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PROCESSES OF CHANGE IN PSYCHOTHERAPY FOR NARCISSISTIC PERSONALITY DISORDER

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The present study aims at determining the role for outcome of potential processes of change in psychotherapy for narcissistic personality disorder (NPD). They were examined on three levels: the content, the process, and the relationship. A total of 161 patients suffering with NPD were recruited in a naturalistic setting as part of the present study. They underwent a long-term clarification-oriented psychotherapy. Sessions 15, 20, and 25 were video- or audio-recorded and analyzed with an observer-rated instrument that measures the quality of the interaction processes from the patient's and therapist's perspectives. Different self-report measures were used to assess therapy outcomes. In-session improvement was observed in both patient and therapist processes across sessions. Patient improvement in the three levels of processes was systematically related with outcome. Only partial relationships were found between therapist improvement and outcome. The present study represents the first systematic insight into core changes in patients with NPD undergoing psychotherapy.

Keywords: narcissistic personality disorder, process-outcome study, mechanism of change, psychotherapy, Clarification-Oriented Psychotherapy

Since the inclusion of narcissistic personality disorder (NPD) in Axis II of the *DSM-III* (American Psychiatric Association, 1980), psychiatry and psychotherapy have shown an increasing interest in the conceptualization and treatment of narcissism (Kernberg, 1998; Ronningstam, 2005a; Sachse, 2019b; Young & Flanagan, 1998).

Patients presenting with pathological narcissism or NPD can exhibit arrogant and domineering attitudes, attention seeking, need for admiration, fluctuation in empathic ability, sense of specialness, or perfectionism and high standards (Caligor, Levy, & Yeomans, 2015; Pincus & Lukowitsky, 2010; Ronningstam, 2010, 2011). This pattern of features is labeled with the term *narcissistic grandiosity* (Cain, Pincus, & Ansell, 2008; Pincus & Roche, 2011). A somewhat different clinical presentation of narcissistic pathology

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is termed *narcissistic vulnerability*, which is marked by more insecure and hypersensitive traits, with a vulnerable and dysregulated self-esteem, intense feelings of shame and guilt, and social withdrawal (Cain et al., 2008; Caligor et al., 2015; Pincus & Roche, 2011). As Ronningstam (2009) notes, a narcissistic patient can present both themes of grandiosity and vulnerability, depending on the reaction, for example, to a threat to self-image that may either trigger the deployment of the grandiose part as a psychological defense or may evoke insecurity and fragility in the self. Another difficulty related to narcissistic pathology is the low capacity to identify and describe one's own feelings (Dimaggio & Lysaker, 2015; Dimaggio et al., 2007; Krystal, 1998; Taylor, Bagby, & Parker, 1997). The latter is connected with emotional dysregulation and strong variations in empathic functioning in patients with pathological narcissism, which is linked with interpersonal difficulties (Ronningstam, 2016).

In addition, pathological narcissism has been associated with other difficulties such as dysthymia and major depression, alcohol and substance use disorders, impulsivity and suicidality, interpersonal problems, and risk for therapy dropout (Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Links, Gould, & Ratnayake, 2003; Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009; Pincus & Lukowitsky, 2010; Ronningstam, 1996, 2005b). These elements highlight the global complexity of narcissistic pathology and the resulting difficulty in treating patients with pathological narcissism. The prevalence of NPD in the clinical population and in outpatient private practices is high (up to 20%; Ronningstam, 2009) and presents general clinical issues in treatment such as the construction of a trusting therapeutic relationship or the management of in-session avoidance, as the focus on problematic and pivotal content may trigger a fragile self-image in the patient (Caligor et al., 2015; Kramer, Berthoud, Keller, & Caspar, 2014; Ronningstam, 2012). Taking into account these challenges, it is critical to develop not only effective treatments for NPD and pathological narcissism, but also a better understanding of the mechanisms of change in psychotherapy these patients through.

MECHANISMS OF CHANGE: THEORETICAL CONSIDERATIONS AND EMPIRICAL EVIDENCE

On the basis of the clinical issues outlined, it is essential not only to go beyond the mere demonstration of outcome in psychotherapy, but also to improve our understanding of the underlying processes at work in treatment (Clarkin, 2014; Kramer, 2019) by conducting psychotherapy studies similar to those that have addressed borderline personality disorder (De Meulemeester, Vansteelandt, Luyten, & Lowyck, 2018; Fonagy & Bateman, 2006; Gratz, Bardeen, Levy, Dixon-Gordon, & Tull, 2015; Levy et al., 2006). At the present time, the mechanisms of changes in NPD are insufficiently understood.

