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CLINICAL CASE APPLICATIONS

Inpatient Therapeutic Assessment With Narcissistic Personality Disorder

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ABSTRACT

Growing evidence supporting the effectiveness of Collaborative/Therapeutic Assessment (C/TA) has led clinicians and researchers to apply C/TA to a variety of clinical populations and treatment settings. This case example presents a C/TA inpatient adaptation illustrated with narcissistic personality disorder. After a brief overview of salient concepts, I provide a detailed account of the clinical interview, test interpretation paired with diagnostic considerations specific to narcissism, planned intervention, and discussion of assessment results. Throughout the case study, I attempt to demonstrate defining features of C/TA, inpatient adaptations, and clinical techniques that encourage meaningful engagement with a “hard to reach” personality.

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Evidence for the effectiveness of Collaborative/Therapeutic Assessment (C/TA) is growing as researchers and clinicians are applying C/TA to different patient presentations and treatment settings. The vast majority of C/TA studies, however, occur in outpatient settings. Limitations of conducting psychological assessment in contemporary inpatient psychiatric units, mixed with a limited amount of information on how to modify C/TA in such settings, might lead psychologists to defer to the traditional information-gathering model of assessment that might not produce therapeutic effects, increase alliance with the treatment team, or encourage after-care adherence. Therefore, the purpose of this article is to present an inpatient adaptation of C/TA with a case of narcissistic personality disorder.

Collaborative/Therapeutic Assessment

Although several variations of C/TA exist (e.g., individualized assessment, therapeutic model of assessment, collaborative assessment, and therapeutic assessment, among others), all models approach the assessment process as a therapeutic technique in which patients actively discuss and make meaning of the assessment results (Finn, 2007; Finn, Fischer, & Handler, 2012). C/TA relies on a respectfully humane tone that encourages collaborative exploration of test results while generating new ways of understanding oneself, as opposed to a detached, one-sided assignment of data to existing nomothetic categories (Finn & Tonsager, 1997). Additionally, C/TA places the patient in the expert role of themselves, tasked with the responsibility to define what they want to learn from the assessment and determine if their questions were answered. Furthermore, C/TA flexibly adjusts the standardization of tests with creativity and care to ensure the patient adequately understands the test rationale and results, provides understandable and jargon-free feedback, and considers psychological tests as “empathy magnifiers” that help examiners “get in our clients’ shoes” (Finn et al.,

2012, p. 13). Finn’s (2007) Therapeutic Assessment (TA) model organized these common characteristics into six general steps to help guide clinical and empirical work. These steps are gathering assessment questions from patients about what they hope to learn about themselves, using extended inquiries of standardized tests to promote further exploration of assessment data, using assessment intervention sessions with planned “encounters” to discover information emerging from previous sessions, structuring feedback with a three-level organization of results, using first-person letters instead of reports to communicate results, and holding follow-up sessions several months after the assessment (Finn, 2007).

Research shows that patients incorporate more information from feedback sessions when test findings are presented in accordance with their current self-views (Schroeder, Hahn, Finn, & Swann, 1993) and when patients are active collaborators in the test interpretation process (Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002; Hilsenroth, Peters, & Ackerman, 2004). Furthermore, C/TA is associated with greater patient engagement and alliance with assessors, as well as an increased motivation for treatment and stronger alliance with subsequent therapists (Ackerman, Hilsenroth, Baity, & Blagys, 2000; De Saeger et al., 2014; Hilsenroth et al., 2002; Hilsenroth et al., 2004). The TA approach by itself leads to significant improvement in patient symptoms and self-esteem (e.g., Finn & Tonsager, 1992; Newman & Greenway, 1997). A meta-analysis conducted by Poston and Hanson (2010) found an overall medium effect size ($d = .42$) for therapeutic psychological assessment on an assortment of therapy outcome measures.

Inpatient Collaborative/Therapeutic Assessment

In the era of managed care, psychiatric inpatient hospitalizations have become shorter, with treatment emphasis placed on medication management and group therapy, reserving

individualized intervention for containing acting-out behaviors during crisis situations (Lancee, Gallop, McCay, & Toner, 1995; Shapiro et al., 2003). Patients on brief inpatient psychiatric units report that they do not receive enough individual attention (Thomas, Shattell, & Martin, 2002) and few studies have examined the potentially negative effects of a “group-only” inpatient treatment model (Wallace, Robertson, Millar, & Frisch, 1999). Inpatient psychological assessment offers a multimethod opportunity to help accurately diagnose, plan treatment, and arrange aftercare that is matched to the patient’s level of functioning (Sweeney, Clarkin, & Fitzgibbon, 1987). Inpatient C/TA could bolster inpatient treatment effects and increase patient self-understanding with digestible and compassionate assessment feedback. Considering the important task of securing follow-up outpatient treatment after discharge, C/TA might even increase aftercare adherence. One unpublished empirical investigation conducted within an inpatient setting (Little & Smith, 2009) found that two sessions of collaborative assessment were associated with increased working alliance, well-being, and treatment satisfaction when compared to treatment as usual. Two other case studies reported positive results when conducting C/TA in an inpatient setting (Fowler, 2012; Michel, 2002).

