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Running Head: SHAME AND SELF-COMPASSION IN NARCISSISM

The Role of Shame and Self-Compassion in Psychotherapy

for Narcissistic Personality Disorder: An Exploratory Study

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The Role of Shame and Self-Compassion in Psychotherapy
for Narcissistic Personality Disorder: An Exploratory Study

Abstract

The present process-outcome study aims at exploring the role of shame, self-compassion and specific therapeutic interventions in psychotherapy for patients with narcissistic personality disorder (NPD). The present exploratory study included a total of $N = 17$ patients with NPD undergoing long-term clarification-oriented psychotherapy. Their mean age was 39 years and 10 were male. On average, treatments were 64 sessions long (range between 45 and 99). Sessions 25 and 36 were rated using the Classification of Affective Meaning States and the Process-Content-Relationship Scale. Outcome was assessed using the SCL-90 and BDI-II. Between session 25 and 36, a small decrease in the frequency of shame was found ($d = .30$). In session 36, the presence of self-compassion was linked with a set of specific therapist interventions (process-guidance and treatment of behavior-underlying assumptions; 51% of variance explained, adjusted). The present study points to the possible central role of shame in the therapeutic process of patients with NPD. Hypothetically, one way of resolving shame is, for the patient, to access underlying self-compassion.

Key-Words: Shame; Self-Compassion; Emotion Processing; Interaction Process; Narcissistic Personality Disorder ; Clarification-oriented Psychotherapy; Experiential Treatment

Practitioner messages:

1. An active therapeutic focus on shame may be useful in patients presenting with Narcissistic Personality Disorder, in particular in the working phase (after session 20) of the therapy process.
2. The emergence of self-compassion may be fostered by a process guiding intervention, in advanced working phase sessions (after session 35) with patients with Narcissistic Personality Disorder.

3. Once patients with Narcissistic Personality Disorder experientially access shame in session, its decrease over the course of the working phase of therapy might serve as an indicator of productive therapy process.

**The Role of Shame and Self-Compassion in
Psychotherapy for Narcissistic Personality Disorder: An Exploratory Study**

Introduction

Patients with narcissistic personality disorder (NPD), or pathological narcissism, may present at times with self-enhancing grandiosity, while at other times with a brittle or fragile sense of self. Such contrasting self-presentation of patients with the same underlying problems should be integrated in a comprehensive understanding of the disorder (Caligor, Levy, & Yeomans, 2015; Levy, Ellison & Reynoso, 2011; Ogrodniczuk, & Kealy, 2013; Pincus & Lukowitsky, 2010; Pincus & Roche, 2011; Roepke & Vater, 2014; Ronningstam & Weinberg, 2013). Core psychological features of NPD encompass a deficit in self-definition and affect regulation, a brittle sense of self and a lack of empathy which foster biased conceptualizations of Self and Other. Self-enhancement, in particular a sense of grandiosity, exaggerated entitlement or arrogance may help maintain a stable self-image. Often more implicitly, fluctuating self-esteem, self-criticism and affect dysregulation persist.

The quality of emotional processing underlying these core features of NPD is of key interest. Deficits in emotional processing as found on several dimensions which may be linked with the underlying subjective experience of shame. Emotional processing with regard to the Self lacks depth, i.e., low levels of emotional self-awareness, and with regard to the others, i.e., deficient emotion recognition and lack of empathy (Dimaggio & Attina, 2012; Marcoux et al., 2014; Pincus, & Lukowitsky, 2010; Ritter et al., 2011; Ronningstam, 2016; Sylvers et al., 2008). Lack of emotional empathy may explain the interpersonal difficulties reported as part of the NPD diagnosis (Ogrodniczuk et al., 2013). This lack of empathy in NPD has been discussed as a prerequisite for the self-referential processing bias related to self-enhancement and grandiosity: it becomes key to focus on the underlying emotional issues related with the understanding of the Self as shameful.

Patients with NPD tend to present with low levels of emotional awareness (Lecours et al., 2013; Mizen, 2014; Ronningstam, 2016; Joyce et al., 2013). Difficulty in describing one's inner emotional states has also been associated with grandiose and entitlement traits (Lawson et al., 2008). These results might indicate that these patients lack the capacity to be aware of their emotional life, and of its deeper meanings. In her conceptual and clinical account of the perceptual recognition of emotion in individuals with NPD, Ronningstam (2005) put forward a triad of emotions to which patients with NPD respond with less accuracy: these patients seem to have difficulties to identify fear, shame, and anger in others (see also Gehrie, 1983; Lewis, 1971; Morrison, 1983). At the same time, these emotions play an important role in the subjective experience of patients with NPD: it was shown that they present with higher levels of explicitly reported shame and an implicit proneness to shame (Ritter et al., 2014). Implicit self-related shame may be a trigger for developing high standards, an excessive drive for success and perfectionism (Dimaggio et al., 2012; Sagar et al., 2009). Ronningstam (2016) added to this elaboration that other-related shame, e.g., attributions of the other people as unworthy or defective, may result in the expression of aggression and hatred, along with blaming, dismissive or overly critical attitudes (Caligor et al., 2015; Ogrodniczuk et al., 2013; Kernberg, 1992; Sachse et al., 2011). As such, malignant forms of narcissism may be characterized by the intentional destructiveness of the significant other (Kernberg, 2004). If this aggressiveness is turned inwards, it may result in suicidal thoughts and actions, which may – paradoxically – have an important function in maintaining the individual's belief system (Ronningstam, 2016; Maltzberger et al., 2010). Additionally, fear may be an important emotion tendency in NPD (Kernberg, 2004; 2008). These patients may fear of “losing face” in social interactions, again a shame-based emotion (Kramer et al., 2014; Lecours et al., 2013), or their self-control; they may experience fear of social exposure, to be humiliated and to experience shame in the future. Because of the shame-based organization of the latter, authors

