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Countertransference When Working With Narcissistic Personality Disorder: An Empirical Investigation

Annalisa Tanzilli and Laura Muzi
Sapienza University of Rome

Elsa Ronningstam
Harvard Medical School

Vittorio Lingiardi
Sapienza University of Rome

Narcissistic personality disorder (NPD) is one of the most challenging clinical syndromes to treat in psychotherapy, especially due to the difficulties of establishing a good enough therapist–patient relationship. Countertransference responses to NPD can be particularly intense, frustrating, and difficult to manage, as is often reported in the clinical literature though not clearly supported empirically. The aims of this study were to (a) investigate the relationship between patients' NPD and therapists' responses; (b) examine the associations between patient, clinician, therapy variables and clinicians' reactions during treatment of NPD patients; and (c) provide an empirically derived portrait of countertransference with NPD. A sample of psychiatrists and clinical psychologists ($N = 67$) completed the Therapist Response Questionnaire to identify patterns of countertransference, the Shedler–Westen Assessment Procedure-200, and the Global Assessment of Functioning Scale to assess the personality pathology and psychosocial functioning of a patient in their care. The results showed that NPD was positively associated with hostile/angry, criticized/devalued, helpless/inadequate, and disengaged countertransference and negatively associated with therapists' positive response, regardless of patients' personality and psychosocial functioning. NPD patients with stronger traits of cluster B personality pathology tended to elicit more negative and heterogeneous countertransference reactions than NPD patients without these features. The countertransference patterns with NPD patients were not strongly influenced by the variables of clinicians and therapy, with the exception of clinical experience. Overall, the portrait of therapists' reactions to NPD provided a clinically nuanced and empirically founded description strongly resembling theoretical–clinical accounts. The therapeutic implications of these findings were discussed.

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

Narcissistic personality disorder (NPD) is a common diagnosis in clinical practice that is often comorbid with substance use, bipolar disorder, suicidality, and other personality disorders (Ronningstam, Weinberg, & Maltsberger, 2008; Stinson et al., 2008; Stormberg, Ronningstam, Gunderson, & Tohen, 1998). It is strongly characterized by significant impairment in a variety of functional domains (Miller, Campbell, & Pilkonis, 2007). Consistent with the clinical literature (Kernberg, 2007), some empirical studies have demonstrated the difficulty of engaging and holding NPD patients in therapy, as shown by the high dropout rate associated with different treatments (Campbell, Waller, & Pistrang, 2009; Hilsenroth, Holdwick, Castlebury, & Blais, 1998) and the decreased utilization of services and institutions of the National Health System (Ellison, Levy, Cain, Ansell, & Pincus, 2013). However, NPD is one of the least studied personality syndromes; to date, no randomized clinical trial has examined the efficacy of any treatment for this challenging disorder. The main issue that has hindered the development of systematic studies on this subject has to do with the considerable controversies surrounding NPD as a diagnostic entity (Caligor, Levy, & Yeomans, 2015; Gabbard & Crisp-Han, 2016). The various theoretical conceptualizations and clinical hypotheses of NPD (Cooper, 1998; Gabbard, 1989; PDM Task Force, 2006; Rosenfeld, 1987), also supported by recent empirical investigations (Russ, Shedler, Bradley, & Westen, 2008), seem to reflect highly variable phenotypical presentations and a wide range of severity of narcissistic pathology. The official Section II of the *DSM–5* (American Psychiatric Association [APA], 2013) provides a specific definition of NPD that is characterized by an exaggerated sense of grandiosity, self-importance, and need for admiration; feelings of entitlement, envy, and exploitation; arrogant, haughty behaviors or attitudes; and a lack of empathy. These criteria are able to capture several distinctive features of NPD, but have limited usefulness when applied to a

Annalisa Tanzilli and Laura Muzi, Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome; Elsa Ronningstam, Department of Psychiatry, Harvard Medical School; Vittorio Lingiardi, Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome.

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Correspondence concerning this article should be addressed to Annalisa Tanzilli, Department of Dynamic and Clinical Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy. E-mail: annalisa.tanzilli@uniroma1.it

broad spectrum of narcissistic individuals seen in everyday clinical practice. In the present study, we used the prototypical portraits of NPD patient and of patients with other personality disorders (PD scale; see SWAP-200's description among "Measures"), which are empirically derived from the Shedler–Westen Assessment Procedure-200 (SWAP-200; Westen & Shedler, 1999a, 1999b). This instrument is designed to furnish a comprehensive assessment of patient personality and psychological functioning by quantifying the clinical observations in a valid, reliable, and systematic way. It provides a detailed, clinically rich description of the narcissistic personality that shows several distinctive aspects of the respective *DSM* category. Likewise, this NPD description highlights many interpersonal difficulties of these patients, such as their tendency to be controlling, more likely to get into power struggles, strongly competitive, dismissive and critical of others, vulnerable to rage or humiliation, and feel privileged and entitled. A noteworthy key component of all phenotypic manifestations of NPD is a poor quality of interpersonal relationships (Gabbard & Crisp-Han, 2016; Ogrodniczuk & Kealy, 2013). NPD patients tend to be vindictive, intrusive, and domineering; they have a strong need to exert control over others (Dickinson & Pincus, 2003; Miller et al., 2007). Many also show distant, socially avoidant, and exploitable interpersonal behaviors (Ogrodniczuk & Kealy, 2013); additionally, they may manifest emphatic disengagement and insensitivity associated with their inability to act with mutuality and reciprocity (Baskin-Sommers, Krusemark, & Ronningstam, 2014; Ritter et al., 2011; see also APA, 2013). Their dysfunctional modes of relatedness are inevitably recreated in the treatment context, which poses significant problems for alliance building (Ronningstam, 2012). Indeed, some narcissistic patients devalue or ignore their therapist's observations due to their sense of superiority and entitlement, or show a limited ability or willingness to self-disclose and self-reflect. Other narcissistic individuals demonstrate a pseudoalliance due to an idealization of the therapist as a person who embodies projected positive qualities that were originally attributed to the self, a need for constant positive regard, or fear of rejection and abandonment (Bender, 2015). Taken together, these interpersonal patterns often provoke confusing, negative, or even disruptive feelings in clinicians of different therapeutic orientations (Freeman & Fox, 2013; Gabbard, 2009). Overall, a careful examination of countertransference to NPD patients may be crucial for making accurate diagnostic formulations based on a deeper understanding of their core psychological dynamics, and helping clinicians plan and provide more effective treatments (Lingiardi & McWilliams, 2015; Ogrodniczuk & Kealy, 2013).

