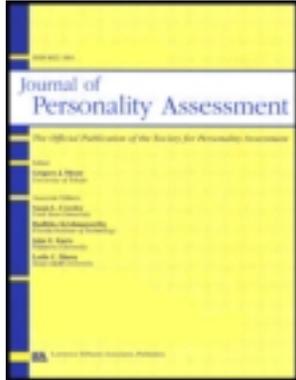


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The Impact of Pathological Narcissism on Psychotherapy Utilization, Initial Symptom Severity, and Early-Treatment Symptom Change: A Naturalistic Investigation

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The impact of pathological narcissism on psychotherapy has seldom been investigated empirically, despite extensive clinical theory proposing that highly narcissistic individuals should be reluctant to engage in treatment and derive smaller benefits from therapy. In this study, we investigate the relationship between scores on the Pathological Narcissism Inventory (PNI; Pincus et al., 2009), which assesses both narcissistic grandiosity and narcissistic vulnerability, and clinical variables in a sample of outpatients ($N = 60$) at a community mental health center. Results indicated that grandiosity, but not vulnerability, was negatively related to the use of adjunctive services and positively predicted client-initiated termination of psychotherapy. In addition, grandiosity and vulnerability were related to initial levels of different symptoms in multilevel models using a subsample ($n = 41$) but not generally related to the linear rate of symptom change in early psychotherapy. The results highlight the clinical utility of assessing pathological narcissism in a real-world psychotherapeutic context.

The construct of narcissism has a long and complicated history in both academic psychology and clinical psychology and psychiatry (Levy, Ellison, & Reynoso, 2011). Recent reviews have suggested that narcissism has been inconsistently defined and measured within and across both traditions (Miller & Campbell, 2008; Pincus & Lukowitsky, 2010), and there has generally been little consensus across disciplines about its nature and external correlates (Cain, Pincus, & Ansell, 2008). Some scholars have argued that this confusion relates to a discrepancy between adaptive narcissism, which tends to relate positively to self-esteem and is captured by measurements in the social-personality psychology tradition (Levy, Reynoso, Wasserman, & Clarkin, 2007; Rosenthal & Hooley, 2010), and pathological narcissism. This latter conceptualization is the focus of theory and research in the clinical domain and is associated with psychiatric symptoms, especially substance dependence, bipolar disorder (especially mania), and characterological depression (Fulford, Johnson, & Carver, 2008; Huprich, Luchner, Roberts, & Pouliot, 2012; Milrod, 1988; Ronningstam & Gunderson, 1989; Stinson et al., 2008; Stormberg, Ronningstam, Gunderson, & Tohen, 1998; Tritter, Ryder, Ring, & Pincus, 2010).

In recent years, the narcissism construct within the clinical tradition has largely been dominated by narcissistic personality disorder (NPD) as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [DSM-IV]; American Psychiatric Association, 1994), but the low prevalence of this diagnosis and its uncertain nomological network led to its being proposed for deletion as a categorical diagnosis in *DSM-5* (Skodol et al., 2011). However, this proposal led to a welter of responses from

theorists and researchers alike arguing for the clinical utility and validity of the broader construct of pathological narcissism (e.g., Miller, Widiger, & Campbell, 2010; Pincus, 2011; Ronningstam, 2011; Shedler et al. 2010). Central to many of these critiques was the idea that pathological narcissism involves two facets: narcissistic grandiosity, characterized by feelings of entitlement, interpersonal manipulateness, and arrogance, and narcissistic vulnerability, involving shyness, shame, and avoidance of relationships, whereas the construct of NPD in the *DSM* seemed to focus exclusively on a grandiose presentation (Miller, Hoffman, Campbell, & Pilonis, 2008; Pincus & Roche, 2011). Some researchers have contended that this narrow focus on grandiosity leads to the low prevalence of *DSM-IV* NPD, because the construct as written might not capture the typical presentation in clinical settings (Levy et al., 2007; Miller et al., 2010; Pincus & Lukowitsky, 2010). Based in part on these critiques, a revised NPD type has been reintroduced in the latest *DSM-5* proposal (American Psychiatric Association, 2011).

PATHOLOGICAL NARCISSISM AND PSYCHOTHERAPY

The clinical utility of the construct of pathological narcissism is evident from the rich literature describing its impact on psychotherapy. Historically, broad agreement exists among clinical writers that pathological narcissism is a negative prognostic sign for success in diverse kinds of psychotherapy. From its beginnings as a descriptive construct in psychiatry, narcissism has been conceived as a personality characteristic that limits an individual's potential to invest in interpersonal relationships (Ellis, 1898/1927; Freud, 1914/1957), and as a consequence, limits the potential for change within the therapeutic relationship. For example, Abraham (1919/1927) described how narcissism could threaten treatment through "narcissistic resistance," in which patients actively disrupt interventions that threaten their grandiose self-image. Riviere (1936/1999) likewise described how narcissistic resistance could render a patient unable to participate in

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psychoanalysis but nonetheless compel him to maintain “a mask of polite friendliness and rationalization” (p. 223), leading the analyst to believe that the therapeutic work was proceeding as normal.

