

Clinician Emotional Response Toward Narcissistic Patients: A Preliminary Report

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Abstract. Patients with narcissistic personality disorder (NPD) are among the most difficult to treat in therapy, especially due to their strong resistance to treatment and other difficulties in establishing a therapeutic relationship characterized by intimacy, safety, and trust. In particular, therapists' emotional responses to these patients can be particularly intense and frustrating, as often reported in the clinical literature; however, they have rarely been investigated empirically. The aims of this preliminary study were 1) to examine the associations between patients' NPD and therapists' distinct countertransference patterns, and 2) to verify whether these clinicians' emotional reactions were influenced by theoretical orientation, gender, and age. A national sample of psychiatrists and clinical psychologists ($N = 250$) completed the Therapist Response Questionnaire (TRQ) to identify patterns of therapist emotional response, and the Shedler-Westen Assessment Procedure-200 (SWAP-200) to assess personality disorder and level of psychological functioning in patients currently in their care with whom they had worked for a minimum of eight sessions and a maximum of six months (one session per week). From the whole therapist sample, we identified a subgroup ($N = 35$) of patients with NPD. Results showed that NPD was positively associated with criticized/mistreated and disengaged countertransference, and negatively associated with positive therapist response. Moreover, the relationship between patients' NPD and therapists' emotional responses was not dependent on clinicians' theoretical approach (nor on their age and gender). These findings are consistent with clinical observations, as well as some empirical contributions, and have meaningful implications for clinical practice of patients suffering from this challenging pathology.

Keywords: therapist emotional response, narcissistic personality disorder, TRQ, SWAP-200, psychotherapy

Patients with narcissistic personality disorder (NPD) are among the most challenging to treat in psychotherapy (Kernberg, 1975, 2007), especially if they also present severe psychiatric symptoms such as substance dependence, bipolar disorder, or depressive features (Pulay & Grant, 2013; Stinson et al., 2008; Stormberg, Ronningstam, Gunderson, &

Tohen, 1998). Consistent with an extensive clinical literature, some empirical studies have supported the belief that a diagnosis of NPD (*DSM-IV*; APA, 1994) or the presence of pathological narcissism as assessed by the Pathological Narcissism Inventory (PNI; Pincus et al., 2009) and the O'Brien Multiphasic Narcissism Inventory (OMNI; O'Brien, 1987, 1988) are the negative prognostic cues for a good outcome in different kinds of psychotherapy. More specifically, they can make treatment extremely difficult and are predictive of early dropout from therapy (Campbell, Waller, & Pistrang, 2009; Ellison, Levy, Cain, Ansell, & Pincus, 2013; Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Magidson et al., 2012; Pincus et al., 2009).

Despite the consistent pan-theoretical agreement about the impact of narcissistic pathology on psy-

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chotherapy, a divergence between the body of clinical and theoretical literature and the research data on this meaningful area has emerged. This is probably due to the lack of a clear and shared conceptual (as well as diagnostic) definition of this pathology, as highlighted by Pulver (1970) and by Gabbard (1994), and the difficulties to measure it in a clinically sophisticated and psychometrically valid way (Bender, 2012; Pincus & Lukowitsky, 2010). Even though Section III of the *DSM-5* (APA, 2013) proposed an “Alternative Model for Personality Disorder Diagnoses” for further studies, the manual still captures one facet of NPD (see also Skodol, Bender, & Morey, 2013): it is described by a pervasive pattern of grandiosity; a sense of privilege and entitlement; an expectation of preferential treatment; an exaggerated sense of self-importance; envy of others; and arrogant, haughty behaviors or attitudes. These criteria primarily describe the “grandiose” narcissism, while ignoring the “vulnerable” one, which is consistently recognized in the clinical literature and is characterized by feelings of helplessness, inadequacy and shame, suffering, and anxiety regarding threats to the self (Gabbard, 1989). These feelings reveal a hypersensitivity to others’ evaluations and underlying “quietly grandiose” expectations for oneself and others (Gabbard, 1989). Several authors from different clinical perspectives have suggested a broad variation in the phenotypic expression of narcissism and the existence of two distinct subtypes of narcissistic individuals (i.e., Cain et al., 2008; Levy, 2012; Pincus & Roche, 2011): overt/covert (Cooper, 1998), oblivious/hypervigilant (Gabbard, 1989), thick-skinned/thin-skinned (Rosenfeld, 1987), or arrogant/entitled and depressed/depleted (PDM Task Force, 2006). This subtyping approach to NPD has received some empirical support highlighting the validity of this distinction. For example, Russ, Shedler, Bradley, and Westen (2008) have identified three subtypes of NPD, labelled grandiose/malignant, fragile, and high functioning/exhibitionistic; the latter is characterized by grandiosity, attention seeking, and seductive or provocative attitude, but also significant psychological strengths.