Several categories of variables have been described and postulated as potential mechanisms of change in personality disorder (PD) treatments.

Fernandez-Alvarez, Clarkin, del Carmen Salgueiro, and Critchfield (2006) have reviewed the participant (patient and therapist) factors influencing treatment outcome. Regarding patient factors, they mention the capacity to engage in treatment and the previous history of positive attachments. Regarding therapist characteristics, they suggest the ability to be open-minded, patient, and flexible in the therapeutic approach practiced; to accept long-term and emotionally intense relationships; to tolerate one's own intense, uncomfortable feelings due to the therapeutic and relational processes; and to be trained and have experience with treating patients with PDs. In terms of therapy relationship factors, Smith, Barrett, Benjamin, and Barber (2006) mention, among others, a good therapeutic alliance between the patient and the therapist, with an active therapist who sets clear limits, is flexible in his or her therapy protocol, focuses on deep issues, handles alliance ruptures accurately, and avoids apparent expression of countertransference. Therapy outcome for patients presenting with a PD is also enhanced with the elaboration of precise interpretations focused on the patient's deep relational issues (Smith et al., 2006). The authors also emphasize the need for further exploration of mechanisms of change in PD, especially concerning the therapeutic relationship and its different aspects for the various PDs.

Kazdin (2009) emphasizes the importance of a better understanding of the key processes and mechanisms that lead to change in therapy, not only to obtain scientific explanations of how therapy works but also to directly enhance clinical change in patients. He presents and distinguishes between different useful concepts used in psychotherapy research to understand processes at work in treatments: moderators, mediators, and mechanisms of change. While a mediator is "an intervening variable that may account (statistically) for the relationship between the independent and dependent variables" (Kazdin, 2009, p. 429), a mechanism of change represents the theoretically anchored process that is responsible for the change. If the study of potential mediators is relevant, it is also necessary to explore other principles such as the gradient, which is the link between the amount of change in the studied variable and the amount of symptom change (Kazdin, 2009).

The empirical study of the mechanisms of change in NPD treatments is in its infancy. Two small exploratory studies have recently explored this question empirically. Kramer, Pascual-Leone, Rohde, and Sachse (2016) carried out a process-outcome analysis with 39 patients with PDs (49% of the total sample presented with NPD) undergoing Clarification-Oriented Psychotherapy (COP). They found that emotional processing, that is, the awareness, regulation, and integration of emotions (Greenberg & Pascual-Leone, 2006), predicted 18% of the change in depression intensity in patients with a good outcome. The same research team explored the role of shame and self-compassion in depression and general symptoms in 17 patients presenting with NPD (Kramer, Pascual-Leone, Rohde, & Sachse, 2018). These results suggested that shame as a therapeutic target is useful in patients with NPD during the working phase of treatment. Indeed, the small decrease in shame that was found was linked with the decrease in depression intensity across treatment.

CLARIFICATION-ORIENTED PSYCHOTHERAPY: PROCESSES AND CLINICAL RELEVANCE FOR NPD

Because the present study focuses on Clarification-Oriented Psychotherapy (COP), we will briefly review its theoretical and empirical underpinnings. COP is an integrative treatment based on person-centered psychotherapy and is mostly conducted in private practices in German-speaking countries. It has been specifically developed for the treatment of NPD and other PDs (Sachse, 2019b). In COP, every patient's and therapist's manifestation can be understood in terms of difficulty or resource from three different angles: content, process, and relationship. *Content* represents what the patient and the therapist express on the verbal level in the interaction. It involves the patient's openness and readiness to explore and clarify his or her internal determinants, such as emotions, cognitions, assumptions, and expectations related to the actual problem. For the therapist, it encompasses the ability to focus on the patient's central content and convey an accurate understanding to the patient. *Process* concerns how the patient relates to his or her content and if this process is disturbed by avoidance. An example of a process difficulty could be a patient who connects with relevant content but with a strong emotional arousal that is difficult to face and thus changes the patient's focus to a less or nonrelevant topic that is easier to connect with. Here, the therapist's function is to address avoidance, notably through process guidance, which has been shown to be helpful (Sachse, 1992; Sachse & Elliott, 2002). *Relationship* concerns the relational aspects of the therapeutic relationship, as, for example, the patient's manifestations of his or her interactional difficulties, the quality of the relationship and the understanding offered by the therapist, and how the therapist deals with the patient's interactional difficulties. With NPD patients, the relationship aspect is pivotal and has to be the focus of at least the first part of therapy, rather than the content and process levels (Ronningstam, 2012; Smith et al., 2006).

