness) within his or her own mind, thereby reducing the need for false self or narcissistic defenses (Bacal & Newman, 1990).

Fairbairn (1952) also emphasized the prioritization of a transformative therapy relationship over the value of interpretive accuracy. He regarded the achievement of a relatively "real" relationship – one less burdened by projections of the patient's internal objects – as the ultimate goal of psychotherapy. According to Fairbairn's perspective, the therapist seeks to gradually break through the patient's closed system of narcissistic relatedness by tolerating the patient's projective "bad object" attributions. Whilst allowing these transference projections, the therapist concurrently maintains an attitude of acceptance and interest – "good object" experience – in order to gradually counteract the effects of a tenacious internal saboteur and the patterns of narcissistic relatedness. The therapist's actual concern and acceptance toward the patient is a crucial element in addressing the patient's fears, including the frightening realization that psychotherapy involves the re-activation of early relational needs and the awareness of the inimical conditions that necessitated their suppression (Bacal & Newman, 1990; Ogden, 2010). From this perspective, the combined acceptance of the patient's projections and the demonstration of accepting, "good object" responsiveness results in the patient's gradual release

from inner bondage to bad objects; the patient thus experiences both self and others in a more realistic light.

### 2.6 Self psychology

Heinz Kohut's (1971) pivotal formulations of narcissistic personality disorder brought further attention to narcissism, while also eventuating in the psychoanalytic theory and clinical approach known as self psychology. Kohut focused specifically on conceptualizing the development of pathological narcissism and its psychoanalytic treatment. Space does not permit a complete elaboration of the continuities and differences between self psychology and object relations theories; these have been discussed at length in volumes that seek to integrate relational psychodynamic theories (Bacal & Newman, 1990; Eagle, 2011; Greenberg & Mitchell, 1983). Kohut situated narcissism within the normal development of the self. Like Sullivan, Winnicott, and Fairbairn, he regarded the development of a robust self as an achievement acquired through the experiencing of others' responsiveness. Kohut elaborated the concept of the selfobject to refer to the influence of others on the formation and maintenance of healthy personality functioning. The term selfobject refers to the individual's experience of another person whose responsiveness supports the cohesiveness and stability of the individual's sense of self. Wolf (1988) defines the selfobject as "neither self nor object, but the *subjective* aspect of a self-sustaining function performed by a relationship of self to objects who by their presence or activity evoke and maintain the self and the experience of selfhood" (p. 184). In other words selfobjects are internal experiences of others who have a restoring or enhancing effect on the self; for practical purposes the term also refers to the person who provides the selfobject experience. Selfobjects heal and renew the self after psychological injury or diminishment, and serve to support self-cohesion – a sense of being an integrated self – throughout the lifespan.

Kohut (1971) described different permutations of selfobject experience. The mirroring selfobject refers to parents' (and other significant figures') responses that confirm the innate goodness of the child's self. The idealized or idealizable selfobject involves the parents' (and others') availability for the child to admire and feel at one with. The child gradually internalizes the self-enhancing functions of these experiences, eventuating in a reduced need for actual selfobject provision by other persons. Nevertheless, the need for some externally provided selfobject experience – such as a spouse's support or a supervisor's recognition – is commensurate with a mature and relatively independent self. Healthy narcissistic functioning is thus a combination of internalized selfobject functions along with ongoing interpersonal relationships that provide phase-appropriate selfobject experiences (Kohut & Wolf, 1978).

In Kohut's view, narcissistic development takes a pathological turn as a consequence of repeated faulty selfobject experiences (Kohut, 1984). The childhood absence of reliably empathic and affirming responsiveness results in a deficient self, devoid of internalized mature selfobjects (Kohut & Wolf, 1978). This leads not only to profound feelings of inadequacy and emptiness, but also to a chronic fragility and propensity for psychological fragmentation. A grandiose self may evolve as a compensatory structure against this sense of vulnerability (Morrison, 1983). The self is superficially supported through the grandiose self's pursuit of admiration and entitled wish-fulfillment, rather than a more mature engagement in sustainable and reciprocal selfobject relations. In other words, immature selfobject substitutes are frantically pursued in an effort to compensate deficient self-structure. According to Kohut (1972), when the fragile self is injured (e.g. through loss of admiration or experience of defeat), narcissistic rage emerges in an effort to repair the self's fragmentation through the enactment of aggression or revenge.

Kohut noted the emergence of "transference-like structures" (1971, p. 25) in his treatment of narcissistic patients, where the patient would expect him to serve as either a mirroring or idealizable selfobject. He discovered that providing these selfobject experiences was necessary, usually for a lengthy period of time, in order for therapeutic progress to occur. Kohut observed that the therapist's consistent empathy for the patient's deficient self-experience and consequent selfobject needs overshadowed traditional psychoanalytic interpretive interventions. He theorized that the therapist, through empathically discovering and meeting the patient's therapeutic needs, is gradually experienced as providing selfobject functions that repair fragmentation and build robust self-structure (Kohut, 1971; Kohut & Wolf, 1978). In turn, the patient's selfobject needs become gradually less frantic and more mature, thus obviating the need for narcissistic grandiosity or rage.

Bacal clarifies that the therapist's selfobject responsiveness "may entail an inquiring attitude or a quiet noninquiring presence, an echoing confirmation, or a confrontational challenge…determined not only by the issues that the patient and the analyst are working on but also by the strength of the patient's self, and by the patient's operative level of developmental achievement" (Bacal, 1994, p. 27). Disruptions in the therapeutic process are expected, and the therapist's empathic repair efforts (termed "optimal frustration") are crucial elements in helping the patient develop the capacity to handle inevitable selfobject shortcomings. These nontraumatic ruptures are thought to evoke earlier selfobject failures, and their resolution promotes the patient's tolerance of difficult affect and the development of mature responses to frustration (Gehrie, 2011). The therapist's optimal therapeutic responsiveness – including the handling of empathic failures and disruptions – are gradually internalized as new psychological structure within the patient's self, allowing for the dissolution of maladaptive compensatory

mechanisms and the development of robustness and vitality (Kohut, 1984; Lachmann, 2008; Wolf, 1988).

## 2.7 Attachment theory

Attachment theory, initiated by the work of John Bowlby, also emphasizes the role of the early parent-child bond in the development of personality. Although originating from John Bowlby's work in the tradition of British object relations, attachment theory has evolved into a broad, interdisciplinary model of human relations and personality development. Attachment theory can be directly applied to the conceptualization of pathological narcissism (Pistole, 1995; Bennett, 2006), and has been described as a useful framework for psychotherapeutic treatment (Eagle, 2003; Shilkret, 2005). Bowlby (1988) emphasized the needs of infants and young children to experience physical proximity, safety, and loving affects with their caregivers or attachment figures. The security of primary relational bonds is regarded as the centre of psychological health, serving important affect-regulation functions and contributing to identity and interpersonal relatedness (Fonagy, Gergely, Jurist, & Target, 2002). Like Fairbairn, Bowlby regarded inconsistent or unsafe attachment figures as fostering dysfunctional inner models of self and other, which are subsequently brought to bear on future attachment relationships. Attachment disruptions also impede the development of affect regulation abilities. A parent's chronic inconsistent or threatening responses, for example, lead the child to feeling inhibited, fearful, and in desperate search for security and validation (Bowlby, 1988). These chronic affect states correspond to features of narcissistic vulnerability, and self-centered and dominating efforts may be employed in an attempt to master feelings of weakness and insecurity, particularly in close relationships (Bennett, 2006). Indeed, preliminary research findings indicate a connection between narcissistic grandiosity and anxious insecure attachment (Kealy,

Ogrodniczuk, Joyce, Steinberg, & Piper, 2013). In this clinical sample, higher levels of grandiose narcissism were associated with fears of abandonment regarding love relationships.

One of the strengths of attachment theory is the operationalization and empirical investigation of attachment security, along with an ongoing and broad research agenda. Further empirical and conceptual development within attachment theory has focused on deficits in mentalization that are the consequences of attachment trauma, commonly observed among patients with personality disorders. Mentalization refers to the capacity to think about mental states – those of oneself and those of others – and to reflect on the independence of minds. This ability is fostered by secure attachment relationships, likely as an evolutionary advantage of being able to anticipate others' motives and to promote cooperation (Fonagy, Gergely, Jurist, & Target, 2002). Mentalization is developed through the child's mental experiences being consistently reflected and re-presented by attachment figures. This process essentially affords the individual a theory of mind in which behaviours and emotions can be thought about beyond their face value. Inhibited mentalization is described in terms of particular modes of mental functioning (which occur naturally during early phases of development). Individuals with attachment trauma are more likely to slip into non-mentalizing states of mind such as "psychic equivalence" mode, where thoughts are experienced concretely and non-symbolically, and "pretend" mode, involving an isolation of mental states from external reality.

From a mentalization-based framework, narcissistic pathology may correspond to frequent shifts between non-mentalizing modes – similar to the movement between developmental positions described in Kleinian theory. Affect states that arise during psychic equivalence and pretend modes may be experienced with an imperative to act that overrides reflection or empathy (Fonagy & Target, 2006). An entitled dominance, for example, may

reflect impaired understanding of underlying mental states such as desire or vulnerability. Narcissistic defenses may instead be experienced concretely, justified as reflections of external reality rather than the products of mental states. Likewise, a psychological injury may be experienced as a deliberate, humiliating attack – without consideration of other possible motives – that requires a physical retaliation to rid the self of intolerable affects (Fonagy et al., 2002).

Mentalization-based treatment (MBT) has been formulated as a comprehensive treatment approach for borderline personality disorder (BPD), and has been found effective for patients with BPD in clinical trials (Bateman & Fonagy, 2013). A therapeutic approach that prioritizes mentalizing – also known as reflective functioning – can be applied to narcissistic pathology (Lecours, Briand-Malenfant, & Descheneaux, 2013). Many of the principles of mentalization-based treatment are consistent with relational psychodynamic approaches. A safe therapeutic relationship, for example, is regarded as crucial to the treatment. Proponents of MBT suggest that the therapy relationship activates the patient's attachment system, heightening the risk of patients' dysregulation in response to changes in the therapeutic alliance or perceived rejection through the therapist's interpretations (Fonagy & Bateman, 2006).

As with other object relations theories, the therapist's activities are regarded as a provision of corrective relational experience for the patient. The therapist appreciates the attachment nature of the therapy relationship and watches out for the ways in which the patient's attachment style and history become manifest in the therapy. The therapist's sensitive responsiveness to the patient's maladaptive interactive patterns is thought to influence new procedural or implicit learning for the patient (Lecours, Briand-Malenfant, & Descheneaux, 2013). The therapist also attempts to maintain a focus on the patient's inner states of mind, modeling a mentalizing stance in which experience and behaviour are not taken at face value

(Bateman & Fonagy, 2004). As in Winnicott's holding environment, patients with limited mentalizing abilities are thought to have difficulty tolerating confrontation and interpretation. Instead, treatment proceeds via a collaborative and empathic milieu, within which the therapist and patient examine issues in terms of mental states, alternate perspectives, and the patient's motivations. The therapist adopts an explicit stance of not knowing, avoiding premature conclusions and suspending action, in order to demonstrate a curiosity and openness to discovering the inner world of intentions, feelings, and desires. Treatment is expected over time to result in the patient's ability to develop a more robust mentalizing capacity, through the experience of a persistent mentalizing focus in secure attachment of the therapy relationship (Bateman & Fonagy, 2004).

### 2.8 Transference-focused psychotherapy

As noted earlier, Kernberg has been an important contributor to theorizing about NPD, offering an alternative formulation of pathological narcissism to that of Kohut. Kernberg's (1970; 1974) perspective incorporates elements of ego psychology, Kleinian theory, and the ideas of other object relations theorists. His conceptual and clinical approach has been honed into a cohesive treatment model known as transference-focused psychotherapy (TFP). Consistent with other object relations theorists, Kernberg regards early experience with caregivers as playing a crucial role in the formation of stable identity and maturity of defensive functioning. Inconsistent, emotionally cold, and rejecting caregiving is thought to limit the child's ability to develop a cohesive internal world, instead producing poorly integrated identity and object relations, typically with a split-off destructive introject (infused with aggressive affect) similar to Fairbairn's internal saboteur.

Kernberg's conceptualization of narcissism emphasizes the splitting of inner experience, whereby contradictory affect states and self-other representations are psychologically held separately from one another. Phenomena associated with narcissistic grandiosity and vulnerability are thus split-off from one another, and often projected onto others. For example, dependency feelings may be split off and defended against through grandiose attitudes and behaviours, and are instead assigned to the individual's "clingy" partner so that a conscious sense of independence is maintained. Indeed, dependency feelings, sadness, guilt, and mourning are interrelated affect states that in Kernberg's view are particularly problematic within narcissistic character functioning. Kernberg has described an "incapacity to depend" (Kernberg, 1984, p. 270) in pathological narcissism in which others are experienced as part-objects – as in Klein's paranoid-schizoid mode – rather than as distinct individuals with psychological depth of their own. These dynamics reflect Kernberg's emphasis on poorly integrated identity in borderline and narcissistic personality pathology. Kernberg (1984) clarifies that pathological narcissism is not really an over-investment in the self, because normative vulnerabilities, shortcomings, and dependency feelings are dissociated from the individual's identity. The identity investment is rather towards a distorted compensatory structure, the grandiose self.

Transference-focused psychotherapy aims toward integration of the disparate aspects of the self along with a toning down of the negative affects that fuel their projection and enactment in interpersonal relations (Kernberg, Yeomans, Clarkin, & Levy, 2008). This involves the consistent interpretation of the client's object relations as they manifest in the transference with the therapist. TFP has been found effective in RCT studies of treatment for borderline personality disorder (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering, et al., 2010), and has been described by its developers as a treatment for NPD (Stern, Yeomans, Diamond, &

Kernberg, 2013). Although the technical recommendations of TFP differ from those of mentalization-based treatment, principles of attachment theory are integrated into this approach and reflective functioning is a desired outcome of successful TFP.

Treatment from a TFP perspective involves the tracking of split-off or poorly integrated self-other experiences as these become manifest in the patient's verbal content, affects, and particularly in the transference relationship between therapist and patient (Caligor, Diamond, Yeomans, & Kernberg, 2009). Once a secure therapeutic relationship has been established – an alliance supported by the therapist's clear limit-setting if necessary – a sequence of interpretive interventions are introduced as the therapist attempts to identify patterns in the patient's experiences and projections of self-other representations. Either or both aspects of a patient's self-other representation may be emergent in the transference; the therapist, for example, may be experienced alternately as a persecuting object or as an idealized object. Frequent sessions (at least two per week) promote the emergence of these dynamics within the therapeutic relationship, which the therapist tolerates and eventually interprets in order to help the patient integrate disparate aspects of psychic experience. Consistent attention to the patient's need to defensively split off vulnerabilities, dependency needs, and guilt or depressive affects leads to their gradual acceptance (Caligor, Diamond, Yeomans, & Kernberg, 2009). The interpretive focus fosters the patient's ability to think about mental experience. Furthermore, the containing function of the therapy relationship, embodied through the therapist's ability to thoughtfully handle the patient's projections, also supports gradual identity integration (Kernberg, Yeomans, Clarkin, & Levy, 2008). Primitive defenses consequently become less necessary, and the patient's investment in the grandiose self is reduced.

One of the tensions that may be observed among psychodynamic models is the degree to which therapeutic action relies on interpretation and insight versus the corrective properties of the therapeutic relationship. Although this has been a historical source of conflict throughout psychoanalysis, contemporary discourse increasingly reflects an effort to integrate these putative mechanisms of action (Eagle, 2011; Gabbard, 2005). For example, the developers of transference-focused psychotherapy, known for emphasizing the interpretation of transference dynamics, evoke attachment theory and Bion's (1962) concept of container-contained to underscore the ameliorative qualities of the therapy relationship. Similarly, self psychology and mentalization-based treatment – both regarded as treatments that de-emphasize interpretation – both employ efforts to engage the patient in understanding their intrapsychic and interpersonal dynamics (e.g. mentalizing the relationship; Bateman & Fonagy, 2013). Indeed, effective interpretation has been described as a relational experience, and a corrective therapy relationship may be regarded as a crucial instigator of insight without interpretation (Eagle, 2011). In other words, these change mechanisms may operate synergistically, with differing emphasis on either element at any given time within a particular treatment (Gabbard & Westen, 2003).

## 2.9 Cognitive behavioural models

Compared with psychodynamic writings, the literature regarding cognitive behavioural perspectives on narcissism is sparse. Theorists and clinicians have nevertheless applied this approach to the treatment of NPD and pathological narcissism. The cognitive behavioural perspective emphasizes the role of social learning in the development of self-concept and expectations of others. Millon and colleagues (2004) have posited parental overindulgence as a pathway for children to learn that they are special and deserving of unique privileges. According to this view, children who are given endless and indiscriminate praise learn that they should

expect admiration regardless of effort. As Millon and colleagues note, "a marked disparity exists between the child's actual competence and the impression he or she has of it" (2004, p. 359). This learning becomes encoded and reinforced as the child discovers an ability to exploit their special status to manipulate others to gratify their wishes, resulting in a long-term pattern of flaunting the normal give-and-take of social relations. In summary, early social learning determines the degree to which an individual develops a reasonable self-concept, or one that involves unrealistically high self-appraisal and inordinate admiration needs (Freeman and Fox, 2013). The resultant beliefs about the self and expectations of others are organized into psychological templates known as schemas. These schemas are evoked at a level of automatic functioning, guiding cognitions and behaviours in responses to day-to-day situations and relationships. Individuals with pathological narcissism are thus guided by schemas that reflect learned beliefs about their own specialness and entitlement to privilege and admiration.

An alternative cognitive-behavioural view suggests a different constellation of schemas among individuals with pathological narcissism. This perspective, associated with the integrative CBT treatment known as schema-focused therapy (SFT; Young & Flanagan, 1998), holds that narcissistic individuals learn in childhood that their emotional sensitivities or failures are not tolerated by parents. At the same time, they tend to experience inadequate limit-setting and discipline, often with an overindulgence of material possessions. This combination of emotional neglect and indulgence leads to core beliefs regarding the prioritization of status over relationships and emotional connection (Behary & Dieckmann, 2013). Thus, the schemas that guide individuals with pathological narcissism consist of shame, emotional deprivation, and unrelenting standards, along with entitlement and approval-seeking. Both the schema-focused and traditional CBT perspectives emphasize the role of parents explicitly setting standards of

attitudes and behaviours, teaching frustration-tolerance, and modeling appropriate self-esteem based realistically on effort and achievement.

Cognitive behavioural treatment involves the examination of self-concept schemas and the modification of maladaptive behaviours within a collaborative therapeutic alliance. Emphasis is placed on securing the patient's agreement regarding the costs of narcissistic attitudes and behaviours before they are pursued as targets of intervention (Freeman & Fox, 2013). For example, the therapist inquires as to the usefulness of dominant interpersonal behaviour versus the social costs involved for the patient. This builds the patient's motivation to examine the behaviour and the associated underlying schemas. Indeed, cognitive therapists (Beck, Freeman, & Davis, 2004) sometimes recommend focusing on behavioural strategies with narcissistic patients in order to avoid resistance that would be anticipated in a focus on cognitions. The therapist might wonder aloud about particular behaviours rather than confront them directly. An overall non-judgemental inquisitive approach is adopted (known as Socratic dialogue), whereby the therapist wonders about different issues and attempts to build the patient's interest in examining characterological issues (Rasmussen 2005). As the patient's motivation builds, further investigation of the patient's core beliefs may be employed, helping the patient to wonder whether such beliefs are realistic, appropriate, or useful. Goals are clearly set and revisited regarding desired treatment outcomes and the specific behaviours that will be focal treatment issues. These may include imagery techniques to enhance prosocial behaviours, role-playing to build empathy, and homework assignments oriented toward restructuring of core beliefs and assumptions (Rasmussen, 2005).

Schema-focused therapy adds an additional array of interventions to these traditional CBT strategies. Like MBT and TFP, schema-focused therapy has been found effective in

clinical trials for borderline personality disorder, and SFT clinicians have described its application for patients with narcissistic personality disorder (Behary & Dieckmann, 2013; Young & Flanagan, 1998). SFT adopts the above-mentioned treatment principles of CBT yet with the addition of elements derived from other psychotherapy models, including object relations theory and experiential and emotion-focused therapies. One of the major tasks of SFT is the identification of maladaptive schemas. The therapist attempts to empathically confront the existence of these belief systems – including through self disclosure of the therapist's emotional responses to the patient – and link them with early childhood experiences. At the same time, the therapist seeks to provide "adaptive re-parenting" wherein thwarted early developmental needs of the patient – for empathy, acceptance, and warmth – are met within the therapy relationship.

Dialectical behaviour therapy (DBT; Linehan, 1993) also applies cognitive behavioural principles to the treatment of personality disorders. DBT has been empirically validated in several RCT studies for the treatment of borderline personality disorder (Kliem, Kröger, & Kosfelder, 2010). Originally developed to address suicidal and parasuicidal behaviours, DBT has since been modified to treat other conditions such as eating disorders and depression (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). Literature connecting DBT with treatment for pathological narcissism is limited, although some authors have proposed implementing DBT in this population (Aumann, 2007; Reed-Knight and Fischer, 2011). DBT is a structured treatment that involves both individual and group delivery of skills-based learning. Patients learn to tolerate difficult affect experiences and to analyze maladaptive behavioural responses to triggering events. As well, meditation-based mindfulness strategies are taught in order to promote the patient's acceptance of self, others, and reality situations. As in traditional CBT, a collaborative stance is emphasized, based on identification of treatment goals that are meaningful

to the patient. Behaviours that threaten the treatment itself are prioritized and confronted in order to help the patient remain focused on their goals.

# 3 EXAMINING PSYCHOTHERAPY FOR PATHOLOGICAL NARCISSISM

## 3.1 Empirical investigations of treatments for pathological narcissism

Despite the richness of the aforementioned conceptual perspectives, and the recent growth of evidence-based treatments for personality disorders such as borderline personality disorder, rigorous empirical investigation regarding the treatment of pathological narcissism is virtually non-existent. A few studies have examined patients with narcissistic features within patient samples consisting of mixed personality disorders (Diamond et al., 2014; Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009). Others (Dimaggio et al., 2008; Riordan, 2012) have applied quantitative measurement to case studies of psychotherapy for narcissistic personality disorder. However, there have yet to be any randomized controlled trials specifically devoted to the investigation of treatment for pathological narcissism or NPD. Considerable feasibility issues would need to be addressed in order for such studies to occur, including the issue of participant recruitment. Public advertising for a treatment study regarding NPD may yield few volunteers, or at least an unrepresentative sample. The length of treatment is another challenge: most therapies for pathological narcissism are considered by experts to be of long duration, often over multiple years. Such projects can be difficult to carry out. Efforts in this direction should nonetheless be made, and would ultimately improve treatment prospects for patients suffering from this condition. Investigation of treatment approaches is particularly necessary in light of the considerable suffering and impairment associated with NPD, and the high prevalence of pathological narcissism in clinical settings. These issues make the lack of treatment research especially striking. The present study was conceived as an exploratory effort in the empirical understanding of treatment for pathological narcissism.

## 3.2 Psychotherapy research from the ground up

Given the frequency with which therapists encounter patients with narcissistic problems, a prudent step toward understanding the treatment of pathological narcissism would involve the perspectives of clinicians themselves. Therapists in the field have likely developed ways of addressing narcissistic pathology that have worked, perhaps integrating conceptual knowledge with their clinical experiences. Westen, Novotny, and Thompson-Brenner (2004) have proposed that clinicians' field-based knowledge is a rich source of information about effective psychotherapy processes, and have recommended that this knowledge be tapped by investigators as an alternative to the RCT paradigm in psychotherapy research. These authors note the need for a line of psychotherapy research to work from the ground up, as an alternative to the "top down" paradigm of laboratory-formulated RCT research. Investigating psychotherapy from the ground up places value on clinicians' accumulated knowledge regarding what works for whom. The current project was designed to take up this challenge with regards to the treatment of pathological narcissism. The objective was to explore how community clinicians think about treating patients with pathological narcissism, and whether different therapy processes are engaged for patients with grandiosity, vulnerability, and non-narcissistic pathology. Qualitative, descriptive accounts of such processes were sought, in order that practice-based therapy models could be compared with conceptually derived models, and for the potential development of treatments for pathological narcissism and NPD.