It is remarkable that systematic research regarding therapists' feelings when treating this clinical population is very scarce. Most empirical studies that have focused on patients' personality diagnoses at the *DSM–IV* cluster B level (especially borderline personality disorder) have shown that these patients tend to elicit more anger and irritation and less amiability, empathy, and nurturing in clinicians. These reactions have been shown to correlate with some therapists' variables, such as gender or degree of clinical experience (Brody & Farber, 1996; McIntyre & Schwartz, 1998; Røssberg, Karterud, Pedersen, & Friis, 2007), although the findings are still controversial (Lecours, Bouchard, & Normandin, 1995; McIntyre & Schwartz, 1998). Recently, some authors have suggested that the more severe the personality pathology, the fewer positive and parental feelings are reported by clinicians (Dahl et al., 2014). Interestingly, Røssberg, Karterud, Pedersen, and Friis (2008) found that some distinctive personality traits of narcissistic individuals (being domineering, vindictive, and cold) are correlated with feelings of being overwhelmed, rejected, and on guard. In another study, Betan, Heim, Zittel Conklin, and Westen (2005) demonstrated that cluster B personality disorders were associated with overwhelmed/disorganized feelings, helplessness, hostility, disengagement, or sexual attraction, regardless of the therapist's theoretical orientation. In particular, patients who met the *DSM–IV* criteria for NPD tended to evoke in clinicians strong reactions, such as rage, boredom, resentment, dread, distraction, and wishes to interrupt the therapy (Colli, Tanzilli, Dimaggio, & Lingiardi, 2014). Consistent with these research findings, some studies have shown that therapists treating patients with narcissistic personality features may come to feel bored, disengaged, aloof, or frustrated, and these reactions are not mediated by patients' symptom severity or global psychopathology (Gazzillo et al., 2015; Lingiardi, Tanzilli, & Colli, 2015). Moreover, these emotional reactions are not affected by clinicians' theoretical approach, their clinical experience, or gender.

It is important to note that most of the empirical investigations mentioned above did not examine countertransference reactions toward patients with NPD according to a categorical diagnostic approach, but dimensionally considered narcissistic personality traits ranging from clinically irrelevant levels to more psychopathological presentations. Recently, a brief preliminary report (Tanzilli, Colli, Muzi, & Lingiardi, 2015)[1] based on a relatively small sample of clinicians ($N = 35$) treating patients who had been diagnosed with NPD according to the SWAP-200 showed that NPD was positively associated with criticized/mistreated and disengaged countertransference and negatively associated with positive therapist response. Moreover, the impact of patients' NPD on therapists' responses (assessed using the original version of the Therapist Response Questionnaire [TRQ]; Betan et al., 2005) was not dependent on the clinicians' theoretical approach, age, or gender.

In the present study, the relationship between patients' NPD and countertransference (assessed using a recently validated version of the TRQ; Tanzilli, Colli, Del Corno, & Lingiardi, 2016) was examined on a wider group of clinicians in order to verify more articulate hypotheses and provide an empirically derived prototype of the countertransference patterns experienced by clinicians when working with NPD. In detail, we set out to address four main issues:

> *Hypothesis 1:* Consistent with the clinical and empirical literature mentioned above, we hypothesized that there are significant associations of large magnitude (i.e., with the Pearson product correlation coefficient's values equal or larger than .05; see Cohen, 1988) between patients' NPD and distinct countertransference patterns, in particular criticized/devalued, hostile/angry, and disengaged. Moreover, we intended to ver-

[1] In September 2014, this work won the Best Poster Award at the National Congress of the Italian Area Group of the Society for Psychotherapy Research (SPR Italy Area Group) in Padua, Italy. For this reason, the preliminary report was published the following year in *Research in Psychotherapy: Psychopathology, Process and Outcome,* the peer reviewed journal of the SPR Italy Area Group.

ify if these associations might be affected by patients' overall level of personality functioning and their degree of impairment in different areas of their life (psychological or symptomatic, social, and occupational; see Caligor et al., 2015), supposing that NPD patients with more severe and impaired levels of psychological and social functioning would evoke stronger therapists' reactions (see Kernberg, 2007).

Hypothesis 2: On the basis of contributions in the field and previous research findings (Betan et al., 2005; Colli et al., 2014; Lingiardi et al., 2015; Ogrodniczuk & Kealy, 2013; Røssberg et al., 2007), we hypothesized that more intense countertransference reactions would be self-reported by clinicians treating NPD patients with several and clinically meaningful traits of other personality disorders compared with clinicians working with NPD patients with less relevant features of different personality pathologies.