In the COP model, relationship manifestations may be understood on two different levels. The first level is the authentic action system, which represents the person's (resourceful) access to need satisfaction via authentic actions that are based on basic interactional motives such as appreciation and significance for others, and other motives. The second level is the strategic action system, which describes all the indirect (and more problematic) means (or interactional maneuvers) the patient uses for need satisfaction. Using these strategies cannot totally fulfill the patient's needs and, on the contrary, can leave the patient dissatisfied with his or her interactions (Sachse, 2019b).

It is recommended that treatment be organized in several phases in the context of an iterative process. During the first 10 to 20 sessions, the therapeutic focus is on understanding and reducing the interactional maneuvers presented by the patient, notably by offering a specific therapeutic relationship complementary to satisfaction of (authentic basic) motives (Caspar, 2007; Sachse, 2019a). After the relational aspects have improved during the first months of treatment, the therapeutic focus can be moved onto the core working phase of COP, namely the clarification of internal determinants such as emotions, cognitions, motives, and expectations concerning interactional

maneuvers, while containing and clarifying (i.e., rendering explicit) the patient's avoidance tendencies.

A few studies have examined the empirical validity of COP (Sachse, 1992, 2006; Sachse & Takens, 2004). In a randomized controlled trial, Bamelis, Evers, Spinhoven, and Arntz (2014) compared findings between Schema-Focused Therapy (SFT), COP, and treatment as usual with different PDs, including mostly avoidant, dependent and obsessive-compulsive PDs (4.95% of the study sample were patients with NPD). The authors found that SFT and COP presented large recovery rates over 3 years of treatment, with comparable drop-out rates. They also highlighted the superiority of SFT on different outcome measures compared with the other two treatments. Nevertheless, methodological problems have to be noted, especially that no supervision was provided in COP and no adherence checks were undertaken. Therefore, it is unclear whether the treatment studied was COP or something else. Also, only a small portion of the sample presented with a *DSM-IV* diagnosis of NPD. A small naturalistic trial of 29 NPD patients treated with COP (Sachse & Sachse, 2016) demonstrated increases in self-efficacy and action-orientation and decreases in interpersonal insecurity, expressed aggressiveness, and obsessional traits ($1.34 < d < 2.31$).

THE PRESENT STUDY

In light of the existing literature and current clinical considerations related to the treatment of patients with NPD, we formulated the following hypotheses:

1. The quality of psychotherapeutic in-session processes assessed in patients and therapists improves across the working phase of therapy. We predicted that the quality of all three levels (content, process, and relationship) from the patient's perspective increases, and the quality of the therapist's relationship, of the therapist's understanding, and the therapist's guidance of the process improve during the working phase of COP.

2. Changes in quality in patient and in therapist processes are assumed to be linked with symptom changes presented by patients at the end of therapy.

METHOD

PARTICIPANTS

Patients. The study was proposed to 184 self-referred patients presenting with NPD. Twenty-three patients were excluded because of missing outcome (13 patients), early dropouts (5 patients), and missing values (5 patients). A total of 161 patients presenting with NPD were included in the present study. All were in treatment at a center in Germany specializing in the treatment of patients with personality disorders. One hundred and two (63.4%) of the patients were male. Their mean age was 38.35 years old (SD = 11.42; range = 18–73). The majority of the patients were married (52.1%), 40.4% were not, 5.6% were divorced, and 1.9% were separated. Concerning their education level, 26.1% had a high school diploma ("Abitur," 12 years of formal education), 26.1% a secondary school level ("Mittlere Reife," 10 years

of formal education, comparable to a British General Certificate of Secondary Education), 21.7% had a main school level ("Hauptschule," 10 years of formal education, offering Lower Secondary Education, according to the International Standard Classification of Education), and 14.9% had a university degree (16–18 years of formal education). Finally, 44.7% were white-collar workers, 33.5% were unemployed, 5.6% had an independent status, and 4.4% were blue-collar workers. Patients were selected from a larger naturalistic trial sample (N = 382), and the inclusion criterion was NPD according to the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). The quality of the SCID-II diagnoses was guaranteed by regular clinical supervision at the center, which encompassed 100% of the cases included in the present study. All patients were German-speaking and provided written consent concerning the use of their data.

Therapists. The therapists (N = 44) were psychologists and psychiatrists in postgraduate training to become psychotherapists according to the German law. There were 33 women and 11 men, with a mean age of 26.4 years (range = 23–34). They all were supervised by the developers of COP.