Kohut (1971) described the difficulties in navigating the particular kinds of transferences that occur during psychoanalytic treatment of narcissistic individuals. Kohut described periods in treatment when the patient would idealize the analyst, treating him or her as a perfect and all-powerful parent figure (the “idealizing transference”). During these times, the primary challenge for the analyst was to resist the temptation to challenge this pattern too quickly. The other characteristic form of transference, according to Kohut, was “mirror transference,” in which the patient’s grandiose sense of self comes to the fore and he or she turns away from the analytic relationship. As a result, the analyst might feel bored, impatient, and frustrated, and might experience an activation of his or her own narcissistic needs in consequence.

Kernberg (1975, 2007, 2010) noted the strong feelings of envy that narcissistic patients often feel toward their therapists, often coinciding with a defensive idealization of the therapist as a brilliant thinker who confers status on the patient by association. The envy can result in a subtle fear of improvement in therapy (which would reveal that there was originally something to improve), whereas the idealization puts pressure on the therapist to be brilliant (but not so brilliant as to threaten the patient’s intelligence by comparison). Kernberg (1975), like Kohut (1971), also warned of the likelihood of a negative reaction on the therapist’s part in the face of these actions, which, if unchecked, could lead the therapist to actively devalue the patient’s importance.

The belief that the treatment of narcissistic individuals is extremely difficult is not limited to clinical theorists in the psychodynamic tradition. On the contrary, cognitive therapists such as Beck, Freeman, and Davis (2004) have noted that individuals with NPD often hold the belief that their distress is due to external factors, which tends to interfere with the very premise of cognitive therapy, and put up other defenses against the treatment, leading to annoyance, anxiety, and errors on the therapist’s part. Likewise, Rasmussen (2005) pointed out that positive change in psychotherapy threatens to reveal to narcissistic individuals that they were flawed and needed treatment in the first place. Rasmussen quoted such a patient as protesting, “If mental health means I have to be nice to the idiots of the world, I’d rather be crazy” (p. 180). Notably, narcissistic pathology is also considered challenging in the context of primary medical care (Magidson et al., 2012).

Despite consistent pan-theoretical agreement that prominent narcissistic pathology makes psychotherapeutic treatment more difficult and leads to poorer outcomes, very little empirical research exists to support these notions (Levy, Chauhan, Clarkin, Wasserman, & Reynoso, 2009). Two studies have examined the impact of narcissistic traits on early dropout from therapy. Using a retrospective record-review method to diagnose personality disorder symptoms, Hilsenroth, Holdwick, Castlebury, and Blais (1998) found that if outpatients met the “requires excessive admiration” criterion for NPD, they were more likely to drop out prematurely from long-term psychodynamic psychotherapy. Although the reliability of these retrospective ratings was adequate, it is unclear whether the information contained in patient records and the coding procedures used resulted in a

valid assessment of narcissistic pathology. The use of *DSM-IV* criterion sets in this study also raises the possibility that the full range of pathological narcissism was not captured. In a similar vein, Campbell, Waller, and Pistrang (2009) found that overall scores on the O’Brien Multiphasic Narcissism Inventory (OMNI; O’Brien, 1987) were unrelated to dropout among 41 outpatients offered cognitive-behavioral therapy for eating disorders, but one OMNI subscale—the “narcissistically abused” scale—was higher among dropouts than among completers. This study was confined to only one patient group and only one type of therapy, however, making it difficult to generalize this finding to the broader population of patients, therapies, and settings.

With regard to the outcome of completed psychotherapy, Daig, Klapp, and Fliege (2009) found that scores on the “threatened self” index of the Narcissism Inventory–90 (Schoenich et al., 2000), a German measure, predicted change in a sample of inpatients offered psychodynamic therapy for psychosomatic complaints (a plurality had a diagnosis of somatoform disorder). Specifically, individuals with higher “threatened self” scores had higher anger and anxious-depressed mood scores at discharge, as well as lower levels of social functioning and mental health, in cross-lagged regression models. However, this study, like Campbell and colleagues’ (2009) investigation, was limited to a fairly circumscribed patient group and one type of therapy. Teusch, Böhme, Finke, and Gastpar (2001) compared the outcome of client-centered therapy (CCT) to CCT plus medication in the treatment of personality disorders and found generally similar effect sizes across personality disorder groups. However, the authors combined individuals with NPD and those with histrionic personality disorder into a single group, making it difficult to tell what specific effect an NPD diagnosis had on treatment response. There is also evidence from a single-subject case study that individuals with significant narcissistic pathology can improve substantially in psychotherapy (Callaghan, Summers, & Weidman, 2003) and mixed evidence of the impact of NPD on functioning from follow-up studies (Plakun, 1989; McGlashan & Heinssen, 1989; Ronningstam, Gunderson, & Lyons, 1995; Stone, 1989), but comparisons of symptom change in psychotherapy for individuals high and low in pathological narcissism are rare.