Hypothesis 3: The countertransference reactions to NPD patients were significantly associated with some clinicians' (e.g., gender, theoretical orientation, and clinical experience) and therapy (e.g., length of treatment) variables. In particular, we hypothesized that therapists' responses to patients' NPD would not be accounted for by clinicians' theoretical orientation but would be influenced by clinical experience, as more experienced clinicians would have less strong and negative countertransference reactions.

Hypothesis 4: The empirically derived prototype of therapists' emotional responses toward NPD patients would be specifically characterized by feelings of anger, frustration and resentment, disregard, disengagement and withdrawal, as well as a lack of close connection and trust.

Method

Sampling Procedure

A national sample of psychodynamic and cognitive–behavioral therapists was recruited by e-mail from the rosters of the largest Italian associations of psychotherapy, several institutions of the National Health System, and centers specializing in the treatment of personality disorders. All clinicians had at least three years of posttraining experience and were performing at least 10 hours per week of patient care. Therapists were directed to select a patient who met the *DSM–TR–IV* (APA, 2000) criteria for a diagnosis of NPD (without comorbid personality disorders) on the basis on their clinical experience and who fulfilled the following inclusion criteria: (a) at least 18 years old; (b) presenting no organic syndrome, psychotic disorder, or syndrome with psychotic symptoms that could complicate the assessment of any variable in the study; (c) not on drug therapy or dependent on a psychoactive substance; and (d) in treatment for a minimum of eight sessions and a maximum of six months (one session per week). We required this temporal interval to maximize the likelihood that therapists would provide accurate information about patients and their therapeutic relationship in the initial phase of treatment. To minimize selection biases, we asked clinicians to consult their calendars and to provide data on the last patient they saw in the previous week who met the study criteria. To minimize rater-dependent biases, each clinician furnished data on only one patient. Our response rate was 33% of therapists ($N = 32$). These therapists participated on a volunteer basis and did not receive any fee. Their data were added to those of the clinicians who had participated in the previous research (Tanzilli et al., 2015). Thus, the full sample reported in this study consisted of 67 therapists. Each therapist provided written informed consent, and the study protocol received ethics approval from the local research ethics review board.

Clinicians

The sample consisted of 67 clinicians: 38 women and 29 men; 41 clinical psychologists and 26 psychiatrists. Their mean age was 45.13 ($SD = 8.62$; range = 31–65). The main self-reported clinical orientations were psychodynamic ($N = 39$) and cognitive—behavioral ($N = 28$). The average length of clinical psychotherapy practice was 9.1 years ($SD = 6.07$; range = 3–23) and the average time spent per week practicing psychotherapy was 20.67 hours ($SD = 6.04$; range = 11–34). The majority of the patients selected for this study were from independent practice ($N = 45$) and the remaining 22 patients were from public mental health institutions.

Patients

The sample consisted of 67 patients: 29 women and 38 men. Their mean age was 37.2 ($SD = 10.06$, range = 18–58). Thirty-eight patients had a comorbid *DSM–TR–IV* (APA, 2000) axis I diagnosis: 12 had a panic disorder, 9 an eating disorder, 8 a substance abuse disorder, 5 a dysthymic disorder, and 4 a generalized anxiety disorder. The average length of treatment was about 4 months ($SD = 1.27$, range 2–6).

Measures

Clinical Questionnaire. We constructed an ad hoc clinician-report questionnaire to obtain information about therapists, patients, and their practiced therapies. Clinicians provided basic demographic and professional data regarding their discipline, theoretical approach, years of experience, and hours of clinical practice and patients' age, gender, and *DSM–IV* axis I diagnoses. Clinicians also provided data on their therapies, such as the length of treatment.

Shedler–Westen Assessment Procedure-200. The SWAP-200 (Shedler, Westen, & Lingiardi, 2014; Westen & Shedler, 1999a, 1999b) is a well-established assessment procedure that was designed to provide a comprehensive assessment of patient personality and psychological functioning. This Q-sort instrument consists of a set of 200 personality-descriptive statements, written in straightforward, experience-near language, to be used by clinicians with varying theoretical orientations and levels of experience. The clinician sorts the items into eight categories, ranging from *not descriptive* (0) to *most descriptive* (7) of the person, in order to comply with the fixed distribution. The SWAP-200 assessment provides: (a) a personality diagnosis that matches the patient assessment with 10 personality disorder scales that are prototypical descriptions of *DSM–IV* axis II disorders (PD scales), and (b) a personality diagnosis based on the correlation/matching of the patient's SWAP-200 description with 11 Q-factors/styles of per-

sonality that have been empirically derived. This tool also includes a dimensional measure of psychological strengths and adaptive functioning. A personality disorder is assigned when the SWAP-200 assessment identifies one or more PD scale and/or Q-factor scores (in standardized *T* points) as ≥60 and a score on the high-functioning scale as ≤60. In this study, we used only the PD scales and the high-functioning index scores of patients who had received a diagnosis of NPD. The SWAP-200 has been shown to have very good validity and reliability (Blagov, Bi, Shedler, & Westen, 2012; Bradley, Hilsenroth, Guarnaccia, & Westen, 2007).

Therapist Response Questionnaire. The TRQ (Betan et al., 2005; Zittel Conklin & Westen, 2003) is a clinician-report instrument that measures countertransference patterns in psychotherapy. It consists of 79 items that describe a wide range of cognitive, affective, and behavioral responses of therapists toward patients, ranging from relatively specific feelings to complex constructs, such as projective identification. These statements are written in everyday language, without jargon, to ensure that clinicians of any theoretical orientation can use the instrument without bias. Clinicians assess each item on a 5-point Likert scale ranging from *not true* (1) to *very true* (5).