Across these different approaches, the narcissistic patients show common core dysfunctions in interpersonal functioning (Dimaggio et al., 2006; Ogrodniczuk & Kealy, 2013). These relational problems are associated with vulnerable and grandiose features of narcissism that can include dominance, vindictiveness, or intrusiveness (Dickinson & Pincus, 2003; Miller, Campbell, & Pilonis, 2007); or coldness, social avoidance, and exploitability, respectively (Kealy & Ogrodniczuk, 2011). Moreover, narcissistic individuals are characterized by emphatic disengagement and insensitivity (Baskin-Sommers, Krusemark, & Ronningstam, 2014), as well as by difficulties building a therapeutic in-

volvement and alliance (Bender, 2005; Ronningstam, 2012). They tend to recreate these dysfunctional and maladaptive ways of relating with others into the treatment context, provoking strong and often disruptive countertransference feelings in clinicians (e.g., Beck, Freeman, & Davis, 2004; Freeman & Fox, 2013; Gabbard, 2009, 2013; Kernberg, 1975, 2010; Kohut, 1971). For this reason, a deeper understanding of therapists’ emotional reactions could be particularly important in treatment of these patients (Ogrodniczuk & Kealy, 2013; see also Lingardi & McWilliams, 2015).

In the empirical literature, only a few studies have examined the associations between patient personality pathology and therapist responses. Research found that all patients belonging to cluster B of *DSM-IV* axis II (antisocial, borderline, histrionic, and narcissistic personality disorders) tend to evoke intense and mixed negative feelings in clinicians (e.g., anger, resentment, dread, devaluation, criticism, or boredom). Moreover, specific personality traits such as being domineering, vindictive, and cold (which are characteristic of narcissistic individuals) were correlated with less positive and complicated countertransference responses, including feeling overwhelmed, rejected, inadequate, and less confident, and these reactions were not influenced by therapists’ theoretical orientations or other characteristics such as gender, age, profession, or experience (Betan, Heim, Zittel Conklin, & Westen, 2005; Colli, Tanzilli, Dimaggio, & Lingardi, 2014; Dahl, Rössberg, Børgwald, Gabbard, & Høglend, 2012; Lingardi, Tanzilli, & Colli, 2015; McIntyre & Schwartz, 1998; Rössberg, Karterud, Pedersen, & Friis, 2007, 2008). However, to date, no studies have empirically investigated clinicians’ emotional reactions in a specific clinical population of patients with a full diagnosis of NPD.

In this preliminary research, we examined the associations between therapists’ emotional responses and NPD patients in order to verify the following hypotheses:

- 1) There are strong associations between NPD and countertransference reactions of disengagement and withdrawal, as well as anger, resentment, or devaluation; and
- 2) These clinicians’ emotional responses cannot be accounted for by their therapeutic approach and other variables (in particular, gender and age).