Three primary considerations arise when adapting the C/TA model to an inpatient setting. First, Finn’s six-session model might need to be shortened to fit the constraints associated with the length of hospitalization. Additionally, the focus and timing of the C/TA sessions need to be flexible to allow for variability in the patient’s mood and availability. Finally, inpatients need to be screened for functional capacities that preclude engagement in the C/TA process (e.g., actively psychotic, confused or intoxicated state, reading level deficits).

Narcissistic personality disorder

Narcissistic personality disorder (NPD) has a complex clinical presentation with variable phenotypic manifestations (Ronningstam, 2011a) and frequent comorbidities (Campbell & Miller, 2011; Miller, Campbell, & Pilonis, 2007; Oldham et al., 1992; Widiger, 2011). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. [DSM–5]; American Psychiatric Association, 2013), NPD is characterized by a pervasive pattern of grandiosity in fantasy and behavior, a need for admiration, and a lack of empathy. Too often there exists a myopic focus on entitlement and grandiosity as defining features of NPD, ignoring a continuous oscillation between high and low self-esteem (Kernberg, 1974, 1984; Kohut, 1971; Rhodewalt, Madrian, & Cheney, 1998; Ronningstam, 2010, 2011b). Within the narcissistic framework are fluctuating levels of esteem, inadequacy, anxiety, envy, shame, boredom, emptiness, reactivity, perfectionism, and rage. Attempts to organize such heterogeneity have resulted in the proposal of three NPD subtypes, including *high-functioning and exhibitionistic, arrogant and entitled* (similar to phallic, malignant, oblivious, thick-skinned, grandiose, and overt narcissism), and *depressed and depleted* (similar to hypervigilant, thin-skinned, covert, shy, introjective, and fragile narcissism; Akhtar, 1989; A. M. Cooper & Ronningstam, 1992; Gabbard, 1989; Kernberg, 1984; PDM Task Force,

2006; Rathvon & Holmstrom, 1996; Reich, 1933/1972; Rosenfeld, 1987; Russ, Shedler, Bradley, & Westen, 2008). Negative consequences of narcissism include aggression (e.g., contempt, argumentativeness, verbal and physical confrontation), impaired relationships (dissatisfaction, infidelity, dislike from others), externalizing behaviors (drug, alcohol, and process addiction), internalizing problems (depression, anxiety, suicidality), and a general lack of insight into their personalities (Miller, Widiger, & Campbell, 2010).

Intrapersonally, the narcissistic individual does not experience a gap between the self and the ego ideal (Yeomans, 2012). This grandiose identity acts as an impenetrable shield to protect the individual from experiencing normative dysphoric experiences, including inferiority, hatred, envy, and rejection. Yeomans (2012) urged clinicians to understand the narcissist’s “refuge or retreat into omnipotence which makes contact with the real world very threatening—even simple contact with you the therapist, is a challenge to their defensive system.” Instead, to regain superiority, these dysphoric experiences are externalized to others via frequent devaluations, such as viewing a therapist as not knowing anything or having anything to offer (Kernberg, 2012). Interpersonally, a narcissistic individual demonstrates “an orientation toward seeking out self-enhancement experiences from the social environment to satiate needs for admiration and recognition” (Roche, Pincus, Lukowitsky, Ménard, & Conroy, 2013, p. 237). Ultimately, the narcissistic individual is often unable to appreciate social acclaim due to hostile and distrustful projections, resulting in a “narcissistic paradox” (Morf & Rhodewalt, 2001, p. 179). For example, narcissistic individuals might exhaust others for self-affirmation to the point of destroying the relationship on which they are dependent. A “narcissistic injury”—an ultimatum from family, court, or an employer; or the painful realization that pursuits toward fame, beauty, money, or power do not adequately compensate for inner emptiness and inadequacy—can lead to an acute crisis, a psychiatric hospitalization, or both.

A psychological assessment involves a patient admitting difficulty, revealing private (and sometimes shameful) experiences, tolerating feelings of vulnerability while trusting an unfamiliar professional, accepting a diagnosis, and following treatment recommendations. Each of these experiences along the assessment process could be inherently difficult for the person with NPD. Specifically, narcissistic patients often demonstrate insecure attachment styles, deny or minimize difficulty in favor of perfectionistic self-concepts, devalue therapeutic attempts and resist interpersonal support, experience difficulty establishing a therapeutic alliance, and end treatment prematurely (Blatt, 1995; Campbell & Miller, 2011; Hewitt et al., 2003; Hewitt, Habke, Lee-Baggley, Sherry, & Flett, 2008; Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Ronningstam, 2011a). Taken together, the clinician is faced with the difficult task of assessing, naming, and navigating through a resistant barrier of narcissism that seems invincible. Theoretically, the benefits associated with C/TA seem ideally suited for the clinical presentation of NPD. For example, C/TA with NPD could strengthen an already vulnerable alliance, improve patient engagement to deter the expected denial of difficulty, scaffold a vacillating self-esteem intolerant of vulnerability, encourage a successful internalization of assessment results rather than

a devaluing reaction to feedback, and hopefully prevent premature treatment termination.