In this study, we used an empirically supported TRQ Italian version (Tanzilli et al., 2016) consisting of nine patterns of therapist response: (a) helpless/inadequate, (b) overwhelmed/disorganized, (c) positive/satisfying, (d) hostile/angry, (e) criticized/devalued, (f) parental/protective, (g) special/overinvolved, (h) sexualized, and (i) disengaged. These dimensions are similar to those of the version of Betan et al.'s study (2005), with the exception of the original criticized/mistreated pattern, which is split into two factors: hostile/angry and criticized/devaluated. All of the nine TRQ factors were demonstrated to show excellent internal consistency (Streiner, 2003). In our study, the following Cronbach's alpha were obtained: helpless/inadequate ($\alpha = .87$), overwhelmed/disorganized ($\alpha = .81$), positive/satisfying ($\alpha = .86$), hostile/angry ($\alpha = .83$), criticized/devalued ($\alpha = .91$), parental/protective ($\alpha = .82$), special/overinvolved ($\alpha = .84$), sexualized ($\alpha = .78$), and disengaged ($\alpha = .81$).

Global Assessment of Functioning Scale. The GAF Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976) is a single global rating provided by clinicians that measures patients' overall adjustment described as their social and occupational functioning during the last week, as well as their level of psychological functioning within the past year. The scale ranges from 1 to 100, organized at 10 descriptive levels. Lower GAF scores designate poorer functioning and scale points below 70 indicate a clinical range. Scores of 70–100 are regarded as the normal, nonclinical range. For the present study, the GAF-current level of functioning was utilized for all data analysis.

Procedure

After receiving clinicians' agreement to participate in a research protocol on psychological assessment of and therapeutic relationship with narcissistic patients, we asked them to evaluate (using the TRQ) their emotional response to the patient they had selected on the basis of the criteria reported above. Between one and three weeks later, they assessed the patient's personality using the SWAP-200. This interval was intended to minimize any potential effect that clinicians' ratings of their emotional reactions might have on the assessment of patients' personality.

Statistical Analyses

Statistical analyses were performed using SPSS 20 for Windows (IBM, Armonk, NY). Bivariate correlations (Pearson's *r*, two-tailed) between the TRQ factors and the SWAP-200 PD scales were conducted to identify countertransference patterns that were significantly associated with patients' NPD. Partial correlations (partial *r*, two-tailed) were performed to investigate the relationships between the TRQ factors and NPD Scale of the SWAP-200, controlling for the overall level of patients' personality functioning (assessed using the SWAP–200 high-functioning scale) and degree of psychological (or symptomatic), social, and occupational impairment (assessed using the GAF Scale). In this way, we obtained results that were specific to the association of patients' NPD and countertransference responses, independent of patients' overall psycho-social functioning. An analysis of variance (ANOVA) was performed to compare two therapists' groups treating NPD patients with and without clinically meaningful traits of other personality disorders (SWAP-200 PD scales) on their countertransference reactions. Next, bivariate correlations were performed to examine the associations between TRQ factors and some therapists' and treatment variables (such as clinicians' gender, year of experience, theoretical approach, and length of therapy). Moreover, a canonical correlations analysis (CCA; Sherry & Henson, 2005) was conducted to assess the impact of therapists' clinical experience and theoretical approach (predictors) on countertransference patterns to patients' NPD (criterion variables). The CCA allowed us to account for the associations between the two sets of variables—the first consisting of the two therapists' variables and the SWAP-200 NPD Scale and the second consisting of the nine countertransference patterns—and overlapping variance in the criterion variables. Finally, bivariate correlations between all of the TRQ items and the SWAP-200 NPD Scale were conducted, and the 20 TRQ items that showed the strongest positive and negative associations with the SWAP-200 NPD Scale were included in the empirically derived prototype of countertransference responses elicited by patients' personality narcissistic pathology.

Results

In this study, we considered data relative to the full sample of therapists ($N = 67$) treating patients with an NPD diagnosis—based on the SWAP-200 assessment (NPD Scale *T* score ≥60 and high-functioning scale *T* score ≤60)—without comorbidity of other personality disorders. Thus, in the sample, there were no data for patients with narcissistic "features" or traits ($50 \leq$ SWAP-200 NPD Scale *T* score < 60). Overall, in this study, the highest means of personality traits characterizing NPD patients were on the SWAP-200 PD borderline, histrionic, and antisocial scales, whereas the strongest countertransference responses were helpless/inadequate, criticized/devalued, hostile/angry, and disengaged (see Table 1).

Table 1
Means, Standard Deviations, Bivariate Correlations Between Therapist Response Questionnaire Factors and SWAP-200 Personality Disorder Scales (N = 67)

SWAP-200[b] Personality Disorder Scales	*M* (*SD*)	TRQ[a] factors: Criticized/ Devalued 2.18 (1.06)	Helpless/ Inadequate 2.42 (.89)	Positive/ Satisfying 1.57 (.47)	Parental/ Protective 1.79 (.63)	Overwhelmed/ Disorganized 1.91 (.63)	Special/ Overinvolved 1.47 (.76)	Sexualized 1.24 (.39)	Disengaged 2.09 (.87)	Hostile/ Angry 2.14 (.78)
Paranoid	50.59 (5.87)	.19	−.02	−.12	−.28*	−.13	−.08	−.02	.04	.18
Schizoid	45.54 (5.53)	−.25*	−.10	−.03	−.07	−.30*	.08	−.09	−.07	−.18
Schizotypal	46.02 (4.07)	−.33**	.02	−.09	−.16	−.28*	−.05	−.16	.06	−.20
Antisocial	53.43 (5.76)	.27*	.31**	−.36**	−.11	.23	−.07	−.05	.16	.24
Borderline	55.62 (3.77)	.09	.32**	−.11	.05	.24	.17	.12	.07	.25*
Histrionic	54.70 (4.03)	−.25*	−.15	−.18	.02	−.17	.17	.14	−.01	−.38**
Narcissistic	63.89 (3.22)	.56***	.36**	−.40***	−.23	.21	−.23	−.17	.47***	.55***
Avoidant	42.26 (6.86)	−.46***	.30*	.07	.03	−.31	.18	−.06	−.22	−.27*
Dependent	43.23 (7.54)	−.64***	−.42***	.12	.37**	−.29*	.26*	−.08	−.34**	−.38***
Obsessive	48.44 (7.02)	−.18	−.25*	.32**	−.17	−.24	.06	.22	−.16	−.37**
High-functioning	51.63 (4.79)	−.39***	−.37**	.36**	.20	−.29*	.21	.19	−.19	−.37**
GAF	60.07 (7.81)	−.43***	−.26*	.27*	.17	−.17	.24	−.03	−.30*	−.46***