Thus, it remains largely an open question whether pathological narcissism increases the risk of negative outcomes in psychotherapy, as so many clinical theorists have predicted. To examine this possibility, we investigated pathological narcissism as it related to both the utilization of therapeutic services and the course of symptom change in a naturalistic sample of outpatients undergoing treatment for a variety of disorders. A preliminary investigation of the relationship of pathological narcissism to various clinical variables, based on a subset of the current sample ($n = 25$), is presented in Pincus et al. (2009). In this study, we report on the associations between pathological narcissism and treatment utilization in a notably larger sample. We also consider the associations between narcissism and self-reported psychiatric symptoms and between narcissism and symptom change over the early course of psychotherapy. Based on the clinical literature just reviewed and previous empirical findings, we expected that narcissism would be associated with higher initial symptoms and with an attenuated response to psychotherapy, as reflected in slower symptomatic improvement over time. In addition, we expected that narcissistic grandiosity would

decrease individuals' use of psychotherapy and other clinical services, whereas narcissistic vulnerability would increase the use of these services. Given that grandiosity and vulnerability are positively correlated, it is unclear whether (and how) narcissistic grandiosity and narcissistic vulnerability might combine to predict service use, symptoms, and symptom reduction. Thus, the additive and interactive effects of grandiosity and vulnerability on these variables were also explored.

METHOD

Participants

Participants were 62 outpatients at a rural, university-based community mental health center, who were recruited through advertisements in the clinic waiting room for a study about personality characteristics, completed a measure of pathological narcissism, and gave permission for researchers to use data from their therapy charts (including therapy notes, diagnostic reports, and self-reported symptoms). Two participants' charts were not available at the time of coding. The age of the remaining 60 participants ranged from 19 to 65 years, with a mean of 36.4 ($SD = 12.8$). Fifty-four (90%) participants listed Caucasian as their primary ethnicity, 3 (5%) were African American, and 2 (3%) were Asian American. One participant (2%) listed her ethnicity as "biracial." Fifty-one participants (85%) were women. These demographic characteristics are fairly typical of the clinic's client base. A number of *DSM-IV* diagnoses were represented in the sample at intake (Table 1). Notably, only 1 participant was diagnosed with NPD, which is consistent with the low prevalence of *DSM-IV* NPD in outpatient samples (Mattia & Zimmerman, 2001; Zimmerman, Rothschild, & Chelminski, 2005). The mean Global Assessment of Functioning (GAF) score at intake was 53.5 ($SD = 7.8$).

TABLE 1.—Diagnoses at intake for participants.

Axis I Diagnosis	<i>n</i>	%	Axis II Diagnosis	<i>N</i>	%
Major depressive disorder	28	45.9	Borderline personality disorder	12	19.7
Generalized anxiety disorder	13	21.3	Personality Disorder NOS	5	8.2
Posttraumatic stress disorder	11	18.0	Narcissistic personality disorder	1	1.6
Panic disorder	11	18.0	Avoidant personality disorder	1	1.6
Dysthymic disorder	8	13.1	Obsessive-compulsive personality disorder	1	1.6
Social phobia	7	11.5	Histrionic personality disorder	1	1.6
Obsessive-compulsive disorder	6	9.8	Schizotypal personality disorder	1	1.6
Anxiety disorder NOS	5	8.2			
Bipolar disorder I	4	6.6			
Specific phobia	4	6.6			
Bipolar disorder II	3	4.9			
Bulimic disorder	3	4.9			
Schizophrenia	2	3.3			
Schizoaffective disorder	2	3.3			
Mood disorder NOS	2	3.3			

Note. *N* = 60. NOS = Not Otherwise Specified. Two participants' charts were not available at the time of coding.

Treatment

Treatment occurred on a naturalistic basis following standard practice in the clinic. All participants participated in semistructured diagnostic interviews and were assigned a psychotherapist, after which psychotherapy generally proceeded on a weekly basis. Therapy followed a variety of theoretical modalities, including psychodynamic, cognitive-behavioral, and humanistic. Clients were also offered pharmacotherapy as needed, but they were required to begin psychotherapy before meeting with a psychiatric provider and had to participate in psychotherapy to receive medications in the clinic. Forty-eight (77%) of the 62 clients in this sample received psychopharmacological services during their treatment in the clinic. Other attention received by the clients in this sample was infrequent but included neuropsychological and cognitive assessments, research interviews, and time-limited group treatment (e.g., skills training). Individual psychotherapy was provided by staff therapists at the clinic, the majority of whom were doctoral students in a clinical psychology program. These doctoral students were supervised on a weekly basis, both individually and in groups, by licensed psychologists. For more information about the treatment setting, see Boswell, Castonguay, and Wasserman (2010). Participants in this study received between 2 and 296 sessions of individual psychotherapy, with a median of 63 sessions.

Measures

Pathological narcissism was measured using the Pathological Narcissism Inventory (PNI; Pincus et al., 2009), a 52-item self-report questionnaire. Items are rated on a 6-point Likert-type scale ranging from 0 (*not at all like me*) to 5 (*very much like me*). Pincus and colleagues (2009) found that the PNI shows a robust seven-factor structure in large nonclinical samples, with factors corresponding to entitlement rage (example item: "I get annoyed by people who are not interested in what I say or do"), exploitativeness ("I can make anyone believe anything I want them to"), grandiose fantasy ("I often fantasize about being recognized for my accomplishments"), self-sacrificing self-enhancement ("I try to show what a good person I am through my sacrifices"), contingent self-esteem ("It's hard for me to feel good about myself unless I know other people like me"), hiding the self ("When others get a glimpse of my needs, I feel anxious and ashamed"), and devaluing ("When others don't meet my expectations, I often feel ashamed about what I wanted"). Research also shows (Tritt et al., 2010; Wright, Lukowitsky, Pincus, & Conroy, 2010) that the PNI has a higher order two-factor structure, with factors corresponding to narcissistic grandiosity (including the Exploitative, Self-Sacrificing Self-Enhancement, and Grandiose Fantasy subscales) and narcissistic vulnerability (comprised of the Contingent Self-Esteem, Hiding the Self, Devaluing, and Entitlement Rage subscales), and that this hierarchical factor structure was invariant across male and female respondents (Wright et al., 2010). The initial validation study also showed that, in contrast with existing narcissism scales, PNI subscales showed overlap with diverse aspects of interpersonal problems on the interpersonal circumplex and theoretically important correlations with psychotherapy usage and suicidality (Pincus et al., 2009), and Tritt and colleagues (2010) found that the higher order vulnerability factor related to depressive temperament in a college sample. In the sample