The following case illustrates how C/TA was conducted with a man, Lee, hospitalized at an inpatient psychiatric hospital. At the time of this assessment, my knowledge of C/TA was a product of weekly supervision supplemented with readings (e.g., Finn, 2007; Finn et al., 2012) and postdoctoral didactics. I begin with the contextual factors, presenting problems and other relevant information obtained during a 1-hr clinical interview. After the clinical interview and consultation with Lee's treatment team and most recent psychiatrist, NPD became the working diagnosis. Next, I discuss the introduction, content, and process of testing with extended inquiries, then present Lee's test data paired with prototypic NPD testing data in an attempt to replicate my diagnostic considerations. Finally, I discuss our final session, which included a planned intervention, summary, discussion of diagnoses, and report review. Throughout the case study, I attempt to demonstrate defining factors of C/TA with specific encounters, describe C/TA adaptations and perceived benefits specific to an inpatient setting, and when my clinical efforts diverged from the C/TA model and why. All identifiable information has been disguised with guidelines put forth by Clift (1986) to maintain patient confidentiality, in addition to paraphrasing Lee and making slight alterations to his test responses that do not affect scoring.

Case illustration

Session 1: Clinical interview

Lee, a 55-year-old, White, heterosexual man who worked as a lawyer, was admitted to an inpatient psychiatric hospital for a primary complaint of dependence on a sedative sleep aid. Prior to his admittance, Lee was hospitalized for the same presenting problem, but after creating a post office box to receive the sleep aid via mail, he relapsed soon after his discharge. After "living like a zombie," hazily putting himself and others at great risk driving while sedated, Lee self-admitted in a lethargic state of confusion, expressing "defeat," exhaustion, and hopelessness. Following a detoxification period with focused behavioral intervention to promote unmedicated sleep, Lee demonstrated lucidity and energy during group and psychiatric appointments. Collateral consultation was made with Lee's previous psychiatrist, who described "a tough case ... heavily dependent on <the sleep aid> with lots more going on that he wouldn't discuss ... probably narcissistic but that's just a hunch."

As the psychologist conducting the assessment, I familiarized myself with the portrait of NPD on objective and performance-based assessment measures. I decided that the C/TA model would be preferable given his previous inpatient experience, personal expressions of "wanting to know more about what drives my addiction," and diagnostic uncertainty regarding personality. Once Lee was psychiatrically stabilized, we met to discuss the purpose and expected benefits of a psychological assessment. He agreed to the recommended psychological assessment, and met with me for the initial interview.

I remember Lee beginning our appointment with a tough, yet deferential, statement, such as, "Hit me with what you got, doc." I responded that I had many questions about his life and

personality, but explicitly placed Lee in the expert role of himself to teach me about his life and how I could help. This seemed effective at establishing rapport, and he responded casually with, "This med I'm hooked on is the worst, I'm like a zombie, and I can't kick it on my own, so I guess I need a shrink to figure it out." I immediately began paraphrasing his question on a shared pad of paper, "Why can't I kick this stuff on my own?" I asked what other questions he had about himself, and he seemed intrigued at the seriousness with which I heard his first question. Lee continued with other assessment questions: "Why can't I sleep on my own? What's wrong with me that I almost kill people on the road? Does this have to do with something in my childhood or something?" After writing this last question, I praised him for his openness and eagerness at understanding himself, but Lee dismissed that, saying something like, "Well that's what I'm here for, I want to figure this out and not waste my time and money." At that point in the interview, it was clear that Lee was able to assertively challenge others and "get to work," perhaps at the expense of empathic connection and support.

I collaboratively wondered aloud about Lee's last question concerning childhood influences, asking, "As the expert on what you have lived, seen, and felt, what is your theory for how your childhood might drive an addiction?" Lee glossed over his development in less than 1 min, sharing extraordinary academic success, a *Leave It to Beaver* home that was "perfect," and occupational and financial success. I reiterated and shared his confusion regarding a cause, and Lee added that his previous therapist considered the death of his father as formatively important. Lee quickly disagreed, explaining that at 16, after his father died, he [snapped fingers] "was fine," remembered going to prom that evening, "and I stood outside and looked up at the sky, and I knew I was going to be fine, and I was." Lee's denial of his father's death as important to understand the drivers of his addiction communicated an unwillingness, or inability, to consider the seriousness of this formative influence. Similarly, attempts at conveying empathy for Lee were dismissed: "Like I said, doc, I'm fine and that's not it."