TREATMENT

Clarification-Oriented Psychotherapy (COP) is based on client-centered psychotherapy and is an integrative treatment relevant for patients with PDs (Sachse, Schülken, Leisch, & Sachse, 2011). It places emphasis on the identification and decrease of interactional maneuvers presented by patients, and on the clarification of core schemas (beliefs, emotions, and motives). On the one hand, COP aims at increasing patient awareness of interactional maneuvers and the internal awareness of the patient's representations and motives linked to his or her interpersonal difficulties. On the other hand, COP aims at modifying the internal determinants of the problematic interactional behaviors and constructing new representations and experiences. In the present study, treatments were supervised and lasted between 40 and 90 sessions (mean = 63.5 sessions), depending on treatment indication. No adverse events were reported.

INSTRUMENTS

The Bearbeitungs-, Inhalts-, Beziehungsskalen [Process-Content-Relationship Scale] (BIBS) is an observer-rated instrument assessing the quality of the clarification processes in patients and therapists on the levels of content, process, and relationship (Sachse, Schirm, & Kramer, 2015; Sachse et al., 2011). It contains 54 items included in nine subscales. Each item is rated on a 7-point Likert scale: the better the process quality, the higher the score on the Likert scale. Three subscales concern the patient: (1) *Content* (7 items): how the patient works on central themes (emotions, schemes), (2) *Process* (7 items): the patient's avoidance (or not) of focusing on affective arousal, and (3) *Re-*

lationship (6 items): assessment of the functional and dysfunctional aspects the relationship offered by the patient (including the interactional games).

The six other subscales concern the therapist: (1) *Therapist relationship* (6 items): the quality of the relationship offered by the therapist, (2) *Therapist understanding* (6 items): how the therapist understands the situation brought by the patient and how empathic the therapist is with the patient, (3) *Therapist process guidance* (8 items): the quality of the therapist's directivity, (4) *Treatment of patient avoidance* (2 items): how the therapist deals with patient avoidance, (5) *Treatment of interactional games* (6 items): the quality of the therapist's interventions aiming at dealing with interactional games, and (6) *Treatment of schemes* (6 items): how the therapist works on patient schemes. The last three scales were not used in the present study. The *Treatment of patient avoidance* and the *Treatment of interactional games* are two clinically helpful subscales, but in the present study, they suffered from selection bias because only patients with a specific score on process or relationship subscales were rated on these therapist subscales. Therefore, the power in these two subscales is insufficient. Concerning the *Treatment of schemes*, the present study focused on the working phase of COP that is represented by clarification processes, which omits schemes treatment. Therefore, a floor effect (absence of reliability in BIBS scores) is expected. Cronbach's alpha for the patient subscales (current sample) averaged at .83, and Cronbach's alpha for the therapist subscales (current sample) averaged at .70.

Concerning rater reliability, a total of six pairs of raters scored 60 cases (37% of the total sample). Video- or audio-recordings of 10 minutes from the midsession section (between minutes 10 and 20) of the 15th, 20th, and 25th sessions were used for both patient and therapist ratings. The total mean of intraclass coefficients was .74 (*SD* = .10, range = .54–.83).

The Beck Depression Inventory (BDI) is a self-report questionnaire that measures the severity of depressive symptoms (Beck, Steer, & Brown, 1996). Each of the 21 items is rated on a Likert-type scale ranging from 0 to 3, with higher scores indicating greater severity. It gives a global score, which is the sum of all items. This questionnaire was translated into German and validated (Cronbach's alpha = .76–.95; Hautzinger, Bailer, Worall, & Keller, 1995). Mean BDI at intake for the sample was 14.86 (*SD* = 8.16; range = 0–41), which indicates a mild depression intensity, and 8.29 at discharge (*SD* = 7.13, range = 0–35), which represents a minimal depression intensity. Pre-post effect was significant, $t(1, 157) = 13.31$, $p = .000$, $d = 0.85$.

The Brief Symptom Inventory (BSI) is a self-report instrument that evaluates psychological distress and symptoms (Cronbach's alpha = .70–.89; Franke, 2000, for the German version). It is composed of 53 items and nine dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). Each item is rated on a 5-point Likert scale, from 0 (*not at all*) to 4 (*extremely*). We used the Global Severity Index (GSI), which is the mean for all rated items. Mean GSI at intake for the sample was 1.22 (*SD* = 0.57; range = 0.25–3.22) and 0.81 at discharge (*SD* = .60, range = 0.02–2.96). Pre-post effect was significant, $t(1, 151) = 14.03$, $p = .000$, $d = 0.70$.

The Inventory of Interpersonal Problems (IIP-D) is a self-report questionnaire that assesses interpersonal functioning (Cronbach's alpha = .71–.82; Horowitz, Strauss, & Kordy, 1994). For the present study, the short form of the IIP-D was used, with six subscales containing a total of 12 items. Each item was rated on a 5-point Likert scale (from 0 = *not at all* to 4 = *very much*). Mean IIP at intake for the sample was 3.83 (*SD* = 1.33; range = .8–.10) and 2.94 at discharge (*SD* = 1.31, range = 0–9). Pre-post effect was significant, $t(1, 157) = 9.96$, $p = .000$, $d = 0.67$.