used here, the internal reliability of the PNI was adequate (Cronbach's $\alpha = .92$), as was the reliability of the Grandiosity ($\alpha = .86$) and Vulnerability ($\alpha = .92$) scales. The reliability of the lower order scales was likewise adequate and ranged from .74 to .91. Because of the naturalistic nature of this study, participants were recruited (and thus completed the PNI) after they had already started psychotherapy. A median of 25 sessions had occurred prior to completion of the PNI in this sample, and a median of 19 sessions had occurred afterward.

Psychiatric symptoms were measured using the Treatment Outcome Package (TOP; Kraus, Seligman, & Jordan, 2005), a 58-item self-report questionnaire that asks clients to rate the frequency of psychiatric symptoms in the past month. Response options range from *all* to *none*. The TOP shows a robust 11-factor structure among mental health patients and mixed samples of patients and community volunteers (Kraus et al., 2005). TOP factors used in this study are the clinical scales of Depression ("felt down or depressed"), Mania ("felt on top of the world"), Psychosis ("seen or heard something that was not really there"), Suicidal Ideation ("planned or tried to kill yourself"), Panic ("had a racing heart"), Violence ("had desires to seriously hurt someone"), and Sleep ("had trouble falling asleep").¹ The TOP scales show adequate test-retest reliability and theoretically appropriate overlap with other symptom scales (Kraus et al., 2005), and patterns of TOP scores differentiate between different *DSM-IV* diagnoses that commonly occur in mental health settings (Wolf, Kraus, & Castonguay, 2007). Of particular importance for repeated-measurement designs in psychotherapy research, the TOP encompasses a broad range of pathology with no noticeable ceiling effects and is sensitive to change over a naturalistic course of psychotherapy (Kraus et al., 2005). Sample-specific reliability coefficients were not available for the TOP, because item scores are not returned in the score report provided to the clinic by the publishers. However, Cronbach's α values were generally acceptable (.69–.93) in the initial validation study (Kraus et al., 2005), with the exception of the Mania scale ($\alpha = .53$). Clinic procedures specify that the TOP be completed before the intake session, before the first session of psychotherapy, before the 7th and 15th sessions, and before every 15th session after that. However, due to several factors (e.g., therapist oversight or the unavailability of questionnaire forms), the schedule of administration varied slightly.

Demographic data, diagnostic data, and information about psychotherapy course and utilization were collected by review of participants' clinic charts. Variables were coded regarding the number of session cancellations, rescheduled appointments, and no-shows by the participants (this information was available from a log of appointments kept by the clinic); whether participants had visited the emergency room for a psychiatric reason and whether they had been hospitalized; and the use of adjunctive services (medication therapy, partial hospitalization programs, and telephone crisis hotlines). If treatment had terminated, coders judged from closing reports whether termination was initiated by the client, by the therapist (e.g., because the therapist changed practice), or by mutual decision (e.g., because sufficient improvement had occurred). Because the num-

ber of cancellations, rescheduled appointments, and no-shows depended to some degree on the length of therapy, these values were normalized by dividing them by the number of sessions attended.

Chart review coders were undergraduate research assistants who were trained to reliability and worked independently. Data were extracted from each chart by two coders, and discrepancies were resolved by consensus. Before consensus was reached, interrater reliability was adequate to excellent for both continuous (range of intraclass correlation coefficient of absolute agreement = .87–.97) and categorical (range of Cohen's kappa = .73–.88) variables. Consensus codes were used in all analyses.

Analyses

The relationship of pathological narcissism to the utilization of psychotherapy and other services was analyzed using SPSS, Version 19. The two higher order PNI scales of grandiosity and vulnerability were used to predict the variables derived from chart review. Hierarchical logistic regression was used to model the relationship of narcissism to categorical variables, and Spearman's rank correlation was used for continuous variables because of their nonnormal distributional properties. Because of the two participants' missing chart data, the sample size for these analyses was 60.

The outcome of psychotherapy in terms of symptom reduction was analyzed using multilevel modeling in R software, version 2.5.0 (R Development Core Team, 2007). Multilevel modeling was chosen because it is tolerant of measurements that are not balanced on time and does not require the assumption that the dependent variable has the same variance at all time points (Kenny, Bolger, & Kashy, 2002; Tasca & Gallop, 2009). Because of the possible effect of narcissism on the discontinuation of therapy, which would lead to nonrandom missingness in the data set and thus bias analyses, only those participants who completed at least three outcome questionnaires were used. This led to the exclusion of 20 participants' data. In addition, only these first three measurement occasions were included in the data set, with the result that the data described participants' early treatment response (i.e., ratings at intake, at the beginning of therapy, and at seven sessions). One participant's data were excluded because only later symptom data were available, making the final sample size for the multilevel modeling (MLM) analyses 41.