[a] TRQ = Therapist Response Questionnaire (Tanzilli et al., 2016). [b] SWAP-200 = Shedler–Westen Assessment Procedure-200. The table lists two-tailed correlation coefficients *r*.
* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

Countertransference Response and Patient Narcissistic Personality Disorder

The first aim of this research was to investigate the relationships between patients' NPD and countertransference patterns. Table 1 shows that the SWAP-200 NPD Scale was positively associated with the hostile/angry, criticized/devaluated, disengaged, and helpless/inadequate countertransference patterns and negatively associated with the positive/satisfying pattern.

Next, we examined the impact of patients' personality functioning and the degree of impairment in various areas in their lives (psychological or symptomatic, social, and occupational) on the significant correlations between the SWAP-200 NPD Scale and TRQ factors. After controlling for the effects of the SWAP-200 high-functioning and GAF scales, the associations of patients' NPD with criticized/devalued, $r = .40$, $p \leq .001$, helpless/inadequate, $r = .25$, $p \leq .05$, positive/satisfying, $r = .30$, $p \leq .05$, disengaged, $r = .38$, $p \leq .001$, and hostile/angry, $r = .38$, $p \leq .001$, countertransference remained statistically significant, despite decreasing in magnitude.

Differences in Countertransference Reactions Between Therapists Treating NPD Patients With and Without Clinically Meaningful Traits of Other Personality Disorders

The second aim of this research was to compare the self-reported countertransference reactions of clinicians when working with NPD patients with and without clinically meaningful features of borderline, histrionic, and antisocial personality disorders. An ANOVA was performed, comparing the mean scores of the TRQ factors in the clinicians' groups treating NPD patients with different cluster B personality traits. As Table 2 illustrates, there was a significant difference between therapists treating NPD patients with and without borderline, histrionic, and antisocial personality

Table 2
Differences in Countertransference Responses Reported by Clinicians Treating Patients' Narcissistic Personality Disorder With or Without Borderline, Histrionic, and Antisocial (or Cluster B) Personality Traits (ANOVA)

TRQ factors[a]	SWAP-200[b] NPD with cluster B personality traits ($n = 40$) *M*	*SD*	SWAP-200 NPD without cluster B personality traits ($n = 27$) *M*	*SD*	*F*	*p*	η^2	Cohen's *d*
Criticized/Devalued	2.35	1.10	1.92	0.95	2.78	.100	.04	.41
Helpless/Inadequate	2.63	0.87	2.12	0.84	5.72	.020	.08	.59
Positive/Satisfying	1.45	0.31	1.75	0.59	7.57	.008	.10	.67
Parental/Protective	1.68	0.71	1.89	0.40	2.29	.135	.03	.35
Overwhelmed/Disorganized	2.05	0.68	1.70	0.47	5.35	.024	.08	.59
Special/Overinvolved	1.57	0.91	1.31	0.41	1.86	.177	.03	.35
Sexualized	1.26	0.41	1.21	0.35	0.26	.611	.01	.20
Disengaged	2.17	0.82	1.98	0.95	0.78	.381	.01	.20
Hostile/Angry	2.29	0.82	1.92	0.68	3.71	.058	.05	.46

[a] TRQ = Therapist Response Questionnaire (Tanzilli et al., 2016). [b] SWAP-200 = Shedler–Westen Assessment Procedure-200.

features on positive/satisfying, $F(1, 66) = 7.57$, $p = .008$, Cohen's $d = .67$; helpless/inadequate, $F(1, 66) = 5.72$, $p = .020$, Cohen's $d = .59$; and overwhelmed/disorganized clinicians' responses, $F(1, 66) = 5.35$, $p = .024$, Cohen's $d = .59$. Moreover, a trend toward significance was found when comparing therapists' groups in hostile/angry countertransference, $F(1, 66) = 3.71$, $p = .058$, Cohen's $d = .46$. In more detail, helpless/inadequate, and overwhelmed/disorganized responses were found to have significantly higher mean ratings in the clinicians' group working with NPD patients with borderline, histrionic, and antisocial personality traits than in the other clinicians' group treating NPD patients without these specific characteristics. Likewise, positive/satisfying responses were found to have significantly higher mean ratings in the clinicians' group working with NPD patients without cluster B personality features than in the other group.