PROCEDURE

Consistent with the sequential ordering of phases in COP, three sessions from the working phase were selected. The first study session was selected in the supposedly early working phase, that is, Session 15, then two subsequent sessions from the working phase were selected, that is, Session 20 and Session 25 (thus three sessions per patient). Concerning the BDI, the GSI, and the IIP-D, questionnaires were filled out by patients after the first and last sessions.

STATISTICAL ANALYSES

Process analyses were performed on completers, independent of outcome.

To test our first hypothesis, namely the improvement of processes in patients and therapists across Sessions 15, 20, and 25, a three-level hierarchical linear model (HLM; Bryk & Raudenbush, 1987) was conducted with processes on Level 1 ($\gamma_{ij} = \beta_{oj} + \beta_{1j} * (\text{session}_{ij}) + r_{ij}$), patients on Level 2 ($\beta_{oj} = \gamma_{00} + \mu_{oj}$; $\beta_{1j} = \gamma_{10} + \mu_{1j}$), and therapists on Level 3 ($\gamma 00 = \pi 00 + r00$; $\gamma 10 = \pi 10 + r10$; $\gamma 11 = \pi 11 + r11$).

To explore our second hypothesis, that is, the link between change in processes in patients and therapists across Sessions 15, 20, and 25, and symptom change between pre-post therapy, symptom change was first computed in delta (score at pre – score at post). Then, a second three-level HLM was used, with COP processes on Level 1 ($\gamma_{ti} = \pi_{0i} + \pi_{1i} * (\text{session}_{ti}) + e_{ti}$), pre-post symptom change on Level 2 ($\pi_{0i} = \beta_{00} + r_{0i}$; $\pi_{1i} = \beta_{10} + \beta_{11} *$(pre-post symptom change) $+ r_{1i.}$, and therapists on Level 3 (see above). Results with robust standard errors were chosen to be presented.

RESULTS

PRELIMINARY ANALYSES

Preliminary analyses showed that the average means of all subscales of the BIBS obtained by patients and therapists at Session 15 were generally within one standard deviation from the means found in the validation study for patients presenting with NPD (Sachse et al., 2015). This was true for all subscales except for patients' *Content*, which was particularly low in the present study. For patients in the present study: mean *Content* = 1.44, *SD* = 1.31, rang = 0–4 (for patients in the validation study: mean *Content* = 2.90; Sachse et al., 2015); mean *Process* = 1.16, *SD* = 1.03, observed range = 0–3.67 (1.98);

mean *Functional Relationship* = 2.09, *SD* = 1.53, range = 0–6.33 (3.33); mean *Dysfunctional Relationship* = 1.63, *SD* = 1.26, range = 0–5 (2.61). For therapists: mean *Relationship* = 4.54, *SD* = 1.30, range = 1.5–6 (4.20); mean *Understanding* = 4.49, *SD* = 1.34, range = 1–6 (4.07); mean *Process guidance* = 3.43, *SD* = 1.19, range = 0–5.63 (3.26). Whereas patients' quality of *Content* was below the one found in Sachse et al. (2015), the treatment delivered by the therapists in the present study corresponded in an adherent way to the principles of COP.

CHANGE IN PROCESSES

In order to test our first hypothesis, the improvement of processes in patients with NPD across treatment (Sessions 15 to 25), HLM analyses showed significant improvement for all patient process variables, namely quality of *Content* (Coefficient = 3.23; *SE* = 0.28; *t*-ratio = 11.46; $p < .001$), quality of *Process* (Coefficient = 3.98; *SE* = 0.28; *t*-ratio = 14.13; $p < .001$), *Functional relationship aspects* (Coefficient = 2.25; *SE* = 0.13; *t*-ratio = 16.58; $p < .001$), and *Dysfunctional relationship aspects* (Coefficient = 2.37; *SE* = 0.14; *t*-ratio = 16.65; $p < .001$). Concerning the therapist, the improvement was significant for all variables, namely *Therapist relationship* (Coefficient = 0.69; *SE* = 0.07; *t*-ratio = 9.47; $p < .001$), *Therapist understanding* (Coefficient = 0.72; *SE* = 0.14; *t*-ratio = 5.08; $p < .001$), and *Therapist process guidance* (Coefficient = 1.61; *SE* = 0.21; *t*-ratio = 7.45; $p < .001$). All processes improved in the predicted direction.