have also called this emotion “shame-anxiety” (Pascual-Leone & Greenberg, 2005). Since these shame-based emotional states are difficult to bear for most persons; hostile anger is a common defensive interactional manoeuvre (Pascual-Leone, Gillis, Singh, & Andreescu, 2013). Patients with NPD have often developed a host of other agency-enhancing interactional manoeuvres as well, like boasting, using imagery of grandiosity, setting exaggeratedly ambitious work goals, engaging in competitiveness, or, also, using harsh self-criticism, self-hatred and self-contempt. Patients with NPD have often developed explicit and implicit strategies for avoiding the hurtful experience of shame (Lecours et al., 2013).

In sum, effective therapy for core shame in patients with NPD need to take into account the interactional consequences of the shame-based organization as a first step, then in a second step deepen and transform the experience of shame.

Shame: a dynamically changing emotion

According to emotion-focused theory, shame may be defined (Greenberg & Iwakabe, 2011) as an affective-meaning state (or self-organization) composed by the internalized evaluative process of self-despising or self-loathing information. As immediate consequence of such an implicit (or explicit) self-organization is the tendency to hide or to make him- or herself “invisible” to the outer world. Clinical observation of cases – including patients with NPD – has it that patients may present with maladaptive shame (Greenberg et al., 2011; Greenberg, 2015). Maladaptive shame may involve the individual’s understanding of his or her person as fundamentally flawed, unworthy or despicable: despite explicit messages from other people expressing the opposite, the person continues to feel, at the core and often implicitly, fundamentally flawed.

When it is part of the patient’s presentation, engaging this maladaptive form of shame is an essential passageway in the process of transforming emotion (Pascual-Leone, 2009; Pascual-Leone & Kramer, in press; Kramer, 2017; Pascual-Leone, 2017), which may be

particularly important in psychotherapy of NPD. The process of emotional transformation describes how patients' maladaptive emotion is changed by emotion, i.e., how patients move from non-differentiated and poorly integrated to adaptive and integrated emotional experiences (Pascual-Leone, 2009). Engaging in and transforming shame seems essential for change in patients with NPD, because we assume that maladaptive shame is strongly connected with negative evaluations about the self which may contribute to a brittle sense of self, to an unstable self-image, and to other identity-related problems in NPD. Early components of the emotion transformation process (Pascual-Leone, 2009), also called early expressions of distress (see Figure 1; global distress and rejecting anger), may be secondary reactions to maladaptive shame and a more fundamentally fragile sense of self. This conception assumes that rejecting anger involves the person expressing strong resentment by rejecting or blaming the other, generally in an intensive and non-agentic way. Later components of the emotion transformation process (Pascual-Leone, 2009) – also called primary adaptive emotions (see Figure 1) – are assumed to be underpinned by a new construction of meaning or insight. The most important emotional states identified in this group are assertive anger, grief, and self-compassion; and they involve an individual's experientially accessing, developing and articulating an unmet existential need or wish. For patients with strong shame-based organizations, the transformational process might involve an individual's development of self-compassion. According to this dynamic conception (Pascual-Leone, 2009), self-compassion is an elaborated affective-meaning state where the person actively gives him- or herself what was ultimately needed at the core in his/her development. Self-compassion is therefore an adaptive way of experientially accessing one's own core needs, requiring a representation of these needs and of one's sense of self, which is deficient in patients with NPD, but might be formed through psychotherapy. The patient's experiential

access of self-compassion can hence be seen as a marker of good progress in emotional transformation of core shame in NPD.

Clarification-Oriented Psychotherapy for core shame in NPD

Clarification-oriented psychotherapy (COP) is an integrative form of psychotherapy, based on humanistic and interpersonal concepts, that was specifically developed for patients with personality disorders, and NPD in particular. COP assumes that patients with NPD present with two action systems, (a) an authentic action system, and (b) a strategic action system (Sachse et al., 2011). The *authentic action system* includes a person's direct access to information related to his or her healthy need satisfaction which helps the person to adaptively respond to the interaction partners. These authentic actions are based on motives and involve a direct experiential access and expression of the underlying need to the interaction partner. In contrast, the *strategic action system* describes the interactional maneuvers, by using indirect expressions of the underlying need. The use of interactional manoeuvres by the person might leave him or her dissatisfied with the actual interactions – sometimes without one being fully aware of it. According to Sachse et al. (2011), this process explains the presenting interpersonal problems of NPD. Such interpersonal manoeuvres involve an external – interpersonal – focus and explain the occurrence of what the typical compensatory manoeuvres of NPD (Ronningstam, 2016). For example, it may involve a patient presenting to others as free of any problems, or of someone who denies any need for treatment, invincible and grandiose. At other times, the patient with NPD presents as someone with a particular “gift” for which the interlocutor should admire him or her or, finally, as someone who is so fragile that he or she requires special care and attention by the interaction partner. The therapy process in COP undergoes several phases. The initial ten to twenty sessions encompass the in-session resolution (i.e., reduction) of such interpersonal manoeuvres by offering a particularly responsive therapeutic relationship tailored to the underlying