## 3.3 Research questions

Question 1

Does pathological narcissism, presenting in either grandiose and vulnerable forms, influence therapists' opinions regarding prospective psychotherapy process?

This was the only question in this study that involved the direct testing of a hypothesis. It was expected that a significant difference would be found in mean therapist responses according to whether the patient presented with grandiose, vulnerable, or non-narcissistic psychopathology. The null hypothesis was thus expressed as $H_0$: $\mu_1 = \mu_2 = \mu_3$.

Question 2

How do community psychotherapists conceive of ideal therapy process for patients suffering from pathological narcissism?

This question represents the core inquiry guiding the study. As an exploratory guide, there was no direct hypothesis-testing associated with this question. This exploratory inquiry was intended to uncover the subjective opinions of practising psychotherapists, to present these in a rich and descriptive form, and to systematically analyze patterns of therapists' responses. Hence the following sub-questions were developed to further this research question:

(a) What core factors represent the different perspectives among psychotherapists regarding ideal therapy process in the treatment of patients with pathological narcissism?

(b) In what way do core factors of ideal therapy process connect with different types of patient psychopathology, in terms of grandiose narcissism, vulnerable narcissism, and non-narcissistic anxiety disorder?

(c) Is there a relationship between therapists' declared theoretical orientation and their perspectives about ideal therapy process for narcissistic and non-narcissistic patients?

Question 3

How do the component responses of therapists [see question 2 (a)] regarding ideal therapy process compare with established models of psychotherapy process?

This exploratory question was aimed at investigating potential relationships between the component structures of therapist responses in the present study with those that have been previously developed and reported in the psychotherapy research literature.

Question 4

Are there relationships between therapists' perspectives regarding ideal therapy process and therapist characteristics?

This question formed a secondary line of inquiry to the examination of therapy process for pathological narcissism. Also exploratory in nature, this question was aimed at investigating whether particular therapist characteristics (e.g. age, experience, confidence) were related to the component responses of therapists in the present study, and to established therapy models examined in question 3. This inquiry was not intended to produce findings generalizable to a broader population, but instead to contribute further understanding of the participant sample and their perspectives, as discovered through questions 2 and 3.

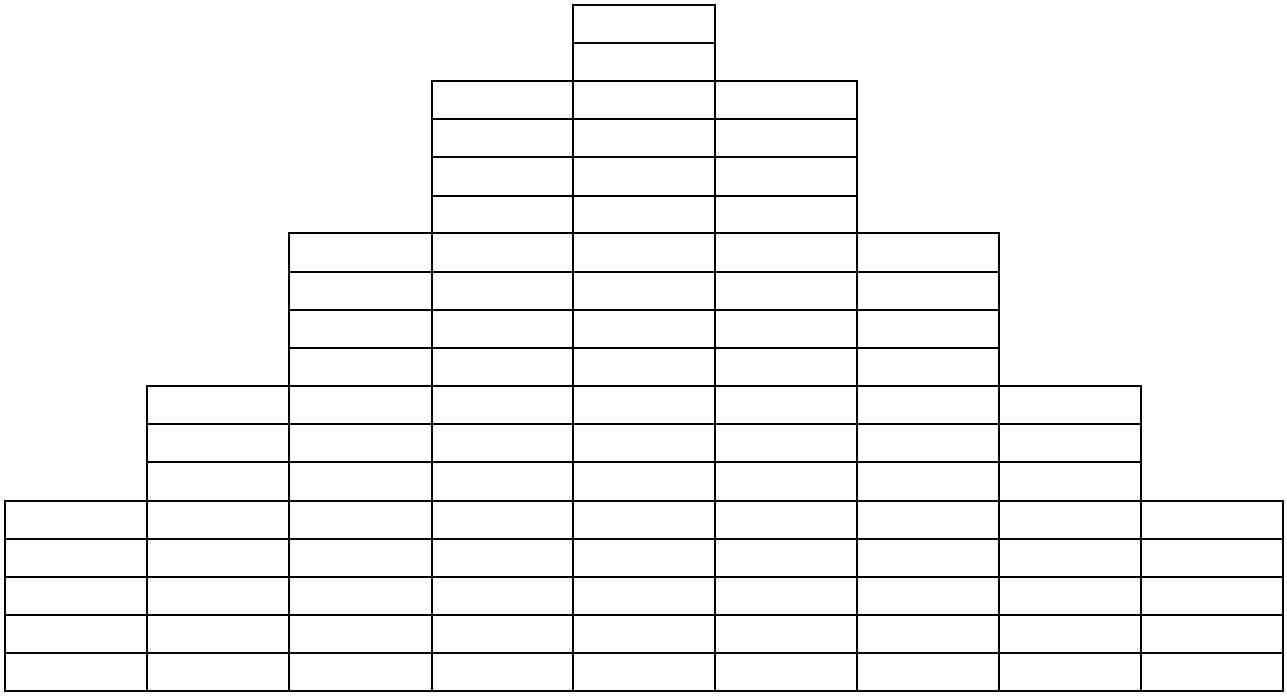
### 3.4 Q-methodology

A research approach grounded in Q-methodology was considered to be the most appropriate means of addressing the research questions of this project. Q-methodology, developed in the 1930s by William Stephenson, is a means of studying human subjectivity where respondents' views are both purely self-referential and yet systematically comparable (Brown, 1980; McKeown and Thomas, 1988; Stephenson, 1953; Watts and Stenner, 2012). The two major objectives of research employing Q-methodology (Q-research) are the discovery of the unique viewpoints of persons familiar with the phenomenon of inquiry, and the elaboration of such perspectives in both rich descriptive form and through systematic, statistical comparison. In this way, Q-methodology has been described as "neither a qualitative nor a quantitative

approach" (Dziopa and Ahern, 2011, p. 39). Like qualitative research, participants in Q-research are selected for their proximity to a particular phenomenon and asked to detail their subjective experience or viewpoint on the subject in question. However, participants are provided with a large but fixed number of descriptive statements, from which to select and rank according to their views. As in quantitative research, this allows for the correlation and factor analysis of individuals' views.

Q-methodology begins with the development of statements that describe various facets of the phenomenon in question. These statements, representing a wide range of potential views, are refined and gathered into a set of Q-sample items (known as the Q-set). Participants then rank these statement items within the Q-set according to the degree to which they represent the participants' views. Items are sorted (known as Q-sorting) on a continuum from "most characteristic or representative" to "least characteristic or representative" of the individual's viewpoint. Q-set items thus represent ordinal, rather than nominal, categories of views; items are considered by the participant purely in relation to one another and within the individual's internal frame of reference (Brown, 1980; McKeown & Thomas, 1988; Watts & Stenner, 2012). The sorting process involves the forced-choice allocation of Q-items into categories – each category containing a fixed number of items – that approximate a quasi-normal distribution. As depicted in Figure 3.1, relatively few items are placed in the tail categories of the distribution, indicating statements that are highly defining of the participants' perspective, as either most characteristic or least characteristic. The majority of items are placed in the middle of the Q-sort, and would be considered to be relatively neutral (compared to the Q-sort tails) in defining the participant's views. A numerical score is assigned to each category, giving each item a score that represents its placement in the Q-sort, and allowing for systematic comparison and analysis.

Figure 3.1 Distribution and scoring of Q-items




Exploratory factor analysis in Q-methodology is employed to investigate groups of participants who sort the Q-items similarly. Referred to as by-person factor analysis, this requires the analysis of participants as variables; the data matrix is transposed so that Q-items become subjects and participants – or more precisely, their Q-sorts – are entered as variables (McKeown & Thomas, 1988; Thompson, 2004). Factors are extracted from a correlation matrix comprised of all participants' Q-sorts, typically using centroid factor analysis or principal components analysis. Factor rotation is then performed to maximize statistical interpretation; varimax rotation, for example, reduces the degree of statistical correlation between factors. Factor loadings are coefficents that indicate the degree to which participants' Q-sort is correlated to the factor. A factor array is developed for each factor, consisting of the weighted average Q-

item scores; standardized factor scores (*z*-scores) indicate the position of each Q-item within the factor array.

Traditional R-method factor analysis typically calls for large participant samples, at least in proportion to the number of variables or items involved, though there is not a firm consensus on factor analytic sample size criteria (Thompson, 2004). Factor analysis in Q-research, however, does not depend on a large number of participants, not only because of the inversion of variables in the factor analytic matrix, but also due to the nature and aims of Q-methodological inquiry (Thompson, 2004; Watts & Stenner, 2012). Q-research is directed entirely at the exploration and examination of subjectivity, and makes no attempt to achieve a reliable level of generalizability to a wide population. Most authorities on Q-methodology advocate for relatively small, non-probability participant samples (including single-case studies) in favour of relatively large and comprehensive Q-samples (Brown, 1980; McKeown & Thomas, 1988; Watts & Stenner, 2012). A systematic review of recently published Q-methodological studies found an average participant sample size of $N = 40$ (range = 26 to 103; Dziopa and Ahern, 2011). With respect to the ratio of Q-items to participants – a methodological concern in traditional factor analysis – there has been little consensus within the Q-research literature, and some Q-methodologists consider it to be relatively unimportant (e.g. Brown, 1980). Recent recommendations have arbitrarily suggested a roughly 1:1 ratio (Watts and Stenner, 2005), and recent studies appear to have followed this advice (Dziopa and Ahern, 2011).

The present study employed Q-methodology in both the collection of responses – asking participants to Q-sort descriptive statements in fixed distribution – and the exploratory factor analytic approach to the data. Unlike many Q-research studies, however, a pre-existing sample of Q-items was used (the Psychotherapy Process Q-set; PQS; Jones, 2000). This afforded the

advantage of descriptive statements having been validated as representative views across several previous studies. This may be regarded as a methodological strength. Many Q-research studies use Q-sets developed by the researcher using statements obtained from extant literature and/or from experts in the field. The relevance of the items to the participant sample is typically untested. The use of the PQS over nearly three decades of research, however, substantiates the relevance of the Q-statements to the psychotherapy field; PQS items have essentially been repeatedly confirmed as representative of psychotherapy process. In addition to Q-methodology, the present study also made use of standard quantitative data analytic approaches in order to address questions concerning the influence of patient psychopathology and therapist variables on participants' Q-sort responses.

# 4 METHOD

## 4.1 Participants

Psychotherapists in active practice were recruited through email and listserv notices broadcast to members of the following organizations: Society for the Exploration of Psychotherapy Integration, American Psychological Association (Divisions of Psychotherapy and Psychoanalysis), American Association for Psychoanalysis in Clinical Social Work, and the Psychotherapy Practice Research Network. Recruitment notices were also distributed throughout the local British Columbia psychotherapy community, through email lists and events hosted by the University of British Columbia Psychotherapy Program and the Simon Fraser University Clinical Psychology Centre. A modest honorarium was offered to acknowledge participants' investment of time in the project. Sixty-nine psychotherapists indicated an interest in participating and requested the study materials. Of these 69 prospective participants, 49% went on to complete the study, yielding a participant sample of 34 psychotherapists. This sample size is consistent with the Q-method research summarized above, as well as with other Q-oriented studies that have explored psychotherapists' subjective opinions about therapy process (Boterhoven de Haan & Lee, 2014; Lister & Gardner, 2006; Schottenbauer, Arnkoff, Glass, & Hafter Gray, 2006; Weis, Schottenbauer, & Hafter Gray, 2009).

## 4.2 Materials

### 4.2.1 Clinical case vignettes

Clinical vignettes of hypothetical patients were developed in order to provide representative prototypes for participants to review. The vignettes were developed by the researcher in order to represent patients presenting with prototypical expressions of (1) narcissistic grandiosity, (2) narcissistic vulnerability, and (3) panic disorder without co-morbid

pathological narcissism or personality pathology. Two versions of each vignette were developed, representing a male and a female patient in each condition, for a total of six vignettes. Although some gender-role descriptive features differed between the male and female vignettes, there were no substantive clinical differences between them.

In order to ensure that these brief descriptions were indeed representative of grandiose and vulnerable expressions of pathological narcissism (and a non-narcissistic case), experts were asked to review both the male and female versions of each vignette. Four psychologists with expertise in pathological narcissism agreed to review and comment on the accuracy of the hypothetical cases. All four experts were internationally recognized authorities in personality and personality disorder research, assessment, and conceptualization; all had published extensively and recently on the subject of pathological narcissism. Each expert was invited to provide recommendations regarding the representativeness of the vignettes. After some minor recommendations, the vignettes were rated by these expert reviewers as being representative of the intended clinical phenomena.

#### 4.2.2 Clinician demographic questionnaire

A brief one-page questionnaire was included to obtain information regarding participants' demographic information, such as age and gender, along with information about their psychotherapy practice. This included questions about professional designation, theoretical orientation, and familiarity with and confidence in treating personality psychopathology.

#### 4.2.3 Psychotherapy Process Q-Set

The Psychotherapy Process Q-Set (PQS; Jones, 2000) is a 100-item instrument that was designed to facilitate the detailed description of psychotherapy process within an individual therapy session. PQS items were developed from extensive consultation of the psychotherapy

literature and experts in the field, in order to assess a range of therapy process elements across various theoretical orientations. Each item captures an aspect of therapy process that is not duplicated by another item in the PQS. Of the 100 items, 39 items describe therapist activities or attitudes, 39 items describe patient behaviours or attitudes, and 22 items refer to therapist-patient interactions or the overall atmosphere within the therapy session. The PQS is scored by sorting the items into nine categories (see Figure 1) that indicate the relevance of each item to the therapy process under investigation. The categories are indicated as item scores ranging from 1 to 9, with a score of 1 indicating an item considered to be least important to the therapy process, and a score of 9 indicating an item considered to be most important to the process. Items are Q-sorted in a forced-choice procedure whereby each category is allowed only so many items to be "placed" within it, approximating a quasi-normal distribution. Items placed towards both "tails" of the distribution are equally defining of respondents' subjectivity. An item placed in the 1 category (i.e. given a score of 1) is thus important as an activity in therapy that would be contraindicated from the perspective of the rater; items with low scores are highly defining as representing saliently absent aspects of therapy process, or the inverse of the item being importantly present in the therapy process. Items placed within or immediately surrounding the middle category (indicated by a score of 5) are considered to be relatively neutral or non-defining of the therapy process. Table 4.1 displays the categories indicated by the scores assigned to PQS items, and the number of allowable items per category. Once a respondent has assigned items to categories, he or she may continue to re-arrange their ranking of items (Q-sorting) until satisfied that the ordering of items reflects his or her views.

Table 4.1 Psychotherapy Process Q-set scoring (adapted from Jones, 1985 / 2009)

| Item score | Number of items | Category |
|---|---|---|
| 9 | 5 | extremely characteristic or salient |
| 8 | 8 | quite characteristic or salient |
| 7 | 12 | fairly characteristic or salient |
| 6 | 16 | somewhat characteristic or salient |
| 5 | 18 | relatively neutral or unimportant |
| 4 | 16 | Somewhat uncharacteristic or negatively salient |
| 3 | 12 | fairly uncharacteristic or negatively salient |
| 2 | 8 | quite uncharacteristic or negatively salient |
| 1 | 5 | Extremely uncharacteristic or negatively salient |

The PQS exists in several languages and has been used extensively in psychotherapy research. Jones intended the PQS to serve as a means of describing therapy process at the level of the individual session, whereby researchers could rate the process of a session with both descriptive richness and the potential for systematic comparison (Jones, 2000). Much of the research using the PQS has been conducted with pairs of clinical judges rating archived therapy sessions across a number of different samples and theoretical orientations. Interrater reliability across the 100 PQS items has been consistently demonstrated, with alpha coefficients between .83 and .89 per rater pair (Ablon, Levy, & Smith-Hansen, 2011). Analyses of individual item reliability have also produced acceptable values, between .50 and .95, across samples (Ablon, Levy, & Smith-Hansen, 2011). Construct and discriminant validity has also been demonstrated across samples (Jones, Krupnick, and Kerig, 1987; Jones and Pulos, 1993). The PQS has been used to track treatment process over time (Pole, Ablon, and O'Connor, 2008), to examine process elements in therapies within randomized controlled trials (Ablon & Jones, 1999; 2002), to identify critical interaction patterns in treatment (Goodman, Edwards, and Chung, 2014), and

in single case studies (De Bei & Montorsi, 2013; Pole, Ablon, O'Connor, & Weiss, 2002), including time-series analysis (Jones, Ghannam, Nigg, & Dyer, 1993). Researchers have also used the PQS to obtain experts' opinions regarding ideal therapy process for particular therapy approaches, developing PQS prototypes for therapies such as psychodynamic therapy, interpersonal psychotherapy, cognitive behaviour therapy, and control-mastery therapy (Ablon, Levy, & Smith-Hansen, 2011). Expert-rated PQS prototypes have then been used to examine the degree to which archived therapies adhere to their espoused model of treatment (Ablon & Jones, 1998; 2002), and to explore common process elements among distinct theoretical approaches (Goodman, 2013).

The PQS has also been employed as a prospective measure to capture therapists' opinions regarding optimal therapy process for particular conditions such as post-traumatic stress disorder (Schottenbauer, Arnkoff, Glass, & Hafter Gray, 2006) and for ideal therapy training models (Weis, Schottenbauer, & Hafter Gray, 2009). This usage of the PQS – in contrast to obtaining observer-scored session ratings – is oriented towards capturing the subjective perspectives of mental health clinicians. The objectives of such research are thus consistent with traditional Q-research. As such, the PQS serves as a well-validated Q-sample from which participants can indicate their views. The present study employed the PQS in this way – in keeping with Q-methodological considerations – in order to obtain detailed impressions from clinicians regarding prospective hypothetical treatments.

### 4.3 Procedure

The study procedure was approved by the Behavioural Research Ethics Board of the University of British Columbia. The recruitment notice indicated the purpose of the study as exploring therapists' ideas about optimal therapy process for pathological narcissism. Upon

initial expression of interest, participants were sent the study materials by email in order to commence participation in the study. Participants were asked to complete the demographic questionnaire before proceeding to the clinical vignettes. Each participant was randomly assigned a set of either three male or three female vignettes, representing narcissistic grandiosity, narcissistic vulnerability, and panic disorder. The vignettes were not labelled with regards to psychopathology, in order to avoid priming participants to a particular diagnostic subtype. Participants were asked to carefully read each of the three vignettes and to think about an ideal therapeutic approach for each hypothetical patient. Participants were instructed to consider which aspects of the therapy process would be most important, which would be relatively unimportant or neutral, and which would be contraindicated in an optimally conducted treatment. Instructions were provided for the use of the PQS in a Microsoft Excel application that allowed for assignment and Q-sorting of item responses to categories numbered from 1 to 9. After the Q-sorting process, each of the 100 items would have a score between 1 and 9 indicating the rank of the item from least to most characteristic of an ideal therapy process. Participants were asked to complete the PQS in response to each clinical vignette, using the Q-sort method to rate an ideal therapy process for each hypothetical patient. Participants were advised that they could complete the project in stages rather than at one sitting, in order to promote the Q-sorting of item responses and to reduce rater fatigue. All participants were encouraged to contact the researcher with any questions or concerns regarding the Q-sort process as they carried out the study procedure. Completed responses were returned by email to the researcher.

# 5 RESULTS

## 5.1 Demographic information

A total of 34 psychotherapists completed participation in the study. Eighteen participants (53%) were female and 16 (47%) were male. The average age was 43 years (SD = 11.6) and the average level of psychotherapy experience was 12.5 years (SD = 8.2). With regards to professional discipline, there were 15 psychologists (44%), 13 social workers (38%), five clinical counsellors (15%), and one psychiatrist. The psychiatrist and one psychologist also identified as psychoanalysts by profession. Although some participants indicated more than one theoretical orientation, most identified with a single primary perspective. Participants' theoretical orientations consisted of 14 psychodynamic (41%), 14 eclectic / integrative (41%), six cognitive-behavioural (18%), three interpersonal, and two humanistic. The therapists were varied in their current involvement with personality disordered patients. The average percentage of participants' caseload devoted to personality disorders was 38%, with nine therapists indicating that personality disorders made up the majority of their caseload, and 11 reporting less than one quarter of their current patients having personality disorder.

## 5.2 Initial examination of Q-sorts

Upon completion and submission of the Q-sorts, the principal investigator examined each Q-sort to ensure that the items had been distributed according to Q-sort protocol. Following the procedure of a previous PQS study, this inspection also checked whether participants had indeed sorted throughout the entire 100 items of each PQS, rather than indiscriminately relegating items to middle piles (Schottenbauer, Arnkoff, Glass, & Hafter Gray, 2006). No Q-sorts were dropped from the study for this reason; items were indeed placed throughout the PQS for all returned Q-sorts, indicating that all participants satisfactorily performed the Q-sorting part of the procedure.

Prior to further analysis, the Q-sorts were also examined to determine whether there were any significant differences between clinical vignettes depicting male patients and vignettes depicting female patients. Among the 34 sets of completed responses, 20 were responses to vignettes of male patients and 14 were responses to vignettes of female patients. Composite Q-sorts were created for male and female patient vignettes, using the mean PQS item scores, for each of the three types of patient psychopathology. Single measure intraclass correlation coefficients were calculated to evaluate the level of agreement between respondents rating male versus female patient vignettes. The level of agreement was found to be high for each of the grandiose (ICC = .90, $p < .0001$), vulnerable (ICC = .91, $p < .0001$), and panic disorder (ICC = .94, $p < .0001$) vignettes. Thus it was concluded that the gender of the patient in the vignettes did not significantly influence respondents' PQS ratings, allowing Q-sorts for male and female patients to be pooled for analysis.

### 5.3 Comparison between patient types: Mean PQS scores

In order to address the question of whether presentations of pathological narcissism accounted for differences in process ratings among participant therapists, a one-way ANOVA was conducted with each of the 100 PQS items as dependent variables and with the grandiose narcissism, vulnerable narcissism, and panic disorder vignettes serving as independent variables. In other words, the mean scores for each PQS item were compared between the three patient types. Due to the multiple significance tests conducted, particularly given the small sample size, a Bonferroni correction was applied to reduce experimentwise error. The significance level was thus set at $p < .0005$ (.05/100). Significant differences were found in 19 (19%) of the PQS items, reported in Table 5.1. Eleven of these items were descriptive of patient attitudes or behaviours, five items were descriptive of therapist activities, and three items pertained to therapist-patient

interactions. Post hoc analyses were conducted using Tukey's honestly significant difference (HSD) test. Since a conservative alpha correction was applied to the overall ANOVA, the significance level for these post hoc comparisons was set at $p \leq .01$, in order to reduce type II errors at the item level among these significantly different responses. Post hoc analyses found 36 differences between patient types among these 19 items, reported in Table 5.1.