MLM analysis occurred in a stepwise fashion. First, fixed effects for the initial TOP symptom level (intercept) and rate of change (slope) were determined using maximum likelihood estimation. Second, a mixed-effects model was estimated using restricted maximum likelihood estimation (Morrell, 1998) to test whether intraindividual variation existed around the mean-level intercept and rate of change. Confidence intervals for these variance components were estimated using Markov chain Monte Carlo sampling (Cowles & Carlin, 1995) within the Coda package (Plummer, Best, Cowles, & Vines, 2006). Finally, PNI higher order scales were examined as predictors of TOP symptom intercepts and rates of change, in both an additive and interactive fashion. For all models, likelihood-ratio tests were used to test the significance of regression coefficients.

¹The TOP also contains several "functioning scales," but these items were not administered frequently enough to be used in analyses.

TABLE 2.—Scores on the Pathological Narcissism Inventory (PNI) in the current sample.

Subscale	<i>M</i>	<i>SD</i>
Exploitative	1.84	1.13
Self-Sacrificing Self-Enhancement	2.92	1.02
Grandiose Fantasy	2.66	1.31
Entitlement Rage	2.10	1.16
Contingent Self-Esteem	2.51	1.22
Hiding the Self	2.99	1.26
Devaluing	1.96	1.22
GRAND	2.47	0.87
VULN	2.39	0.84
PNI total	2.43	0.72

Note. *N* = 62. Scores are based on scale means and range from 0 (*not at all like me*) to 5 (*very much like me*). GRAND = Grandiosity; VULN = Vulnerability.

RESULTS

PNI Scores

PNI scores for the total sample of 62 outpatients can be found in Table 2. The mean subscale and higher order scale scores are comparable to those found in large nonclinical samples (Pincus et al., 2009; Wright et al., 2010) and similar samples of psychiatric outpatients in Canada (Kealy, Tsai, & Ogrodniczuk, 2012) and Italy (Fossati, Feeney, Pincus, Borroni, & Maffei, 2012). Grandiosity and vulnerability were moderately correlated ($r = .41, p = .001$).

Service Utilization

The two higher order PNI scales predicted a number of treatment utilization variables. The hierarchical logistic regression models describing these relationships can be found in Table 3. Participants with higher levels of narcissistic grandiosity were more likely to initiate termination of psychotherapy themselves. This effect size (an odds ratio of 2.44) indicates that a 1-point increase in narcissistic grandiosity (on a scale of 0–5) more than doubled the likelihood of client-initiated termination, and this relationship held when controlling for narcissistic vulnerability and the interaction of grandiosity and vulnerability. Grandiosity was also marginally (and negatively) related to the likelihood of

TABLE 3.—Hierarchical multiple logistic regression analyses predicting client-initiated termination and the use of therapeutic services from narcissistic grandiosity and narcissistic vulnerability.

Predictor(s)	Odds Ratio (OR)					
	Client Termination	Crisis Call	Emergency Room Visit	Hospitalization	Partial Hospital	Psychiatric Care
Model 1						
GRAND	2.44*	0.45	0.99	0.52	0.33*	0.58
Model 2						
VULN	1.30	1.18	2.59	1.27	0.93	0.96
Model 3						
GRAND	2.51*	0.32*	0.64	0.37*	0.25*	0.53
VULN	0.92	1.93	3.12*	2.00	1.63	1.27
Model 4						
GRAND	2.67*	0.25*	0.56	0.33*	0.19*	0.52
VULN	0.80	2.57	3.24*	2.29	2.32	1.24
GRAND × VULN	0.51	1.83	1.28	1.50	1.94	1.52

Note. *N* = 60. GRAND = Grandiosity; VULN = Vulnerability. * $p < .05$.

making a telephone call to the county crisis hotline ($p = .06$) and to the likelihood of psychiatric hospitalization ($p = .07$). These relationships were statistically significant, however, when controlling for vulnerability and for the interaction between the two higher order subscales. Grandiosity was also negatively related to the likelihood of attending a partial hospital program, and this relationship remained significant when controlling for vulnerability and the Grandiosity × Vulnerability interaction. Narcissistic vulnerability was unrelated to most service utilization variables on its own, but it was marginally (and positively) related to the likelihood of visiting the psychiatric emergency room ($p = .06$). This effect was significant when controlling for grandiosity and for the interaction of grandiosity and vulnerability. Contrary to hypotheses, neither grandiosity nor vulnerability predicted the use of psychoactive medication by participants during therapy. Likewise, Spearman’s rank correlations showed that neither narcissistic grandiosity nor vulnerability was related to therapy session cancellations (grandiosity, $\rho = .150, p = .27$; vulnerability, $\rho = .032, p = .82$), rescheduled appointments (grandiosity, $\rho = .192, p = .16$; vulnerability, $\rho = .055, p = .68$), or no-shows (grandiosity, $\rho = .040, p = .77$; vulnerability, $\rho = -.028, p = .84$).