motivational system. Sachse et al. (2011) propose to use the complementary or motive-oriented therapeutic relationship (for a clinical example of this intervention type with a patient suffering from NPD see Kramer, Berthoud, Keller and Caspar, 2014). As part of the initial sessions and only when the interactional maneuvers are significantly reduced in-session, the patient defines the therapeutic goal, which includes the definition of the actual problem, which will then serve as the vector for all further clarification and deepening work. The core working phase of COP for NPD – typically after session 15-20 – involves the patient's exploration of momentary experiences and constructing relevant personal meaning, with the aim of broadening and deepening the patient's scope of self-understanding (self-processes related to the identified problem). COP increases the patient's awareness with regard to the central functions underlying his or her interpersonal manoeuvres. Internal determinants, such as core affects, needs, assumptions and motives related to shame, are deepened during the working phase of this treatment which is only feasible when the patient can reliably use internal information (without re-using an external focus, as in the earlier sessions of therapy). In a final treatment phase of COP, the therapist fosters change in the internal determinants by using various techniques, including a version of a two-chair dialogue for fostering change. In a recent effectiveness study on 29 patients with NPD undergoing COP, pre-post effect sizes were found to be large (*d*'s varying between 1.2 and 2.3; Sachse & Sachse, 2016).

From a psychotherapy process perspective, Kramer, Pascual-Leone, Rohde and Sachse (2016) demonstrated for 39 patients with a variety of personality disorders (including NPD), that good outcome cases – defined as a reliable clinical change index greater than 1.96 (Jacobson & Truax, 1991) on outcome measures – were characterized by more self-compassion and rejecting anger in early working phase sessions – session 25 – than poor outcome cases. This result points to the potential centrality of self-compassion in psychotherapeutic change of NPD, however, it is unclear whether the patient's experiential

access to self-compassion increases over the course of the working phase in COP. Access to rejecting anger was interpreted as an important stepping stone towards such deeper and more meaningful emotional processing (Pascual-Leone, 2009; Figure 1). One further stepping stone towards deeper processing may be the access of shame (see Figure 1) which we expect should be accessed and transformed (i.e., diminished in intensity) throughout the working phase of COP for NPD. We expect that such between-session change of shame in the working phase of therapy would depend on the degree of the patient's initial functioning and would be linked with outcome in COP. Kramer et al. (2016) showed that a therapist's process-guiding towards patient's core issues in the first part of early working phase sessions was linked with the engagement in shame (or fear) in the second part of the same session. It remains unclear what the role of self-compassion is in later working phase sessions for patients with NPD. From an emotion-focused perspective (Greenberg, 2015; Pascual-Leone, 2009), self-compassion may emerge in the context of a trustful patient-therapist interaction, allowing the patient to experientially access and acknowledge his/her inner motives and needs. The present exploratory study aims at addressing these issues for a sub-sample of the cited study, by more closely examining patients who presented with NPD over the course of the working phase of COP.

Study hypotheses

The present process-outcome study focuses on the early and late working phase of COP for NPD. By doing so, we will focus on the standard definition of NPD by DSM-IV (APA, 1994). During working phase, the patient's (less productive) interactional manoeuvres are reduced in session, and the patient is able to attend to the current inner experience in a potentially productive way; these processes may occur after the initial 20 sessions of COP. For this reason, we formulate hypotheses on emotional processing after session 20.

(H1a) Shame decreases from early working phase session (25) to late working phase session (36).

(H1b) Change in shame is negatively related with symptom intensity in patients with NPD; the greater the symptom load at intake, the smaller the change in shame in the working phase of therapy.

(H2a) Late-working phase sessions (36) present with more in-session self-compassion than earlier working phase sessions (25).

(H2b) The presence of self-compassion in the second part of late working phase sessions (i.e., after minute 20 into the session) is linked with the quality of the patient-therapist interaction in the first part of the same sessions (i.e., between minute 10 and 20).

(H3) In-session shame is related to symptom change post-treatment.

Method

Participants

Patients. A total of 17 patients participated in this naturalistic trial. These patients were self-referred and consulted at a German-speaking Consultation Center specialized in the treatment of Personality Disorders (PDs). All participants met criteria on the SCID-II for Narcissistic Personality Disorder (NPD), although their initial explicit formulation of their problem might be consistent with a different psychological disorder. All patients participated in an earlier process-outcome analysis (Kramer, Pascual-Leone et al., 2016) which used a mixed sample of $N = 39$ patients suffering from various personality disorders, of which $N = 20$ presented with NPD. In order to be included in the primary process-outcome analysis, the patients must present with PD and have process and outcome data available, and must not present with schizophrenia nor bipolar disorder. In order to be selected for the current specialized analysis, patients must present with NPD and have one additional audio- or video tape from session 36 (or, if not available, 37). For $n = 3$ individuals from the sample of the

primary analysis, these tapes did not exist or were not available. Therefore, the present sample is composed of a total of $N = 17$ patients. In addition to the NPD diagnosis, seven (41%) presented with comorbid major depression, four (24%) with substance abuse, two (12%) with somatoform disorder and one (6%) with generalized anxiety disorder. On axis II, four patients (24%) presented with an additional co-morbid personality disorders: two (12%) with histrionic, one (6%) with dependent, and another (6%) with avoidant personality disorders. DSM-IV-diagnoses (APA, 1994) were established by trained researcher-clinicians using the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Williams, & Gibbon, 2004) for axes I and II of the DSM-IV. The mean age of the sample was 39.4 years ($SD = 9.9$) and ranged between 22 and 60; seven patients were female (41%). All patients gave written informed consent for their data to be used for research. The study was approved by the institute's internal board.