LINKS BETWEEN PROCESSES OF CHANGE AND OUTCOME IN TREATMENTS FOR NPD

In order to test our second hypothesis, the links between change in processes and symptom change presented by patients with NPD after treatment, HLM models were applied for each symptom change (pre- to postchange) and each process variable.

Concerning patient improvement and outcome change, significant correlations were found between all patient processes and BSI, IIP, and BDI, except for *Content* and BDI, and *Process* and BDI, as Table 1 shows.

A different pattern was discovered concerning therapist improvement and outcome change. Two significant correlations were found between the improvement of therapist processes and symptom change presented by patients, as Table 2 shows. *Therapist relationship* change was linked with BDI change, and *Therapist process guidance* change was linked with BSI change. Nonsignificant relationships were found between change in *Therapist relationship* and BSI and IIP changes; between change in *Therapist understanding* and BDI and IIP changes; and between change in *Therapist process guidance* and BDI and IIP changes.

For exploratory purposes and to understand which process variables were associated with the decrease of depression, we made Pearson's correlations between *Therapist relationship* at Session 15 and change in BDI, between *Therapist understanding* at Session 15 and change in BDI, between

TABLE 1. Relationship Between Client's Processes and Outcomes (*N* = 161)

Client's variables	*Coefficient*	*SE*	*t* ratio	*p* value
Content				
BDI	−0.02	0.03	−0.56	.57
BSI	−1.35	0.4	−3.7	< .001
IIP	−3.06	0.58	−5.24	< .001
Process				
BDI	−0.06	0.03	−1.93	.055
BSI	−0.78	0.26	−2.96	.004
IIP	−2.07	0.41	−4.99	< .001
Functional Relationship				
BDI	−0.05	0.01	−3.19	.002
BSI	−0.78	0.18	−4.25	< .001
IIP	−1.61	0.27	−5.79	< .001
Dysfunctional Relationship				
BDI	−0.03	0.01	−2.04	.04
BSI	−0.48	0.17	−2.76	.006
IIP	−1.48	0.23	−6.36	< .001

BDI: Beck Depression Inventory; BSI: Brief Symptom Inventory; IIP: Inventory of Interpersonal Problems.

Therapist process guidance at Session 15 and change in BDI. A small, significant correlation ($r = .16$, $p = .04$) was found between *Therapist understanding* and change in BDI. No other process variable was related to BDI change.

LINKS BETWEEN THERAPIST INTERVENTIONS AND PATIENT PROCESSES

For exploratory purposes, we tested predictor models between patient and therapist processes.

First, a linear regression model was used with therapist processes (*Relationship*, *Understanding*, and *Process guidance* were entered into the model, in a single block) at Session 15 as independent variables and patient processes (*Content*, *Process*, and *Functional* and *Dysfunctional Relationship aspects* were entered into the model) At session 20 as dependent variables. All therapist processes together at Session 15 predicted patient *Process* at Session 20, $F(1, 160) = 4.27$, $p = .003$. All therapist processes together at Session 15 predicted patient *Functional Relationship aspects* at Session 20, $F(1, 160) = 3.66$, $p = .007$. And all therapist processes together at Session 15 predicted patient *Dysfunctional Relationship aspects* at Session 20, $F(1, 159) = 5.71$, $p = .000$. This model was nonsignificant for patient *Content* at Session 20, $F(1, 160) = 2.25$, $p = .06$. A second linear regression model was used with therapist processes at Session 20 as independent variables and patient processes at Session 25 as dependent variables. All therapist processes together at Session 20 predicted patient *Content* at Session 25, $F(1, 160) = 12.78$, $p = .000$, patient *Process* at Session 25, $F(1, 160) = 17.21$, $p = .000$), patient

TABLE 2. Relationship Between Therapist's Processes and Outcomes (*N* = 161)

Therapist's variables	Coefficient	*SE*	*t* ratio	*p* value
Therapist relationship				
BDI	−0.02	0.01	−3.26	.001
BSI	0.12	0.29	0.43	.66
IIP	−0.83	0.53	−1.57	.19
Therapist understanding				
BDI	−0.01	0.01	−1.08	.28
BSI	0.05	0.3	0.18	.85
IIP	0.05	0.3	0.18	.85
Therapist process guidance				
BDI	−0.02	0.02	−0.73	.46
BSI	−0.70	0.32	−2.16	.03
IIP	−0.73	0.54	−1.36	.18

BDI: Beck Depression Inventory; BSI: Brief Symptom Inventory; IIP: Inventory of Interpersonal Problems.