Method

Sampling Procedure

A national sample of psychiatrists and clinical psychologists with at least three years of post-training experience who performed at least 10 hours of direct patient care per week were recruited by e-mail from the rosters of the two largest Italian associations of

psychodynamic and cognitive psychotherapy,¹ several institutions of the National Health System, and centers specializing in the treatment of personality disorders. The clinicians were asked to select an adult patient they were currently treating who met the following criteria: at least 18 years old, not currently psychotic, not under pharmacological treatment for psychotic symptoms, and well known by the clinician (the patient had to be in care for a minimum of eight sessions and a maximum of six months, one session per week). To ensure random selection of patients from clinicians' practices, we requested clinicians to consult their calendars to identify the last patient they saw during the previous week who met the study criteria. Each clinician provided data about only one patient. Out of the 400 clinicians contacted, 250 indicated their willingness to participate, for an overall response rate of 62.5%. All participants provided written informed consent. In this preliminary study, we considered only data relative to a subgroup of therapists ($N = 35$) treating patients with NPD (without comorbidity of other personality disorders).

Measures

Clinical questionnaire. For the purpose of this study, we constructed a clinician-report questionnaire to gather information about clinicians, their patients, and their practiced therapies. Clinicians provided basic demographic and professional data, including discipline (psychiatry or psychology), theoretical approach (psychodynamic or cognitive-behavioral), employment address, years of experience, hours of clinical work, and number of patients in treatment, as well as the patients' age, gender, race, education level, socioeconomic status, *DSM-IV* axis I diagnoses and Global Assessment of Functioning (GAF) score. Clinicians also provided data on the therapies, such as length of treatment and number of sessions.

Shedler–Westen Assessment Procedure–200. The Shedler–Westen Assessment Procedure–200 (SWAP-200; Shedler & Westen, 2004, 2007; Shedler, Westen, & Lingardi, 2014; Westen & Shedler, 1999a, 1999b) is a well-established psychometric procedure designed to provide a comprehensive assessment of personality and personality pathology. It consists of a set of 200 personality-descriptive statements, written in straightforward, experience-based language in order to be used by clinicians with various theoretical orientations and experience. The SWAP-200 utilizes a Q-Sort method, which requires the rater to sort the items into

eight categories, from “not descriptive” (assigned value of 0) to “most descriptive” (assigned value of 7) of the person, to comply with the fixed distribution (Block, 1978). The SWAP-200 assessment provides: a) a personality diagnosis expressed as the matching of the patient assessment with 10 personality disorder scales, which are prototypical descriptions of *DSM-IV* axis II disorders, and b) a personality diagnosis based on the correlation/matching of the patient SWAP description with 11 Q-factors/styles of personality derived empirically. This tool also includes a dimensional profile of healthy and adaptive functioning. The presence of a personality disorder can be determined when the SWAP-200 assessment points out that one or more PD and/or Q-factor scores (in standardized T points) are ≥ 60 and the high-functioning scale is ≤ 60 . PD and/or Q-factor scores range from 55 to 60, revealing the presence of subclinical traits of that personality disorder (Westen & Shedler, 1999a, 1999b). In this way, SWAP-200 is able to obtain both categorical and dimensional diagnoses. In this study, we used only the personality disorder scales (PD scales). Finally, SWAP-200 has shown very good validity and reliability, both with clinicians who have not been trained in the use of the instrument (Blagov, Bi, Shedler, & Westen, 2012; Cogan & Porcerelli, 2004; Shedler & Westen, 2004; Westen & Shedler, 1999a, 1999b) and with clinicians who followed a specific instrumental training (Bradley, Hilsenroth, Guarnaccia, & Westen, 2007).

Therapist Response Questionnaire. The Therapist Response Questionnaire (TRQ; Betan et al., 2005; Zittel & Westen, 2003) is a clinician-report instrument designed to assess countertransference patterns in psychotherapy. It consists of 79 items measuring a wide range of cognitive, affective, and behavioral responses that therapists have toward their patients. The statements are written in everyday language, without jargon, to ensure that clinicians of any theoretical orientation can use the instrument without bias. Moreover, the items assess a range of responses, from relatively specific feelings (e.g., “I feel bored in session with him/her”) to more complex constructs (e.g., “More than with most patients, I feel like I’ve been pulled into things that I didn’t realize until after the session is over”). The clinicians assess each item on a 5-point Likert scale, ranging from 1 (*not true*) to 5 (*very true*). The questionnaire comprises eight countertransference dimensions derived by a factor analysis: overwhelmed/disorganized, helpless/inadequate, positive, special/overinvolved, sexualized, disengaged, parental/protective, and criticized/mistreated. In the present study, the eight factor-derived scales demonstrated excellent internal consistency (Streiner, 2003). The following Cronbach’s alpha values were obtained: overwhelmed/disorganized,

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.78; helpless/inadequate, .83; positive, .82; special/overinvolved, .75; sexualized, .76; disengaged, .77; parental/protective, .85; and criticized/mistreated, .81.