Table 5.1 Differences in mean PQS scores by patient type: One-way ANOVA with Tukey's HSD

| | | One-way ANOVA with mean scores | | | | Post-hoc test; Tukey's HSD | | |
|---|---|---|---|---|---|---|---|---|
| **PQS item & description** | | **F (2,99)** | **G** | **V** | **PD** | **G v V** | **G v PD** | **V v PD** |
| 1 | P verbalizes negative feelings toward T | 12.05 | 5.79 | 4.47 | 3.65 | .01 | .000 | |
| 6 | **T is sensitive to the P feelings, attuned, empathic** | 10.65 | 6.35 | 7.94 | 7.68 | .000 | .002 | |
| 16 | *Discussion focuses on physical symptoms / health* | 25.77 | 3.65 | 3.71 | 6.38 | | .000 | .000 |
| 20 | P is provocative, tests limits of therapy relationship | 19.79 | 5.82 | 3.68 | 3.47 | .000 | .000 | |
| 34 | P blames others or external forces for difficulties | 9.86 | 5.65 | 4.44 | 3.44 | | .000 | |
| 37 | **T behaves in a didactic manner** | 10.01 | 3.00 | 3.29 | 4.85 | | .000 | .002 |
| 38 | *There is discussion of homework* | 12.53 | 4.35 | 5.35 | 6.71 | | .000 | .01 |
| 39 | *The relationship has a competitive quality* | 8.80 | 3.88 | 2.59 | 2.21 | .007 | .000 | |
| 44 | P is wary or suspicious | 8.34 | 4.47 | 5.18 | 3.35 | | | .000 |
| 45 | **T adopts supportive stance** | 9.81 | 4.82 | 6.26 | 6.56 | .002 | .000 | |
| 48 | **T encourages independence of action or opinion** | 11.99 | 4.35 | 6.24 | 5.82 | .000 | .001 | |
| 49 | P experiences ambivalent / conflicted feelings about T | 13.32 | 5.41 | 4.94 | 3.68 | | .000 | .001 |
| 55 | P conveys positive expectations about therapy | 15.77 | 4.53 | 5.03 | 6.50 | | .000 | .000 |
| 63 | P interpersonal relationships are major theme | 13.83 | 7.32 | 7.12 | 5.62 | | .000 | .000 |
| 66 | **T is directly reassuring** | 13.38 | 3.59 | 4.41 | 5.65 | | .000 | .007 |
| 73 | P is committed to the work of therapy | 8.95 | 5.24 | 5.38 | 7.06 | | .001 | .002 |
| 83 | P is demanding | 13.44 | 4.94 | 3.35 | 3.18 | .000 | .000 | |
| 84 | P expresses angry or aggressive feelings | 8.71 | 5.76 | 4.41 | 4.24 | .003 | .001 | |
| 87 | P is controlling | 9.21 | 4.44 | 3.06 | 2.82 | .003 | .000 | |

F values are significant at $p < .0005$. Post hoc tests are significant at $p \leq .01$. P = patient, T = therapist in PQS item descriptions. G = grandiose narcissism; V = vulnerable narcissism; PD = panic disorder. Items in normal font are patient behaviour items; items in bold are therapist behaviour items; items in italics are interaction items.

As shown in Table 5.1, therapists overall indicated that an ideal treatment with a grandiose patient would be most different from that with a non-narcissistic patient, involving considerably more challenging and negative patient behaviours (Q items 1, 20, 34, 83, 84, 87). Therapists also generally felt that there would be several differences in treating a patient with vulnerable narcissism compared to an individual without pathological narcissism. There were similarities in how the ideal treatment processes for grandiose narcissism and vulnerable narcissism differed from that with a non-narcissistic patient; for either presentation of pathological narcissism, therapy would require dealing with the patient's ambivalence, pessimism, and commitment regarding the therapy process (Q items 49, 55, 63, 73). Therapy for narcissistic vulnerability would also involve handling the patient's suspicion (Q 44). Some overall differences in therapists' responses also emerged between the narcissistic patient types. Compared to the grandiose patient, treatment of a vulnerable patient was generally regarded as requiring a more empathic, supportive, and encouraging approach (Q items 6, 45, 48), with less need to deal with difficult or negative patient behaviours (Q items 1, 20, 83, 84, 87).

## 5.4 Core factors of ideal therapy process: PQS factor extraction and rotation

Although comparison of participants' individual PQS item ratings revealed some overall differences in responses to narcissistic pathology, this analysis did not provide information regarding patterns of therapist responses. Exploratory factor analysis was used to address this aspect of inquiry, in order that clusters of therapists' approaches could be distinguished and examined with regards to their underlying structure. Principal components analysis, the factor analytic method most commonly used in PQS research, was conducted in order to identify patterns of opinion regarding ideal therapy process. All Q-sorts – those responding to grandiose ($N = 34$), vulnerable ($N = 34$), and panic disorder ($N = 34$) vignettes – were entered

simultaneously (total $N = 102$ Q-sorts). In keeping with Q-factor analysis, the data were transposed so that participants' Q-sorts were entered as variables, and the 100 PQS items as "subjects". Principal components analysis with varimax rotation was conducted on all 102 Q-sorts. The analysis initially produced 20 factors with Eigenvalues > 1.00. However, visual inspection of the scree plot suggested a four factor solution, and thus a second analysis was conducted, extracting four fixed orthogonal factors that accounted for 54.09% of the variance. The first factor, labelled "Introspective Relational", had an Eigenvalue of 35.64 and accounted for 34.94% of the variance. This was the highest loading factor for 39 of the 102 Q-sorts (38.2%), representing the views of 19 participant therapists. The second factor, labelled "Cognitive / Objective-oriented Alliance", had an Eigenvalue of 8.31 and accounted for 8.15% of the variance. Thirty-five Q-sorts (34.3%) from 24 therapists loaded higher on this factor than any other. Factors three and four, labelled "Inhibited, Fragile Patient" and "Angry, Provocative Patient", had Eigenvalues of 6.19 and 5.04 and explained 6.06% and 4.94% of the variance, respectively. These factors each contained the highest loadings for 14 Q-sorts (13.7%), and each represented the views of 14 participants.

### 5.5 Factor composition and description

The four orthogonal factor arrays were constructed with each of the 100 PQS items being weighted for its influence on the cluster of therapists' responses. Standardized factor scores – computed as linear regression coefficients – indicate the contribution of each PQS item to each factor. The resulting four arrays (of 100 PQS items each) thus serve as prototype Q-sorts representing the four factors, with standardized factor scores indicating the position of PQS items within the factor array. The ordering of all 100 items in the PQS is important and meaningful with respect to the participants' views on optimal treatment; comparisons of PQS ratings involve

the entire array of 100 Q-sorted items. The items with the highest and lowest scores for each factor, however, represent the most and least characteristic elements of that particular therapy process. Items with factor scores closer to zero (the middle of the Q-distribution) are considered relatively neutral or unimportant to the process represented by one of the factors. The interpretive factor descriptions given below are thus based on those items that are most defining, by virtue of being the highest- and lowest-ranked PQS items in each factor array. The factor descriptions refer to the PQS items (numbered Q items), with reverse-scores (r) indicating items ranked as least characteristic of each factor. These items convey elements that are defining of therapy process by their absence or reversal.

Factor 1: Introspective Relational

The ideal therapy process represented by this factor involves the commitment of therapist and patient to the exploration of internal phenomena and emotional experience within a discovery-facilitative relationship. The patient is dedicated to the process of looking within (Q 97) – as opposed to externalizing (Q 34, r) – and he or she brings forth significant material (Q 88, Q 15, r) and contemplates inner feelings and motivations (Q 58, r) in order to achieve a new understanding (Q 32). The therapist is attuned and sensitive to the patient's feelings (Q 6), demonstrating tact (Q 77, r), respect (Q 51, r), and non-judgemental acceptance (Q 18) towards the patient. In turn, the patient feels understood (Q 14). The therapist also maintains a keen sense of the therapeutic process (Q 28) – including desired interventions – yet without actively controlling the session (Q 17, r) or prescribing extra-session work (Q 38). In the therapy process indicated by this factor, didactic instruction (Q 37, r), direct reassurance (Q 66, r), and advice-giving (Q 27, r) are all regarded as interventions for the therapist to avoid, and direct problem-solving by the therapist should not be expected by the patient (Q 52, r). Instead, the therapist is

focused on the patient's emotional experience (Q 81), including feelings that the patient is reluctant to accept (Q 50; Q 67), in order that the patient can experience some relief in their expression (Q 60). Themes concerning the patient's experience and behaviour are introduced by the therapist (Q 62) and discussed in a way that is novel for the patient (Q 82). The therapy relationship is also an important component of the process represented by this factor. The patient is seen as contributing to this relationship by having a basic sense of trust (Q 44, r) and commitment (Q 73), and by not having a controlling interpersonal style (Q 87, r). The therapist works to prevent his or her own emotional issues from contaminating the relationship (Q 24, r). Furthermore, the therapy relationship itself is openly discussed (Q 98), and transference work is introduced through the linking of the therapy relationship with other relationships (Q 100).

Factor 2: Cognitive / objective-oriented alliance

As a representation of optimal therapy process, this factor involves the therapist and patient working on clearly elaborated objectives within a positive, task-oriented alliance. Discussion is specific (Q 23) and focused on the patient's current life situation (Q 69), physical symptoms (Q 16), and treatment goals (Q 4). The therapist explains the treatment rationale (Q 57) and communicates in a clear manner (Q 46) and with tact (Q 77, r) and respect (Q 51, r). The patient in turn is seen to understand how the therapy will proceed (Q 72), to feel optimistic about it (Q 55), and to be committed to the work involved (Q 73). The therapist takes on a supportive role toward the patient (Q 45), providing direct reassurance (Q 66) and advice (Q 27), and the patient feels helped (Q 95). Cognitive themes are a focus of the therapy process (Q 30), and therapist and patient discuss particular activities for the patient to attempt between sessions (Q 38). Discussion does not, however, turn to childhood memories (Q 91, r) or sexual experiences (Q 11), and the therapist avoids interpretation of unconscious psychological

phenomena (Q 67, r). The absence of certain patient attitudes and behaviours are important to the process in this factor. The patient is not controlling (Q 87, r) or demanding (Q 83, r), and does not express negative feelings toward the therapist (Q 1, r). Indeed, the patient is seen as experiencing the therapy relationship in an objective, task-oriented manner, with no ambivalent feelings regarding the therapist (Q 49, r), and no seeking of affection from (Q 78, r) or intimacy with (Q 10, r) the therapist. Erotic and competitive dynamics within the dyad are also seen as counter-therapeutic (Q 19, r; Q 39, r). In line with these features, the therapist seeks to prevent his or her own emotional issues from encroaching on the relationship (Q 24, r). The therapist also avoids making transference interpretations (Q 100, r).

Factor 3: Inhibited fragile patient

The therapy process exemplified by this factor revolves to a large extent around the patient's attitudes and behaviours, particularly feelings that correspond with descriptions of narcissistic vulnerability. In the ideal treatment indicated by this factor, the patient's dysphoria and anxiety are front and centre (Q 7; Q 94; Q 26). These include self-conscious emotions and feelings that are linked with social expectancies, such as feelings of inadequacy (Q 59), shame or guilt (Q 71), shyness (Q 61), and suspicion (Q 44). Overt aggression on the part of the patient, however, is seen as counter-therapeutic (Q 84). The patient's interpersonal sensitivities extend to the therapy relationship, in that the patient is concerned about the therapist's evaluation of his or her person (Q 53), and actively seeks the therapist's approval or affection (Q 78). Indeed, this factor depicts the patient as not understanding the therapy process (Q 72, r), not being committed to it (Q 73, r), and not taking an introspective stance (Q 97). Discussion of scheduling or fees does not occur (Q96, r). Furthermore, the patient's behaviour in session is muted (Q 13, r) and compliant (Q 20, r), with minimal negative expression toward the therapist (Q 1, r). The process

represented by this factor involves a non-judgemental (Q 18), supportive (Q 45) therapist who is affectively engaged (Q 9, r) and attuned to the patient's experience (Q 6). The therapist is tactful (Q 77, r) and respectful (Q 51, r). The therapist also avoids the intrusion of his or her own emotional conflicts (Q 24, r), and there are no erotic overtones in the therapy relationship (Q 19, r). The patient's interpersonal relationships are a prominent theme (Q 63), and the patient talks about feeling close to or needing someone (Q 33). The therapist expresses opinions in response to the patient's material (Q 93, r), and draws attention to feelings regarded as unacceptable (Q 50). Accordingly, the therapist does not intervene to strengthen the patient's defenses (Q 89, r).

Factor 4: Angry, provocative patient

As with the third factor, patient attitudes and behaviours figure prominently in the ideal process represented by Factor 4. In this factor, characteristic patient behaviours are largely consistent with descriptions of narcissistic grandiosity. The patient is demanding (Q 83), provocative (Q 20), and angry (Q 84). He or she resists introspection and reflection (Q 58; Q 97, r), blaming others for difficulties (Q 34). This factor sees the patient as neither committed to (Q73, r) nor optimistic about (Q 55, r) the therapy. Indeed, the patient expresses negative feelings toward the therapist (Q 1), rejects the therapist's comments (Q 42), and does not feel helped by the process (Q 95, r). The patient is seen as ideally being emboldened in the sessions, with a self-assured and superior (Q 59, r; Q 61, r) attitude, an absence of overt shame, guilt, or dysphoric affect (Q 71, r; Q 26, r), and with no difficulty commencing the session (Q 25, r). This factor sees the patient avoiding greater intimacy with the therapist (Q 10, r). The therapist communicates clearly (Q 46) and – without condescension (Q 51, r) – suggests that the patient accept responsibility for his or her problems (Q 76). Ideally the patient does not rely upon the therapist to solve his or her problems (Q 52, r). Treatment goals are discussed (Q 4), and the

dialogue focuses on cognitive themes (Q 30), interpersonal relationships (Q 63), and self-image (Q 35). The therapist avoids bolstering the patient's defenses (Q 89), and identifies patterns in the patient's experience (Q 62), encouraging new ways of relating to others (Q 85). By contrast, physical symptoms are not focused on (Q 16, r), nor is the patient's experience of catharsis (Q 60, r).

### 5.6 Most and least characteristic aspects of ideal process

Table 5.2 presents the standardized factor scores for the four factors, across the entire 100 items of the PQS. The 15 most and 15 least characteristic items for each factor are indicated in Table 5.2 in bold type (least characteristic items are further distinguished by being negatively signed).

Table 5.2 Standardized factor scores for ideal therapy process; 4 factors, 102 Q-sorts

| Item | Item description | IR | CA | IFP | APP |
|---|---|---|---|---|---|
| 1 | P verbalizes negative feelings toward T | 0.461 | **-1.132** | **-1.331** | **1.727** |
| 2 | T draws attention to P's non-verbal behavior | 0.562 | 0.121 | -0.593 | -0.011 |
| 3 | T remarks are aimed at facilitating P speech | 0.480 | 0.158 | -0.198 | -0.601 |
| 4 | P treatment goals are discussed | -0.051 | 1.881 | -0.295 | **1.603** |
| 5 | P has difficulty understanding T | -1.052 | -0.900 | -0.341 | -0.493 |
| 6 | T is sensitive to the P feelings, attuned, empathic | **1.446** | 1.186 | **1.208** | -0.355 |
| 7 | P is anxious or tense | -0.552 | 0.532 | **1.241** | -0.977 |
| 8 | P is concerned about dependence on T | -0.236 | -0.381 | 0.097 | -0.487 |
| 9 | T is distant/aloof | -0.864 | -1.050 | **-1.981** | -0.109 |
| 10 | P seeks greater intimacy with T | 0.722 | **-1.294** | 0.049 | **-1.433** |
| 11 | Sexual feelings and experiences are discussed | 0.431 | **-1.053** | -0.642 | -0.258 |
| 12 | Silences occur during the hour | -0.458 | 0.080 | -0.313 | -0.566 |
| 13 | P is animated or excited | -0.030 | 0.407 | **-1.703** | 0.167 |
| 14 | P does not feel understood by T | **-1.668** | -0.859 | 0.078 | 1.141 |
| 15 | P does not initiate topics; is passive | **-1.424** | -0.213 | 0.476 | -0.765 |
| 16 | Discussion focuses on physical symptoms and/or health | -1.061 | **1.619** | -0.504 | **-1.543** |
| 17 | T actively exerts control over interaction | **-1.598** | 0.827 | -0.645 | 0.362 |
| 18 | T conveys non-judgmental acceptance | **1.252** | 1.136 | **1.338** | 0.579 |
| 19 | The therapy relationship has an erotic quality | -0.342 | **-1.742** | **-1.603** | -0.790 |
| 20 | P is provocative, tests limits of therapy relationship | -0.100 | -0.943 | **-1.621** | **2.052** |
| 21 | T self-discloses | -0.730 | 0.240 | -0.506 | -0.821 |
| 22 | T focuses on guilt | 0.349 | -0.663 | 0.345 | -0.863 |
| 23 | Dialogue has a specific focus | -0.685 | **1.502** | -0.361 | 0.773 |
| 24 | T emotional conflicts intrude into relationship | **-1.560** | **-1.150** | **-0.963** | -0.903 |
| 25 | P has difficulty beginning the hour | -0.454 | -1.036 | 0.640 | **-1.249** |
| 26 | P experiences discomforting affect | 0.159 | 0.063 | **1.988** | **-1.174** |
| 27 | T gives explicit advice and guidance | **-1.967** | **1.543** | -0.457 | -0.506 |
| 28 | T accurately perceives therapy process | **1.421** | 1.028 | 0.433 | 0.804 |
| 29 | P talks of wanting to be separate or distant | -0.167 | -0.766 | -0.884 | 0.669 |
| 30 | Discussion centers on cognitive themes | -1.041 | **2.163** | 0.184 | **1.499** |
| 31 | T asks for more information or elaboration | 0.010 | 1.075 | 0.067 | 0.495 |
| 32 | P achieves a new understanding or insight | **1.481** | 1.006 | 0.304 | 0.242 |
| 33 | P talks of feeling close to or needing someone | 0.736 | -0.928 | **1.896** | -0.634 |
| 34 | P blames others or external forces for difficulties | -1.207 | -0.945 | 0.359 | **2.455** |
| 35 | P self-image is focus of discussion | 0.845 | 0.220 | 0.503 | **1.286** |
| 36 | T points out P use of defenses | 0.622 | -0.572 | 0.472 | 0.804 |
| 37 | T behaves in a didactic manner | **-2.050** | 1.121 | -0.557 | -0.591 |
| 38 | There is discussion of homework | **-1.768** | **2.504** | 0.137 | 0.183 |
| 39 | The relationship has a competitive quality | -0.858 | **-1.806** | -0.891 | 0.501 |
| 40 | T interpretations refer to actual people | 0.514 | -0.494 | 0.967 | 0.438 |
| 41 | P aspirations/ambitions are discussed | 0.327 | 0.427 | -0.225 | 1.028 |
| 42 | P rejects T comments/observations | -0.706 | -0.599 | -0.546 | **1.527** |
| 43 | T suggests meaning of other's behavior | -0.124 | -0.114 | -0.301 | 0.440 |
| 44 | P is wary or suspicious | **-1.345** | -0.948 | **1.585** | 1.002 |
| 45 | T adopts supportive stance | -0.689 | **1.527** | **1.426** | -0.464 |
| 46 | T communicates in clear coherent style | 0.907 | **1.270** | -0.116 | **1.356** |
| 47 | T accommodates when the interaction is difficult | 0.103 | 0.698 | 0.143 | -0.651 |
| 48 | T encourages independence of action or opinion | -0.359 | 1.000 | 0.866 | -0.785 |
| 49 | P experiences ambivalent/conflicted feelings about T | 0.156 | **-1.184** | 0.339 | 0.538 |
| 50 | T points out P's unacceptable feelings | **1.239** | -0.421 | **1.179** | 0.097 |
| 51 | T condescends to or patronizes P | **-1.496** | **-1.529** | **-1.693** | **-1.333** |

| Item | Item description | IR | CA | IFP | APP |
|---|---|---|---|---|---|
| 52 | P relies upon T to solve his/her problems | **-1.135** | -0.514 | 0.601 | **-1.744** |
| 53 | P concerned about what T thinks of him/her | -0.492 | -0.949 | **2.892** | -0.271 |
| 54 | P is clear and organized in self-expression | 0.061 | 0.513 | -0.318 | -0.061 |
| 55 | P conveys positive expectations about therapy | 0.466 | **1.290** | -0.888 | **-1.447** |
| 56 | P is distant from his/her feelings | -0.748 | -0.624 | 0.146 | 0.167 |
| 57 | T explains treatment rationale | -0.259 | **1.651** | -0.615 | 0.030 |
| 58 | P resists examining thoughts, reactions, or motivations | **-1.453** | -0.885 | 0.638 | **1.327** |
| 59 | P feels inadequate or inferior | -0.795 | -0.406 | **2.401** | **-1.872** |
| 60 | P has a cathartic experience | **1.311** | -0.134 | -0.830 | **-1.178** |
| 61 | P is shy or embarrassed | -0.659 | -0.426 | **1.726** | **-1.904** |
| 62 | T identifies recurrent theme | **1.214** | -0.055 | 0.953 | **1.492** |
| 63 | P interpersonal relationships are major theme | 0.919 | -0.453 | **1.542** | **1.846** |
| 64 | Love or romantic relationships are discussed | 0.554 | -0.735 | 1.164 | 0.921 |
| 65 | T clarifies, restates, rephrases P communication | 0.397 | 0.892 | -0.407 | 0.457 |
| 66 | T is directly reassuring | **-1.472** | **1.375** | 0.052 | -0.868 |
| 67 | T interprets unconscious wishes, feelings, or ideas | **1.768** | **-1.552** | -0.271 | -0.108 |
| 68 | T actively distinguishes reality from fantasy | 0.209 | 0.725 | 0.342 | 0.305 |
| 69 | P current or recent life situation is emphasized | -0.117 | **1.369** | 0.200 | 1.048 |
| 70 | P struggles to control feelings/impulses | -0.862 | 0.526 | -0.624 | 0.182 |
| 71 | P is self-accusatory; expresses shame or guilt | -0.492 | -0.107 | **1.200** | **-1.591** |
| 72 | P understands the nature of therapy | 1.135 | **1.211** | **-1.206** | -0.716 |
| 73 | P is committed to the work of therapy | **1.573** | **1.456** | **-1.701** | **-1.601** |
| 74 | Humor is used | 0.142 | 0.378 | -0.480 | 0.013 |
| 75 | Termination of therapy discussed | 0.357 | 0.522 | -0.530 | 0.095 |
| 76 | T suggests P accept responsibility for his/her problems | -0.501 | 0.250 | -0.531 | **1.181** |
| 77 | T is tactless | **-1.575** | **-1.577** | **-1.683** | -1.114 |
| 78 | P seeks T approval, affection, or sympathy | -0.305 | **-1.277** | **2.218** | -0.501 |
| 79 | T comments on changes in P mood/affect | 0.932 | 0.017 | 0.151 | 0.252 |
| 80 | T presents experience/event in different perspective | -0.020 | 0.917 | 0.651 | 0.807 |
| 81 | T emphasizes P feelings to deepen them | **1.900** | -0.646 | 0.192 | -0.659 |
| 82 | T reformulates P's in session behavior | **1.254** | -0.582 | -0.087 | 0.235 |
| 83 | P is demanding | -0.691 | **-1.146** | -0.681 | **1.312** |
| 84 | P expresses angry or aggressive feelings | 0.516 | -0.926 | **-0.912** | **1.305** |
| 85 | T encourages P to try new ways of behaving w/ others | -0.998 | 0.696 | 0.485 | **1.176** |
| 86 | T is confident and self-assured | 0.523 | 0.363 | 0.445 | 0.391 |
| 87 | P is controlling | **-1.322** | **-1.251** | -0.275 | 1.173 |
| 88 | P brings up significant issues | **1.532** | 0.644 | -0.903 | -0.437 |
| 89 | T acts to strengthen defenses | -0.604 | -0.193 | **-1.188** | **-1.162** |
| 90 | P dreams or fantasies are discussed | 0.883 | -0.967 | -0.720 | -0.804 |
| 91 | Childhood memories are discussed | 1.028 | **-1.325** | 0.004 | -0.794 |
| 92 | T links P's feelings/perceptions to the past | 0.824 | -0.524 | 0.619 | 0.859 |
| 93 | T is neutral | 0.968 | -0.371 | **-1.197** | -0.161 |
| 94 | P is sad or depressed | -0.361 | -0.454 | **1.598** | -0.965 |
| 95 | P feels helped | 0.950 | **1.250** | -0.189 | **-1.235** |
| 96 | Scheduling or fees are discussed | 0.319 | 0.536 | **-1.463** | 0.091 |
| 97 | P is introspective | **2.099** | 0.505 | **-1.684** | **-1.888** |
| 98 | Therapy relationship is discussed | **1.811** | -0.904 | -0.716 | -0.001 |
| 99 | T challenges P perspective | -0.049 | 0.418 | 0.496 | 0.765 |
| 100 | T interprets transference | **1.683** | **-1.131** | 0.333 | 0.252 |

IR = Introspective Relational (factor 1); CA = Cognitive / Objective-oriented Alliance (factor 2); IFP = Inhibited, Fragile Patient (factor 3); APP = Angry, Provocative Patient (factor 4). The 15 most and 15 least characteristic items for each factor are indicated in bold type; negatively signed scores indicate least characteristic items.