Symptom Levels and Symptom Change in Psychotherapy

The Bayesian estimation procedure revealed that there was statistically significant individual-level variance in both initial symptom levels and linear rates of symptom change, suggesting that there was ample variability between individuals that could potentially be predicted by individual differences in pathological narcissism assessed by the PNI. To examine this possibility, linear mixed-effects models were estimated in which the PNI scales were used to predict each individual’s initial symptom level (at 0 sessions of psychotherapy) and linear rate of change early in the therapy.

Depression. Narcissistic vulnerability predicted participants’ levels of depression symptoms ($b = 0.56, t = 2.78, p = .006, r = .44$), and this effect remained when controlling for grandiosity ($b = 0.73, t = 3.07, p = .003, r = .49$). However, grandiosity itself did not relate to depression symptoms ($b = 0.09, t = 0.41, p = .69, r = .07$). Neither scale predicted rates of linear change in depression over the course of early therapy, and the interaction of grandiosity and vulnerability did not predict either depression level or change in depression scores over time.

Mania. In contrast to depression, narcissistic grandiosity predicted clients’ levels of mania symptoms ($b = 0.26, t = 2.51, p = .01, r = .40$), and this effect persisted when controlling for vulnerability ($b = 0.28, t = 2.23, p = .03, r = .36$). Vulnerability itself was not significantly related to mania levels ($b = 0.12, t = 1.07, p = .28, r = .17$). Neither variable predicted change in mania symptoms over time, however, and grandiosity and vulnerability did not interact to predict either level of mania or rate of change in mania.

Panic. There was a trend for narcissistic vulnerability to predict panic levels ($b = 0.51, t = 1.82, p = .07, r = .30$). This effect was statistically significant when controlling for grandiosity ($b = 0.73, t = 2.16, p = .03, r = .35$), although grandiosity was not significantly related to panic scores, either alone ($b = 0.01, t = .04, p = .99, r = .01$) or along with vulnerability

($b = -0.39, t = 1.15, p = .24, r = -.19$). Neither grandiosity nor vulnerability nor their interaction predicted change in panic scores over time.

Psychosis. Vulnerability was positively related to levels of psychosis on the TOP ($b = 0.56, t = 2.33, p = .02, r = .37$), and this effect remained when controlling for grandiosity ($b = 0.70, t = 2.40, p = .02, r = .39$). Grandiosity was not related to psychosis levels ($b = 0.13, t = .53, p = .60, r = .09$), nor did either variable nor their interaction predict change in psychosis symptoms over time.

Sleep. Narcissistic vulnerability was positively related to initial sleep problems on the TOP ($b = 0.42, t = 2.23, p = .03, r = .36$). Grandiosity was not related to sleep problems by itself ($b = -0.05, t = .25, p = .83, r = -.04$), but when grandiosity and vulnerability were both entered into the model, grandiosity was marginally (and negatively) associated with these scores ($b = -0.40, t = 1.84, p = .06, r = -.32$), whereas vulnerability continued to be positively associated with them ($b = 0.64, t = 2.94, p = .004, r = .47$). In addition, the interaction of grandiosity and vulnerability significantly predicted changes in sleep problems over the course of early therapy ($b = -0.03, t = 1.94, p = .045, r = -.35$). Figure 1 shows predicted curves of sleep problems over time for individuals with different levels of grandiosity and vulnerability. Those with low grandiosity scores did not change much over time, whereas the sleep problems scores of those high in grandiosity moved in opposite directions depending on their vulnerability. According to the model, individuals with high grandiosity and high vulnerability see their sleep problems decline slightly from relatively high levels, whereas individuals high in grandiosity but low in vulnerability increase in sleep symptoms over the course of early therapy from a low baseline level.

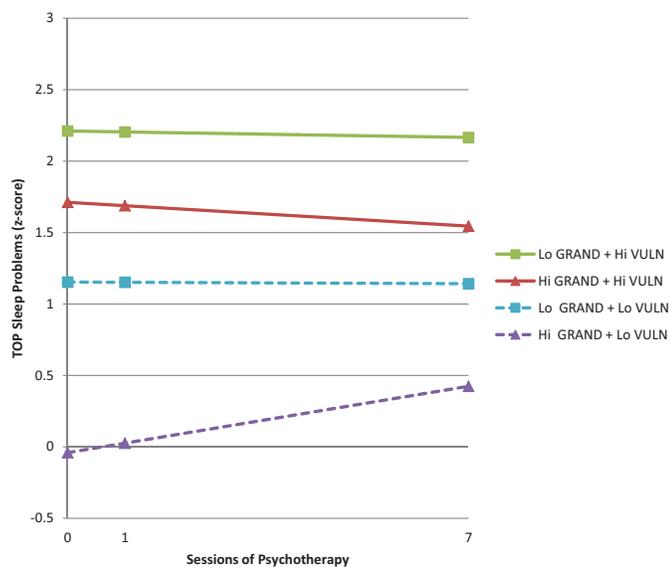


FIGURE 1.—Predicted early-therapy scores on the Treatment Outcome Package (TOP) Sleep Problems scale for participants high (+1 SD from sample mean) and low (–1 SD from sample mean) on narcissistic grandiosity (GRAND) and narcissistic vulnerability (VULN) on the PNI. Sleep Problems scores represent standard deviations from community (nonclinical) norms, with higher scores representing higher levels of pathology. (Color figure available online.)