Treatment

Clarification-oriented psychotherapy (COP) represents an adaptation of client-centered psychotherapy to the specific problems related with personality disorders, and in particular narcissistic personality disorder (NPD; Sachse, Sachse, & Fasbender, 2011). This treatment involves the step-by-step working through of specific interpersonal manoeuvres, such as presenting oneself as being invincible or particularly vulnerable in order to justify demands for assistance in specific domains. After the focus on the interpersonal manoeuvres, the core task of the COP therapist is to clarify and render explicit the network of assumptions, emotions and motives underlying a patient's clinical presentation (Sachse et al., 2011) where it is assumed that, particularly for NPD, a fragile sense of self together with self-evaluations about oneself as worthless and flawed underlie the presence of shame. Therefore, the treatment promotes certain types of emotional transformation related to shame and associated negative self-evaluations. A manual describes the stages and techniques involved in COP for

NPD (Sachse et al. 2011), which was used to train all therapists who were also supervised by the model's developers. Treatments lasted between 45 and 99 weekly sessions with a mean of 64 sessions (SD = 10).

Instruments

Symptom Check List SCL-90-R (Derogatis, 1994). This questionnaire consists of 90 items addressing various signs of distress. Our study used the Global Severity Index (GSI, score ranging from 0 to 4), which is a mean rated over all symptoms. Clinical cut-off score is .80. The German version was used in the present study and previously yielded satisfactory validation coefficients (Franke, 1995). Internal consistency (Cronbach's alpha) for this sample was .94.

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). The German version of the BDI-II was used; this version has shown satisfactory validation coefficients (Hautzinger et al., 1995). This self-report measure assesses depressive symptoms using 21 items. The intensity of each symptom is rated on a four point Likert-type scale (0-3). The sum score of all items is computed, with the clinical cut-off of 10 for mild depression. Internal consistency for the scale for this sample was .89.

Classification of Affective-Meaning States (CAMS; Pascual-Leone & Greenberg, 2005). The CAMS is an observer-based rating system for the assessment of distinct affective meaning states that emerge during the course of therapy sessions and that can be reliably categorized according to precisely defined criteria involving para-verbal and verbal markers. It has been developed based on emotion-focused theory (i.e., Greenberg, 2015). In this study, the CAMS assesses two affective-meaning states which are the central subjective emotion categories: (1) Shame (and fear) and (2) Self-compassion. A manual (Pascual-Leone & Greenberg, 2005) guides the rater for the task of the moment-by-moment analysis of audio-/video-recordings. Several studies have demonstrated excellent reliabilities and validity of the

CAMS (e.g., Pascual-Leone, 2009; Kramer et al., 2015). Raters in this study were blind to one another's coding on the CAMS, to treatment outcomes of cases they were coding, and to research hypotheses. Reliability was demonstrated in the parent study on a sub-sample of $n = 10$ sessions out of 34 sessions (29%) of cases with NPD. The results for inter-rater reliability on the distinct emotion categories were excellent (Mean Cohn's $\kappa = .91$; $SD = .11$, ranging between .71 and 1.00).

Processing-Content-Relationship Scale (Bearbeitungs-, Inhalts- Beziehungsskalen (BIBS; Sachse, Schirm & Kramer, 2015) is an observer-rated instrument assessing the quality of the therapeutic interaction according to clarification-oriented psychotherapy (COP). Each of the 54 items is rated on a Likert-type scale, ranging from 0 to 6. Global ratings are made for both patient's and therapist's contributions to the therapy process using segments lasting 10 minutes of the middle of the video-/audio- recorded session (between minutes 10 and 20). On this scale, higher scores reflect better interaction quality. From the patient's perspective, three sub-scales are defined (process, content, and relationship), from the therapist's perspective, six sub-scales are defined (relationship, understanding, process-directiveness, therapeutic work with focus on of process, on relationship and on content assumptions); the present study includes the three patient's sub-scales and the theoretically central therapist's sub-scales of process-directiveness, therapeutic work with focus on relationship and on basic assumptions. Excellent psychometric properties were reported for the BIBS (Sachse, Schirm & Kramer, 2015). In particular, accuracy for patients with personality disorders was demonstrated, as well as the validity of coding a mid-session segment instead of the entire therapy session. Cronbach's alpha for the present NPD sample (all items together) was $\alpha = .94$. In total, 18 sessions (out of a total of 34 sessions) of the NPD cases were rated by two raters independently which represents a 53% of reliability sample and the reliability was

excellent (Mean Intra-Class Correlation Coefficient; $ICC(1, 2) = .93$; $SD = .06$; range between .81 and .98; Shrout & Fleiss, 1979).