Procedure

We provided all of the clinicians in the complete sample ($N = 250$) with the material to conduct this research. The clinicians had to evaluate their emotional responses concerning the patient who met the study criteria using the Therapist Response Questionnaire (TRQ) and evaluate the same patient's personality using the SWAP-200 between one and three weeks later. We considered this interval because of the different time commitments required by the measures. The TRQ is a faster and more user-friendly questionnaire; for this reason, it was completed by the therapists after the session with the designated patient, while the SWAP-200 is a more complex and time-consuming assessment procedure and required that therapists planned a specific moment during their agenda to complete it.

Moreover, separating the two evaluations also reduced any possible effect that assessing clinicians' emotional responses could have on the rating of that same patient's personality. From the complete therapist sample, we took a subgroup of clinicians ($N = 35$) working with patients who received a diagnosis of NPD based on the SWAP-200 assessment ($T_{\text{NPD scale}} \geq 60$ and $T_{\text{high-functioning scale}} < 60$). Data related to patients with other personality disorders in comorbidity were excluded.

Statistical Analyses

SPSS 20 for Windows (IBM, Armonk, NY) was used to conduct all of the analyses. We performed bivariate correlations (two-tailed Pearson's r) between all of the TRQ factors and the NPD scale of the SWAP-200 to examine whether specific patterns of therapist responses were frequently associated with patients' narcissistic personality pathology.

To study whether these specific associations were dependent on the clinicians' approach, as well as on other variables (such as gender and age), we per-

Table 1. Hierarchical multiple Analyses Predicting Therapist Response Questionnaire (TRQ) Factors from Clinician Variables and Patient Narcissistic Personality Disorder (SWAP-200) ($N = 35$)

Countertransference, clinician variables, and patient personality pathology	R	R^2	Standardized β	F change (model)	(p)
<i>Criticized/Mistreated</i>					
Step 1: Clinician Variables	0.25	0.06		0.67	0.578
Gender (1 = female; 2 = male)			0.03		
Age			-0.14		
Theoretical orientation (1 = cognitive-behavioral; 2 = psychodynamic)			-0.03		
Step 2: Patient personality pathology	0.64	0.41		17.89	0.000
Narcissistic Personality Disorder (SWAP-200)			0.60		
<i>Positive</i>					
Step 1: Clinician Variables	0.28	0.08		0.85	0.453
Gender (1 = female; 2 = male)			0.22		
Age			-0.13		
Theoretical orientation (1 = cognitive-behavioral; 2 = psychodynamic)			0.08		
Step 2: Patient personality pathology	0.47	0.22		5.55	0.025
Narcissistic Personality Disorder (SWAP-200)			-0.39		
<i>Disengaged</i>					
Step 1: Clinician Variables	0.17	0.03		0.30	0.828
Gender (1 = female; 2 = male)			0.08		
Age			0.15		
Theoretical orientation (1 = cognitive-behavioral; 2 = psychodynamic)			-0.07		
Step 2: Patient personality pathology	0.70	0.50		27.28	0.000
Narcissistic Personality Disorder (SWAP-200)			0.67		

* $p \leq .05$ ** $p \leq .01$. *** $p \leq .001$.

formed a series of (block) hierarchical multiple regression analyses. All of the multiple regressions—one for each TRQ factor that was associated with the NPD scale of the SWAP-200 in the previous analysis as a dependent variable—were estimated in two steps. The first step included the clinicians' age, gender, and theoretical orientation, while the second step contained the NPD scale of the SWAP-200. Changes in R^2 were considered as a measure of two-step significance. The F test, which is referred to as the F -change, was used to test whether the improvement in R^2 was statistically significant.