I communicated my understanding by moving on, asking about more recent changes that might explain his addiction, to which Lee continued to demonstrate honest openness, sitting back in his seat while acknowledging a recent unwanted divorce after a 20-year marriage. Lee reacted with indifference to admitting his divorce, but struggled to understand why his children "cut ties" last year. As Lee spoke softly and delicately regarding his unreturned calls to his children, tears welled in his eyes, and he nodded in agreement to a reflection of how lonely he seemed, in both his daily life and in his fight toward sobriety. To end the interview, I restated my commitment toward open collaboration and transparent dialogue and invited him to talk with me about our insights thus far. Lee ended similar to how he began, with a matter-of-fact appraisal of his "sad state" and a challenging deference: "I want to know how you're going to help." Pointing to his assessment questions, I explicitly shared his desire to find answers. Perhaps reacting to his perception that I did not have much to offer, I added, "I have studied these tests for years, know how to interpret them, and believe that an assessment can help us answer these questions." This is a helpful phrase encouraged by C/TA,

wherein the patient is placed in the expert role of themselves, and the clinician is placed in the expert role of the tests.

Although not consistent with standard C/TA practice, I decided to add one more question based on my first impression of Lee's psychology. With Lee's interest peaked, I added, "How do you remain unaffected by disaster?" I elaborated on my observations of his unshakable response to death, divorce, high doses of sedatives, and familial estrangement, as such stressors cause the common man to wince, if not crumble. In an effort to solidify his commitment and honest engagement during the assessment process, I asked, "If these tests I give helped answer your questions, do you even need those answers since you seem so strong?" Lee reassured me and himself that he was committed toward broadening his self-understanding and improving his functioning.

Sessions 1 and 2: Standardized testing

After the 1-hr interview, the second half of our first appointment began testing with the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). Consistent with the C/TA model, the MMPI-2 was deliberately given first to show Lee that I was staying focused on our agreed on questions, as the face validity of this measure seemed most relevant to his central assessment questions. I introduced the test by linking it to his questions: "This questionnaire will help us begin to answer your why questions surrounding sleep and addiction, as well as other symptoms that might underlie these problems." Lee negatively reacted to the length of the MMPI-2, but instead of avoiding his aversion to the test, I justified the length with a brief education on the development of the items through empirical-criterion keying and decades of research. Lee seemed more engaged and intellectually appreciative of the test.

Lee completed the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, Davis, & Millon, 1997) during the first half of our second testing session the following day. The MCMI-III was similarly introduced with an added explanation of personality and his typical ways of interacting in relationships. After completing the MCMI-III, Lee remarked that the MCMI-III "will probably say that I'm full of myself or something." I curiously asked why he expected those results, and Lee thought his endorsed items "might show that I'm just better at dealing with life than other people." Because Lee was discussing content salient to diagnostic questions, I slowed our pace and asked Lee to "unpack" his statements. Lee admitted being called a "narcissist" by his ex-wife, who reportedly criticized his "strength" and "independence" as "shameful" attributes. Lee expressed defeat because he was "not able to save my marriage," and anger that she perceived him with such disdain. As I listened to Lee, it became apparent that he was experiencing complications mourning the loss of his marriage, and he was unable to reconcile his ex-wife's profoundly negative impression of his ego. After venting his frustration and confusion, Lee sighed heavily, threw his hands in the air, sat back in his chair, tilted his head upward, and closed his eyes in silence. It was as if Lee erased his pain and anger with a sleeping posture of defeat, and I commented, "Lee, you're trying to sleep through this pain." He stared at me, agreed, quivered slightly, and

admitted that he "can't sleep. It is on my mind all the time." I delicately ended the second testing session praising his ability to demonstrate vulnerability and trust in the assessment process.

After a 15-min break, Lee completed the Thematic Apperception Test (TAT; Murray, 1943) and Rorschach (Rorschach Performance Assessment System [R-PAS], R-Optimized Administration; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011) to finish the second testing session. The TAT and Rorschach were introduced as measures that "would help me get to know you as an individual, apart from Scantron sheets." Typically, I would offer additional justification for the use of these unconventional measures, referring to the importance of a multimethod assessment, high false positives when using self-report to assess personality, and the potential to bolster one's "self-story" with data that might not be recognized by the individual (Hilsenroth, Handler, & Blais, 1996). However, Lee did not dismiss or minimize the importance of these tasks, as he seemed able to rely on our growing alliance and trust that these measures were appropriate. I expressed appreciation for his willingness, and we completed both measures with extended inquiries to collaboratively explore his responses (specifics to the extended inquiry are discussed in the following assessment results).