Functional Relationship at Session 25, $F(1, 160) = 13.39$, $p = .000$, and patient *Dysfunctional Relationship* at Session 25, $F(1, 160) = 22.25$, $p = .000$.

Second, a linear regression model was used with patient processes at Session 15 (*Content*, *Process*, *Functional Relationship aspects*, and *Dysfunctional Relationship aspects* were entered into the model in a single block) as independent variables and therapist variables at Session 20 (*Relationship*, *Understanding*, and *Process guidance* were entered into the model) as dependent variables. All patient processes together at Session 15 predicted therapist *Relationship* at Session 20, $F(1, 160) = 3.49$, $p = .009$. All patient processes together at Session 15 predicted therapist *Understanding* at Session 20, $F(1, 160) = 2.91$, $p = .023$. And all patient processes together at Session 15 predicted therapist *Process Guidance* at Session 20, $F(1, 160) = 4.53$, $p = .002$. A second linear regression model was used with patient processes at Session 20 as independent variables and therapist processes at Session 25 as dependent variables. Here again, all patient processes together at Session 20 predicted therapist *Relationship* at Session 25, $F(1, 159) = 6.33$, $p = .000$, therapist *Understanding* at Session 25, $F(1, 159) = 5.29$, $p = .001$, and therapist *Process Guidance* at Session 25, $F(1, 159) = 5.60$, $p = .000$.

DISCUSSION

The present study examined the role for outcome of potential change processes on three different levels (content, process, and relationship) in the working phase of Clarification-Oriented Psychotherapy (COP) in a large sample of patients presenting with carefully *DSM-IV*–diagnosed NPD. Although the study was conducted in a naturalistic context, we can nonetheless say that the treatments delivered adhered to the COP model. First, treatments were supervised by COP developers, which allowed us to hypothesize a good treatment adherence. Second, the high average quality of patients' processes

that were found supported this hypothesis (see the validation study: Sachse et al., 2015).

Three key points were highlighted. First, in accordance with our hypothesis, significant improvement of all therapist and patient processes were observed through Sessions 15, 20, and 25 of treatment. Second, the improvements presented by patients in terms of content, process, and therapy-relational aspects were significantly linked with every outcome, with two notable exceptions (depressive symptoms and content, depressive symptoms and process). Third, whereas the therapists improved their abilities in terms of relationship, understanding, and process guidance, this improvement was only partially linked with outcome.

IMPROVEMENT IN QUALITY OF PATIENTS' AND THERAPISTS' PROCESSES

Our results showed that the quality of in-session processes in patients (*Content*, *Process*, and *Relationship*) and therapists (*Relationship*, *Understanding*, and *Process guidance*) increased significantly between Sessions 15 and 25 over the course of the working phase of psychotherapy. In parallel, we found a pre-posttherapy reduction of symptoms reported by patients presenting with NPD. More precisely, we found a significant decrease in terms of intensity of depression, in psychological distress and symptoms, and in interpersonal problems during the entire therapy, which demonstrates the effectiveness of COP in a large sample of patients with NPD. Even if they presented with a somewhat lower quality of processes at Session 15 compared to the Sachse et al. (2015) sample, patients in the present sample had a positive evolution both in terms of centrality of content, reduction of avoidance, and quality of relationship, and in terms of outcome.

LINKS BETWEEN QUALITY OF CHANGE PROCESSES AND OUTCOME

As Kazdin (2009) states, one of the main identifiers of a mechanism of change in psychotherapy is the relationship between the amount of change in the processes and the amount of change in symptoms. We tested this criterion with Hypothesis 2 in the present study.

We found that patient improvement in terms of centrality of content, quality of the relationship offered, and avoidance reduction seems to be a pattern responsible for change, notably regarding the decrease in general and interpersonal symptoms presented by patients. In other words, the more the patients presenting with NPD progress over time in COP, the more the quality of content, relationship, and process has a positive impact on their relational problems. This is a key finding because patients presenting with NPD suffer from interpersonal difficulties, which can occur in the therapeutic relationship (Ogrodniczuk & Kealy, 2013; Ronningstam, 2012). Interestingly, whereas the therapist's contribution to the relational mechanisms of change in PD treatments has been described and explored, little is known and dis-

cussed about the patient's contribution (Kramer et al., 2016, 2018; Smith et al., 2006). Our study offers elements for a better understanding of the contribution of patients with NPD to the relational mechanisms of change in therapy. We can mention, for example, the trust the patient can show toward the therapist and the possibility for the patient to be confronted (functional relationship), or the control and the interactional maneuvers the patient uses in the relationship (dysfunctional relationship).