Results

Sample Characteristics

In line with our hypothesis, we focused on the subgroup of therapists ($N = 35$) treating patients with a diagnosis of NPD, based on the SWAP-200 assessment ($T_{\text{NPD scale}} \geq 60$ and $T_{\text{high-functioning scale}} < 60$).

Clinicians. The clinician sample consisted of 20 females and 15 males; 23 were psychologists, and 12 were psychiatrists. Their mean age was 41.1 ($SD = 6.20$, range = 34–56). Two main clinical-theoretical approaches were represented: psychodynamic ($N = 19$) and cognitive-behavioral ($N = 16$). The average length of clinical experience as a psychotherapist was 8 years ($SD = 3$, range = 3–17), and the average time spent per week practicing psychotherapy was 15 hours ($SD = 4.9$, range = 13–25). Twenty five of the patients described were from private practice, and the remaining ten were from public mental health institutions.

Patients. The patient sample consisted of 21 males and 14 females; their mean age was 35.6 years ($SD = 3.1$, range = 29–42). Seventeen patients had comorbid DSM-IV axis I diagnosis, of whom nine had an eating disorder, four had a generalized anxiety disorder, two had a substance use disorder, and two had a panic disorder. The mean SWAP-200 High-Functioning scale score was 50 ($SD = 4.3$), while the mean Global Assessment of Functioning (GAF) score was 58 ($SD = 6.1$). The length of treatment (one session per week) averaged five months ($SD = 0.9$, range = 2–6).

Clinician Emotional Response and Patient Narcissistic Personality Disorder

Our first aim was to investigate the relationship between patient NPD and clinicians' emotional responses. We found that the SWAP-200 narcissistic PD scale was positively associated with disengaged ($r = .68$, $p < .001$) and criticized/mistreated ($r = .62$, $p < .001$) countertransference, but negatively associated with positive ($r = -.40$, $p < .05$) therapist response.

We performed the hierarchical multiple regression analyses to verify if these associations were dependent on clinicians' theoretical approaches (psychodynamic or cognitive-behavioral), as well as on gender and age. As shown in Table 1, the therapists' variables did not impact on countertransference responses to patients with NPD because the R^2 values of the first step or block (including therapists' gender, age, and theoretical orientation) were not statistically significant.

Discussion

The aim of this study was to investigate the relationship between the patients' narcissistic personality pathology and therapists' countertransference responses. Our findings confirmed that patients with NPD tend to evoke negative emotional reactions in clinicians that could resemble responses by other significant people in the patients' lives (Gabbard, 2009).

Consistent with clinical observations and empirical contributions (see Introduction; Betan et al., 2005; Colli et al., 2014; PDM Task Force, 2006; McWilliams, 2011), one pattern of therapist response related to a patient's narcissistic pathology was disengaged countertransference, characterized by feelings of boredom, frustration, distraction (e.g., mind-wandering tendency, inability to maintain attention or to track therapeutic dialogue, and so on), avoidance, and wishes to terminate the session, which led to therapist emotional disattunement and decreased empathetic functioning. These findings suggest that narcissistic patients can be experienced "as speaking 'at' the therapist instead of 'to' the therapist" (Gabbard, 2009, p. 134), leaving clinicians unable to emotionally invest in the therapeutic relationship and escaping commitment or intimate connection with the patient. In other words, therapists' emotional withdrawal tends to reduce their ability to observe, recognize, or inquiring about what is happening in the therapeutic setting (Luchner, 2013; McWilliams, 2004). The disengaged and detached therapeutic attitude might also be considered a defensive reaction against the recognition of anger, aggression, and hostility toward the patient (Dahl et al., 2012).