Assessment results

On the MMPI-2, Lee scored a Welsh Code of 312/8+7-4/056:9#K'+LF-. A 3-1 code type, with an elevated K, is consistent with an overly conventional and emotionally constricted individual with strong needs to be accepted, a virtuous self-view, and rigid optimism to distressing life events (described as "Pollyannish" or "la belle indifférence"; Friedman, Lewak, Nichols, & Webb, 2001). Stress is often expressed through hypochondriacal complaints and physical symptoms, whereas depressive symptoms might include sleep disturbance, weight fluctuations, and feelings of inferiority and hopelessness (Graham, 2011). Subclinical elevations on Scale 8 reflected difficulty with thinking, memory, and concentration, whereas a low Scale 9 indicated a loss of drive and energy. Socially, this profile is consistent with an emotionally distant and passive role in close relationships, and similar individuals report marital problems. Developmentally, individuals with similar profiles tended to report strict, demanding, and morally rigid caregivers and might have a history of caretaking for a sick parent (Friedman et al., 2001). Lee's code type differed from those traditionally associated with NPD (98/89, 96/69, and 87/78) and it did not show elevations on Pd and Pa clinical scales (Raskin & Novacek, 1989; Rathvon & Holmstrom, 1996; Wink & Gough, 1990). However, Lee did show subclinical elevations of narcissism on an embedded MMPI measure previously identified as a reliable and valid indicator of NPD (MMPI-PD Scales; Morey, Waugh, & Blashfield, 1985).

On the MCMI-III, Lee's responses indicated elevations on the Narcissistic (Admirable Self-Image, Interpersonally Exploitive, and Cognitively Expansive) and Antisocial (Interpersonally Irresponsible, Acting-Out Mechanism) clinical personality patterns scales, as well as the Drug Dependence scale. Taken together, this profile is consistent with "an arrogant sense of

Table 1. Lee's thematic tpperception test sample response.

Card No.	Response
17BM (Man climbing rope)	I guess I'll use my imagination here right? This guy is climbing a rope, can't tell if he is naked or not. I guess he is naked, and why you would skid down a rope naked is beyond me. The guy's face looks like John Kennedy, I must be influenced by his biography that I'm reading, or when I see a muscled body I think of Arnold Schwarzenegger. This guy is climbing the rope and what the purpose is beyond me. We might say he is an acrobat in a circus or something but there is nothing to indicate that whatsoever. This picture I don't like because there is too much, well not too much, but enough that doesn't fit. The guy is climbing up, but doesn't look tense enough. The muscles don't look like he strained enough to be climbing up. The face doesn't fit. He is looking at something off in the distance, I can't tell you what, but maybe somebody came in.

self-worth, a talent for feigning dignity and confidence, indifference to the welfare of others ... self-reliance, unsentimentality ... and a need to nourish the whims of an overinflated ego" (Millon et al., 1997).

Lee provided responses to 10 TAT cards chosen to simulate scenarios consistent with his life history (see Table 1 for a sample TAT response). The "most detailed and validated TAT structured scoring rating system to date" (Archer & Smith, 2014, p. 376) is the Social Cognition and Object Relations Scale (SCORS; Westen, 1995; Westen, Lohr, Silk, Gold, & Kerber, 1990). The SCORS yielded deficits specific to the Affective Quality of Representations ($M = 2.5$, indicating neglecting and attacking relational expectancies), Emotional Investment in Relationships ($M = 2.8$, indicating shallow, egocentric relationships that only allude to others' needs), Self-Esteem ($M = 3.3$, indicating an unrealistically grandiose self-view), and Complexity of Representations of People ($M = 4.2$, indicating simplistic and minimally elaborated personalities). Lee scored higher on Emotional Investment in Values and Moral Standards ($M = 5.8$), as his responses demonstrated moral strivings with a sense of remorse or guilt.

Robust themes that emerged across Lee's responses included strict, emotionally absent, and dominating authority figures that inspire rebellious acquiescence in the child; a general distrust in others' benevolent intentions; a denial of dysphoric experiences; a glorification of achievements despite impoverished conditions; frequent verbiage that included "waiting," "thinking," "struggling," "rebellious," or "resigning"; frequent references to famous and powerful figures; and a devaluation of the attempted actions of characters. Research investigating the presence of narcissism suggests that TAT themes often involve independence, power struggles, entitlement, selfishness, ambition, grandiosity, idealization, exploitation, oversensitivity to criticism, and needs for attention and admiration (Harder, 1979; Leary, 1957; Shulman, McCarthy, & Ferguson, 1988). Lee's responses included most of these themes, especially independence, power struggles, ambition, grandiosity, and needs for attention and admiration.

Consistent with C/TA, an extended inquiry of his TAT responses began with questions such as these: "What was this