Despite the factor prototypes being uncorrelated (as a consequence of varimax orthogonality), several items were considered highly important to ideal process across different factors. The therapist being respectful towards the patient (Q 51, r) is a defining item for each factor, and the therapist being tactful (Q 77, r) and containing his or her own emotional conflicts (Q 24, r) are important features in the first three of the four factors. The therapist being non-judgemental (Q 18), empathic (Q 6), and interpretive of unacceptable feelings (Q 50) are highly characteristic of both the Introspective Relational process (factor 1) and the Inhibited, Fragile Patient process (factor3). The Introspective Relational and the Angry, Provocative Patient (factor 4) factors both share highly characteristic items concerning the therapist's identification of recurrent themes (Q 62) and the patient's responsibility for problem-solving (Q 52, r). The Angry, Provocative Patient and the Cognitive / Objective-oriented Alliance (factor 2) processes are both defined by clear therapist communication (Q 46), discussion of cognitive matters (Q 30), and the patient's reserved stance towards therapeutic intimacy (Q 10, r). Factors 2 and 3 also share the view that the therapist's supportive stance (Q 45) is essential, while the expression of negative transference (Q 1) and an erotic atmosphere (Q 19) are counter-therapeutic. The patient being controlling (Q 87) was a least-characteristic item for both the Introspective Relational and Cognitive Alliance factors, while the patient's commitment to therapy (Q 73) was highly important for both of these approaches. In contrast, this latter item (Q 73) was least characteristic for both the Inhibited and the Angry Patient factors, as was the therapist's support of defenses (Q 89) and the patient's introspection (Q 97). Factors 3 and 4 also shared an emphasis on interpersonal relationships (Q 63).

Many PQS items that were most characteristic for one factor were least characteristic for another. This was the case for 21 of the 100 items. Although important distinctions are evident

throughout the 100 items, these "most versus least" items may be considered the most distinguishing aspects of the therapy processes represented by the four orthogonal factors. Only four of these highly distinguishing items were descriptive of therapist behaviours: therapists' advice-giving (Q 27) and reassurance (Q 66) were highly characteristic of the Cognitive Alliance factor yet contraindicated for the Introspective Relational factor, while therapists' interpretation of unconscious material (Q 67) and transference (Q 100) were least characteristic of Cognitive Alliance yet highly valued within the Introspective Relational process. The discussion of between-session homework (Q 38) also distinguished between these factors, being highly important for the Cognitive Alliance process. With the exception of item 16, "discussion focuses on physical symptoms and/or health" – important for factor 2 yet contraindicated in factor 4 – the remaining 15 highly distinguishing items are descriptive of patient activities rather than therapeutic interventions. Furthermore, these items differentiate factors 3 and 4 from one another and from factors 1 and 2 (none of the highly distinguishing items between factors 1 and 2 pertained to patient behaviours). These items tend to reflect patient attitudes and behaviours that are consistent with reports of narcissistic vulnerability (Q 26, Q 44, Q 59, Q 61, Q 71, Q 78, Q 84) and narcissistic grandiosity (Q 1, Q 26, r; Q 55, r; Q 58; Q 59, r; Q 61, r; Q 71, r; Q 83; Q 84; Q 95, r; Q 97, r) as experienced in psychotherapy. In other words, factors 3 and 4 corresponded strongly with representations of vulnerable and grandiose narcissism, respectively. The perspectives indicated by the Inhibited and Angry Patient factors thus appear to reflect therapists' concerns with handling patients' in-session behaviours, with intervention strategies contingent upon the here-and-now emergence of patients' psychopathology.

## 5.7 Distribution of factors

### 5.7.1 Influence of patient type

The factors extracted from the 102 Q-sorts were not evenly distributed between the three types of patient. Table 5.3 displays the distribution of Q-sorts according to primary factor loading across the three types of vignette. The first factor, Introspective Relational, was distributed most evenly between the types of patient indicated by the clinical vignettes. The majority of panic disorder Q-sorts (71%) had primary loadings on the Cognitive Alliance factor, with no loadings on factors 3 or 4. The Inhibited Fragile Patient factor was almost exclusively associated with responses to vulnerable narcissism, while the Angry Provocative Patient factor was, with one exception, associated with grandiose narcissism.

Table 5.3 Distribution of Q-sorts by highest factor loading

| Factor | Grandiose narcissism | Vulnerable narcissism | Panic Disorder |
|---|---|---|---|
| 1 Introspective Relational | 16 | 13 | 10 |
| 2 Cognitive / Objective-oriented alliance | 4 | 7 | 24 |
| 3 Inhibited, Fragile Patient | 1 | 13 | 0 |
| 4 Angry, Provocative Patient | 13 | 1 | 0 |

The influence of patient psychopathology on factor loadings was confirmed statistically using one-way ANOVA with the vignette type as the independent variable and the factor loadings for each factor as the dependent variables (comparing the mean factor loadings between patient type). Patient type was found to have no effect on loadings for the Introspective Relational factor, $F$ (2, 99) = .09, $p$ = .91. Factor loadings were distributed relatively evenly across grandiose, vulnerable, and panic disorder vignettes. Significant effects were found for the

Cognitive Alliance factor, $F$ (2, 99) = 25.64, $p < .0001$, the Inhibited Patient factor, $F$ (2, 99) = 12.09, $p < .0001$, and the Angry Patient factor, $F$ (2, 99) = 27.71, $p < .0001$. Post hoc analysis using Tukey's HSD found that loadings on the Cognitive Alliance factor were higher for panic disorder compared with those for both narcissism vignettes, $p < .0001$. The factor loadings on the Inhibited Patient factor were higher for vulnerable narcissism than for either grandiose narcissism, $p < .0001$, and panic disorder, $p = .001$, and the Angry Patient factor had higher loadings for grandiose narcissism compared with both vulnerable narcissism and panic disorder, $p < .0001$.

### 5.7.2 Therapists' theoretical orientations

Primary factor loadings were also distributed across therapists' self-identified theoretical orientation. The majority of responses from the 12 therapists who identified as purely psychodynamic had a primary loading on the Introspective Relational factor (24 out of 36 Q-sorts; 67%). Among the three purely cognitive-behavioural clinicians, the Cognitive Alliance factor was the most frequently represented (six out of 9 Q-sorts; 67%). For the 13 therapists who expressly indicated an eclectic or integrative orientation, the Cognitive / Objective-oriented Alliance was the most frequently represented primary factor (14 out of 39 Q-sorts; 36%), followed by the Inhibited Fragile Patient (7 out of 39 Q-sorts) and the Angry Provocative Patient (8 out of 39 Q-sorts) factors, which together represented 38% of eclectic therapists' responses. Five therapists also indicated specific combinations of individual theoretical approaches, rather than an eclectic orientation, and one therapist identified with an interpersonal psychotherapy orientation. Groups of therapists based on theoretical orientation were not large enough to permit statistical analysis. Table 5.4 displays the primary factor loadings for the different

vignettes according to therapists' self-reported theoretical orientation. The four factors were distributed across orientations, with none endorsed exclusively by a particular school of thought.

Table 5.4 Distribution of primary factor loadings according to patient type and theoretical orientation

| | | Factor with highest loading, by patient | | |
|---|---|---|---|---|
| **Theoretical orientation** | **N (therapists)** | **Grandiose narcissism** | **Vulnerable narcissism** | **Panic Disorder** |
| Psychodynamic | 6 | IR | IR | IR |
| | 2 | IR | IR | CA |
| | 2 | APP | IFP | IR |
| | 1 | APP | IFP | CA |
| | 1 | CA | CA | CA |
| Eclectic | 5 | APP | IFP | CA |
| | 2 | IR | IR | CA |
| | 1 | APP | IFP | IR |
| | 1 | CA | IFP | CA |
| | 1 | IR | CA | CA |
| | 1 | IR | APP | CA |
| | 1 | APP | CA | CA |
| | 1 | IR | IR | IR |
| CBT | 1 | APP | IFP | CA |
| | 1 | APP | CA | CA |
| | 1 | CA | CA | CA |
| Interpersonal | 1 | IR | IFP | CA |
| CBT + Psychodynamic | 1 | IR | IR | CA |
| Interpersonal + Psychodynamic | 1 | IR | IR | CA |
| CBT + Humanistic | 1 | CA | CA | CA |
| Humanistic + Eclectic | 1 | APP | IFP | CA |
| CBT + Interpersonal | 1 | IFP | CA | CA |

IR = Introspective Relational (factor 1); CA = Cognitive / Objective-oriented Alliance (factor 2); IFP = Inhibited, Fragile Patient (factor 3); APP = Angry, Provocative Patient (factor 4)

### 5.7.3 Therapists' differential responses to patient psychopathology

Also indicated in Table 5.4 is the degree to which clinicians selected different responses for different patient types. While some therapists endorsed a similar ideal process across all

three patient types, the majority indicated modifying their approach based on patient characteristics. Five groups of response patterns were identified. Ten therapists (30%) responded with all three of their Q-sorts – representing grandiose narcissism, vulnerable narcissism, and panic disorder – having primary loadings on only one factor. These included seven participants (group 1; 20.6%) with primary loadings on the first factor, Introspective Relational, for all three clinical vignettes. Three participants (group 2; 8.8%) had primary loadings on the second factor, Cognitive / Objective-oriented Alliance for all three vignettes. The 24 remaining therapists responded with at least two of their Q-sorts having primary loadings on different factors. Six participants (group 3; 17.6%) endorsed the Introspective Relational process for both the grandiose and vulnerable narcissistic patients, while endorsing the Cognitive Alliance process for the patient with panic disorder. Another five participants (group 4; 14.7%) also endorsed the Cognitive Alliance process for panic disorder, with four of these therapists indicating this approach would also be suitable for narcissistic vulnerability but not for grandiosity, and one endorsing this approach for panic disorder and grandiosity but not for narcissistic vulnerability. Thirteen participants (group 5; 38.2%) responded with all three Q-sorts having primary loadings on different factors. In order to examine whether these patterns were associated with therapist characteristics, one-way ANOVAs were conducted using the aforementioned five groups as independent variables and therapists' age, years of experience, and current practice with personality disorders (self-reported proportion of current caseload) as dependent variables. No significant differences were found: $F(4, 29) = 0.215$, $p = .928$; $F(4, 29) = 0.158$, $p = .958$; $F(4,29) = 2.101$, $p = 0.107$, respectively.

## 5.8 Correspondence of factors with expert-rated therapy prototypes

An advantage of the PQS is that prototypes of ideal therapy process can be developed and systematically compared, with the degree of concordance between prototypes expressed as a single correlation coefficient. Such comparisons were undertaken in this study in order to examine whether the clusters of therapist responses corresponded to established psychotherapy models. The four factor prototypes were thus correlated with expert-developed PQS prototypes representing well-known psychotherapy approaches.

PQS prototypes for psychodynamic therapy (PDT), cognitive behaviour therapy (CBT), and interpersonal therapy (IPT) were developed by experts in each model in previous studies by Stuart Ablon and Enrico Jones (Ablon & Jones, 1998; 2002). The aforementioned therapies are well-researched and commonly practiced treatments for a range of mental disorders. Additional prototypes representing two psychodynamically-oriented approaches, transference-focused psychotherapy (TFP; Kernberg, Yeomans, Clarkin, & Levy, 2008), and reflective functioning (RF; Fonagy & Bateman, 2006), and one integrative CBT-based approach, dialectical behaviour therapy (DBT; Linehan, 1993), were developed by experts in each of these approaches, reported recently in a study by Geoff Goodman (Goodman, 2013). These latter therapies were designed to treat patients with severe personality disorders; each approach is an empirically-supported treatment for borderline personality disorder (RF represents the principles of mentalization-based treatment).

Pearson product-moment correlations were calculated to determine relationships between the six expert-prototypes and the factor prototypes in the present study; these are presented in Table 5.5. The first factor, Introspective Relational, was highly correlated with the expert-rated psychodynamic therapy (PDT) prototype, the reflective function (RF) prototype, and with TFP.

This factor was also associated to a lesser extent with DBT, and not at all with CBT or IPT. The Cognitive / Objective-oriented Alliance factor was strongly associated with CBT and DBT, and to a lesser extent with IPT and RF, but not at all PDT or with TFP.

Table 5.5 Correlations between PQS factors and expert-rated prototypes of therapy process

| | **Expert-rated PQS prototypes** | | | | | |
|---|---|---|---|---|---|---|
| **Factor** | **PDT** | **CBT** | **IPT** | **TFP** | **DBT** | **RF** |
| 1 Introspective Relational | **.83** | .19 | .18 | **.64** | **.27** | **.64** |
| 2 Cognitive / Objective Alliance | -.10 | **.85** | **.34** | -.15 | **.71** | **.31** |
| 3 Inhibited, Fragile Patient | .12 | .12 | .11 | **.24** | .15 | **.27** |
| 4 Angry, Provocative Patient | .10 | .14 | -.03 | **.40** | .12 | .18 |

Coefficients in bold type are statistically significant at $p < .05$. PDT = psychodynamic therapy; CBT = cognitive-behavioural therapy; IPT = interpersonal therapy; TFP = transference-focused psychotherapy; DBT = dialectical behaviour therapy; RF = reflective functioning.

Correlations between expert prototypes and the PQS composites representing our third and fourth factors were less robust. The Inhibited, Fragile Patient factor had relatively weak associations with RF and with TFP, and the Angry, Provocative Patient factor was only associated with TFP.

### 5.9 Therapist adherence to expert-rated therapy process

Although several strong correlations were found between the four factors obtained in this study and expert-rated PQS prototypes, further analysis using these prototypes was carried out at the level of individual participants' Q-sorts. This allowed for examination of the degree to which therapists in this sample subscribed to the ideal therapy processes espoused in the professional and academic literature. Associations between therapist variables and adherence to expert-ideals

could then be explored. Pearson correlations were conducted between each of the 102 Q-sorts and the six expert-developed PQS prototypes. The resultant correlation coefficients thus represent the degree to which participant therapists' Q-sorts adhered to the process ideals of major therapy models. Coefficients were highest for reflective functioning (RF) indicating strongest adherence to a mentalization-promoting approach, $M$ = .42 ($SD$ = .17), followed by CBT, $M$ = .40 ($SD$ = .22), and DBT, $M$ = .38 ($SD$ = .19). Adherence to ideal psychodynamic (PDT) and transference-focused (TFP) process had mean scores of $M$ = .32 ($SD$ = .21) and $M$ = .31 ($SD$ = .18), respectively. Coefficients were lowest for interpersonal therapy (IPT) process ideals, $M$ = .20 ($SD$ = .13).

Adherence scores for each expert-developed therapy model, along with each of the four factors extracted in the current study, were then correlated with participants' age, level of experience, current practice with personality disorders, and self-rated expertise with NPD. Significant negative correlations were found between therapist age and adherence to CBT ($r$ = -.31, $p$ = .001), IPT ($r$ = -.23, $p$ = .02), and DBT ($r$ = -.27, $p$ = .006). Age was also negatively associated with the Cognitive / Objective-oriented Alliance factor ($r$ = -.21, $p$ = .031) which, in light of the aforementioned correlations, would be expected given the degree to which this factor maps onto the CBT and DBT expert prototypes. A similar pattern was found with respect to years of therapist experience. Significant negative associations were found between clinicians' level of experience (in years) and adherence to ideal CBT process ($r$ = -.22, $p$ = .026) and DBT process ($r$ = -.20, $p$ = .043). Thus, the clinicians in this sample who advocated for CBT or DBT process tended to be younger and less experienced psychotherapists.

Participants' current exposure to personality pathology was conveyed as the estimated proportion of their caseload devoted to working with patients with personality disorders.

Significant positive associations were found between current practice with personality disorders and adherence to ideal psychodynamic therapy ($r = .33$, $p = .001$), TFP ($r = .27$, $p = .006$), and RF ($r = .23$, $p = .025$). Given the association between these prototypes and factor 1, current personality disorder practice ($r = .33$, $p = .001$) was also positively correlated with loadings on the Introspective Relational process factor. Taken together, these correlations indicate that therapists in this sample whose responses were similar to the various psychodynamically-oriented treatments tended to report a greater proportion of current patients having personality disorders. It is important to note that this is a self-reported estimate – possibly reflecting diagnostic bias – rather than an objective measure of participants' practice with personality pathology.

Participants responded to several questions regarding their confidence as therapists in treating narcissistic personality disorder. A composite variable, designated as "NPD expertise" was created by summing the scores to questions regarding (1) general confidence as a therapist, (2) confidence in treating personality disorders, (3) familiarity with NPD, and (4) confidence in treating NPD. Responses to these questions were highly correlated (ranging from $r = .56$ to $r = .80$, $p < .0001$). Confidence in treating NPD was found to be positively associated with adherence to ideal psychodynamic therapy ($r = .31$, $p = .001$), and TFP ($r = .25$, $p = .01$), and thus was also correlated with the Introspective Relational process factor ($r = .29$, $p = .004$). Confidence in treating NPD was negatively correlated with adherence to ideal CBT ($r = -24$, $p = .017$), and DBT ($r = -.20$, $p = .047$), and accordingly also with loadings on the Cognitive Alliance factor ($r = -.26$, $p = .007$). No associations were found between NPD expertise and IPT, RF, or either of factors 3 or 4.

Table 5.6 Correlations between therapist variables and adherence to factor prototypes and expert-rated prototypes of therapy process

| | **Factor prototypes** | | | | **Expert-rated therapy prototypes** | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Therapist variables** | **IR** | **CA** | **IFP** | **APP** | **PDT** | **CBT** | **IPT** | **TFP** | **DBT** | **RF** |
| Therapist age | -.02 | **-.21** | -.01 | .04 | .03 | **-.31** | **-.23** | .08 | **-.27** | -.13 |
| Years experience | .08 | -.16 | -.03 | -.03 | .12 | **-.22** | -.10 | .13 | **-.20** | -.03 |
| PD practice[1] | **.33** | -.12 | -.12 | -.11 | **.33** | -.06 | -.06 | **.27** | -.05 | **.23** |
| NPD expertise[2] | **.29** | **-.26** | .05 | -.14 | **.31** | **-.24** | -.09 | **.25** | **-.20** | .07 |

Coefficients in bold type are statistically significant at $p \leq .05$. IR = Introspective Relational (factor 1); CA = Cognitive / Objective-oriented Alliance (factor 2); IFP = Inhibited, Fragile Patient (factor 3); APP = Angry, Provocative Patient (factor 4); PDT = psychodynamic therapy; CBT = cognitive-behavioural therapy; IPT = interpersonal therapy; TFP = transference-focused psychotherapy; DBT = dialectical behaviour therapy; RF = reflective functioning.

[1] Current proportion of practice treating patients with personality disorders
[2] Self-rated confidence and familiarity treating narcissistic personality disorder

# 6 DISCUSSION

## 6.1 The perspectives of community clinicians

This is the first study to systematically examine the treatment of pathological narcissism from the perspectives of community psychotherapists. The main finding of this study concerned the discovery and interpretation of four distinct views regarding the optimal psychotherapeutic treatment of pathological narcissism. Therapists in real-world community practice were able to provide insight into their prospective treatment priorities using a comprehensive, ordinal measure of psychotherapy process. Their responses suggest that narcissistic pathology is regarded by many clinicians to warrant a distinct treatment process compared to non-narcissistic psychological distress. There was not, however, uniformity of views with regards to grandiose and vulnerable presentations of narcissism in psychotherapy. For example, many of the therapists sampled (48%) advocated for a theoretically coherent and consistent treatment process across both types of pathological narcissism; indeed, some therapists extended the same prospective approach across all narcissistic and non-narcissistic patients. More than half of respondents, however, felt that the different narcissistic presentations would need different kinds of engagement in therapy, largely oriented around the patient's in-session expression of maladaptive attitudes and behaviours. Interestingly, the non-narcissistic hypothetical patient evoked the greatest consensus, with more than two-thirds of therapists recommending a firmly cognitive and alliance-oriented approach. These findings have implications for the expansion of research regarding pathological narcissism, and in particular regarding the development and research of treatment, as well as clinician knowledge exchange.

The therapy processes elaborated by clinicians in this study were found to be associated with theoretical treatment ideals. Indeed, the two most robust approaches, the Introspective

Relational process and the Cognitive / Objective-oriented Alliance process, were highly correlated with expert-rated psychodynamic and cognitive behavioural therapies, respectively. This finding suggests avenues of exploration regarding the modification of existing therapies for pathological narcissism, and for the future research of such treatments. As well, the echoing of theoretical ideals in community approaches raises questions about the oft-discussed gulf between theory and practice in psychotherapy.

### 6.2 General process differences: narcissistic interpersonal dynamics

The discovery of overall differences in anticipated therapy process between grandiose, vulnerable, and non-narcissistic patients is consistent with literature regarding the treatment of pathological narcissism. This finding, obtained through a direct comparison of mean PQS scores (i.e. prior to factor analysis), suggests an overall recognition among therapists that patients with prominent narcissistic features have unique therapeutic needs that revolve around these patients' interpersonal difficulties. Therapists overall indicated that, compared with a non-narcissistic patient, both presentations of a narcissistic patient would require a greater focus on interpersonal issues and a relatively limited emphasis on symptoms or between-session activities. Some of these patients' interpersonal difficulties, such as ambivalence and pessimism regarding the therapy, were anticipated to emerge in the therapeutic relationship, presumably to facilitate their resolution. Patients with grandiose features were expected to bring even more pronounced interpersonal challenges for therapeutic management, expressing negative feelings toward the therapist and testing the limits of the therapy relationship. Indeed, the overall atmosphere of a therapy session was rated as being more competitive with a grandiose patient than with either a vulnerable or non-narcissistic patient.

Previous research has found narcissistic grandiosity to be associated with domineering, vindictive, and intrusive interpersonal behaviours (Dickinson & Pincus, 2003; Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009; Pincus et al., 2009). These behaviours are expected to create challenges for treatment providers across a range of clinical contexts, including psychotherapy (Kealy & Ogrodniczuk, 2011; Pincus, Cain, & Wright, 2014). It may well be the case, however, that the expression of such behaviours within a responsive clinical milieu may contribute to their amelioration; Ogrodniczuk and colleagues (2009) found that grandiose patients in a day treatment program experienced some reduction in controlling and vindictive behaviours, both of which were highly prominent at the start of treatment. Vulnerable narcissism has also been associated with interpersonal dysfunction, particularly social avoidance, exploitability, and coldness (Dickinson & Pincus, 2003; Pincus et al., 2009). Although less studied in clinical settings, these interpersonal problems have also been chronicled as potential treatment impediments (Ogrodniczuk & Kealy, 2013; Pincus, Cain, & Wright, 2014). In particular, vulnerable patients have been described as being excessively sensitive to perceived criticism or rejection, leaving therapists to tread lightly and avoid interventions that risk evoking further dysphoria (Gabbard, 2009).

Although the factor analysis in the present study revealed complex and diverse views about optimal therapist responses, some overall therapeutic responses to pathological narcissism emerged from our comparison of patient types. Therapists generally indicated a less didactic approach for narcissistic patients, perhaps due to an appreciation of these patients' fragile and tentative alliance, and their sensitivity to threats to their self esteem. Narcissistic patients may be prone to experiencing a therapist's expert-like stance as an affront to their own autonomy or self-esteem, and may feel implicitly criticized or controlled by a didactic approach. Beutler and

colleagues (2011) found that patients with higher levels of trait resistance – including dominant, irritable, and arrogant personality features – respond relatively poorly to directive forms of therapy, something these therapists seemed to recognize in their PQS ratings. Therapists' generally lower provision of direct reassurance to narcissistic patients may also arise out of concern for the patient's self-esteem: some narcissistic individuals might interpret reassurance as a patronizing gesture rather than an expression of support. Furthermore, therapists may feel less confident conveying a sense of optimism and encouragement to a patient with complex narcissistic problems than to an individual suffering from panic disorder; clinicians may be concerned about inflating the narcissistic patient's expectations in the face of an anticipated difficult treatment.