Procedure

Session selection. Two therapy sessions from the beginning and end of the working phase (i.e., mid-treatment vs. late-treatment), were chosen and analysed for the present study. Session 25 was selected for analysis and served as the basis for our earlier process-outcome analysis (Kramer et al., 2016), in order to ensure that there is a early working phase session which is not dealing with interpersonal manoeuvres anymore (see above). In addition, session 36 was selected for analysis and served as late-working phase session. This session was selected as being as much distant from the early session, and not yet being part of the termination phase of therapy (starting after session 38-40 for some cases). This target late-working phase session was not available in only one case, so the closest available session (i.e., 37) was used in this case.

Raters, training, and coding procedures. A total of five raters were used for both scales (CAMS and BIBS). Procedures for selecting and training to reliability of all raters were identical to those used in the parent study (Kramer et al., 2016). Importantly, all trainings (involving 40 hours per rating scale) in the scales were completed prior to the ratings included in the present study. In order to code emotions using the CAMS, we used continuous cross-classification ratings (a code was given at each moment of the material). In a further step, a minimum of one minute per code was used as a threshold for coding emotion using the CAMS, except for the categories of negative evaluation and existential need. The entire sessions (in total 34 sessions; two per patient) were coded with both rating systems.

Statistical analyses

In order to assure that both therapy sessions (sessions 25 and 36) were comparable on key variables, we compared the number of CAMS codes and the BIBS ratings by using Paired

Sample *t*-tests, because basic assumptions for ANOVAs were not satisfied. H1a (change in shame) was tested using Paired Sample *t*-test, h1b (impact of intake psychopathology on change in shame) using linear regression (method enter; adjusted values used for R Square, because of the small sample size). H2a (change in self-compassion) was tested using Paired Sample *t*-test, h1b (impact of interaction quality on self-compassion in session 36) using linear regression (method enter; adjusted values used for R Square). H3 (link with outcome) was tested using a linear regression model (method enter, adjusted values used for Rsquare). Statistics were computed on spss23.

Results

Preliminary Analyses

The number of CAMS codes did not differ between the mid- (25) and late-(36)-in-treatment sessions ($t(1,16) = 1.12; p = .28; d = .37$). From a total of 134 observed minutes (both sessions taken together) in the composed category of shame and fear, 80% (107 minutes) were specifically shame-based emotions. Therefore, and because of the present study's focus on shame, we only included those units that were rated as shame and excluded the 27 instances of maladaptive fear from our subsequent analyses.

The overall patient and therapist contributions, using the BIBS, did not differ between session 25 and 36 (see Table 1), however, there are medium effect sizes based on the total score of BIBS that suggest an overall decrease in quality of the interaction (a noteworthy trend with, $p = .06$).

Mean GSI at intake was 1.21 (SD = 0.81; ranging from 0.15 to 2.83), at discharge 0.71 (SD = 0.74; ranging from 0.00 to 2.85; pre-post effects: $t(1, 16) = 2.97; p = .01; d = .64$). In total, $n = 11$ (65%) of the patients presented with a reliable clinical change index on the GSI, according to Jacobson and Truax (1991). Mean BDI at intake was 19.56 (SD = 14.25; ranging from 1 to 46), at discharge 13.00 (SD = 10.57; ranging from 1 to 30; pre-post effects: $t(1, 16)$

= 3.39; $p = .00+$; $d = .52$). In total, $n = 12$ (71%) of the patients presented with a reliable clinical change index on the BDI, according to Jacobson and Truax (1991). Taken both outcome indexes together, $n = 8$ (47%) of the patients presented with a reliable clinical change index.

Exploratory Pearson's correlation analyses revealed that change in shame (between sessions 25 and 36) correlated with intake measures (BDI: $r = -.41$; $p = .11$; GSI: $r = -.48$; $p = .05$) and outcome (BDI change: $r = .45$; $p = .05$; GSI change: $r = .30$; $p = .24$). Correlation analyses revealed also that the frequency of self-compassion after minute 20 in session 36 was linked with the interaction quality measured before this minute mark (patient content: $r = .66$; $p = .00+$; patient process: $r = .22$; $p = .40$; patient interactional manoeuvres: $r = .33$; $p = .20$; therapist process-guidance: $r = .69$; $p = .02$; therapist treatment of interactional manoeuvres: $r = -.55$; $p = .02$; therapist treatment of schemes: $r = .85$; $p = .00+$).

The Role of Shame in Psychotherapy for Narcissistic Personality Disorder

Contrary to our hypothesis (H1a; Table 1), we did not find a statistically significant change in the frequency of shame, although there was a small between-session effect ($d = .30$), substantiating a small decrease in shame over therapy. When linking the difference in shame between session 25 and 36 with intake predictors (H1b), we found the following significant relationship: the greater the intake (general) symptom load, the smaller the decrease in shame between session 25 and 36 ($F(1, 16) = 4.52$; $p = .049$; 23% of variance of change in shame explained; 18% adjusted). A similar effect was not found for the link between the intensity of depression at intake and change in shame ($F(1, 16) = 2.90$; $p = .11$; 17% of variance of change in shame explained; 12% adjusted).