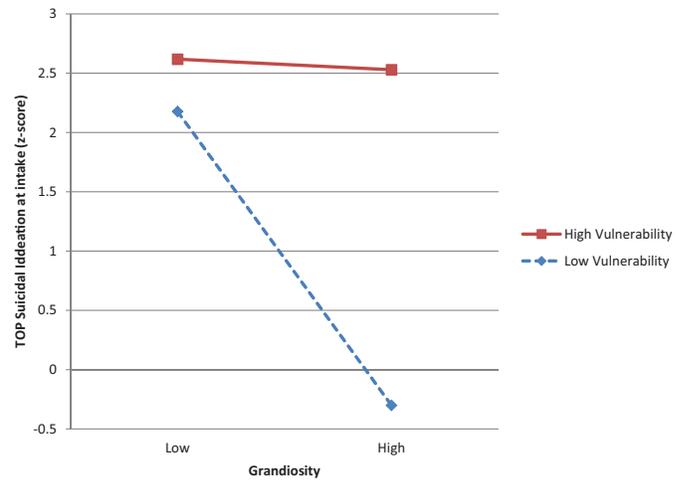


FIGURE 2.—Predicted initial scores on the Treatment Outcome Package (TOP) Suicidal Ideation scale for participants high (+1 SD from sample mean) and low (–1 SD from sample mean) on narcissistic grandiosity and narcissistic vulnerability on the PNI. Suicidal Ideation scores represent standard deviations from community (nonclinical) norms, with higher scores representing higher levels of pathology. (Color figure available online.)

Suicidal ideation. Neither narcissistic grandiosity ($b = -0.12, t = .33, p = .76, r = -.05$) nor narcissistic vulnerability ($b = 0.40, t = 1.04, p = .29, r = .17$) predicted initial levels of suicidal ideation, but the interaction of these two variables was related to suicidality at a trend level ($b = 0.82, t = 1.87, p = .06, r = .31$). Figure 2 displays this interaction; individuals with high levels of vulnerability reported high levels of suicidal ideation regardless of grandiosity scores, but those with low vulnerability only reported high levels of suicidal ideation if they also had low grandiosity. Otherwise, they tended to report very little suicidal ideation. Neither variable predicted change in suicidal ideation scores over time, however.

Violence. Grandiosity was significantly and positively related to TOP violence scores at intake ($b = 0.66, t = 2.34, p = .02, r = .37$), and this effect remained significant when vulnerability was added to the model ($b = 0.66, t = 1.93, p = .05, r = .31$). In addition, the interaction of grandiosity and vulnerability predicted violence scores ($b = 0.83, t = 2.65, p = .008, r = .43$). Figure 3 shows this interaction, which suggests that high levels of violence (chiefly homicidal ideation) were likely only with the combination of high grandiosity and high vulnerability; otherwise, TOP violence scores were moderate. The PNI higher order scales did not relate to change in violence scores over the course of early therapy.

DISCUSSION

To our knowledge, this study is the first to assess the impact of pathological narcissism on psychotherapy utilization, initial symptom severity, and early-treatment symptom change using a comprehensive measure of pathological narcissism (including both grandiosity and vulnerability). Consistent with expectations, narcissistic grandiosity was related to decreased utilization of several clinical services and with a higher rate of client-initiated psychotherapy discontinuation. This is generally

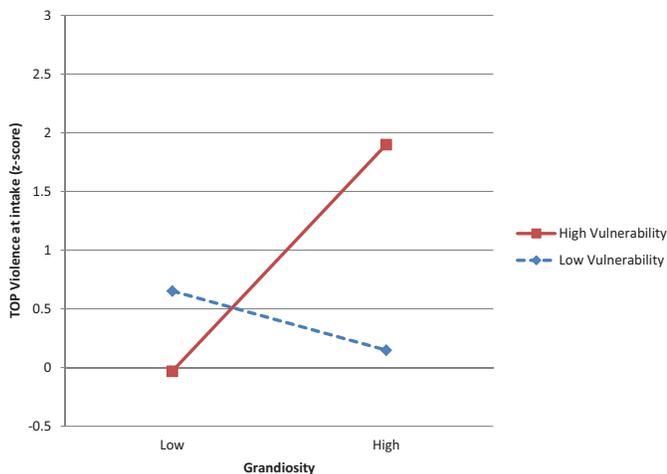


FIGURE 3.—Predicted initial scores on the Treatment Outcome Package (TOP) Violence scale for participants high (+1 *SD* from sample mean) and low (−1 *SD* from sample mean) on narcissistic grandiosity and narcissistic vulnerability on the PNI. Violence scores represent standard deviations from community (nonclinical) norms, with higher scores representing higher levels of pathology. (Color figure available online.)

consistent with the findings of Hilsenroth et al. (1998) and Campbell et al. (2009), in that higher levels of narcissism predicted therapy dropout, although these prior studies used different measures of narcissism than we used here.