Countertransference Response to Patient Narcissistic Personality Disorder: Therapists' and Treatment Variables

Our third aim was to verify whether countertransference responses to patients' NPD were significantly associated with therapists' (e.g., gender, years of clinical experience, theoretical orientation) and treatment (length of treatment) variables. Bivariate correlations showed that therapists' gender, theoretical approach, and length of treatment were not significantly related to countertransference responses; conversely, the years of experience demonstrated a positive and significant correlation with the positive/satisfying countertransference pattern, $r = .29$, $p \leq .05$, and the negative and significant correlations with criticized/devalued, $r = -.28$, $p \leq .05$, helpless/inadequate, $r = -.25$, $p \leq .05$, disengaged, $r = -.27$, $p \leq .05$, and hostile/angry, $r = -.31$, $p \leq .01$, countertransference. Next, we verified the impact of clinical experience and theoretical orientation on therapists' responses to NPD patients. A CCA was conducted using the two therapists' variables and SWAP-200 NPD Scale as predictors and the nine countertransference reactions as criterion variables. In a canonical correlation, underlying functions or roots are extracted, the significance of which reflects meaningful underlying relations between these two set of variables (predictors and criterion variables). Overall, there are as many functions as there are variables in the smaller variable set. For each function, the relative weights of the variables, called *structure coefficients* (r_s), are examined to facilitate interpretation. Likewise, it is important to note the *squared canonical structure coefficients* (r_s^2) that indicate the proportion of variance accounted for by each function. In this study, the CCA yielded three functions with *squared canonical correlations* (R_c^2) of .674, .064, and .031, respectively. Collectively, the full model (across all functions) was statistically significant: the Wilks's $\lambda = .296$, $F(27, 161, 27) = 3.09$, $p < .001$. Because Wilks's λ represents the variance unexplained by the model, $1 - \lambda$ yields the full model effect size in an r^2 metric. The r^2 type effect size was .704, indicating that the full model explained ~70% of the variance shared between the variable sets. The dimension reduction analysis, which tests the hierarchal arrangement of extracted functions for statistical significance, highlighted that only the full model (functions 1 to 3) was statistically significant, explaining the 67.4% of shared variance between the variable sets. Conversely, the other functions (2 to 3 and 3 to 3)—$F(16, 112) = .351$, $p = .990$, and $F(7, 57) = .265$, $p = .965$, respectively—did not explain a statistically significant amount of shared variance between the variable sets (6.38% and 3.15%, respectively). Table 1 presents the standardized canonical function coefficients and structure coefficients for function 1.

Looking at the coefficients of the significant canonical function 1, it is possible to note that the most relevant criterion variables were primarily criticized/devaluated, hostile/angry, disengaged, helpless/inadequate, and positive/satisfying. Regarding the predictor variable set, the SWAP-200 NPD Scale and therapist's clinical experience were better predictors and had larger canonical coefficients. Overall, these results seem to support a relationship between all variable sets. Despite the very strong impact of patients' NPD on the countertransference reactions, it is important to highlight the relevant effect of therapists' experience (see Table 3).

Empirically Derived Prototype of Countertransference When Treating NPD Patients

To provide an empirically derived prototype of countertransference reactions when treating patients with NPD, the TRQ items were correlated to the SWAP-200 NPD Scale, and those with higher and lower correlations were identified. A higher positive correlation between a TRQ item and patient's SWAP-200 NPD Scale would indicate that a particular TRQ item is more descriptive of a prototypically narcissistic patient than are other TRQ items. Likewise, a greater negative correlation between a TRQ item and a patient's SWAP-200 NPD Scale would suggest that the therapist reaction reflected in the item is negatively related to the patient's NPD.

Table 4 shows the TRQ items that were found to correlate significantly with patients' NPD. This multifaceted portrait consists of intense feelings of anger, annoyance, and frustration; a sense of devaluation and criticism from the patient; an experience of helplessness and inadequacy; disengagement or withdrawal; and some elements of disorganization. Moreover, it is important to highlight that therapists' responses include a lack of close connection and trust, minimal interest, and severe difficulty tuning in emotionally to the patient.

Discussion

The main aim of this study was to investigate the relationship between patients' NPD and countertransference. To our knowledge, this was the first empirical study to specifically address this topic using a wide population of NPD patients. The findings partially confirmed the first hypothesis (see Table 1): NPD patients tended to evoke in their treating clinicians intense and negative emotional reactions, potentially disrupting the ability to benefit from the therapeutic relationship (Gabbard, 2009; McWilliams, 2004). Consistent with clinical observations and empirical contributions (Betan et al., 2005; Kernberg, 1975, 2014; Gazzillo et al., 2015), we found significant associations between patients' NPD and a criticized/devalued countertransference pattern, wherein therapists felt devaluated, unappreciated, demeaned, or belittled by their patient, as well as a hostile/angry pattern, which indicated feelings of anger, resentment, and irritation. These results could be explained by the characteristic defensive style of NPD patients, who typically criticize and devalue others in their struggle with feelings of inferiority and attempts to stabilize their fluctuating self-esteem (Clemence, Perry, & Plakun, 2009; Perry & Perry,

Table 3
Canonical Solution for Therapists' Variables and Patients' SWAP-200 Narcissistic Personality Disorder Scale Predicting Therapist Response Questionnaire Factors for Function 1

Patient personality, TRQ[a] factors, and therapist variables	Significant canonical function 1			
	Standardized canonical function coefficients	Structure coefficients r_s	Squared structure coefficients r_s^2 (%)	Cohen's *d*
Criticized/Devalued	−.61	**−.67**	44.89	−1.81
Helpless/Inadequate	−.31	**−.45**	20.25	−1.01
Positive/Satisfying	.29	**.50**	25.00	1.16
Parental/Protective	−.18	.30	9.00	.63
Overwhelmed/Disorganized	.30	−.24	5.76	−.49
Special/Overinvolved	.05	.33	10.89	.70
Sexualized	.27	.24	5.76	.49
Disengaged	−.39	**−.60**	36.00	−1.50
Hostile/Angry	−.58	**−.67**	43.56	−1.81
R_c^2			67.38	
SWAP-200[b] NPD Scale	−.94	**−.98**	96.04	−9.85
Therapist's Approach	.14	−.06	0.36	−.12
Therapist's Experience	.15	**.54**	29.16	1.28

[a] TRQ = Therapist Response Questionnaire (Tanzilli et al., 2016). [b] SWAP-200 = Shedler–Westen Assessment Procedure-200. Structure coefficients (r_s) > |.45| are in bold.