Quality of Interaction's role in Patient's Self-Compassion in Session 36

In accordance with the assumed centrality of self-compassion in late working phase sessions, we tested whether its in-session frequency was greater in session 36, compared to session 25, which it was not (H2a; see Table 1).

For session 36, we examined the role of the interaction quality early in session 36 (measured between minutes 10 and 20 into the session) for the emergence of self-compassionate stances in the patient later in the same session (measured after the 20 minute mark of session 36). The regression analysis showed in table 2 (H2b) reveals that patient contributions (i.e., content, process, and interactional manoeuvres) explained 45% (29% adjusted) of the occurrence of self-compassion and that specific therapist contributions (i.e., process-guidance and treatment of assumptions) explained 78% (51% adjusted) of the occurrence of self-compassion later in the same therapy session. Interestingly, the treatment of the patient's interactional maneuvers correlated negatively with the self-compassion after minute 20 (see the preliminary Pearson's correlations).

Prediction of Outcome

The small decrease in shame between sessions 25 and 36 predicted decreases in depression over the entire psychotherapy ($F(1, 16) = 1.56; p = .048$) and explained 14% (9% adjusted) of the variance of decrease in depression (BDI), as predicted by H3.

Clinical Illustration: "The skinny herring"

The following sequence (2300336) illustrates the clarification of the brittle sense of self (minutes 8 to 15 of session 36) in a male patient with NPD, based on his saying "I am too skinny, like a herring". (discussion see below)

"T1: ...it sounds like this is a really awful feeling... can you put words to that? ...what does it mean?"

P1: yes.

T2: What would you say? what does the feeling tell you right now, in this moment now...

P2: it's almost as if there's something that I absolutely don't want to hear about me. And if I hear it then it bothers me a lot. It's like a mix. It creates a heavy sense of pressure...

T3: mhm

P3: and then I get angry and irritated.

T4: Irritated and something heavy... I also get the sense that there is something that hits you, that bothers you in the heart of this.

P4:...yes it does...

T5: Can we look at what is it that hurts you about this...? stay with that feeling right now, you're doing a good job [*gentle process-guiding by therapist, focusing on the underlying pain*]. What hurts the most when someone comes up to you and says, "you are too skinny, you are like a herring"

P5: It feels true.

T6: You think it is true, you think you are too thin.... Ok, you are doing a good job [*encouraging process-guiding by therapist*], keep with that feeling for now. Try to ask yourself: 'What does it mean to me?: to be too skinny, to be like a herring'.

P6: [Pause] It's heavy, like being disabled. [*emergence of unclear negative self-evaluation; see P10*]

T7: it's heavy, like being disabled?

P7: mhm... it's heavy.

T8: I hear yes, this is a big source of suffering for you. What it is about the impression that makes it so "heavy", when you say I am way too skinny? And also it's so heavy like being disabled for you...what makes it so heavy?

P8: it's like I don't feel comfortable with it, it weighs on me, and I can't accept it.

T9: Your sense is: it's very bad. To be skinny isn't good for you...?

P9: yeah, absolutely.

T10: what you think what makes it so difficult to be skinny? Why is it so difficult for you?

P10: I just don't like it... it means something might be wrong with me, with me as a person.*[clear representation of negative self-evaluation; see P6]*

T11: Almost like, it's some uncomfortable sense that I'm not normal... something is *wrong* with me. And everybody can see that something might be wrong with me.

P11: Exactly, yes.

T12: and so there's this conviction, right?, by seeing me as too skinny, it's obvious to everybody that I'm not "okay."

P12: mhm...

T13: mhm... What would you say... what does it mean to you *not* to be "okay?", "not normal"?...

P13: it's heavy, it's a lot of negative things... I have to just accept it all, I have to accept everything, people laughing at me and things like that.

T14: mhm so for you, there are lots of consequences to not being normal, not being okay, you have to put up with a lot of stuff...others laugh at you... maybe, then there's a feeling like, "nobody really wants me"...? "Nobody really likes me"... try to look into that feeling. What is it? What's it all about?

P14: mhm yeah, I am afraid of losing everything, of losing my friends...

T15: mhm, I think it's good that you can really take a look at this. This feeling that, "something is wrong with me," and that it comes with these negative consequences, like others laugh at me, or no one likes me or, I'll lose my friends...

P15: mhm

T16: ...and all that is so horrible, you don't want those things... What's the most difficult of these consequences that you just imagined?

P16: To be excluded from my own life, from my friends, that's the most difficult, yeah.

T17: ...not to be respected, not to be taken seriously... and then always, again and again, to get the feeling that, something is really wrong with me as a person.

P17: That's it. It always comes back and hits me in the face, yeah.

T18: So, now I kind of understand a bit better what it means when you say, "I think I am too skinny," -- It means a whole lot more to you. It's actually a symbol of your feeling that you are not okay. You look into the mirror and it confirms that something is wrong with you, as a person.

P18. Yes, that's what always happens, and what makes it so heavy."

Discussion

The present exploratory study examined the role of emotional processing in two working phase sessions of clarification-oriented psychotherapy (COP) – one in early working phase and one late working phase – in a small sample of patients diagnosed with narcissistic personality disorder (NPD). Whereas no significant between-session changes were found, the closer examination of the patient's experiential access of shame and self-compassion revealed a specific pattern of results which should be tested in larger samples.