test like for you? Did you notice anything in particular about your responses? What cards did you like or dislike? What responses seem relevant to your life?" Lee preferred Card 14 (dark room with opened window), which inspired "expansive isolation, a breath of fresh air from the stuffy room." He was able to personalize his response by describing his preference to be alone. Lee acknowledged "seeing lots of Hollywood" (referring to his responses that included Clark Gable, John F. Kennedy, Arnold Schwarzenegger, and four other famous figures), explaining that this occurred "because the cards look like movie sets." I decided to maintain our growing alliance by not pushing a narcissistic meaning to these responses. Lee disliked Card 12M (man with hand over boy with eyes closed) because "this is just a moment in time, a snapshot, and nothing to tell what led up to it or what will happen next." I discussed the "pull" of this card for one's relationship with a male authority figure, often one's father, mentor, or therapist, and Lee demonstrated active involvement attempting to develop meaning to his assessment data. Specifically, Lee shared memories of coming to his father for "direction," wondered what his father would tell him now, and simply stared at Card 12M as he seemed to reminisce. Overall, the TAT administrative process paralleled a relational dynamic found in his stories, characterized by feeling forced to perform without adequate resources. Lee would often comment, "This is all you're giving me?" or "I'm supposed to tell a story with just this?" or "There is hardly anything to hang your hat on to make a story." Finn (2007) described assessments as "empathy magnifiers," which captured my emotional experience as I began to understand the profound absence that motivated Lee's hypervigilant search for direction.

Lee and I completed our second testing session with the Rorschach (R-PAS administration; see Table 2 for example responses, Figure 1 for the R-PAS score summary, and Figure 2 for the R-PAS Code Sequence). Lee produced 26 responses to all 10 inkblots within a valid protocol, and his Complexity score ($SS = 101$) and proportion of pure form responses were both in the normal range ($F\% SS = 97$). His perception was accurate, conventional, and realistic, with no evidence of a thought disorder ($WSumCog SS = 100$, $FQ\% SS = 98$, $P SS = 103$). Lee required a significant amount of pulls ($Pu SS = 131$), indicating ambitious achievement strivings perhaps in an attempt to impress and ease insecurity. Although he described himself as detail-focused, Lee did not show evidence of precise or obsessively detailed perception ($Dd\% SS = 75$). Lee's responses indicated a coping style characterized by thoughtful deliberation infrequently impacted by emotion ($M/MC SS = 123$) with an above-average sense of agency ($M = 113$). Lee rarely incorporated color into his responses ($C Raw = 0 SS = 95$, $WSumC SS = 83$), and frequently demonstrated distancing ($FD SS = 122$, $V SS = 119$). Taken together, Lee's responses indicate that he tends to avoid emotion, experience less vitality and liveliness, feel empty and hollow, and might be prone to a critical evaluation of himself and his environment. Lee demonstrated a slight disinterest in relationships or a tendency to expect disappointment in others ($COP SS = 88$, $H SS = 98$, $MAH SS = 90$), leading to the interpretation that he often relies on chance, luck, or fate to determine his well-being ($p/[a+p] SS = 124$). His responses were consistent with someone who identifies with power and aggressiveness ($AGC SS = 132$) while also feeling

Table 2. Lee's Rorschach sample responses.

Card No.	R No.	Response	Inquiry
I	1	This thing in the middle looks like one of those, I don't know, wizards or characters out of a Cole King novel	Those are his arms, right there, and a head with a helmet on. This is his body, and a belt with a cape behind him, that is why it reminded of a Cole King novel. (The cape is behind him?) Sure, this darker part here. But I can't tell if he is a good guy or a bad guy.
	2	These two things on the side look like people dancing with arms out, legs down here	Yes, the head, feet, like that (demonstrates) this is the arm here, another arm back, like someone reaching out and holding on, that is why I said dancing. It doesn't make sense that this is a person, because the shape is wrong, he's must be watching himself dance in the mirror
	3	Stealth fighter	I said that? Well okay, um, yea this is the nose, fuselage, wings going back and offset (tilts card level), and these are the wings. What is it called? I used to have a video game, called Stealth; that is what it reminds me of.
	4	Whole thing looks like a devil mask with the eyes and mouth	Eyes, mouth, like a jack-o-lantern, but it has horns, and this could be the face, nose, mouth in the white part, and devil horns coming out. (Coming out?) Just here, sticking up
IX	22	So these are all mirror images flip flopped left or right? You don't have to answer that, but it sure looks like that. [Coughs, waits 10 sec] We see a lot of bits and pieces of things but no real image. Two red parts are shoulders, this is the body, and this is the head, wrapped in an orange and green mask, with nostrils, eyes. It's strange. I'm kind of frustrated not to have a solid answer. I like solving puzzles, and it is tough to not have a solution	The shoulders are encased in some sort of body armor, body neck, head here, curled up here to the top of the skull. Nostrils here, eyes here, I don't know what to make of this green part. The body armor is the red part, like neck shoulders, and because it is red, it's kind of beefed up like shoulder pads and body armor, again like a warrior in a video game.

damaged, flawed, or somehow harmed by life (MOR SS = 117). Content analysis indicated a proneness to perceive fantasized and unrealistic elaborations ([H] SS = 127) with an emphasis on appearances that disguise vulnerability (Cg SS = 116, frequently involving armor, shoulder pads, athletic helmets).