2004). These countertransference reactions can provoke enactments of judgment, harsh comments, premature interpretation, criticism, and/or accusatory statements (Gabbard, 2009; Ronningstam, 2016).

Another pattern of therapist reactions associated with NPD was the disengaged pattern, characterized by feelings of distraction, distance, indifference, withdrawal, or boredom in sessions, which could lead to a lack of emotional connection between the therapist and patient (Betan et al., 2005; Colli et al., 2014). A possible explanation is that NPD patients typically have extreme difficulty acknowledging their need for closeness and intimacy, and often deny the existence of the psychotherapist as an independent person (Kernberg, 2014) or use him/her as a "sounding board" (Gabbard, 2009). On the other hand, therapists may be inclined to disavow frustrations related to the experience of being chronically ignored by developing a defensively detached attitude (Dahl, Røssberg, Bøgwald, Gabbard, & Høglend, 2012). Recent studies have shown that therapists' disengaged feelings may negatively influence the therapeutic process and outcome, including transference work and recognition of cognitive–affective phenomena that arise during sessions (Dahl, Ulberg, Friis, Perry, & Høglend, 2016; Ulberg, Amlo, Hersoug, Dahl, & Høglend, 2014).

Expanding our preliminary findings (Tanzilli et al., 2015), another countertransference dimension that was found in relation to NPD was the helpless/inadequate pattern. Some clinicians felt strongly incompetent, ineffective, invisible, insecure, anxious, and less confident. In treatment settings, these reactions could lead to difficulty managing or maintaining therapeutic boundaries, such as by accepting the provision of special modifications to accommodate the patient's imperative demands (Gabbard & Lester, 1995; Luchner, 2013). Some empirical contributions suggest that therapist's feelings of inadequacy and hopelessness, even in small doses, might predict less favorable outcome in patients with severe personality pathology (Dahl et al., 2016; Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015).

Finally, in line with previous studies, our findings confirmed that NPD patients tended to evoke less positive countertransference reactions (Betan et al., 2005; Bourke & Grenyer, 2010; Colli et al., 2014; Dahl et al., 2014; Røssberg et al., 2007, 2008).

Overall, all of these countertransference patterns to NPD seem to reflect specific aspects of patients' attachment patterns. In particular, some studies supported that narcissistic individuals show a dismissing attachment characterized by an inflated representation of the self and a defensive detachment from relationships in which others are seen as irrelevant in their capacity to aid in emotional regulation, as well as a contemptuous derogation and/or brittle idealization of attachment figures (including therapists) (Diamond et al., 2014; Meyer & Pilkonis, 2011; Tanzilli, Colli, Gualco, & Lingiardi, 2017; Westen, Nakash, Thomas, & Bradley, 2006).

Contrary to our expectations, the results of this study revealed that the associations between patients' NPD and patterns of therapists' emotional responses were not fatally affected by patients' level of personality functioning and their degree of psychological, social, or occupational impairment, despite their decrease in magnitude. Overall, NPD patients with globally lower personality and psycho-social functioning levels tended to elicit the most intensely negative responses in therapists, posing more clinically relevant challenges (Caligor et al., 2015).

Another aim of the study was to examine whether NPD patients with clinically relevant traits of cluster B personality pathology evoked more intense reactions from therapists with respect NPD patients without mixed personality features. Our results showed that therapists feel more helpless, inadequate, and disorganized when working with NPD patients characterized by borderline, histrionic, and antisocial personality traits and face more significant challenges in treatment. These results seem to support previous research showing that the co-occurrence of NPD with cluster B personality characteristics may be a complicating factor that can severely threaten psychotherapy continuance and favor early treatment termination (Diamond et al., 2013; Kernberg, 2007).

The third aim of this study was to verify whether the relationship between patients' narcissistic personality and therapists' responses could be accounted for by clinicians' variables. As ex-

Table 4
TRQ Items With Strongest Significant Positive and Negative Relationships to Narcissistic Personality Disorder Patients (N = 67)

Item numbers[a]	TRQ item[b]	TRQ factor	*r* (*p*)
77	More than with most patients, I feel like I've been pulled into things that I didn't realize until after the session was over.	Criticized/Devalued	.61 (<.001)
25	My mind often wanders to things other than what s/he is talking about.	Disengaged	.59 (<.001)
6	I feel dismissed or devalued.	Criticized/Devalued	.55 (<.001)
12	I feel criticized by him/her.	Criticized/Devalued	.53 (<.001)
27	I get enraged at him/her.	Hostile/Angry	.51 (<.001)
39	I have to stop myself from saying or doing something aggressive or critical.	Hostile/Angry	.50 (<.001)
8	I feel annoyed in sessions with him/her.	Hostile/Angry	.49 (<.001)
22	I feel frustrated in sessions with him/her.	Helpless/Inadequate	.47 (<.001)
63	I feel unappreciated by him/her.	Criticized/Devalued	.45 (<.001)
55	I feel pushed to set very firm limits with him/her.	Overwhelmed/Disorganized	.44 (<.001)
40	I feel like I understand him/her.	Positive/Satisfying	−.39 (.001)
3	I find it exciting working with him/her.	Positive/Satisfying	−.36 (.003)
65	I like him/her very much.	Positive/Satisfying	−.33 (.006)
23	S/he makes me feel good about myself.	Positive/Satisfying	−.32 (.009)
1	I am very hopeful about the gains s/he is making or will likely make in treatment.	Positive/Satisfying	−.29 (.018)
42	I feel like I want to protect him/her.	Parental/Protective	−.27 (.030)
56	I find myself being flirtatious with him/her.	Sexualized	−.26 (.034)
7	If s/he were not my patient, I could imagine being friends with him/her.	Positive/Satisfying	−.26 (.035)
64	I have warm, almost parental feelings toward him/her.	Parental/Protective	−.25 (.042)
76	I self-disclose more about my personal life with him/her than with my other patients.	Special/Overinvolved	−.25 (.048)