Another pattern of therapist reactions to narcissistic patients is criticized/mistreated reaction, which includes feelings of being devalued, unappreciated, disapproved, or the explicit object of contempt and denigration (Gabbard, 2009), with increasing risk of angry and resentful reactions. The results seem to suggest that these reactions can be due to the devaluating style typical of NPD patients. In fact, many patients with narcissistic dynamics struggle with a fragile sense of self and try to disavow their own vulnerability by making others (including the therapist) feel inferior and impotent (Betan & Westen, 2009; Kernberg, 1975, 2010). As

also suggested by Freeman and Fox (2013), narcissistic individuals continually seek information consistent with their positive (or grandiose) views of self and reject or do not perceive nonconfirmatory experiences. For these reasons, they may react with anger, aggression, or insults in order to respond to the perceived loss or threat of loss of their narcissistic “prizes.”

Finally, our findings were consistent with previous studies in which cluster B patients, including narcissistic ones, tend to evoke less positive countertransference reactions (Bourke & Grenyer, 2010; Dahl et al., 2014; Røssberg et al., 2007, 2008). Moreover, strong negative or mixed feelings toward these patients, along with their high dropout rate, difficulties in acknowledging and verbalizing internal subjective experiences, and their reluctance and unclear motivation for treatment, can negatively impact the building of a good therapeutic alliance (Ronningstam, 2012).

The second aim of this research was mainly to verify whether the associations between countertransference patterns and patient narcissistic pathology can be accounted for by therapists' theoretical orientation. Our results confirm that the relationship between NPD and therapist response is not dependent on clinicians' theoretical preferences or technical styles (Betan et al., 2005; Colli et al., 2014).

Some limitations of this research deserve mention. First, this is a preliminary study and the patient sample is still limited; thus, these results may be not fully representative of the therapist reactions elicited by individuals with NPD. The future direction of our study is to extend the sample, while including an adequate and balanced number of therapists belonging to both the psychodynamic and cognitive-behavioral theoretical orientations. The second limitation of this research is its exclusive use of clinician-report instruments to obtain data about both the patients' diagnoses and countertransference responses. It would certainly be useful to include an independent assessment of patients' narcissistic pathology, as well as an evaluation of therapist responses through an observer-rated analysis (for example, introducing a supervisor's perspective, or using session video or transcripts). However, most published studies on narcissistic pathology also rely on a single informant—the patient, with the inherent limits of self-report measures applied to patients with narcissistic and personality disorders in general (Cooper, Balsis, & Oltmanns, 2012; Klonsky, Oltmanns, & Turkheimer, 2002; Russ et al., 2008). Moreover, previous studies support that clinically experienced observers, such as clinicians who treat patients, tend to make highly reliable and valid judgments if their observations and inferences are quantified with psychometrically sophisticated instruments, such as those used in our study

(Shedler & Westen, 2007; Westen & Shedler, 1999a; Westen & Weinberger, 2004).

To our knowledge, this study is the first to specifically evaluate the impact of patients' NPD on therapists' responses. The empirical investigation of Betan et al. (2005) examining therapists' emotional responses, with respect with personality-disordered patients, aggregated subjects at the cluster level rather than at the individual disorder level, and the narrative description of countertransference reactions in the presence of narcissistic pathology is based on few NPD patients ($N = 13$). Consistent with the study of Colli et al. (2014), our research confirms that narcissistic patients tend to evoke disengaged and detachment feelings, but it offers a more nuanced and detailed overview of the “average expectable” countertransference patterns, by also including the criticized, mistreated, and devaluated therapist reactions.

These preliminary findings provide a valuable and empirically grounded picture of the most common countertransference experiences with NPD patients and a richer view of narcissistic pathology. Paying great attention to the aspects that characterize therapeutic relationships with these challenging patients may be particularly important for better understanding their core psychopathological dynamics, as well as implementing effective and patient-tailored therapeutic interventions in clinical practice.

Finally, this study examined a model of relationships assuming that patient pathology leads to emotional responses in therapists. In the future, it would be relevant to investigate a more complex model of the relationship that assumes the interactions between and reciprocal influence of patient and therapist characteristics, while seeing therapist reactions as part of a relational matrix and also taking into account his/her contributions to potential impasses and resistance in the treatment of patients, especially those with NPD (Gabbard, 2001, 2009; Mitchell & Aron, 1999).

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