Participants also recommended lower levels of empathic attunement, support, and encouragement of independent action for patients with grandiose narcissism than for other patients. This could signify clinicians' sensitivity to a greater need for such responses among narcissistically vulnerable and anxious patients. However, it may also reflect concerns about potentially fostering and reinforcing the grandiose patient's hostile and externalizing worldview. Rather than express empathy and support toward such attitudes, therapists may instead attempt to convey a sense of curiosity and restraint with patients who tend to act impulsively and without regard for others; clinicians may be cautious about potentially encouraging the patient's grandiosity.

### 6.3 In-session focus on narcissistic interpersonal problems

The interpersonal difficulties associated with pathological narcissism were further represented as key considerations in two of the four unique perspectives that emerged through factor analysis of participants' Q-sorts. The third and fourth factors, together accounting for

about 10% of the variance in the PQS ratings, were largely organized around prominent patient behaviours associated with vulnerable and grandiose narcissistic presentations. Factor 3 was labelled the Inhibited, Fragile Patient process due to the prominence of the patient's dysphoria, wariness, and self-conscious emotions in therapists' PQS ratings. The expression and management of the patient's interpersonal issues – including both avoidant and approval-seeking behaviours – were prioritized by therapists who expected to take on a non-judgemental, supportive, and empathically attuned stance. Factor 4 was labelled the Angry, Provocative Patient process due to the anticipated handling of overtly challenging patient behaviours, including affronts to the therapist and the therapeutic process, and expressions of anger and arrogance. Patients' antagonistic behaviours were central to this perspective, with therapists recommending a focus on self-image, beliefs, and promotion of alternative interpersonal interactions.

The most characteristic patient behaviours in factors 3 and 4 were consistent with the interpersonal profiles of narcissistic vulnerability and grandiosity (Ogrodniczuk & Kealy, 2013; Pincus et al., 2009), respectively, and all but one of the Q-sorts with primary loadings on each of these factors corresponded to these narcissistic subtypes. The majority of therapists who endorsed one of these factors also endorsed the other (11 out of 14 participants). Taken together, these factors reflect therapists' attention to each narcissistic subtype's interpersonal dysfunction through the in-session experiencing of the patient's maladaptive behaviours. This may reflect therapists' beliefs that these interpersonal features are indeed core aspects of narcissistic psychopathology that, if left unaddressed, will perpetuate suffering. This perspective, which has its roots in Sullivan's interpersonal theory (Pincus, 2005; Sullivan, 1953), holds that a considerable degree of individuals' self-image emanates from and is reinforced by the reflections

obtained through interpersonal interaction. In other words, a patient's maladaptive interactive style will evoke maladaptive responses in others, which will in turn influence the patient's self-concept in a self-perpetuating vicious circle. Promoting awareness of interpersonal patterns, and providing non-confirming responses to maladaptive behaviours would be hallmark therapeutic strategies from this perspective. Accordingly, therapists endorsing both Inhibited Patient and Angry Patient factors emphasized in-session discussion of interpersonal issues, along with interventions aimed at challenging, rather than bolstering, the patient's defenses.

Another possibility raised by the prominence of interpersonal problems in these factors is the handling of dysfunctional behaviours as a prerequisite to addressing core narcissistic psychopathology. Clinicians who expressed these views may regard such behaviours – albeit in different form per narcissistic subtype – as impediments to deeper therapeutic work, perhaps through threatening the therapeutic alliance. The handling of dysfunctional behaviours may thus be prioritized in order to pave the way for a focus on identity, self-reflection, or intimacy. This is suggested by defining statements regarding the patient's limited introspection (both factors), a focus on self-image and cognitive themes (Angry, Provocative Patient), and attention to feelings regarded by the patient as unacceptable, perhaps including intimacy yearnings (Inhibited, Fragile Patient). Introspection regarding these core aspects of personality functioning may be hindered – remaining inaccessible for therapeutic work – either due to the vulnerable patient's suspicious avoidance and hypersensitivity, or the grandiose patient's dominance and belligerence. Attention to "treatment interfering behaviours" (Linehan, 1993) may thus be prioritized in order to open up further therapeutic possibility. This perspective can be contrasted with these clinicians' views on treating panic disorder: their tendency to endorse the Cognitive Alliance

process for panic disorder suggests less concern about a tenuous alliance with non-narcissistic patients.

Although both the Inhibited and Angry Patient factors brought the patient's interpersonal relationships into focus, some specific interventions differed according to the patient's narcissistic presentation. In responding to grandiose narcissism, these therapists prioritized clear communication, a focus on patterns in the patient's experience, and discussion of beliefs, self-image, and the patient's acceptance of responsibility. These elements are broadly consistent with Kernberg's recommendations for the treatment of NPD: clarification, confrontation, and interpretation (Kernberg, 1984). The therapist, for example, might implement a stepwise series of clearly communicated interventions concerning the patient's avoidance of responsibility in favour of self-enhancement gratification. By contrast, therapists' responses toward vulnerable patients consisted mainly of a non-judgemental, affectively engaged, and empathically attuned stance. This bears some resemblance to the ideals of Rogers' person-centered therapy (Rogers, 1951), and to Kohut's emphasis on an empathic ambience within which the narcissistic patient can restore a fragmented self (Kohut, 1984; Wolf, 1988). For example, rather than confronting a vulnerable patient, the therapist might focus mainly on seeking and conveying a deep understanding of the patient's shifting emotional states, including those beyond the patient's conscious awareness.

Despite considerable debate regarding their technical disparity, Kernberg's and Kohut's recommendations have increasingly been regarded as potentially complementary in addressing differing aspects of narcissistic pathology (Gabbard, 2005; Kealy & Ogrodniczuk, 2011; Levy, 2012b; Mitchell, 1986). Indeed, some authors have proposed that the focal divergence between these approaches may at least partially reflect different types of narcissistic patients (Gabbard,

2005; Levy, 2012b). Kernberg's work often refers to patients with overt arrogant and aggressive tendencies, including those with malignant rage, acting-out behaviours, and borderline personality features. Kohut, in contrast, appears to have described somewhat higher-functioning patients with fragile self-image but less-clamorous antagonism. Although in this study both the Angry and Inhibited Patient factors were correlated with the TFP prototype (the empirically-supported operationalization of Kernberg's approach), their lack of association with the (more generic) ideal psychodynamic prototype suggests that these therapists were not putting forth an overarching psychodynamic process encompassing both transference-focused and self-psychological ideals. This could be due to a lack of familiarity with these theories, the complexity of integrating such models, or clinicians' sense of constraint in the face of these patients' behavioural issues. The countertransference literature refers to negative reactions to NPD such as boredom, resentment, frustration, and inadequacy (Betan, Heim, Conklin, & Westen, 2005; Gabbard, 2009; Rossberg, Karterud, Pedersen, & Friis, 2007; Ogrodniczuk & Kealy, 2013), feelings that could limit confidence in a cohesive therapeutic strategy. Hence, the anticipated challenges of narcissistic interpersonal problems may have left these clinicians feeling less-certain about carrying out a treatment based on established conceptual ideals.

### 6.4 A distinct treatment for anxiety

The emergence of the Cognitive / Objective-oriented Alliance factor underscores the distinction for many therapists between therapy process for narcissistic versus non-narcissistic psychopathology. This factor was associated with the non-narcissistic patient vignette, and was favoured by the majority of clinicians (24 out of 34) as the therapy process of choice for panic disorder. Furthermore, no therapist endorsed this factor singularly for an expression of pathological narcissism; the Cognitive Alliance process was only chosen for a narcissistic

subtype by therapists who also endorsed it for panic disorder. In other words, this process is generally advocated as an ideal for panic disorder, with a minority of clinicians also favouring it for one or both narcissistic subtypes. This approach is characterized by a specific focus on the patient's current and consciously accessible issues – including physical symptoms, cognitions, and treatment goals – as opposed to unconscious phenomena, childhood experiences, or transference issues. A positive and clearly-understood alliance is emphasized, focusing on the tasks of therapy, which include the therapist's provision of support, reassurance, and advice, along with between-session homework. Although several of these are regarded as core elements of supportive psychotherapy (Gabbard, 2005; Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002), this combination of process features is also representative of a cognitive behavioural approach, grounded in a task-oriented therapeutic alliance. Indeed, the Cognitive Alliance factor was found to be uniquely and strongly correlated with expert-rated ideal cognitive behavioural therapy (CBT).

The recommendation of a CBT-oriented approach for the non-narcissistic vignette is not surprising in light of the robust empirical support for CBT for panic disorder (Koerner, Vorstenbosch, and Antony, 2012; Mitte, 2005; Sanchez-Meca, Rosa-Alcazar, Martin-Martinez, and Gomez-Conesa, 2010), and given the widespread dissemination of CBT principles among mental health clinicians. These principles include learning techniques aimed at reducing physical panic attack symptoms, identification and modification of anxiety-fuelling cognitions or beliefs, and practising novel behavioural responses to anxiety-producing stimuli (e.g. exposure). The occurrence of these process features in the Cognitive Alliance factor indicates the uptake of empirically-supported CBT as an optimal treatment for anxiety disorders. At the same time, therapists who contributed to this factor also affirmed the importance of the therapeutic alliance

– particularly the agreement on therapy goals and tasks – which has been found repeatedly and in various contexts to be one of the most robust predictors of psychotherapy outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011). It is possible that the negative associations between age and experience with an overall adherence to CBT process could reflect a greater uptake of evidence-based treatment protocols among younger, more recently trained clinicians. Participants' broad recommendation for CBT-oriented panic disorder treatment is all the more striking given that relatively few identified as cognitive-behaviour therapists. A previous survey of 591 clinical psychologists similarly found the vast majority of respondents to recommend CBT for panic disorder, despite more than half the sample identifying with other theoretical orientations (Stewart & Chambless, 2007).

Despite the general endorsement of CBT-oriented treatment for panic disorder, relatively few clinicians selected this approach for presentations of both grandiose and vulnerable narcissism. Very few ($N = 3$) participants felt this would be an ideal process across all three patient types. While perhaps due to the low number of purely CBT-oriented participants, it could also reflect an expectation that grandiose patients may not respond well to a structured, task-focused approach. Four other clinicians, however, endorsed the Cognitive Alliance process for both panic disorder and narcissistic vulnerability. These clinicians may anticipate some of the dysphoric affect states and socially avoidant features of vulnerable narcissism to benefit from an examination of the patient's cognitive attributions within a supportive therapeutic bond.

Despite a very limited cognitive behavioural literature on pathological narcissism, there are nonetheless recommendations for treatment from this perspective. Freeman and Fox (2013) recommend allying with the patient's self-focus to seek agreement on key areas of behaviour change, collaborating on toning down the patient's most difficult interpersonal behaviours. The

use of guided discovery to expand the patient's ability to empathize has also been recommended, though with a primary focus on presenting problems and behavioural strategies (Rasmussen, 2005). Schema-focused therapists (Young & Flanagan, 1998) target core maladaptive beliefs in a modified form of CBT for NPD, though the integration of experiential techniques makes for a very different therapy process than expert-rated CBT ideals (Boterhoven de Haan & Lee, 2013); "adaptive re-parenting" is provided by the therapist to counteract the patient's reliance on immature schemas (Behary & Dieckmann, 2013). Principles of dialectical behaviour therapy (DBT; Linehan, 1993) – a well-known empirically-supported treatment for borderline personality disorder – may also have been incorporated by those clinicians who endorsed the Cognitive Alliance factor for narcissistic patients, a notion also suggested by the strong correlation between the prototypes for this factor and ideal DBT process.

### 6.5 Psychodynamic process: narcissism and beyond

Accounting for the largest portion of the variance in factor loadings, the Introspective Relational perspective represented a treatment that was not uniquely associated with any one type of psychopathology. Some participants ($N = 7$) indicated this process as the ideal approach for all patient types. Others ($N = 9$) endorsed it for at least one form of pathological narcissism while favouring a CBT approach for panic disorder, and a minority ($N = 3$) looked to this process for panic disorder but not for pathological narcissism. In other words, the Introspective Relational process emerged as a trans-diagnostic approach for some clinicians, whereas for others it is a process facilitated more selectively on the basis of the patient's pathology.

Therapists whose views made up the Introspective Relational process emphasized the patient's constructive contributions to therapy, in terms of being committed to therapy activities such as introspection, contemplation, and discussion of emotional experience and meaning in

order to foster psychological insight. These therapists also prioritized an accepting, nondirective, and empathically attuned stance – rather than a teaching or advice-giving role – whilst facilitating the patient's emotional experience and insight into patterns or themes that operate unconsciously and interpersonally. This factor thus represents a collaborative exploratory effort between patient and therapist, where disavowed feelings can emerge – in the patient's mind and in the therapy relationship – for the purpose of thinking about them. This process was found to be highly correlated with expert-determined ideal psychodynamic psychotherapy process. The strength of the Introspective Relational factor in this study may be attributable to the relatively large number of psychodynamically-oriented therapists in the participant sample. It is noteworthy, however, that a number of self-identified eclectic therapists also selected this approach, perhaps indicating the influence of psychodynamic discourse on narcissism beyond adherents of this theoretical orientation.

Narcissism has received prominent attention – both theoretical and clinical – within the psychodynamic literature. Patients with narcissistic difficulties populate numerous case reports of psychodynamic therapy, and narcissistic pathology has been a key concern since Freud's early writings (Freud, 1914). While Kohut's self-psychology and Kernberg's object relations models represent key perspectives on the subject, there have been numerous variant recommendations regarding psychodynamic therapy for NPD (Masterson, 1993; Rinsley, 1989; Bromberg; 1983; Lachmann, 2008). Furthermore, relational psychoanalytic theories are broadly concerned with the structure of the self, and the nature of relational experience in promoting or hindering identity development (Bacal & Newman, 1990; Eagle, 2011; Greenberg & Mitchell, 1983). Narcissistic issues are thus often implicity referred to, though with different terminology, in this literature (e.g. Klein, 1946; Fairbairn, 1952; Winnicott, 1956). Clinicians' endorsement of the

Introspective Relational process for both presentations of pathological narcissism is also consistent with these theories. Both expressions of pathological narcissism are regarded within the psychodynamic literature as having origins in arrested or distorted identity development, stemming largely from pathogenic early relational experience. Despite differing points of emphasis – as in the contributions of Kernberg and Kohut – these theories are united by core conceptual and technical principles, and by efforts that demonstrate and advocate for their complementarity and integration (Bacal & Newman, 1990; Eagle, 2011).

The Introspective Relational process embodies several core psychodynamic principles, such as the promotion of self-examination, contemplation of psychologically threatening issues, and an interpretive focus regarding the therapy relationship. These principles reflect the centrality of insight in psychodynamic therapy, and its role in the amelioration of narcissistic pathology. From this perspective, a successful therapy process is oriented around the expansion of the patient's self-awareness, including an understanding of maladaptive attitudes and interpersonal patterns. This is facilitated by encouraging the patient's unbounded expression of thoughts and feelings (i.e. free association), and by the identification of patterns and themes in such material. Analysis of transference is another means of promoting self-understanding, as the therapist gradually helps the patient to see their relational dynamics unfold in the therapy relationship (Gill, 1982; Caligor, Diamond, Yeomans, & Kernberg, 2009). Insight and self-reflection are thought to afford the patient a greater range of strategies for handling threats to self-image. Rather than rely on maladaptive defenses and narcissistic illusion, the patient may develop a capacity to tolerate and reflect on life's inevitable vulnerabilities and disappointments (Kernberg, 2014; Lachmann 2008; Mitchell, 1986).

The therapist's accepting, empathically sensitive, and non-intrusive stance (i.e. a relative absence of advice-giving, homework, and therapist's emotional conflicts) is also a central aspect of the Introspective Relation factor, and of ideal psychodynamic process. This relational principle is thought to facilitate a therapeutic alliance founded on the patient's experience of the therapist as a benign and understanding figure – indeed as a "secure base" in attachment terms (Bowlby, 1988; Eagle, 2003) – in order to make insight-oriented work possible. At the same time, the maintenance of a non-intrusive and empathic ambiance has been theorized as having inherent healing properties, regardless of the use of insight-oriented interventions (Bacal, 1994; Loewald, 1960; Wolf, 1988). This kind of relational atmosphere – encompassed within the Introspective Relational factor – has been conceptualized using various terms and metaphors, including the holding environment (Modell, 1976; Winnicott, 1965), selfobject experience (Bacal, 1994; Kohut, 1984), containment (Bion, 1962), and implicit relational knowing (Stern, et al., 1998). These relational conceptualizations regard the therapist's acceptance and attunement as corrective experiences for a patient with an impaired self-representation. The novel, optimal relational experience in the therapy relationship – conveyed mostly at an implicit level – is held to disconfirm maladaptive belief systems and modify procedurally-based self-other representations (Eagle, 2011; Emde, 1990; Gabbard & Westen, 2003; Lecours, Briand-Malenfant, & Descheneaux, 2013; Weiss, 1993). Furthermore, the therapist's consistently non-judgemental and empathic functioning is posited to become gradually internalized by the patient, resulting in new psychological structures and capacities (Bacal & Newman, 1990; Gabbard & Westen, 2003; Greenberg & Mitchell, 1983; Gehrie, 2011; Kealy, 2013; Wolf, 1988).

The dual emphasis on insight / interpretation and corrective experience / relationship in contemporary relational theory can be found in current psychodynamic models for the treatment

of personality disorders. Transference-focused psychotherapy (TFP) and mentalization-based treatment – represented by the reflective functioning (RF) prototype – both espouse the centrality of a responsive therapy relationship that increasingly fosters the patient's capacity for exploration and introspection. TFP, based on Kernberg's approach, emphasizes interpretive intervention, while a mentalizing approach (RF) stresses the patient's sense of security in the therapy relationship, somewhat similar to Kohut's recommendations. In practice these approaches are less dichotomous than they might appear (de Groot, et al., 2006; Gabbard, 2005), and prototypes of each were found to have strong associations with the Introspective Relational factor. It is unknown whether clinicians who endorsed this factor were referencing these empirically-supported treatments for borderline personality disorder, or whether they were simply affirming core relational psychotherapy principles contained within them. Among all participants, adherence to all of the psychodynamic process prototypes was positively associated with current practice experience in in treating personality disorders, and several psychodynamic approaches were also associated with therapists' confidence in treating NPD.

The psychodynamic process indicated by the Introspective Relational factor was also recommended by some participants ($N = 10$) as an ideal approach for panic disorder. Clinicians with primary loadings on this factor may recognize psychodynamic therapy for panic disorder as an approach with empirical support from a randomized controlled trial (Milrod, et al., 2007). They may, however, also be expressing confidence in a psychodynamic approach as a transdiagnostic process, perhaps based on their experience of working successfully with a wide variety of patients.

Alternatively, more nuanced process differences may be subsumed within the Introspective Relational factor due to the inability of the PQS to capture subtle non-verbal cues

that could be distinct for different types of patient. Process items in the PQS may not be able to convey, for example, a tentative wording of an intervention, or a therapist's light-hearted tone of voice. These subtle interactions may be difficult for therapists to recommend prospectively due to their implicit level of operation. Many of these therapeutic nuances occur spontaneously, as discrete "now moments" (Stern et al., 1998), or as a gradual role-responsiveness that goes largely unnoticed by the clinician (Sandler, 1976). Adding to this complexity is the notion within psychodynamic thinking that the unique nature of the patient as a person – their developmental narrative and personal subjectivity – carries more weight than psychopathology in determining optimal therapy process. Clinicians endorsing a general psychodynamic process may indeed expect significant variation among patients with different psychopathologies, yet with reservations regarding the specific ways in which such differences – in relation to other patient factors – may influence the intersubjective field. From this perspective, a broadly psychodynamic framework can encompass highly specific, individualized responsiveness (Bacal & Carlton, 2011) that is perhaps only hinted at by PQS statements referring to the therapist's attunement and accurate perception of the therapy process.

### 6.6 Common and specific psychotherapy processes

Notwithstanding the almost imperceptible nuances of each unique psychotherapy relationship, clinicians' views on therapy process in this study can be considered in relation to the ongoing debate regarding common and specific factors in psychotherapy. This discourse concerns the question of whether effectiveness is due to processes specific to the therapy model for a particular disorder, or due to mechanisms of action that are common to all therapies and across various psychological problems (Laska, Gurman, & Wampold, 2014; Wampold, 2001). While the present study did not directly tackle this issue, it did indicate a mixture of both

common and specific interventions in clinicians' ideas about optimal treatment. Certain process elements stood out as highly representative shared ideals, such as showing respect for the patient (i.e. not being condescending) and avoiding tactless or personally-motivated interventions. Being accepting and empathic were also common, highly regarded therapist responses (except for the Angry Provocative Patient factor). These activities are all intuitively desirable therapist behaviours that contribute to the therapeutic alliance, particularly the bond aspect of the alliance (Horvath & Luborsky, 1993). The alliance – perhaps the most central construct in common factors literature – has been found to have a robust relationship with therapy outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011), and clinicians in this sample were generally concerned with preserving a good working bond with prospective patients.

Some therapist activities were found to be highly distinctive, such as the provision of direct advice, reassurance, and homework in a CBT-oriented approach, and interpretation of unconscious and transference dynamics in the Introspective Relational process. Clearly therapists continue to value specific treatment interventions, a finding consistent with the major technical recommendations of cognitive and psychodynamic approaches. Although not analyzed statistically, this specificity did not always conform to self-identified theoretical orientation. Two psychodynamic clinicians, for example, did not recommend any psychodynamic process, with one endorsing a CBT-oriented approach for each vignette. However, several psychodynamic clinicians selected a treatment that matched their orientation for all three vignettes, and it is possible that a similar trend would occur if more CBT therapists were sampled.

Technical differences are highlighted further by the lack of correlation between the Cognitive Alliance factor and ideal psychodynamic process, and between the Introspective

Relational factor and ideal CBT. Interestingly, despite the lack of direct association between these approaches, they were each associated with dialectical behaviour therapy (DBT) and reflective functioning (RF), perhaps signifying the integrative nature of these therapies designed for personality disorders. These treatments share a common emphasis on helping the patient develop a more flexible and thoughtful relationship toward his or her emotions and core beliefs (de Groot, Verheul, Trijsburg, 2008; Goodman, 2013), and they may achieve this purpose by blending processes that are regarded by community clinicians as distinct approaches. An advantage of this is the potential optimization of multiple mechanisms of action within one treatment. Transference-focused psychotherapy (TFP), perhaps not surprisingly, was not associated with a CBT-oriented approach; therapists' views on panic-focused CBT process did not correspond with an emphasis on transference distortions. Given its associations with all three other factors, however, TFP appears to be integrative of some clinicians' appreciation for the in-session confrontation of narcissistic interpersonal dynamics. Taken together, these findings suggest that despite general attention to the alliance, the notion of distinct psychotherapy processes is prominent in the minds of community clinicians. One implication of this, given the aforementioned correlational findings, is a potential indication for further dissemination of integrative therapies such as DBT and mentalization-based treatment.

### 6.7 Practice recommendations from the ground up

Another prominent issue within the psychotherapy research literature has been the connection between research and practice. Concern has been raised about discrepancy between the development and validation of evidence-based treatments and the actual practice of clinicians (Kazdin, 2008; Teachman et al., 2012). In what has been termed the research-practice gap, some authors have suggested that psychotherapists largely ignore evidence-based treatment

recommendations and rely simply on their own intuition or therapy lore (Baker, McFall, and Shoham, 2008; Mischel, 2008). Although the present study examined only opinions about optimal treatment (and not actual therapy sessions), the findings offer some partial refutation of this suggestion. The non-narcissistic vignette, depicting a textbook example of panic disorder, was exclusively assigned therapy processes that resemble treatments with clinical trial support. Indeed, the majority of clinicians – including many who identified as eclectic or psychodynamic in orientation – would offer a CBT process, which for panic disorder has the most robust empirical support. Responses for the narcissism vignettes, however, cannot be compared to evidence-based recommendations: there have been no clinical trials of treatment for NPD. Nevertheless, the endorsement by many clinicians of a psychodynamic process is highly consistent with an extensive theoretical literature, multiple case reports, and with the ideals of empirically-supported treatments for borderline personality disorder. A substantial proportion of clinicians in this sample thus appeared tuned in to research and conceptual development in psychotherapy, although their interest in participating and completing a time-consuming process measure for this study may indicate more of a research inclination than other community therapists.