The PNI higher order subscales of narcissistic grandiosity and narcissistic vulnerability were also associated with diverse psychiatric symptoms. In general, these relationships seem to mirror those in the clinical literature and provide additional validity evidence for the PNI higher order scales (see also Pincus, 2013). Narcissistic grandiosity was associated with increased levels of TOP mania scores and TOP violence scores (the latter only in the context of high vulnerability). These patterns support the clinical insight that pathological narcissism, especially grandiosity, leads to expansive self-absorption and aggression that could disrupt therapeutic engagement even among treatment-seeking individuals (e.g., Abraham, 1919/1927; Beck et al., 2004; Kernberg, 2004, 2007). In contrast, narcissistic vulnerability was associated with internalizing symptoms and feelings of depletion (TOP depression, panic, psychosis, and sleep problems). Thus, the results reported here suggested that vulnerable and grandiose elements of narcissism related uniquely to psychiatric symptoms at intake. In addition, the interaction of grandiosity and vulnerability was marginally related to suicidality and homicidal ideation and patterns of change in sleep problems over the early course of therapy. Thus, the results support the notion that a multifaceted narcissism construct (e.g., Miller et al., 2010; Pincus & Lukowitsky, 2010; Russ, Shedler, Bradley, & Westen, 2008) has clinical utility beyond the *DSM-IV* description of NPD, which focuses exclusively on grandiosity (Cain et al., 2008).

The fact that only one participant in this sample carried a formal diagnosis of NPD highlights the importance of assessing facets of pathological narcissism as dimensional variables, even among individuals who would not meet criteria for a proper diagnosis of *DSM-IV* NPD. The sample used in this study was not chosen on the basis of narcissistic pathology, but even at fairly

moderate levels, pathological narcissism related to important clinical variables. These findings lend support to the argument that a revised and broadened view of pathological narcissism would be a clinically useful and broadly relevant construct for inclusion in a comprehensive nosological system of personality pathology (Miller et al., 2010; Pincus, 2011; Ronningstam, 2009, 2011). Nevertheless, it remains to be seen how the PNI would relate to clinical outcomes in a more severely narcissistic sample (e.g., one in which individuals with NPD were oversampled).

We found little evidence supporting our hypothesis that pathological narcissism significantly interferes with symptom change over the early sessions of psychotherapy. Although narcissistic patients are often considered difficult and resistant, PNI scores generally were not associated with rates of symptom reduction. It should be noted that this finding is not necessarily inconsistent with the clinical observations discussed earlier, most of which pertain to therapies that are designed to last much longer than the seven-session segments analyzed in this study. However, given that several studies suggest that substantial symptom change occurs in early treatment (e.g., Hansen, Lambert, & Forman, 2002; Howard, Kopta, Krause, & Orlinsky, 1986; Kopta, Howard, Lowry, & Beutler, 1994), it is meaningful (and somewhat surprising) that pathological narcissism does not seem relate to the success of this phase of treatment. It is possible that one or more unexamined variables moderate the impact of narcissism on therapeutic change, such as a diagnostic or interpersonal characteristic of the patient (Kolden et al., 2005). However, our results suggest overall that pathological narcissism negatively impacts psychotherapy utilization and is associated with the severity of symptoms at intake, but, if utilization issues can be resolved, pathological narcissism does not generally appear to interfere with initial symptom reduction in a naturalistic clinical context.

Several limitations of this study deserve mention. First, because participants were recruited by clinic referrals and were enrolled in a naturalistic way, narcissism was measured at various points during psychotherapy. Thus, narcissism could not be evaluated as a purely prognostic factor in this analysis, because it was not measured before therapy began. In addition, the individuals in the sample received varying “doses” of therapy, and because narcissistic grandiosity was associated with client-initiated termination, we restricted the analyses of symptom change to early treatment (in most cases, from intake to Session 7). This reduced the sample by about a third and eliminated symptom data collected later in treatment, which reduced the power of these analyses and prevented any consideration of ongoing symptom improvement. Third, this study entailed independent tests of several models of the relationship between pathological narcissism and the criterion variables. It is thus possible that one or more of these findings occurred by chance. For this reason, the results of this study should be considered exploratory, and future research examining predictions about specific facets of narcissism and specific symptoms would provide a stronger test of these associations.

Overall, this study provides support for the long-standing clinical notion that client narcissism impacts psychotherapy utilization and course. To clarify this picture, large-scale projects with enough power to examine moderators of these effects would be especially helpful. For example, certain other client, therapist, or dyadic variables might influence the impact of pathological

narcissism on psychotherapy. It is also possible that certain types of interventions might be less vulnerable to the deleterious effects of client narcissism than others, and future research in this area would be very useful. In addition, given the detailed theoretical and empirical literature on the interpersonal impact of pathological narcissism (Dickinson & Pincus, 2003; Friedman, Oltmanns, Gleason, & Turkheimer, 2006; Lukowitsky & Pincus, in press), research is needed to elucidate the mechanisms by which narcissism relates to service utilization and psychotherapy outcome. For example, client narcissism might lead to a harmful activation of narcissistic elements of the therapist's personality (Luchner, Mirsalimi, Moser, & Jones, 2008), leading to disengagement with the therapeutic process (Diamond, Yeomans, & Levy, 2011; Stern, Yeomans, Diamond, & Kernberg, 2013), or narcissism might cause a heightened sensitivity to shame on the part of the client (Gramzow & Tangney, 1992) and a tendency to respond with hostility to narcissistic injury (South, Oltmanns, & Turkheimer, 2003). These negative feelings might then lead to early termination and reluctance to use adjunctive services. Further research on these questions would help determine how pathological narcissism explicitly impacts psychotherapy.

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