While Reflections (*r*) and Personal Knowledge Justifications (PER) are often used as Rorschach variables indicative of narcissism, empirical research has expressed caution due to low specificity when distinguishing NPD from other personality disorders (i.e., antisocial personality disorder; Gacono, Meloy, & Berg, 1992; Hilsenroth et al., 1996). Therefore, 11 Rorschach variables associated with grandiosity and narcissistic qualities were collectively considered (see Table 3). Reflections (*r*) and Personal Knowledge Justification (PER) variables received an R-PAS standard score, whereas others were simply counted and utilized during a qualitative description of the appearance of narcissism in the Rorschach. Lee frequently incorporated reflections (*r* SS = 128) without card turns (Horn, Meyer, & Mihura, 2009), indicative of narcissistic or pleasurable self-involved traits (Meyer et al., 2011). Therefore, Lee might experience himself as reflected in the world in a self-centered way, creating a need for mirroring support, admiration, and approval to alleviate fears of inadequacy and deficiency (Blais, Hilsenroth, Castlebury, Fowler, & Baity, 2001; Meyer, Erdberg, & Shaffer, 2007; Meyer et al., 2011; Weiner, 2003). Lee also provided several Personal Knowledge Justifications (PER SS = 125), often validating his responses with private knowledge and authority to assuage underlying doubts about his productions. Lee's responses also included moments of Expanded Personal Reference (EPR raw score = 4), Omnipotence (OMP raw score = 5), Idealization (IDL raw score = 3), Exhibitionism (EXH raw score = 2), Magic (MAG raw score = 3), Narcissistic Devaluation (NDV raw score = 4) and Narcissistic Deflation (NDF raw score = 2). Taken together, Lee's life

history and testing data on objective and performance-based measures of personality warranted a diagnosis of NPD.

Before proceeding to the intervention and summary and discussion session, three levels of feedback consistent with TA were organized and ordered using Lee's overall presentation, testing data, current assessment alliance, psychological strengths, and level of insight. Together, it was determined that Level 1 findings included apparent symptomatology, Level 2 findings discussed NPD, and Level 3 findings consolidated Lee's personality with contextual factors involving loss to understand what drives his addiction. Overall, this organization of results corresponded to C/TA's recommended flow "from surface to depth."

Session 3: Intervention session

The C/TA intervention phase encourages shifts in self-schema and new understandings by creating an "experience in which a client might learn something as part of his or her growth" (Brownell, 2009, p. 404; Finn, 2007; Finn & Martin, 1997). Clinicians are tasked with creatively designing an encounter individually tailored to the patient to bring identified problems "into the room." Therapeutic techniques or modified assessment instruments can allow for a new, positive outcome to a symptom or pattern the patient previously felt powerless to manage.

Given Lee's assessment questions and testing data, my goal was to demonstrate his tendency toward independent and grandiose self-reliance with a constriction of affect. In an attempt to draw out his narcissism, I chose to begin our third session by challenging him to interpret his own test data while deceptively denying any interpretative assistance. I stated, "Lee, I hope that you have learned enough during our meetings to answer your own assessment questions because I don't have