The ability of clinicians to identify ideal therapy process using a measure like the PQS suggests a promising potential direction for practice-based psychotherapy research. Rather than examine whether clinicians are implementing academically developed and tested therapy protocols, this line of inquiry can explore what psychotherapists have learned from their work in the field. As Westen, Novotny, and Brenner (2004) point out, therapists tend to engage in constant hypothesis formulation and testing in their work as they provide and modify interventions according to the responses of their patients. Over time, a knowledge base builds up

regarding what works and what doesn't work. A purely "top-down" psychotherapy research paradigm regards this knowledge as less-valid than that generated by controlled experimental conditions. Westen and colleagues advocate a shift in evidence-based practice paradigm to seek and utilize the knowledge of clinicians; tapping into therapists' practice-based hypothesis testing may produce knowledge about psychotherapy process that cannot be obtained from controlled experimental studies.

This project was situated within this practice-based revision of knowledge creation, joining similar efforts in understanding psychotherapy "from the ground up" through the experience-honed opinions of clinicians. Q-methodology is particularly well-suited to this type of inquiry – previous contributions have examined processes for engaging with resistant clients (Lister & Gardner, 2006) and treatments for PTSD (Schottenbauer et al., 2006) – regarding a range of issues. For example, investigators could explore clinicians' views on optimal treatment for various conditions, especially those with relatively low prevalence rates, or with complexities that reduce the feasibility of experimental study. In fact the options for such research are diverse, including topics as varied as optimal process for patients who belong to oppressed minority groups, working with couples who are confronting infidelity, and optimal ways of managing difficult countertransference. When paired with traditional clinical research, this "ground up" paradigm can further strengthen the research-practice relationship, providing useful knowledge from clinicians' expertise regarding challenging issues, and deepening the investment of clinicians as stakeholders in the psychotherapy research enterprise.

### 6.8 Treating pathological narcissism: future directions

One of the contributions of the present study is the explication of practising clinicians' approaches to pathological narcissism, knowledge that has practical value for the field. The

factors representing clinicians' responses provide a basis for treatment models that could be applied to therapist training or continuing professional development. For example, introductory treatment guides for pathological narcissism could be disseminated to trainees as clinical knowledge from the field. These would be based on the processes with the most robust endorsement for narcissistic patients – those resembling psychodynamic principles and those focused on in-session interpersonal problems – and which offer vivid descriptions of clinicians' therapeutic ideals. Education using such introductory guides could provide a starting point for clinicians with limited exposure to the challenges of pathological narcissism, complementing the complex and sometimes confusing conceptual literature on the subject.

The factors from this study can also provide a foundation for further research regarding the treatment of NPD and pathological narcissism. The aforementioned factor-based treatment models could be implemented by groups of therapists for patients with narcissistic pathology, and investigated using a quasi-experimental design. These treatment models – endorsed by community clinicians as valid practice approaches – could thus be examined as to their actual effectiveness with narcissistic patients. This would be a significant step forward in light of the lack of direct treatment research with this population, serving to pave the way for eventual controlled clinical trials. The use of community-derived treatments in clinical trials may enhance external validity and the subsequent uptake of findings among practising therapists. One of the ultimate aims of such a research program would be the establishment of evidence-based treatments and/or therapeutic principles that can be disseminated and implemented for the benefit of patients with narcissistic psychopathology.

Another research direction suggested by the present study concerns the closer exploration of therapy process with narcissistic patients. This could be accomplished using a variety of

research strategies, including mediator and moderator analysis (within an experimental clinical design), single-case time-series analysis, and appraisal of actual sessions (e.g. using the PQS) in a significant-events approach. The methodology of the present study could also be expanded upon to facilitate direct investigation of therapy process. One way of doing so would be to ask clinicians to use the PQS to rate their therapeutic ideals in relation to actual NPD patients on their caseload. These patients could then also be asked, perhaps also with a Q-sort instrument, to rank the processes they felt were most helpful as facilitated by their therapists. Another logical variation on the present study would be to use qualitative interviews in order to explore the rationale and intentions behind clinicians' PQS ratings. This kind of inquiry, perhaps using a grounded theory approach, could shed light on the ways in which therapists' clinical reasoning adheres to or diverges from theory-based treatment models. Likewise, patients with different expressions of narcissistic pathology could be recruited for qualitative exploration of their experiences of psychotherapy, uncovering descriptions of what is and what is not helpful from their perspective.

Further research is also needed to strengthen the knowledge base regarding narcissistic psychopathology itself. This work has been hampered in the past by imprecise construct definition, lack of consensus regarding the phenomenology of narcissism, divergent assessment methods, and limited use of clinical samples (Cain, Pincus, & Ansell, 2008; Pincus & Lukowitsky, 2010). Fortunately, there are signs that this state of affairs has been changing to facilitate collaborative dialogue and refined construct definition and measurement (Bender, 2012; Kealy, Hadjipavlou, & Ogrodniczuk, 2014; Pincus, 2011). The fundamental goal of such research is to improve our understanding of the phenomenology and etiology of pathological narcissism. This includes the exploration of associated clinical features, personality traits, and

social issues. The current findings contribute to these efforts by providing added justification for the clinical relevance of narcissistic interpersonal problems, further supporting the extant conceptual and empirical literature on the grandiose and vulnerable expressions of narcissistic pathology. This could be extended in future studies that involve actual NPD patients, using a variety of experimental or correlational designs to discover more about these patients' clinical profiles, interpersonal functioning, and self-regulatory mechanisms.

Finally, a secondary yet noteworthy contribution of this study is the raising of awareness – through the exploration of clinicians' subjectivity – regarding the treatment of pathological narcissism. Narcissism has been blighted by stigma, with the term used more commonly to demean than to denote clinical disorder. It is probably much easier to identify self-regulatory deficits in someone else than it is to contemplate one's own narcissistic functioning and to associate distortions of self-image with pain and impairment. Within the mental health field, the issue of narcissistic pathology – whether as categorical disorder or dimensional personality phenomena – may not be consistently within the sight of policymakers, or even some clinicians. Hence, pathological narcissism may occupy a position of being marginalized within the mental health community, with pessimistic attitudes regarding its treatment that parallel those toward borderline personality disorder in recent times (Kealy & Ogrodniczuk, 2010). The ultimate objective of research regarding narcissistic pathology is to eventually improve the lives of those who suffer and their families and communities. Studies that explore treatment options thus promote engagement in this broader purpose of seeking to benefit patients with pathological narcissism.

## 6.9 Limitations of this study

It is important to note the limitations involved in this investigation into the treatment of pathological narcissism. First of all, the participant sample, while comparable to previous similar studies using the PQS, nevertheless included a fairly low number of clinician respondents, and may not be representative of the larger population of psychotherapists. Thus, the therapy process factors that emerged from this sample cannot be generalized across therapists in the community. A response bias – due to participants' non-random self-selection – also limits generalizability, in that respondents may have been more interested in pathological narcissism and the delineation of therapy process than the average community practitioner. The low number of participants limited the ability to detect subtle differences in the comparison of therapy process according to patient pathology. The relatively small sample size, combined with the need to correct for experiment-wise error (due to the testing of 100 PQS items), resulted in the power to detect only large differences in ratings between the grandiose, vulnerable, and non-narcissistic vignettes. Although several differences were nonetheless found, a study with higher statistical power might reveal other features that would further distinguish therapists' responses to these patient presentations. From a Q-methodological paradigm, however, the size of the participant sample was appropriate for the purpose of revealing psychotherapists' opinions regarding ideal treatment processes. Q-research typically makes no claim for generalizability, with participant sampling oriented purely toward the discovery and analysis of the subjective viewpoints of persons who are qualified to express them. The present study's participant sample is thus commensurate with its exploratory purpose.

One further sampling issue is worth noting. Relatively few respondents identified with a purely cognitive-behavioural orientation. This may be due to limited engagement with CBT-

oriented clinicians in the participant recruitment, or due to reduced interest among CBT practitioners in the issue of narcissism. CBT, however, may be well-integrated among other therapeutic strategies: CBT was robustly represented for the anxiety disorder vignette, particularly among eclectic therapists. Overall there were not enough participants in clearly identifiable theoretical groupings to allow for statistical analysis of therapists' schools of thought. While it may be possible to categorize participants with more than one orientation (e.g. interpersonal and CBT) as eclectic, these clinicians notably did not identify with the eclectic category and instead selected two discrete approaches. It was therefore decided to respect these participants' choices. Future research would do well to explore the process ideals of devoted cognitive-behavioural therapists and, with a larger sample, to facilitate comparison between clinicians' avowed theoretical orientations and their actual process responses.

Another challenge associated with the present study was the use of clinical vignettes rather than actual patients. Although the study was explicitly titled as a project concerning pathological narcissism, the vignettes were not themselves labelled. It is thus possible that some clinicians may not have recognized the intended psychopathology depicted in each vignette. These vignettes were, however, rated by four independent experts as being representative, and the use of prototype vignettes has been found to be reliable in the identification and diagnosis of personality disorders (Westen, Shedler, & Bradley, 2006). Nevertheless, having participants view video footage of actual patients would add personal nuances to the pathology prototypes, potentially providing non-verbal cues that could elicit emotional reactions (i.e. countertransference) and further ideas about optimal therapeutic responses. A related issue was the challenging task faced by clinicians in using 100-item Q-sorts to rate prospective optimal therapy process for three clinical vignettes (for a total of 300 item ratings). Careful instructions

were provided to participants, including guidance to reduce rater-fatigue. None of the respondents who completed the project complained of difficulties with the study tasks, and many reported it to have been an intriguing process. Completed Q-sorts were also checked to ensure compliance with proper Q-sorting procedure.

A final, and crucial, limitation of this study was the restriction to investigation of clinicians' ideas about psychotherapy process, rather than an exploration of actual real-world practice. It cannot be concluded that the approaches espoused by participants would line up with the processes they would facilitate in sessions with real patients. Exploring therapists' descriptions of optimal treatment strategies is not the same as investigation into their capacity to implement them. The kind of inquiry involved in the present study provides no way of examining the degree to which therapists' recommended approaches would actually be helpful. This can only be done using a research design that involves actual patient samples and independent assessments of actual therapy processes. The PQS could be used to rate therapy process occurring over a number of sessions, correlating these ratings with outcome measures (as in previous research by Ablon & Jones, 1998; 2002). This would provide valuable information regarding treatment processes that have an actual bearing on patients' narcissistic difficulties, rather than those anticipated prospectively by clinicians.

# 7 SUMMARY

This study was initiated in order to contribute to the understanding of therapeutic process with regards to pathological narcissism. Despite growing consensus regarding the phenomenological expression of this personality syndrome, there has been a marked paucity of empirical research regarding treatment efforts. In this study, Q-methodology was employed to discover psychotherapists' ideas regarding optimal therapy processes, using vignettes that depicted patients with grandiose narcissism, vulnerable narcissism, and a non-narcissistic patient with panic disorder. Participants (N = 34) Q-sorts of ideal therapy process for each hypothetical patient were compared with regards to mean scores per type of patient. This analysis revealed several significant differences in ideal therapy process according to patient pathology. Process differences were particularly concentrated on difficult interpersonal behaviours having more expression among narcissistic patients compared to those with panic disorder.

Factor analysis was employed to explore the core elements of clinicians' opinions regarding ideal therapy process across the three patient types. Four factors representing distinct therapy process ideals were discovered using principal components analysis with varimax rotation of all 102 Q-sorts (34 participants rating 3 clinical vignettes). The Introspective Relational process factor prioritized the use of an empathically-attuned therapy relationship to facilitate the patient's awareness and reflection regarding emotions and unconscious psychological experiences. This factor was highly associated with expert-rated psychodynamic process and was distributed across all three types of patient. Adherence to this factor was associated with experience and confidence in the treatment of personality disorders. The Cognitive / Objective-oriented Alliance factor represented a collaborative and supportive therapeutic relationship led by the tasks of modifying behaviours, discussing belief systems, and

practising between-session behaviours. Strongly associated with expert-rated CBT process, this factor was endorsed mainly for the non-narcissistic patient, indicating a preference for an evidence-based therapy for panic disorder. The Inhibited, Fragile Patient factor and the Angry, Provocative Patient factor were each representative of therapy process organized around the interpersonal behaviours typically associated with vulnerable narcissism and grandiose narcissism, respectively. These factors were endorsed mainly by the same group of clinicians, and were less robustly associated with established conceptually-driven therapy models.

The findings from this study contribute to the growing literature regarding pathological narcissism – a significant and challenging mental health concern – and in particular to the understanding of approaches employed in community practice to treat patients who suffer from it. The factors representing clinicians' process ideals bore considerable resemblance to established expert-rated therapy models, and provide clear descriptive accounts of how an optimal treatment process should unfold. These could be used in future research regarding the treatment of pathological narcissism, and in the training and preparation of therapists working with patients who struggle with severe distortions of self-image and interpersonal relatedness.

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## APPENDICES

### Appendix A: Clinical vignettes for PQS rating

**Male patient 1: Mr. G.** (representing grandiose narcissism)

Mr. G. is a 35-year-old man who is seeking psychotherapy at the request of his wife due to longstanding relationship difficulties. His wife issued an ultimatum that he obtain treatment or else she would end the marriage. Mr. G. reports that their frequent conflicts are due, in his view, to his wife's lack of respect for him and refusal to comply with what he wants her to do. He indicates that he has a superior intelligence to his wife, and for that matter, to most people he meets. He reasons that others should simply abide by his instructions.

Mr. G. acknowledges becoming angry when people don't show enough respect for him; he feels that he regularly outperforms his co-workers, yet his efforts are not admired. In fact, he feels that other people – whether at work or on the golf course – tend to envy his abilities and personal attributes. He reasons that this is why he has been held back from a position of more importance at his firm. He often imagines himself taking over the company and firing everyone who has been "disrespectful" to him over the years. He has an alternate fantasy of leaving his firm and becoming a professional golfer – he feels certain he could become a professional athlete if only his wife would cease restricting his trips to the gym and the golf course.

Mr. G. acknowledges that he has had extramarital affairs, which his wife is unaware of. He feels that he should be entitled to these liaisons, although he knows his wife would feel hurt and would end the marriage if she found out about them.

He expresses little enthusiasm for engaging in psychotherapy – he doubts whether any therapist would have much to offer him – but he wants to maintain his marriage and find a way to be less irritated by others.

**Male patient 2: Mr. V.** (representing vulnerable narcissism)

Mr. V. is a 42-year-old man who is seeking psychotherapy to address longstanding feelings of depression and anxiety. He indicates that for most of his life he has struggled with chronic feelings of emptiness and a sense of being profoundly lost and alone. He feels this way in spite of being married and having two children. He sometimes wonders what his family sees in him, and that unless he was a good provider, they would likely turn against him.

In addition to longstanding depressive feelings, Mr. V. reports experiencing pronounced dysphoria if someone slights him or rejects him in any way. In fact, he often anticipates being rejected, and consequently feels a need to constantly prove himself to others. Among colleagues at his work he feels himself to be "a boy among men" in that he regards others as being more articulate and capable than himself. He often ruminates on events that have occurred which confirm his inferiority, and he tends to dwell on experiences which, in his view, produced a profound sense of humiliation.

Mr. V. reports having few close friends and few activities that he allows himself to engage in for pleasure; he devotes his time instead to avoiding the disapproval of others. He feels he works harder than anyone else he knows, but he reasons that he must do so simply to keep up with others and avoid being shamefully exposed as a fraud. At the same time, he acknowledges that he takes secret pride in being more industrious than others, and he resents not

being admired for his diligence. He doesn't believe that his wife understands him. However, he feels that she exploits his sensitivities and tries to make him feel inferior and weak, which results in painful depressive affect along with urges to flee the marriage. He fantasizes that an ideal partner would provide a perfect, transcendent love that would wash away his negative feelings.

Mr. V. approaches psychotherapy cautiously, regarding the therapist as an expert authority figure who might also seek to make him feel bad.

**Male patient 3: Mr. P.** (representing panic disorder)

Mr. P. is a 31-year-old man who is seeking psychotherapy to address a recent onset of panic attacks. He describes himself as having always been somewhat of a worrier, but only recently having experienced full panic attacks. He described these episodes as occurring "out of the blue" and without apparent warning.

Since having his first panic attack in a public place, he finds himself preoccupied with dread that this will re-occur. He worries that he will be in the middle of an important meeting, and that he will not be able to breathe, and that his co-workers will call for an ambulance. Mr. P. has also developed a fear that he might become stuck in traffic one day, with cars gridlocked all around him, and that he will have no way of getting out in the event that he is overcome by panic feelings. Consequently he avoids driving during busy times and he has had an increase in absenteeism at work.

A review of Mr. P.'s history indicates that he has enjoyed stable relationships with family members, friends, and colleagues. He is well-liked by others and regarded as being competent and reliable at work. He values being organized and well-prepared – these are traits he identified with in his parents – but denies feeling driven by obsessions. He appears to have developed a reasonable sense of self-esteem based appropriately on his accomplishments and relations with others.

Mr. P. reports having a stable marriage – he feels his wife is very supportive – and they are excited to be expecting their first child in four months' time. He feels puzzled by the onset of panic symptoms during a time when things are going well in his life.
Mr. P has always been interested in psychology and thus is keen to begin psychotherapy.

**Female patient 1: Ms. G.** (representing grandiose narcissism)

Ms. G. is a 35-year-old woman who is seeking psychotherapy at the recommendation of her employer. She has met with her manager several times due to her colleagues repeated complaints regarding Ms. G.'s interactions with them. Her employer believes she is suffering from "stress" which is manifest in a condescending attitude and domineering behaviour toward her co-workers. When others disagree with her she retorts venomously, occasionally flying into a vitriolic rage.

Ms. G.'s employer has told her that, despite her proficiency in her work, her employment will be terminated unless she obtains professional help for this issue. She owns up to these behaviours, but feels that her disdain for her co-workers is justified because they truly are incompetent, petty, and envious of both her appearance and her abilities. Ms. G. also admits to feeling "stressed" – but only because she doesn't get the recognition she feels she deserves.

Ms. G. also becomes irritated with her husband sometimes when he fails to admire her. When this happens she makes an extra effort to attract the attention of other men in an attempt to make her husband feel jealous and take notice of her. This behaviour has, on a couple of occasions, resulted in brief extramarital affairs. She feels little guilt for these liaisons, other than

regret for her husband's hurt feelings upon finding out about them. Ms. G. sometimes wonders about starting a family and feels some conflict about doing so. On one hand she fantasizes that she would be the ideal mother for a child to look up to, and that her child would no doubt be perfect. On the other hand, she worries that becoming pregnant would make her vulnerable, and that she would lose the upper hand in her marriage.

She agrees to try psychotherapy to manage her stress and maintain her position at work.

**Female patient 2: Ms. V.** (representing vulnerable narcissism)

Ms. V. is a 42-year-old woman who is seeking psychotherapy to address longstanding feelings of depression and anxiety. She indicates that for most of her life she has struggled with chronic feelings of emptiness and a sense of being profoundly lost and alone. She feels this way despite being married and having two children. She sometimes wonders what her family sees in her, and worries that they would turn against her if she was not constantly a step ahead on all aspects of managing the household.

In addition to longstanding depressive feelings, Ms. V. reports experiencing pronounced dysphoria if someone slights her or rejects her in any way. In fact, she often anticipates being rejected, and consequently feels a relentless need to prove herself to others. This concern becomes particularly acute around her peers. She believes she is secretly disparaged for not working outside the home. Ms. V. feels that, despite the advantages afforded by her decision to stay home with her children, she is weaker and less capable than other mothers.

She often ruminates on events that have occurred which indicate her inferiority, including interpersonal experiences which, in her view, confirm her status as an outsider who is sure to be rejected. She tends to feel humiliated when she thinks about past disappointments.

Ms. V. reports having few close friends and few activities that she allows herself to engage in for pleasure; she devotes her time instead to avoiding the disapproval of others. She feels she constantly goes the extra mile in ensuring that her husband and children are happy with her. She feels she works harder than anyone could ever know, simply to keep up with life's demands – including an immaculate home – and to avoid being shamefully rejected by others. At the same time, she acknowledges a deep resentment that her efforts aren't recognized or admired. Ms. V. indignantly feels that her husband does not properly understand or appreciate her, despite giving evidence that suggests he is reasonably supportive of her. If her husband actually expresses any negative appraisal she retreats amidst a torrent of depressive affect, along with urges to flee the marriage. She fantasizes that an ideal partner would provide a perfect, transcendent love that would wash away her negative feelings.

Ms. V. approaches psychotherapy cautiously, regarding the therapist as an expert authority figure who might also seek to make her feel bad.

**Female patient 3: Ms. P.** (representing panic disorder)

Ms. P. is a 31-year-old woman who is seeking psychotherapy to address a recent onset of panic attacks. She describes herself as having always been somewhat of a worrier, but only recently having experienced full panic attacks. She described these episodes as occurring "out of the blue" and without apparent warning.

Since having her first panic attack in a public place, she finds herself preoccupied with dread that this will re-occur. She worries that she will be in the middle of an important meeting, and that she will not be able to breathe, and that her co-workers will call for an ambulance. Ms. P. has also developed a fear that she might become stuck in traffic one day, with cars gridlocked

all around her, and that she will have no way of getting out in the event that she is overcome by panic feelings. Consequently, she avoids driving during busy times and she has had an increase in absenteeism at work.

A review of Ms. P.'s history indicates that she has enjoyed stable relationships with family members, friends, and colleagues. She is well-liked by others and regarded as being competent and reliable at work. She values being organized and well-prepared – these are traits she identified with in her parents – but denies feeling driven by obsessions. She appears to have developed a reasonable sense of self-esteem based appropriately on her accomplishments and relations with others.

Ms. P. reports having a stable marriage – she feels her husband is very supportive – and they are excited to be expecting their first child in four months' time. She feels puzzled by the onset of panic symptoms during a time when things are going well in her life.

Ms. P has always been interested in psychology and thus is keen to begin psychotherapy.

## Appendix B: Clinician demographic questionnaire

*Please complete the following items to provide us with information about certain aspects of your professional status and your psychotherapy practice. Please answer scaled questions with an X.*

**Sex:** ___Male ___Female **Age:** Years_____

**Experience providing psychotherapy:** Years_____

**Professional designation**

___Psychiatrist ___Psychologist ___Social Worker
___Counsellor ___Occupational therapist ___Psychiatric nurse
___Other (please indicate) _____

**Theoretical orientation**

___Psychodynamic ___Cognitive behavioural ___Humanistic / experiential
___Interpersonal ___Eclectic ___Other:_____

**Please rate your general level of confidence as a psychotherapist**

| ___1 | ___2 | ___3 | ___4 | ___5 |
|---|---|---|---|---|
| Not at all confident | | Somewhat confident | | Quite confident |

**Please rate your level of confidence in treating personality disorders**

| ___1 | ___2 | ___3 | ___4 | ___5 |
|---|---|---|---|---|
| Not at all confident | | Somewhat confident | | Quite confident |

**Please estimate the percentage of patients with personality disorder on your caseload:___%**

**Please rate your familiarity with patients who suffer from Narcissistic Personality Disorder**

| ___1 | ___2 | ___3 | ___4 | ___5 |
|---|---|---|---|---|
| Not at all familiar | | Somewhat familiar | | Quite familiar |

**Please indicate your confidence in treating patients with Narcissistic Personality Disorder**

| ___1 | ___2 | ___3 | ___4 | ___5 |
|---|---|---|---|---|
| Not at all confident | | Somewhat confident | | Quite confident |

**Please indicate your level of optimism regarding treatment outcome for patients with Narcissistic Personality Disorder**

| ___1 | ___2 | ___3 | ___4 | ___5 |
|---|---|---|---|---|
| Not at all optimistic | | Somewhat optimistic | | Quite optimistic |

## Appendix C: Psychotherapy Process Q-set

Excel version created by John Lundin and Sherwood Waldron, based on the Psychotherapy Process Q-set Coding Manual by Enrico E. Jones (1985; revised 2009).

**Item 1: Patient expresses, verbally or non-verbally, negative feelings (e.g. criticism, hostility) toward therapist (vs. makes approving or admiring remarks).**

Place toward *characteristic* end if patient expresses, verbally or non-verbally, feelings of criticism, dislike, envy, scorn, anger, or antagonism toward therapist. E.g. patient rebukes therapist for failing to provide enough direction in the therapy.