If the improvement in therapist's variables was partially linked with symptom reduction presented by patients, we highlighted that it can be responsible for change concerning two different issues. First, the qualitative improvement in the relationship offered by therapist is linked with the reduction in depression presented by patient. This means that by offering acceptance, respect, warmth, authenticity, and congruence, the therapist may have an impact on the decreased intensity of depression presented by patients with NPD. In addition, the improvement in therapist process guidance was related to general symptom change. It should be mentioned that process guidance has been linked with outcome in previous studies of humanistic psychotherapies (Sachse 1992, 1993; Sachse & Elliott, 2002). This finding suggests that by internalizing the patient's perspective, and by guiding the patient into a deeper understanding of his or her internal determinants such as emotions and representations related to the interpersonal problems, the therapist can have a direct impact on the general symptoms presented by patients with NPD. Clinically, our results suggest that therapists may intervene in depressive and general symptoms presented by patients with NPD by working on the quality of the relationship they can offer to the patient and by learning to use a process-directive position, as opposed to a more nondirective approach, or a content-directive approach that would advocate explicit guidance on specific contents from the outset of treatment. Process guidance means leaving the choice of the content to the patient, which can be highly important in the case of NPD, and at the same time guiding the content in a direct way, by focusing step-by-step on core and deep internal determinants.

Although change in therapist understanding across the three sessions studied was not related to symptom change, we nonetheless found that therapist understanding score at Session 15 was correlated with outcome. The therapist's case formulation includes two different aspects: (1) the internal case formulation elements and (2) the expression, by the therapist, of his or her understanding in the sessions. Our results suggest that the second element, the therapist's understanding of the client's problems (Sachse, 2019a), must be of good quality early in treatment (Session 15) and may guide the therapist's future interventions.

Of note, our conclusions are supported by the results of our exploratory analyses of regressions. These analyses suggest that therapist interventions at Session 15 predict patient processes at Session 20 (except for *Content)* and that therapist's interventions at Session 20 predict patient processes at Session 25. Indeed, COP interventions by the therapist seem to foster the progression of process and relationship levels between Sessions 15 and 20. On a clinical level, this means that the therapist's impact on a patient pre-

senting with NPD can be maximized with interventions focused on the levels of process (Dimaggio, Montano, Popolo, & Salvatore, 2015; Krystal, 1998; Ogrodniczuk, 2013; Sachse, 2019a; Taylor et al., 1997) and relationship (Colli, Tanzili, Dimaggio, & Lingiardi, 2014; Kernberg, 1998; Kramer et al., 2014; Ronningstam, 2012, Sachse, 2019b). By prioritizing the work on process and relationship, therapists could also have an impact on the content level, in a second step. Interestingly, reversed linear regression analyses also suggest that patient processes at Sessions 15 and 20 predict therapist interventions at Sessions 20 and 25. This result can be interpreted as a mutual influence between therapist and patient, also called responsiveness (Kramer & Stiles, 2015; Stiles, Honos-Webb, & Surko, 1998). This concept suggests that behaviors are influenced by context, which includes interaction partners. In the present study, not only did therapist processes influence patient processes (except for *Content*), but patient processes also influenced therapist processes, in the context of a treatment for NPD.

LIMITATIONS AND FUTURE PERSPECTIVES

A number of limitations have to be acknowledged for the present study. First of all, our study did not include a control group, which makes it difficult to distinguish between general and therapy-specific processes. Second, only self-report questionnaires were used and no disorder-specific questionnaire was included in outcomes, such as the Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979) and the Pathological Narcissism Inventory (PNI; Pincus et al., 2009), which will be very relevant for future studies. In addition to addressing these limitations, a further study could include the demonstration of changes in SCID-II NPD criteria or in other specific problems related to pathological narcissism at follow-up. Third, the impact of comorbidities was not included in the analyses conducted.

In sum, the present study contributes to the understanding of potential mechanisms of change in therapy for patients presenting with NPD. We first found an improvement in the quality of processes in terms of content, relationship, and process during the working phase of COP. While change in patient processes was strongly linked with every outcome change presented by patients, including interpersonal symptoms, improvement in relationship and process guidance from the therapist's perspective had an impact on depression and general symptom remissions. If the present study represents a first step in the exploration of mechanisms of change in NPD, future research should focus on the other criteria proposed by Kazdin (2009) for the identification of change mechanisms in psychotherapy, such as specificity (the observed change is sufficiently different from other constructs) and experimental manipulation (the direct manipulation of the process has an impact on outcome). Moreover, it would be relevant to focus on different therapeutic frameworks, such as psychodynamic treatments, for example, in order to develop a more precise understanding of mechanisms of change at work in different psychotherapy approaches for NPD.

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