Working through shame may be a central task for patients with narcissism

Clinical and empirical accounts underline the centrality of shame in NPD (e.g., Morrison, 1983; Lachmann, 2011; Lecours et al., 2013; Lewis, 1971; Ogrodniczuk & Kealy, 2013; Ritter et al., 2014; Ronningstam, 2016). This study is the first to specifically examine shame in patients with NPD in the actual therapy hour. Even though our study reported no

significant changes in frequency of shame between sessions 25 and 36 in psychotherapy, its small decrease ($d = 0.30$) was related with clinical features at intake. More symptoms at intake tended to impede on the reduction of shame throughout the working phase of psychotherapy. As reported by Sharp et al. (2015), a general psychopathology factor may impede here on, or moderate, the process of change, which was observed for several aspects of symptom load in personality disorders. This result seems particularly interesting in the light of the link with outcome: this small decrease in shame in the working phase predicted 14% (9% adjusted) of the outcome variance (on the BDI-II) at the end of treatment. We may speculate that the access, awareness, exploration, deepening and completion of shame-based emotions may be productive tasks in psychotherapy for patients with NPD. These results may extend what was called, from a psychodynamic perspective, “shame tolerance” in treatments for NPD (Lecours et al., 2013; see also Lachmann, 2011), although shame deepening and completion are additional patient tasks related specifically to emotion transformation (Pascual-Leone, 2009). As shown by Kramer et al. (2016), the in-session experiential access of shame (in session 25 into the therapy process) may be fostered by what was called process-directivity, the subtle following and encouraging guiding of the patient’s attention towards his or her core issues (Greenberg, 2015; Greenberg et al., 1993). In the transcript excerpt, T5 and T6 are prototypical examples of the combination of both gentle focusing on the core underlying “hurt” and encouraging the patient that he is doing a “good job” in this task. More case studies of this kind should combine the qualitative description of the process in single cases with the standardized nomothetic assessment of change (Kramer, 2017).

Implicit shame-based self-organizations may be linked with more explicit negative self-evaluations. In NPD, negative self-evaluations that are underpinned by shame-based emotions may reflect the brittle identity, such as “I am fundamentally unworthy”, “I am so unworthy that I should disappear” or “I am a flawed person.” As shown in a case study

(Kramer et al., 2014), the emergence in the focus of joint attention – and patient’s emotional self-awareness – of negative self-evaluation in the process of therapy can, again, be fostered by a process-guiding psychotherapist stance. In the present study, T9, T10 and T11 are, sequentially, therapist process-guiding interventions which aim at fostering the representation (in the patient) of new aspects of his negative self-evaluation. The emergence of representation of the latter in the patient actually starts at P6 (with the rather imprecise “like being disabled”) and becomes quite clear at P10 (with the mention “something might be wrong with me, with me as a person”). Again, these observations should be tested in a controlled design.

Self-compassion: knowing what is “good” for you

Self-compassion is a transdiagnostic and therapy-integrative feature of a productive stance in psychotherapy, in particular as part of the resolution of shame-based emotions (Gilbert, 2011). There are several operational definitions of self-compassion, in one perspective, it is based on a behavioral skills conception where generic “compassion skills” can be taught to patients (Gilbert & Procter, 2006), in a different definition, self-compassion may be the result of an empathic process with the shoring up the Self (Gehrie, 2011; Lachmann, 2011). In the present study, we defined self-compassion as a dynamically emerging self-organization which implies an elaborated and highly idiosyncratic affective-meaning state involving the individual’s experiential awareness of otherwise implicit core needs (Greenberg, 2015; Greenberg & Iwakabe, 2011).

The present study did not find significant between-session changes in the raw frequency in self-compassion: the actual *frequency* of self-compassion does not capture the transformative power of emotion in NPD. Instead, our results suggest that the *timing* of patient’s access to self-compassionate organization could be more critical. Both patients’ and therapists’ interactional quality in the first part of the advanced working phase session –

session 36 – was linked with the patient’s access to a self-compassionate stance in the second part of the same session. In cases where the patient formulated clear and idiographically central contents (i.e., insights with regard to his/her thoughts, emotions, interaction patterns), kept his or her attentional focus on these contents, and refrained from attempts to interpersonally control or manipulate the therapist, we may hypothesize that the patient could then move forward and access more self-compassion. In cases where the therapist used high frequencies of process-guidance (Greenberg et al., 1993; Sachse & Elliott, 2011) – when the therapist constructively and directly addressed the internal determinants of the interaction maneuvers –, patients accessed more self-compassion. It is interesting that for session 36, the therapist working with the problematic interactional maneuvers was related negatively with the emergence of self-compassion. This might be interpreted in terms of the stage model in COP, suggesting that productive process in PDs, including the emergence of self-compassion, should be associated with a constructive and deeply trustful therapeutic relationship where work on interaction problems in the Here and Now may be overcome (see also Ronningstam, 2016).