Place toward *uncharacteristic* end if patient expresses, verbally or non-verbally, positive or friendly feelings about therapist, e.g. makes what appear to be complimentary remarks to therapist.

**Item 2: Therapist draws attention to patient's non-verbal behavior, e.g. body posture, gestures, tone of voice.**

Place toward *characteristic* end if therapist draws attention to patient's non-verbal behavior, such as facial expressions, blushes, or body movements. E.g. therapist points out that although patient says s/he is angry, the patient is smiling.

Place toward *uncharacteristic* end if there is little or no focus on non-verbal behavior.

**Item 3: Therapist's remarks are aimed at facilitating patient speech.**

Place toward *characteristic* end if therapist's responses or behavior indicate that he or she is listening to the client and encouraging him or her to continue, such as: um-hmm, yeah, sure, right, and the like.

Place toward *uncharacteristic* end if therapist does not respond in such a manner as to facilitate patient talk (does not refer to questions, exploratory comments).

**Item 4: The patient's treatment goals are discussed.**

Place toward *characteristic* end if there is talk about what the patient wishes to achieve as a result of therapy. These wishes or goals may refer to personal or `inner' changes (E.g. "I started therapy in order to get over my depressions") or change in life circumstances ("I wonder if therapy will result in my getting married").

Place toward *uncharacteristic* end if there is no reference or allusion by therapist or patient to the possible consequences of the therapy.

**Item 5: Patient has difficulty understanding the therapist's comments.**

Place toward *characteristic* end if patient seems confused by therapist's comments. This may be defensive or a result of therapist's lack of clarity. E.g. patient repeatedly says "What?" or otherwise indicates that s/he doesn't know what the therapist means.

Place toward *uncharacteristic* end if patient readily comprehends therapist's comments.

**Item 6: Therapist is sensitive to the patient's feelings, attuned to the patient; empathic.**

Place toward *characteristic* end if therapist displays the ability to sense the patient's 'private world' as if it was his or her own; if the therapist is sensitive to the patient's feelings and can communicate this understanding in a way that seems attuned to the patient, e.g. therapist makes a statement that indicates an understanding of how the patient felt in a certain situation.

Place toward *uncharacteristic* end if therapist does not seem to have a sensitive understanding of patient's feelings or experience.

**Item 7: Patient is anxious or tense (vs. calm and relaxed).**

Place toward *characteristic* end if patient manifests tenseness or anxiety or worry. This may be demonstrated by direct statements, e.g. "I feel nervous today," or indirectly by stammers, stuttering, etc., or other behavioral indicators.

Place toward *uncharacteristic* end if patient appears calm or relaxed or conveys a sense of ease.

**Item 8: Patient is concerned or conflicted about his or her dependence on the therapist (vs. comfortable with dependency, or wanting dependency).**

Place toward *characteristic* end if patient appears concerned about dependency, e.g. shows a need to withdraw from the therapist, or in some manner reveals a concern about becoming dependent on the therapy.

Place toward *uncharacteristic* end if patient does not convey concern about dependency. This may take the form of expressions of helplessness; or the patient may appear either comfortable or gratified by a dependent relationship with the therapist.

Place toward the neutral range if patient experiences a sense of relative independence in the therapy relationship.

**Item 9: Therapist is distant, aloof (vs. responsive and affectively involved).**

Place toward *characteristic* end if therapist's stance toward the patient is cool, formal, and detached, or marked by emotional retreat or withdrawal.

Place toward *uncharacteristic* end if therapist is genuinely responsive and affectively involved.

**Item 10: Patient seeks greater intimacy with the therapist.**

Place toward *characteristic* end if patient appears to either wish or attempt to transform the therapy relationship into a more social or personal and intimate relationship. E.g. patient expresses concern about the therapist; or attempts to gain knowledge of the therapist's personal life.

Place toward *uncharacteristic* end if patient does not appear to seek greater closeness with the therapist.

**Item 11: Sexual feelings and experiences are discussed.**

Place toward *characteristic* end if the patient's sexuality is discussed. This can take the form of a discussion of sexual problems, or the patient's sexual feelings or fantasies or actual sexual experiences. E.g. patient talks of wanting to have sex with a romantic partner more frequently.

Place toward *uncharacteristic* end if patient does not discuss sexual or erotic material.

**Item 12: Silences occur during the hour.**

Place toward *characteristic* end if there are many periods of silence during the hour, or a few extended periods of silence.

Place toward *uncharacteristic* end if there are few silences.

**Item 13: Patient is animated or excited.**

Place toward *characteristic* end if patient directly expresses, or behaviorally displays, a feeling of excitation or appears aroused in some way. E.g. patient becomes animated in response to therapist's interpretation.

Place toward *uncharacteristic* end if patient appears bored, dull, or lifeless.

**Item 14: Patient does not feel understood by therapist.**

Place toward *characteristic* end if patient expresses concern about feeling misunderstood by the therapist or assumes that the therapist cannot understand his or her experience or feelings. E.g. a widow doubts the therapist's ability to understand her plight since he has never been in her situation.

Place toward *uncharacteristic* end if patient somehow conveys the sense that the therapist understands his or her experience or feelings. E.g. patient comments, in response to therapist's remarks, "Yes, that's exactly what I mean."

**Item 15: Patient does not initiate or elaborate topics.**

Place toward *characteristic* end if patient does not initiate or elaborate topics for discussion, brings up problems, or otherwise fails to assume some responsibility for the hour. E.g. patient states that s/he doesn't know what to talk about.

Place toward *uncharacteristic* end if patient is willing to break silences, or supplies topics either spontaneously or in response to therapist's probes, and actively pursues or elaborates them.

**Item 16: There is mention or discussion of body functions, physical symptoms, or health.**

Place toward *characteristic* end if discussion emphasizes somatic concerns or physical symptoms. E.g. patient may complain of fatigue or illness, or of having headaches, menstrual pains, poor appetite, and the like.

Place toward *uncharacteristic* end if physical complaints are not an important topic of discussion. A more extreme, uncharacteristic placement indicates that the absence of discussion is salient.

**Item 17: Therapist actively exerts control over the interaction (e.g. structuring, introducing new topics).**

Place toward *characteristic* end if therapist intervenes more than is usually expected in the therapeutic context. Do not rate on the basis of perceptiveness or appropriateness of interventions. E.g. rate as *very characteristic* if therapist is so active that he or she frequently interrupts to ask questions or make a point.

Place toward *uncharacteristic* end if therapist intervenes relatively infrequently, and makes little effort to structure the interaction; or if therapist tends to follow the lead of patient, e.g. allowing patient to introduce main topics for discussion and subsequently helping patient to follow his or her train of thought.

**Item 18: Therapist conveys a sense of non-judgmental acceptance. (N.B. Placement toward *uncharacteristic* end indicates disapproval, lack of acceptance).**

Place toward *characteristic* end if therapist refrains from overt or subtle negative judgments of the patient; "unacceptable" or problematic behavior of the patient may be explored while conveying the sense that the patient is worthy. Therapist displays "unconditional positive regard."

Place toward *uncharacteristic* end if therapist's comments or tone of voice convey criticism, a lack of acceptance, or objection to the patient's behavior. A more extreme placement indicates therapist communicates that patient's character or personality is somehow displeasing, objectionable or disturbed.

**Item 19: There is an erotic quality to the therapy relationship.**

Place toward *characteristic* end if the therapy relationship seems somehow sexualized. This could range from the presence of a warm, erotically tinged relationship to coy, or seductive behavior on the part of the patient, to overtly stated wishes for sexual gratification. E.g. patient talks of sexual experiences in such a way as to invite the sexual interests of the therapist.

Place toward *uncharacteristic* end if therapy relationship seems basically unsexualized; a more extreme placement in this direction indicates that patient (or therapist) avoid topics or behavior which might be viewed as betraying a sexual interest; or, that there is an attempt to manage or suppress erotic feeling.

**Item 20: Patient is provocative, tests limits of the therapy relationship. (N.B. Placement toward *uncharacteristic* end implies patient behaves in a compliant manner).**

Place toward *characteristic* end if patient seems to behave in a manner aimed at provoking an emotional response in the therapist. E.g. patient may invite rejection by the therapist by behaving

in a way which might anger him or her, or by violating one or another aspect of the therapy contract.

Place toward *uncharacteristic* end if patient is particularly compliant, deferential, or seems to be playing the role of the "good patient" as a way of courting the therapist.

**Item 21: Therapist self-discloses.**

Place toward *characteristic* end if therapist reveals personal information, or personal reactions to the patient. E.g. therapist tells patient where he or she grew up, or tells the patient "I find you a very likable person."

Place toward *uncharacteristic* end if therapist refrains from such self-disclosure. More extreme placement in this direction indicates therapist does not self-disclose even when patient exerts pressure for therapist to do so. E.g. therapist does not answer question directly when patient asks whether the therapist is married.

**Item 22: Therapist focuses on patient's feelings of guilt.**

Place toward *characteristic* end if therapist focuses on, or somehow draws attention to, patient's guilty feelings, particularly when there is an intent to help alleviate such feelings. E.g. therapist remarks that patient appears to feel guilty when she occasionally does not respond to one of her daughter's incessant requests for help.

Place toward *uncharacteristic* end if therapist does not emphasize patient's feelings of guilt.

**Item 23: Dialogue has a specific focus.**

Place toward *characteristic* end if when reflecting upon the hour the rater can identify a single or several clear foci. E.g. the foremost topic of the hour was the patient's feeling that throughout the course of his life, and in many different ways, he has failed to live up to his father's expectations of him.

Place toward *uncharacteristic* end if discussion or dialogue seems somewhat diffuse.

**Item 24: Therapist's own emotional conflicts intrude into the relationship.**

Place toward *characteristic* end if therapist appears to respond to the patient in a somehow ineffective or inappropriate way, and when this response does not stem solely from the therapy encounter, but conceivably derives from the therapist's own emotional or psychological conflicts (e.g. countertransference reaction). E.g. therapist seems to avoid or shows personal interest in certain affects or issues which the patient expresses or needs to express.

Place toward *uncharacteristic* end if therapist's personal emotional responses do not intrude in the therapy relationship inappropriately.

**Item 25: Patient has difficulty beginning the hour.**

Place toward *characteristic* end if patient manifests discomfort or awkwardness in the initial moments or minutes of the session. E.g. There is a lengthy silence or the patient says "Well, I don't know what to talk about today."

Place toward *uncharacteristic* end if patient begins hour directly without lengthy pauses, difficulty beginning, or prompting questions from the therapist.

**Item 26: Patient experiences discomforting or troublesome (painful) affect during the session.**

Place toward *characteristic* end if patient experiences discomforting or troublesome affect. Placement toward the extreme ends indicates intensity of affect.

Place toward *uncharacteristic* end if patient does not experience troublesome feelings.

**Item 27: Therapist gives explicit advice or guidance (vs. defers even when pressed to do so).**

Place toward *characteristic* end if therapist gives explicit advice or makes particular suggestions which patient is then free to accept or ignore. E.g. therapist says, "You know, you might find it helpful to consult a lawyer about how to handle your inheritance." Or therapist might guide patient to consider a range of options and to explore each alternative. E.g. therapist may point out possibilities the patient overlooks and direct patient to explore possible consequences of each line of action.

Place toward *uncharacteristic* end if therapist refrains from giving advice; extreme placement in this direction indicates that the therapist does not supply such guidance despite pressure from the patient to do so, or when it might be useful to do so.

**Item 28: Therapist accurately perceives the therapeutic process.**

Place toward *characteristic* end if the therapist seems to accurately perceive the patient's emotional state, intent of his or her speech, or experience of the therapy relationship. This should be inferred from the therapist's comments, interventions, or general stance toward the patient. Judgment should be independent of the type of therapy (i.e. cognitive-behavioral, psychoanalytic) being conducted; rather the rater should attempt an assessment of the process observed in this particular hour.

Place toward *uncharacteristic* end if the therapist appears in some manner to misperceive the patient's emotional state, the intent of his or her speech, or the nature of the interaction between them, or if the therapist tends to inaccurately formulate the problem.

**Item 29: Patient talks of wanting to be separate or distant from someone (excludes therapist).**

Place toward *characteristic* end if patient talks about wanting greater distance or a sense of independence from someone (excludes therapist) e.g. states wish to finally be free of his or her parents' influence.

Place toward *uncharacteristic* end if patient does not talk of wanting to be separate, independent, or detached.

**Item 30: The content of the session centers on cognitive themes, i.e. ideas or belief systems.**

Place toward *characteristic* end if dialogue emphasizes particular conscious ideational themes, beliefs or constructs used to appraise others, the self, or the world. E.g. therapist suggests they

look more closely at a patient's idea or belief that unless he accomplishes everything he attempts perfectly, he is worthless.

Place toward *uncharacteristic* end if there is little or no discussion of such ideas or constructs.

**Item 31: Therapist asks for more information or elaboration.**

Place toward *characteristic* end if the therapist asks questions designed to elicit information, or presses the patient for a more detailed description of an occurrence. E.g. therapist asks about the patient's personal history, or inquires what thoughts went through the patient's mind when s/he met an acquaintance by chance on the street.

Place toward *uncharacteristic* end if therapist does not actively elicit information.

**Item 32: Patient achieves a new understanding or insight.**

Place toward *characteristic* end if a new perspective, or new connection or attitude, or warded-off content emerges during the course of the hour. E.g. following the therapist's remark, the patient appears thoughtful and says, "I think that's true. I had never really thought about the situation that way before."

Place toward *uncharacteristic* end if no evidently new insight or awareness emerges during the hour.

**Item 33: Patient talks of feeling close to or wanting to be close to someone (excludes therapist).**

Place toward *characteristic* end if patient talks about being, or wanting to be, close or intimate with someone (excluding therapist). E.g. patient states he or she is lonely, and would like to be with someone.

Place toward *uncharacteristic* end if patient does not make statements about being or wanting to be close and intimate.

**Item 34: Patient blames others, or external forces, for difficulties.**

Place toward *characteristic* end if patient tend to externalize, blaming others or chance events for difficulties. E.g. patient claims his or her problems with work stem from the fact that he or she has had bad luck with employees.

Place toward *uncharacteristic* end if patient tends to assume responsibility for his or her problems, e.g. noting that his or her unhappiness in romantic relationships may be the result of choosing unsuitable partners.

**Item 35: Self-image is a focus of the session.**

Place toward *characteristic* end if a topic discussed by the patient and/or the therapist is the patient's concept, feelings, attitudes, or perceptions of him or her self, whether positive or negative. E.g. patient talks of how it is sometimes difficult **(**to her**)** to stand up for herself because she then experiences herself as being too aggressive.

Place toward *uncharacteristic* end if images of the self play little or no part in the dialogue.

**Item 36: Therapist points out patient's attempts to ward off awareness of threatening information or feelings.**

Place toward *characteristic* end if a major topic is defensive maneuvers (e.g. undoing, denial) used by the patient to ward off awareness of threatening information or feelings. E.g. the therapist points out how the patient is compelled to profess love for his father directly after having made critical remarks about him.

Place toward *uncharacteristic* end if this sort of interpretation of defenses plays little or no role during the hour.

**Item 37: Therapist behaves in a teacher-like (didactic) manner.**

Place toward *characteristic* end if therapist's attitude or stance toward patient is like that of a teacher to a student. This can be judged independently of specific content, i.e., therapist can impart information to make suggestions without behaving in a didactic or teacherly way, and alternative interpretations can be offered in the form of instruction.

Place toward *uncharacteristic* direction if therapist does not assume a tutor-like role in relation to the patient.

**Item 38: There is discussion of specific activities or tasks for the patient to attempt outside of session.**

Place toward *characteristic* end if there is discussion of a particular activity the patient might attempt outside of therapy, such as testing the validity of a particular belief or behaving differently than s/he might typically do, or reading books. E.g. there is talk about the patient facing a feared situation or object that s/he usually avoids.

Place toward *uncharacteristic* end if there is no talk about the patient attempting particular actions of this sort outside of therapy.

**Item 39: There is a competitive quality to the relationship.**

Place toward *characteristic* end if either patient or therapist seems competitive with the other. This may take the form of boasting, "one-upping," or putting the other down. E.g. the patient suggests that therapists live a cloistered life while s/he is out living and working in the real world.

Place toward *uncharacteristic* end if there is little or no feeling of competitiveness between patient and therapist.

**Item 40: Therapist makes interpretations referring to actual people in the patient's life (N.B. Placement toward *uncharacteristic end* indicates therapist makes general or impersonal interpretations.)**

Place toward *characteristic* end if therapist's interpretations refer to particular people the patient knows. E.g. therapist says, "you felt hurt and angry when your mother criticized you."

Place toward *uncharacteristic* end if interpretations do not refer to particular people, or refer to other aspects of the patient's life. E.g. therapist comments, "You seem to be inclined to withdraw when others become close."

**Item 41: Patient's aspirations or ambitions are topics of the session.**

Place toward *characteristic* end if patient talks about life projects, goals, or wishes for success or status. E.g. patient talks about his or her hopes to become a lawyer and earn a substantial income.

Place toward *uncharacteristic* end if patient shows a constriction of future expectations, whether in the form of realistic planning or wishful thinking.

**Item 42: Patient rejects (vs. accepts) therapist's comments and observations.**

Place toward *characteristic* end if patient typically disagrees with or ignores therapist's suggestions, observations, or interpretations. E.g. after the therapist made a major interpretation, the patient casually remarked that s/he didn't think that was quite it.

Place toward *uncharacteristic* end if the patient tends to agree with therapist's remarks.

**Item 43: Therapist suggests the meaning of others' behavior.**

Place toward *characteristic* end if therapist attempts to interpret the meaning of the behavior of people in the patient's life. E.g. the therapist suggests that the patient's romantic partner has problems with intimacy.

Place toward *uncharacteristic* end if therapist does not make comments about the meaning of the behavior of others.

**Item 44: Patient feels wary or suspicious of the therapist (vs. trusting and secure).**

Place toward *characteristic* end if patient appears, wary, distrustful, or suspicious of the therapist. E.g. patient wonders whether the therapist really likes him or her, or if there is another, hidden meaning in the therapist's remarks.

Place toward *uncharacteristic* end if patient seems to be trusting and unsuspicious.

**Item 45: Therapist adopts supportive stance.**

Place toward *characteristic* end if therapist assumes a supportive, advocate-like posture toward the patient. This may take the form of approval of something the patient has done, or encouraging, for example, the patient to assert him or herself. Or the therapist may agree with the patient's positive self-statement, or emphasize the patient's strengths, e.g. "You did this in the past, and you can do it again."

Place toward *uncharacteristic* end if therapist tends not to assume a supportive role of this sort.

**Item 46: Therapist communicates with patient in a clear, coherent style.**

Place toward *characteristic* end if therapist's language is unambiguous, direct, and readily comprehensible. Rate as very *characteristic* if therapist's verbal style is evocative, and marked by a freshness of words and phrasing.

Place toward *uncharacteristic* end if therapist's language is diffuse, overly abstract, jargon-laden, or stereotypic.

**Item 47: When the interaction with the patient is difficult, the therapist accommodates in an effort to improve relations.**

Place toward *characteristic* end if therapist appears willing and open to compromise and accommodation when disagreement occurs, or when conflicts arise in the dyad. E.g. when the patient becomes annoyed with the therapist, he or she makes some effort to mollify the patient.

Place toward *uncharacteristic* end if therapist does not exert an effort to improve matters when the interaction becomes difficult.

**Item 48: The therapist encourages independence of action or opinion in the patient.**

Place toward *characteristic* end if therapist urges patient to think for him or herself and to take action based on what he or she thinks best. E.g. therapist notes that he has now heard from the patient what her mother and colleagues think she should do, but it's not clear what she wants or thinks.

Place toward *uncharacteristic* end if therapist does not introduce the issue of independence or initiative as a topic.

**Item 49: The patient experiences ambivalent or conflicted feelings about the therapist.**

Place toward *characteristic* end if patient expresses mixed feeling about the therapist or if the patient's overt verbalizations about the therapist are incongruent with the tone of his or her behavior or general manner, or if there seems to be some displacement of feelings. E.g. the patient cheerfully agrees with the therapist's suggestions, but then goes on to express hostility toward people who tell him or her what to do.

Place toward *uncharacteristic* end if there is little expression of patient ambivalence towards therapist.

**Item 50: Therapist draws attention to feelings regarded by the patient as unacceptable (e.g. anger, envy, or excitement.)**

Place toward *characteristic* end if therapist comments upon or emphasizes feelings that are considered wrong, inappropriate, or dangerous by the patient. E.g. therapist remarks that patient sometimes feels a jealous hatred of his more successful brother.

Place toward *uncharacteristic* end if therapist tends not to emphasize feeling reactions that the patient finds difficult to recognize or accept.

**Item 51: Therapist condescends to or patronizes the patient.**

Place toward *characteristic* end if therapist seems condescending toward patient, treating him or her as if less intelligent, accomplished, or sophisticated. This may be inferred from the manner in which therapist delivers comments, or offers advice.

Place toward *uncharacteristic* end if therapist conveys by his or her manner, tone of voice, or comments, that s/he does not assume an attitude of superiority.

**Item 52: Patient relies upon therapist to solve his/her problems.**

Place toward *characteristic* end if patient appears to present problems to the therapist in a manner which suggest a hope or expectation that the therapist will offer specific suggestions or advice in the way of a solution. E.g. patient states uncertainty as to whether or not to break up with a romantic partner and asks the therapist what he or she should do. Note that the appeal for a solution need not be explicitly stated but may be implied by the manner in which the patient discusses the problem.

Place toward *uncharacteristic* end if patient does not appear explicitly or implicitly to rely on the therapist to solve problems.

**Item 53: Patient is concerned about what therapist thinks of him or her.**

Place toward *characteristic* end if patient seems concerned with what the therapist might think of his or her behavior, or is concerned about being judged. E.g. the patient might comment, "You are probably thinking that was a stupid thing to do." Rater may also infer this from patient behavior, e.g. patient boasts of accomplishments in order to favorably impress the therapist.

Place toward *uncharacteristic* end if patient does not seem concerned with the kind of impression s/he is creating, or appears unworried about being judged by therapist.

**Item 54: Patient expresses himself or herself in a clear and organized fashion.**

Place toward *characteristic* end if patient expresses him or herself in a manner which is easily understandable, and relatively clear and fluent.

Place toward *uncharacteristic* end if patient's speech is characterized by rambling, frequent digression, or vagueness. This can sometimes be judged by the rater's inability to readily follow the connections between topics the patient discusses.

**Item 55: Patient conveys positive expectations about therapy.**

Place toward *characteristic* end if patient expresses the hope or expectation that therapy will be of help. A more extreme placement in this direction indicates that the patient expresses unrealistically positive expectations, i.e. therapy will solve all of his or her problems and will be a protection against future difficulties. E.g. client may convey hope that therapy will provide quick results.

Place toward *uncharacteristic* end if patient expresses criticisms of therapy, e.g. conveys a sense of disappointment that therapy is not more effective or gratifying. A more extreme placement indicates patient expresses skepticism, pessimism or disillusionment about what can be accomplished in therapy.

**Item 56: Patient discusses experiences as if distant from his or her feelings.**

Refer to patient's attitude toward the material spoken, how much he or she appears to care about it, as well as how much overt affective expression there is.

Place toward *characteristic* end if patient displays little concern or feeling, and is generally flat, impersonal, or half-heartedly indifferent (tension may or may not be apparent).

Place toward *uncharacteristic* end if affect is apparent and patient is emotionally involved with the material. Place toward *very uncharacteristic* end if patient expresses sharp affect, or outbursts of emotion, and deeply felt concern.

**Item 57: Therapist explains rationale behind his or her technique or approach to treatment, or suggests that the patient use certain techniques.**

Place toward *characteristic* end if therapist explains some aspect of the therapy to the patient. E.g. therapist may reply in response to a direct question or request by the patient that s/he prefers not to answer immediately, since this would provide a better opportunity to explore thoughts or feelings associated with the question. Also includes the therapist answering questions about treatment process.