[a] Items presented in descending order of magnitude. [b] TRQ = Therapist Response Questionnaire (Tanzilli et al., 2016). The table lists two-tailed correlation coefficients *r*.

pected, theoretical approach does not influence the countertransference reactions (Betan et al., 2005; Lingiardi et al., 2015; McIntyre & Schwartz, 1998). These findings could be due to the increased interest in the clinical implications of therapists' responses shown by clinicians and researchers with different therapeutic approaches and training (Cartwright, 2011; Leahy, 2007; Wright, Basco, & Thase, 2006). Moreover, consistent with expectations and some previous studies (Brody & Farber, 1996; Lecours et al., 1995) therapists' clinical experience affected countertransference patterns showing an important influence (see Table 3).

Finally, the last aim of the present research was to provide an empirically derived prototype of therapists' specific constellation of thoughts, feelings, and behaviors experienced toward NPD patients in clinical practice. The composite description that emerged (see Table 4) is remarkably similar to theoretical and clinical accounts (see the Introduction section). Compared with Betan et al.'s (2005) prototype, which was based on a smaller sample ($N = 13$), this countertransference portrait strongly emphasizes feeling anger and frustration ("I get enraged at him/her"; "I feel annoyed in sessions with him/her"); a sense of devaluation and criticism ("I feel criticized by him/her"; "I feel dismissed or devaluated"); and boredom, withdrawal, and emotional detachment ("My mind often wanders to things other than what s/he is talking about"). Likewise, clinicians reported feelings of inefficacy ("I feel frustrated in sessions with him/her") and components of disorganization ("I feel pushed to set very firm limits with him/her"). Unsurprisingly, clinicians were least likely to endorse feelings of trust, mutual comprehension, positive anticipation of the session, and hopes for a positive therapeutic outcome (see the least descriptive TRQ items in Table 4; e.g., "I am very hopeful about the gains s/he is making or will likely make in treatment"). Overall, this empirically derived prototype shows how countertransference reactions may impair a therapist's genuine emotional warmth toward the patient and adversely affect the therapeutic relationship (Bender, 2015; Ronningstam, 2012).

This study has some limitations. First, the method of data collection (clinician report) of patient narcissistic personality disorder and countertransference from a single informant might be vulnerable to some biases. In other words, the assessment of the narcissistic personality disorder could be influenced by the perception of a significant countertransference reaction (and vice versa). Ideally, patients' personalities would have been diagnosed by an independent observer. However, many other studies have relied on a single source of data—the patient—as assessed through self-report instruments. Moreover, the judgments of experienced therapists cannot be seen as less reliable than the self-descriptions of patients with personality pathology, especially given that narcissistic persons' self-evaluations are characterized by notable biases (Cooper, Balsis, & Oltmanns, 2012; Klonsky, Oltmanns, & Turkheimer, 2002; Westen & Weinberger, 2004). Second, the sample size was not very large; however, to our knowledge, this was the first empirical investigation to examine the relationship between patients' NPD and therapists' emotional reactions in an adequately sized group of clinicians of varying theoretical orientations. Third, there is an absence of data about the therapy process and outcome. It would be interesting to monitor the change in

countertransference patterns throughout the treatment of NPD patients and verify the effect of therapists' emotional responses in successful therapies, as well as in cases of dropout or treatment failure. Finally, although the NPD Scale of the SWAP-200 considered in this study refines and dimensionalizes existing diagnostic categories and criteria in the *DSM–IV–TR* (for a detailed description of the SWAP-200 NPD Scale, see Westen & Shedler, 1999a), in our sample, grandiose narcissistic features were more prevalent than vulnerable traits. A closer examination of therapists' emotional responses toward different types of narcissistic patients, including vulnerable and high-functioning/exhibitionistic subtypes (Russ et al., 2008), is recommended for further research. Furthermore, it would be interesting to examine the potential effect of patients' mood disturbances, both unipolar and hypomanic, on the relationship between narcissistic features and therapists' emotional reactions (Shahar, Scotti, Rudd, & Joiner, 2008; Simonsen & Simonsen, 2011; Stormberg et al., 1998).

Future studies also need to attend to how clinicians' challenging countertransference and negative reactions can improve the understanding of narcissistic patients' internal conflicts and emotional experiences. In particular, the interaction between patients' presentation and therapists' accompanying reactions can provide relevant information about the patients' internal sense of identity, agency, and regulation of self-esteem and emotion, in addition to more specific aspects of attachment patterns or other origins of interpersonal experiences and relatedness. Identifying some of the actual roots and underpinnings to patients' functioning, whether motivational or deficit based, can provide important guidance for choice and timing of interventions (Yeomans, Clarkin, & Kernberg, 2015). It is clearly recommended that clinicians work through their own countertransference reactions in order to manage them and ensure that they do not impair the therapy's effect, especially when working with narcissistic pathology, which is one of the most challenging clinical syndromes (Hayes, Gelso, & Hummel, 2011).

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