The observation that the therapeutic modification of internal determinants of the interaction manoeuvres was linked with self-compassion in an advanced working phase session was in line with our hypotheses. In such advanced therapy sessions as part of the COP model, the therapist may be advised to use a version of a two-chair dialogue, adapted to problems related with NPD, in order to increase the internal distance between the Self and the problematic internal aspects, and in order to bring about change related to the core internal determinants. In particular, the clinical work with counter-affects (Sachse et al., 2011) may be important here, which is when clients counter the shameful NPD-specific assumption by saying, e.g., “something might be wrong with me (...) as a person” (P10). Doing this generally involves fostering self-compassionate imageries or dialogues between two

components of the Self. It might also involve the emergence of pride in what was actually accomplished, and pride in oneself as a person. For example, a patient with NPD may feel pride when saying: “I realize now that that I have value, not only because I have accomplished many things, but because I am who I am.” (This verbatim example is from a male patient in session 36 during the modification phase of the clarification-oriented work). More research is needed to understand the role of access of pride in the therapeutic process of NPD, which was not the focus of the present study.

Limitations and perspectives

The present process-outcome analysis focuses on a small sample of patients with NPD, as such it is mandatory to consider it as exploratory at best. The naturalistic design enables greater generalization, but is also limited by the absence of a control group, which would help to delineate therapy-specific processes from generic changes. The lack of comparison patients with a non-PD diagnosis would have been necessary to delineate the role of shame and self-compassion in NPD, as compared with other diagnostic categories. It might also be interesting to re-test the same hypotheses on different sub-types of NPD, as described in contemporary accounts (Caligor et al., 2015). Most importantly, when linking in-session processes (i.e., interactions and patient’s emotion processing), we need to insist that we have to assume simultaneous association – instead of causality. This is because it might have been that third variables (e.g., level of experiencing, therapeutic collaboration) or the emotion processing variable (i.e., self-compassion) in the very first minutes of the session influenced the therapist’s choice of intervention. Because of lack of power, we decided not to control for this possible influence, but insist that this type of control is necessary in larger studies. Also, the influence of co-morbid disorders, medication use and socio-demographic level (i.e., education, intelligence) was not possible in present design. Because certain therapies lasted much longer than 40 sessions in the current sample, it might have been interesting to analyze

even later sessions, with the hypothesis that the non-significant change in shame and self-compassion observed in the present study might become significant there. Outcome was measured pre- and post-therapy, which prevented from controlling for early change (i.e., symptom change prior to session 25) which may have occurred in the present sample. The secondary analysis of a previously analyzed dataset may be prone to Type I error. Finally, it is unclear whether the observed links are relevant for other therapy forms for NPD.

Despite these limitations, we can state that, to our knowledge, this is the first psychotherapy research study which examines in-session shame and self-compassion in a sample of patients with NPD, and without the often observed co-morbid borderline personality disorder. As such, it should be acknowledged that systematic research in this domain is still lacking and more should be done in order to understand treatment-underlying mechanisms of change (Kramer, 2017; Ogrodniczuk, 2013). The present study has opened exploratory avenues to a more differentiated picture of the role of patient in-session emotional processing, in relationship with therapist interventions, symptom distress and change. This study has focused on the analyses of two sessions from the working phase, which implies an optimal design for analyzing both within-session and between-session processes. Future research should focus on the links between changes in shame and self-compassion in NPD, in order to determine possible mediator effects in relation with final treatment outcome. The role of access to pride in session may be a promising avenue. As such, we propose a patient-focused approach to psychotherapy research, which focuses on the *observation* of patient-related change mechanisms such as emotional processing in the therapy session (Greenberg, 1999). Such research designs assume that therapist interventions are facilitators of these patients' in-session processes who are assumed to function as agents of change.

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Table 1

Comparison of in-session frequencies of emotions and therapist and patient interaction style between sessions 25 and 36 ($N = 17$)

	Session 25	Session 36	$t(1, 16)$	p	d
	M (SD)	M (SD)			
<i>Early expression of distress (CAMS)</i>					
Shame	5.47 (6.17)	3.94 (3.77)	0.92	.37	0.30
<i>Primary adaptive emotion (CAMS)</i>					
Self-Compassion	0.35 (0.61)	0.53 (1.12)	-0.51	.62	0.20
<i>Total BIBS</i>	3.45 (0.74)	2.91(0.77)	3.20	.06	0.72
<i>Patient interaction</i>	3.95(1.10)	3.18(1.10)	2.93	.13	0.70
<i>Therapist interaction</i>	2.95(0.74)	2.63(0.80)	1.69	.11	0.42

Table 2

Early in-session process predictors of late in-session presence of self-compassion ($N = 17$)

	R^2	B	SE	β	t	p -value
Patient contributions	.45					.04
Content		.64	.23	.77	2.83	
Process		.00	.27	.00	0.00	
Interact manoeuvres		-.15	.29	-.18	-0.52	
Therapist contributions	.78					.00+
Process-guidance		.24	.15	.34	1.56	
Treatment manoeuver		.09	.29	.08	0.32	
Treatment assumption		.64	.34	.59	1.85	

Note. All predictors measured on the BIBS (Beziehungs- Inhalts- Bearbeitungsskalen)

between minute 10 and 20 of session 36. Self-Compassion measured on a one-minute basis using the CAMS (Classification of Affective-Meaning States) for this particular analysis only started at minute 20 into session 36.

Patient contribution corrected $R^2 = .29$; Therapist contribution corrected $R^2 = .51$.

Figure 1.

Sequential model of emotional processing

(adapted with permission from Pascual-Leone & Greenberg, 2007).