Place toward *uncharacteristic* end if little or no explanation is made by the therapist to explain the rationale behind some aspect of the treatment, even if there is pressure, or there may be some utility in doing so.

**Item 58: Patient does not examine thoughts, reactions or motivations related to his or her role in creating or perpetuating problems.**

Place toward *characteristic* end if patient is reluctant to examine his or her own role in perpetuating problems, e.g. by balking, avoiding, blocking, or repeatedly changing the subject whenever a particular topic is introduced.

Place toward *uncharacteristic* end if patient actively contemplates, or is able to pursue, trains of thoughts regarding his or her role in creating or perpetuating problems.

**Item 59: Patient feels inadequate and inferior (vs. effective and superior).**

Place toward *characteristic* end if patient expresses feelings of inadequacy, inferiority, or ineffectiveness. E.g. patient states that nothing he attempts really turns out the way he hopes it will.

Place toward *uncharacteristic* end if patient expresses a sense of effectiveness, superiority, or even triumph, e.g. recounts personal achievements, or claims attention for a personal attribute or skill.

**Item 60: Patient has cathartic experience (N.B. rate as *uncharacteristic* if emotional expression is not followed by a sense of relief).**

Place toward *characteristic* end if patient gains relief by giving vent to suppressed or pent-up feeling. E.g. patient cries intensely over the death of a parent, and then tells the therapist s/he feels better or appears to feel better as a result of expressing feelings.

Place toward *uncharacteristic* end if the experience of strong affect is not followed by a sense of relaxation or relief.

Rate as neutral if cathartic experience plays little or no role in the hour.

**Item 61: Patient feels shy and embarrassed (vs. unselfconscious and assured).**

Place toward *characteristic* end if patient appears shy, embarrassed, or not self-assured, or at the extreme, humiliated or mortified.

Place toward *uncharacteristic* end if patient appears unselfconscious, assured, or certain of him or herself.

**Item 62: Therapist identifies a recurrent theme in the patient's experience or conduct.**

Place toward *characteristic* end if therapist points out a recurrent pattern in the patient's life experience or behavior. E.g. therapist notes that patient repeatedly seeks out unavailable sexual partners.

Place toward *uncharacteristic* end if therapist does not identify such a theme or recurrent pattern.

**Item 63: Patient's interpersonal relationships are a major theme.**

Place toward *characteristic* end if a major focus of discussion is the patient's social or work relationships, or personal, emotional involvements (*excludes* discussion of therapy relationship [see Item 98] and *excludes* discussion of love or romantic relationships [see Item 64]). E.g. patient discusses at some length his or her distress over conflicts with a boss.

Place toward *uncharacteristic* end if a good portion of the hour is devoted to discussion of matters that are not directly connected to relationships, e.g. the patient's compulsion to work, or drive to achieve, or his/her preoccupation with food and eating.

N.B.: Item does not refer to discussion of relationships in the distant past. (See Item 91, Memories or reconstructions of infancy and childhood are topics of discussion.)

**Item 64: Feelings about romantic love relationships are a topic of the session.**

Place toward *characteristic* end if romantic or love relationships are talked about during the hour. E.g. patient talks about feelings toward a romantic partner.

Place toward *uncharacteristic* end if love relationships do not emerge as a topic.

**Item 65: Therapist restates or rephrases the patient's communication in order to clarify its meaning.**

Place toward *characteristic* end if one aspect of the therapist's activity is restating or rephrasing the patient's affective tone, statements, or ideas in a somewhat more recognizable form in order to render their meaning more evident. E.g. therapist remarks, "What you seem to be saying is that you're worried about what therapy will be like."

Place toward *uncharacteristic* end if the therapist seldom employs this kind of clarifying activity during the hour.

**Item 66: Therapist is directly reassuring (N.B. Place in *uncharacteristic* direction if therapist tends to refrain from providing direct reassurance).**

Place toward *characteristic* end if therapist attempts to directly allay patient's anxieties and instill hope that matters will improve. E.g. therapist tells patient there is no reason for worry; he or she is sure the problem can be solved.

Place toward *uncharacteristic* end if the therapist tends to refrain from providing direct reassurance of this kind.

**Item 67: Therapist draws the patient's attention to wishes, feelings, or ideas that may not be in awareness.**

Place toward *characteristic* end if therapist draws the patient's attention to feelings, thoughts, or impulses that may not be clearly in awareness. Rater must attempt to infer the quality of mental content (i.e. the extent to which it is in awareness) from the context of the hour (excludes interpretation of defensive maneuvers: see Item 36).

Place toward *uncharacteristic* end if therapist focuses on material that appears to be clearly in the conscious awareness of the patient.

**Item 68: Real vs. fantasized meanings of experiences are actively differentiated.**

Place toward *characteristic* end if therapist or patient notes differences between patient's fantasies about an occurrence and the objective reality. E.g. therapist points out that although the patient may have harbored death wishes toward the deceased, he or she did not, in reality, cause the heart attack. Distortions and erroneous assumptions should also be included, e.g. therapist asks where patient got that idea when he or she repeatedly describes the world as dangerous.

Place toward *uncharacteristic* end if little of the activity of the therapy hour is concerned with distortions of reality.

**Item 69: Patient's current or recent life situation is emphasized in the session.**

Place toward *characteristic* end if patient or therapist emphasizes very recent or current life events. E.g. patient talks about depression over a spouse's recent death.

Place toward *uncharacteristic* end if discussion of current life situation is not an important aspect of the hour.

**Item 70: Patient struggles to control feelings or impulses.**

Place toward *characteristic* end if patient attempts to manage or control strong emotions or impulses. E.g. patient fights to hold back tears while obviously distressed.

Place toward *uncharacteristic* end if patient does not attempt to manage or control emotions or impulses.

**Item 71: Patient is self-accusatory; expresses shame or guilt.**

Place toward *characteristic* end if patient expresses self-blame, shame, or guilt. E.g. that patient claims that if s/he had paid more attention to a spouse's low moods, the spouse might not have committed suicide.

Place toward *uncharacteristic* end if patient does not make statements reflecting self-blame, a sense of shame, or pangs of conscience.

**Item 72: Patient understands the nature of therapy and what is expected.**

Placement toward *characteristic* end reflects the extent to which the patient appears to comprehend what is expected of him or her in the situation and what will happen in therapy.

Placement toward *uncharacteristic* end suggests that the patient is uncertain, confused or misunderstands his or her role in therapy and what is expected in the situation.

**Item 73: The patient is committed to the work of therapy.**

Place toward *characteristic* end if patient seems committed to the work of therapy. May include willingness to make sacrifices to continue this endeavor, in terms of time, money, inconvenience; may also include genuine desire to understand more about the self in spite of the psychological discomfort this may entail. E.g. a patient was so interested in beginning treatment that he or she was willing to give up a weekly golf game to keep his/her appointments.

Place toward *uncharacteristic* end if patient seems ambivalent about therapy, or unwilling to tolerate the emotional hardships that therapy might entail. May be expressed in terms of complaints about the expense of therapy, in scheduling conflicts, or statements of doubt about the effectiveness of treatment, or uncertainty about wanting to change.

**Item 74: Humor is used.**

Place toward *characteristic* end if therapist or patient display humor during the course of the hour. This may appear as a defense/coping mechanism in the patient; or the therapist may use wit or irony to make a point or to facilitate development of a working relationship with the patient. E.g. patient demonstrates an ability to laugh at herself or her predicament.

Place toward *uncharacteristic* end if the interaction appears grave, austere or somber.

**Item 75: Termination of therapy is mentioned or discussed.**

Place toward *characteristic* end if patient or therapist talks of the end of therapy. Includes all reference to termination, i.e. whether it is wished for, feared, or threatened.

Place toward *uncharacteristic* end if discussion of termination seems to be avoided. E.g. the upcoming termination is mentioned, but neither patient nor therapist pursues the subject.

Rate as neutral if no reference to termination is made.

**Item 76: Therapist suggests that patient accept responsibility for his or her problems.**

Place toward *characteristic* end if therapist attempts to convey to the patient that s/he must take some action, or change somehow, if his or her difficulties are to improve. E.g. therapist comments, "Let's look at what you may have done to elicit that response (from another person).

Place toward *uncharacteristic* end if therapist's actions are in general not aimed at persuading patient to assume greater responsibility.

**Item 77: Therapist is tactless.**

Place toward *characteristic* end if therapist's comments seem to be phrased in ways likely to be perceived by the patient as hurtful or derogatory. This lack of tact or sensitivity may not be a result of therapist's annoyance or irritation, but rather a result of lack of technique, polish, or verbal facility.

Place toward *uncharacteristic* end if therapist's comments reflect kindliness, consideration, or carefulness.

**Item 78: Patient seeks therapist's approval, affection, or sympathy.**

Place toward *characteristic* end if patient behaves in a manner that appears designed to make therapist like him or her, or to gain attention or reassurance.

Place toward *uncharacteristic* end if patient does not behave in this fashion.

**Item 79: Therapist comments on changes in patient's mood or affect that occur during the hour.**

Place toward *characteristic* end if therapist makes frequent or salient comments about shifts in the patient's mood or quality of experience during the hour. E.g. therapist notes that in response to his comments, patient has shifted from a `devil may care' attitude to feeling hurt but working more seriously on his or her problems.

Place toward *uncharacteristic* end if therapist tends not to comment on changes in patient's states of mind during the hour.

**Item 80: Therapist presents a specific experience or event in a different perspective.**

Place toward *characteristic* end if therapist restates what the patient has described in such a way that the patient is likely to look at the situation differently ('reframing' or `cognitive restructuring'). A new (and usually more positive) meaning is given to the same content. In rating this item, a particular event or experience that has been 'reframed' should be identified. E.g. After a patient berates him or herself for having started an ugly quarrel with a romantic partner, the therapist says that this is his or her way of expressing what he or she needs in that relationship.

Place toward *uncharacteristic* end if this does not constitute an important aspect of the therapist's activity during the hour.

**Item 81: Therapist emphasizes patient feelings in order to help him or her experience them more deeply.**

Place toward *characteristic* end if therapist stresses the emotional content of what the patient has described in order to encourage the experience of affect. E.g. therapist suggests that the interaction the patient has just described in a story-telling manner probably made her or him feel quite angry.

Place toward *uncharacteristic* end if therapist does not emphasize the experience or affect, or appears interested in patient's objectified descriptions.

**Item 82: The patient's behavior during the hour is reformulated by the therapist in a way not explicitly recognized previously.**

Place toward *characteristic* end if therapist makes frequent or a few salient comments about the patient's behavior during the hour in a way that appears to shed new light on it. E.g. therapist suggests that the patient's late arrival for the hour may have a meaning; or therapist notes that whenever the patient begins to talk about emotional topics, he or she quickly shifts to another focus.

Place toward *uncharacteristic* end if therapist tends not to reformulate the patient's behavior during the session.

**Item 83: Patient is demanding.**

Place toward *characteristic* end if patient makes multiple demands/requests of the therapist or pressures therapist to meet a specific request. E.g. patient makes multiple demands such as evening appointments, medication, or requests more structure or more activity on therapist's part.

Place toward *uncharacteristic* end if patient is reluctant or hesitant to make usual or appropriate requests of the therapist, e.g. fails to ask for another appointment despite a schedule conflict with another, highly important event.

**Item 84: Patient expresses angry or aggressive feelings.**

Place toward *characteristic* end if patient expresses resentment, anger, bitterness, hatred or aggression verbally or non-verbally (N.B. excludes such feelings directed at therapist: see Item 1).

Place toward *uncharacteristic* end if the verbal or non-verbal expression of such feelings does not occur.

**Item 85: Therapist encourages patient to try new ways of behaving with others.**

Place toward *characteristic* end if therapist suggests alternative ways of relating to people. E.g. therapist asks patient what he thinks might happen if he were to be more direct in telling his mother how it affects him when she nags. More extreme placement implies that the therapist actively coaches patient on how to interact with others, or rehearses new ways of behaving with others.

Place toward *uncharacteristic* end if therapist tends not to make suggests about how to relate to others.

**Item 86: Therapist acts confident or self-assured (vs. uncertain or defensive).**

Place toward *characteristic* end if therapist's manner indicates a feeling of confidence and competence.

Place toward *uncharacteristic* end if therapist appears uncertain, embarrassed, or at a loss.

**Item 87: Patient is controlling.**

Place toward *characteristic* end if patient exercises a restraining or directing influence in the hour, e.g. patient dominated the interaction with compulsive talking, or interrupted the therapist frequently.

Place toward *uncharacteristic* end if patient does not control the interaction, working with therapist in a more collaborative fashion.

**Item 88: Patient brings up significant issues and material.**

Place toward *characteristic* end if the rater judges that what the patient brings up and talks about during the hour is importantly related to patient's psychological conflicts, or are topics of real concern.

Place toward *uncharacteristic* end if discussion seems unrelated to or somehow removed from issues of central concern.

**Item 89: Therapist intervenes to help patient avoid or suppress disturbing ideas or feelings.**

Place toward *characteristic* end if therapist's stance is characterized by a calm, attentive compliance intended to avoid upsetting the patient's emotional balance or to strengthen the patient's defenses.

Place toward *uncharacteristic* end if therapist does not act to shore up defenses or suppress troublesome thoughts or feelings.

**Item 90: Patient's dreams or fantasies are mentioned or discussed.**

Place toward *characteristic* end if a topic of discussion is dream content or fantasy (day-dreams or night-dreams) material. E.g. patient and therapist explore the possible meanings of a dream the patient had the night before starting therapy, or the patient talks of what life would have been like if she'd chosen a different romantic partner.

Place toward *uncharacteristic* end if there is little or no discussion of dreams or fantasy during the hour.

**Item 91: Memories or reconstructions of infancy and childhood are topics of discussion.**

Place toward *characteristic* end if some part, or a significant part, of the hour is taken up by a discussion of childhood or memories of early years of life.

Place toward *uncharacteristic* end if little or no time is devoted to a discussion of these topics.

**Item 92: Patient's feelings or perceptions are linked to situations or behavior of the past.**

Place toward *characteristic* end if several links or salient connections are made between the patient's current emotional experience or perception of events with those of the past. E.g. therapist points out (or patient realizes) that current fears of abandonment are derived from the loss of a parent during childhood.

Place toward *uncharacteristic* end if current and past experiences are discussed, but not linked.

Place toward neutral category if these subjects are discussed very little or not at all.

**Item 93: Therapist refrains from stating opinions or views of topics the patient discusses.**

Place toward *characteristic* end if therapist tends to refrain from stating opinions or views of topics patient discusses. Therapist assumes role of neutral commentator, and the patient's view of matters is made pre-eminent in the dialogue. E.g. therapist asks how it would be for the patient if she, as the therapist, approved of his expressing his anger, and subsequently inquires how it would be for him if she disapproved.

Place toward *uncharacteristic* end if therapist expresses opinions, or takes positions either explicitly or by implication. E.g. therapist tells patient that it is very important that he learn how to express his anger; or comments that the relationship the patient is in right now is not a very good one, and that she should consider getting out of it.

N.B.: A stance of neutral commentator is not synonymous with passivity or disengagement. The therapist can be active and affectively engaged and still maintain a neutral stance.

**Item 94: Patient feels sad or depressed (vs. joyous or cheerful).**

Place toward *characteristic* end if patient's mood seems melancholy, sad, or depressed.

Place toward *uncharacteristic* end if patient appears delighted or joyful or somehow conveys a mood of well-being or happiness.

**Item 95: Patient feels helped by the therapy.**

Place toward *characteristic* end if patient somehow indicates a sense of feeling helped, relieved, or encouraged by the way the therapy is progressing.

Place toward *uncharacteristic* end if patient feel discouraged or frustrated with the way therapy is progressing (N.B. Item does not refer to events outside of therapy.)

**Item 96: There is discussion of scheduling of hours, or fees.**

Place toward *characteristic* end if therapist and patient discuss the scheduling or re-scheduling (times, dates, etc.) of a therapy hour; or if there is discussion of the amount of fee, time of payment, and the like.

Place toward *uncharacteristic* end if these topics are not taken up.

**Item 97: Patient is introspective, readily explores inner thoughts and feelings.**

Place toward *characteristic* end if patient appears unguarded, and relatively unblocked. In this instance the patient pushes beyond ordinary constraints, cautions, hesitancies or feelings of delicateness in exploring and examining thoughts and feelings.

Place toward *uncharacteristic* end if patient's discourse appears hesitant or inhibited, shows constraint, reserve or a stiffening of control, and does not appear loose, free, or unchecked.

**Item 98: The therapy relationship is a focus of discussion.**

Place toward *characteristic* end if therapy relationship is discussed. E.g. therapist calls attention to features of the interaction or interpersonal process between the patient and him or herself.

Place toward *uncharacteristic* end if therapist or patient does not comment on the nature of transactions between them, i.e. focuses on content.

**Item 99: Therapist raises questions about the patient's view (vs. validates the patient's perceptions).**

Place toward *characteristic* end if therapist somehow raises a question about the patient's view of an experience or an event. E.g. therapist might say "How is that so?" or "I wonder about that," or simply utter an "Oh?" This item does not refer to interpretations or reframing in the sense of providing a new or different meaning to the patient's discourse, but instead refers simply to somehow raising a question about the patient's viewpoint.

Place toward *uncharacteristic* end if therapist somehow conveys a sense of agreement, concurrence with, or substantiation of the patient's perspective. E.g. therapist says, "I think you're quite right about that" or "You seem to have a good deal of insight into that."

**Item 100: Therapist draws connections between the therapeutic relationship and other relationships.**

Place toward *characteristic* end if therapist makes comments linking the patient's feelings about the therapist and feelings toward other significant individuals in his or her life. Includes current relationships, and past or present relationships with parents (transference/parent link). E.g. therapist remarks that she thinks the patient is sometimes afraid she will criticize her just as her mother does.

Place toward *uncharacteristic* end if therapist's activity during the hour does not attempt to link the interpersonal aspects of therapy with experiences in other relationships.

**Appendix D: Most characteristic items of factor prototypes and expert-rated prototypes**

Most characteristic of Introspective Relational process (factor 1)

| | |
|---|---|
| 97 | Patient is introspective, readily explores inner thoughts and feelings |
| 81 | Therapist emphasizes patient feelings to help experience them more deeply |
| 98 | The therapy relationship is a focus of discussion |
| 67 | Therapist interprets warded-off or unconscious wishes, feelings or ideas |
| 100 | Therapist draws connections between therapeutic and other relationships |
| 73 | The patient is committed to the work of therapy |
| 88 | Patient brings up significant issues and material |
| 32 | Patient achieves a new understanding or insight |
| 6 | Therapist is sensitive to the patient's feelings, attuned to the patient; empathic |
| 28 | Therapist accurately perceives the therapeutic process |

Most characteristic of Cognitive / objective-oriented Alliance process (factor 2)

| | |
|---|---|
| 38 | There is discussion of specific activities for patient to attempt outside of session |
| 30 | Discussion centers on cognitive themes, i.e. about ideas or belief systems |
| 4 | The patient's treatment goals are discussed |
| 57 | Therapist explains rationale behind his or her technique or approach to treatment |
| 16 | There is discussion of body functions, physical symptoms, or health |
| 27 | Therapist gives explicit advice or guidance |
| 45 | Therapist adopts supportive stance |
| 23 | Dialogue has a specific focus |
| 73 | The patient is committed to the work of therapy |
| 66 | Therapist is directly reassuring |

Most characteristic of Inhibited, Fragile Patient process (factor 3)

53 Patient is concerned about what therapist thinks of him or her
59 Patient feels inadequate and inferior (vs. effective and superior)
78 Patient seeks therapist's approval, affection, or sympathy
26 Patient experiences discomforting or troublesome (painful) affect
33 Patient talks of feelings about being close to or needing someone
61 Patient feels shy and embarrassed (vs. un-self-conscious and assured)
94 Patient feels sad or depressed (vs. joyous or cheerful)
44 Patient feels wary or suspicious (vs. trusting and secure)
63 Patient's interpersonal relationships are a major theme
45 Therapist adopts supportive stance

Most characteristic of Angry, Provocative Patient process (factor 4)

34 Patient blames others, or external forces, for difficulties
20 Patient is provocative, tests limits of the therapy relationship
63 Patient's interpersonal relationships are a major theme
1 Patient verbalizes negative feelings toward therapist (vs. makes approving remarks)
4 The patient's treatment goals are discussed
42 Patient rejects (vs. accepts) therapist's comments and observations
30 Discussion centers on cognitive themes, i.e. about ideas or belief systems
62 Therapist identifies a recurrent theme in the patient's experience or conduct
46 Therapist communicates with patient in a clear, coherent style
58 Patient resists examining thoughts, reactions or motivations related to problems

Most characteristic of psychodynamic therapy (Ablon & Jones, 1998)

90 Patient's dreams or fantasies are discussed
93 Therapist is neutral
36 Therapist points out patient's use of defenses
100 Therapist draws connections between therapeutic relationship and other relationships
6 Therapist is sensitive to the patient's feelings / attuned and empathic toward patient
67 Therapist interprets warded-off or unconscious wishes, feelings, or ideas
18 Therapist conveys a sense of nonjudgemental acceptance
32 Patient achieves a new understanding or insight
98 The therapy relationship is a focus of discussion
46 Therapist communicates with patient in a clear, coherent style

Most characteristic of cognitive-behavioural therapy (Ablon & Jones, 1998; 2002)

38 There is discussion of specific tasks for patient to attempt outside of session
30 Discussion centers on cognitive themes
4 Patient's treatment goals are discussed
85 Therapist encourages patient to try new ways of behaving with others
17 Therapist actively exerts control over the interaction
45 Therapist adopts a supportive stance
23 Dialogue has a specific focus
31 Therapist asks for more information or elaboration
69 Patient's current or recent life situation is emphasized in discussion
27 Therapist gives explicit advice and guidance

Most characteristic of interpersonal therapy (Ablon & Jones, 2002)

63 Patient's interpersonal relationships are a major theme
81 Therapist emphasizes patient's feelings in order to help him/her to experience them more deeply
33 Patient talks of feelings about being close to or needing someone
64 Love or romantic relationships are a topic of discussion
57 Therapist explains rationale behind technique or approach to treatment
23 Dialogue has a specific focus
75 Termination of therapy is discussed
66 Therapist is directly reassuring
2 Therapist draws attention to patient's nonverbal behaviour
40 Therapist makes interpretations referring to actual people in patient's life

Most characteristic of transference-focused psychotherapy (Goodman, 2013)

98 The therapy relationship is a focus of discussion
63 Patient's interpersonal relationships are a major theme
67 Therapist interprets warded-off or unconscious wishes, feelings, or ideas
2 Therapist draws attention to patient's nonverbal behaviour
36 Therapist points out patient's use of defenses
100 Therapist draws connections between therapeutic relationship and other relationships
50 Therapist draws attention to feelings regarded by patient as unacceptable
79 Therapist comments on changes in patient's mood or affect
93 Therapist is neutral

Most characteristic of dialectical behaviour therapy (Goodman, 2013)

69 Patient's current or recent life situation is emphasized in discussion
4 Patient's treatment goals are discussed
6 Therapist is sensitive to the patient's feelings / attuned and empathic toward patient
18 Therapist conveys a sense of nonjudgemental acceptance
2 Therapist draws attention to patient's nonverbal behaviour
31 Therapist asks for more information or elaboration
72 Patient understands the nature of therapy and what is expected
85 Therapist encourages patient to try new ways of behaving with others
38 There is discussion of specific tasks for patient to attempt outside of session
28 Therapist accurately perceives the therapeutic process

Most characteristic of reflective functioning (Goodman, 2013)

99 Therapist challenges the patient's view
98 The therapy relationship is a focus of discussion
3 Therapist's remarks are aimed at facilitating patient's speech
6 Therapist is sensitive to the patient's feelings / attuned and empathic toward patient
68 Real versus fantasized meanings of experiences are actively differentiated
69 Patient's current or recent life situation is emphasized in discussion
79 Therapist comments on changes in patient's mood or affect
81 Therapist emphasizes patient's feelings in order to help him/her to experience them more deeply
46 Therapist communicates with patient in a clear, coherent style
48 Therapist encourages independence of action or opinion in patient
100 Therapist draws connections between therapeutic relationship and other relationships