Section & Variable	Raw Scores			Cpb. Adj.	
	Raw	%ile	SS	%ile	SS
R & Admin.					
R	26	69	107	65	106
R8910	7	40	96	47	99
Pr	0	24	89		
Pu	3	98	131		
CT	6	68	107		
R8910%	27%	18	86	17	86
Location					
W	10	56	102	55	102
D	16	86	116	87	117
Dd	0	5	75	5	75
WD	26	89	118	89	118
W%	38%	47	99	49	100
Dd%	0%	5	75	5	75
Space					
SR	0	19	87	19	87
SI	1	18	86	29	92
AnyS	1	15	84	17	85
Content					
H	2	45	98	39	95
(H)	4	97	127	96	127
Hd	1	41	97	41	97
(Hd)	2	86	116	79	113
A	12	91	120	91	120
(A)	0	34	94	34	94
Ad	1	20	87	20	87
(Ad)	0	43	97	43	97
An	1	47	99	47	99
Art	0	18	86	18	86
Ay	1	76	111	76	111
Bl	0	38	95	38	95
Cg	4	86	116	85	115
Ex	0	41	97	41	97
Fi	0	30	92	30	92
Sx	0	34	94	34	94
NC	4	21	88	24	89
SumH	9	81	113	83	114
NPH	7	92	121	89	119
NPH/SumH	78%	80	113	78	112
Object Qualities					
Sy	4	27	91	32	93
Vg	0	18	86	18	86
2	3	10	80	10	80
Sy%	15%	22	89	27	91
Vg%	0%	18	86	18	86
FQ and Popular					
FQo	15	71	108	72	108
FQu	9	74	109	79	112
FQ-	2	53	101	56	102
FQn	0	41	97	41	97
WDo	15	78	111	77	111
WDu	9	90	120	91	120
WD-	2	66	106	55	102
WDn	0	41	97	41	97
M-	0	36	95	36	95
P	6	59	103	67	107
FQo%	58%	50	100	41	97
FQu%	35%	69	107	73	109
FQ-%	8%	46	98	50	100
WD-%	8%	57	103	52	101
Determinants					
M	6	82	113	77	111
FM	3	51	100	51	100
m	1	42	97	30	92
FC	2	54	101	58	103
CF	0	12	82	23	88
C	0	36	95	36	95
Y	0	14	84	14	84
C'	0	17	85	17	85
T	0	28	91	28	91
V	2	89	119	85	117
r	3	97	128	97	128
FD	3	93	122	94	124
F	10	51	101	53	101
a	2	18	86	22	88
p	8	94	123	92	122
Ma	2	53	101	57	102
Mp	4	91	120	87	118
Blend	4	56	102	53	101
CBlend	0	28	91	28	91
WSumC	1.0	13	83	12	82
SumC	2	21	88	22	89
(CF+C)/SumC	NA				
MC	7.0	53	101	50	100
M/MC	86%	94	123	94	124
YTVC'	2	23	89	22	88
mY	1	23	89	26	91
F%	38%	42	97	38	95
PPD	6	26	90	27	91
MC - PPD	1.0	76	111	78	112
p/(a+p)	80%	94	124	93	122
Mp/(Ma+Mp)	67%	81	113	81	113
Blend%	15%	50	100	50	100
Cognitive Codes					
DV1 (1)	1	77	111	77	111
DV2 (2)	0	49	100	49	100
DR1 (3)	1	80	113	80	113
DR2 (6)	0	48	99	48	99
PEC (5)	0	43	97	43	97
INC1 (2)	1	65	106	48	99
INC2 (4)	0	45	98	45	98
FAB1 (4)	0	33	94	33	94
FAB2 (7)	0	47	99	47	99
CON (7)	0	49	100	49	100
WSumCog	6	50	100	51	100
SevCog	0	35	94	35	94
Lev2Cog	0	41	97	41	97
Thematic Codes					
ABS	0	40	96	40	96
PER	3	95	125	95	125
COP	0	21	88	27	91
MAH	0	26	90	26	90
GHR	6	76	111	74	110
AGM	0	31	93	31	93
AGC	8	98	132	98	131
MOR	3	87	117	87	117
MAP	2	86	116	78	112
PHR	3	64	105	58	103
ODL	3	66	106	63	105
MAHP	2	64	105	59	103
MAP/MAHP	NA				
GPHR	9	73	109	73	109
PHR/GPHR	33%	50	100	50	100
ODL%	12%	63	105	64	105
Other Calculations					
IntCont	1	31	93	32	93
CritCont%	15%	40	96	42	97
EII-3	-0.5	35	94	44	98
TP-Comp	0.3	43	97	47	99
V-Comp	3.7	66	106	68	107
SC-Comp	3.5	22	89	22	89
Complexity	72	53	101		
LSO	33	54	102		
Cont	19	37	95		
Det	20	58	103		
Other Composite Subcomponents					
W-SI-Sy	11	21	88	22	89
(H)(Hd)(A)(Ad)	6	93	122	92	121
H(H)(A)(A)/SumHA	82%	78	112	79	112
VFD	5	95	125	94	123
(r*3+Pair)%	46%	77	111	78	112
CFC - FC	-2	18	86	18	86

Figure 1. Lee's R-PAS score summary for all variables. R-PAS score summary reproduced from the Rorschach Performance Assessment System™ (R-PAS™) Scoring Program (© 2010–2015) and excerpted from the *Rorschach Performance Assessment System: Administration, Coding, Interpretation, and Technical Manual* (© 2011) with copyrights by Rorschach Performance Assessment System LLC. All rights reserved. Used by permission of Rorschach Performance Assessment System LLC.

anything to add. Please tell me why you can't sleep, self-medicate, and put others at harm." I hoped this strategy would sidestep a potential power struggle and dismissal of test findings, while encouraging an enactment of his invincible bravado. Although somewhat controversial, mild deception has been demonstrated in a similar case with a narcissistic individual struggling with angry outbursts (Fischer & Finn, 2014). I trusted that Lee's psychological strengths, resiliency, and additional supports within the inpatient unit allowed for this unconventional approach.

As expected, Lee rose to the challenge without hesitation. With broad strokes and impressive verbiage, Lee eagerly presented a superficial narrative of being "stronger than others ... not really needing much sleep ... but stupidly trusting another doc only to become addicted." I pushed a bit further, asking Lee to relate his interpretation to the items he endorsed, stories he told, or images perceived in the inkblots. He struggled and did not produce any connections, becoming increasingly quiet. I asked Lee to describe his feelings in the room, to which he responded, "Fine."

With the problematic pattern in the room, C/TA encourages immediate exploration so the patient describes what occurred in his or her own words, which can then be adopted by the assessor. I apologized, then admitted that I had lied and actually did have interpretations to offer. Before discussing those results, though, I asked Lee to pause, reflect, and describe what had just occurred in the last couple minutes. After some thought, Lee described "going into it alone ... not knowing for sure ... it wasn't a big deal." I agreed that he seemed nonchalant and confident, but shared that I was surprised to hear that he felt alone and unsure. Lee added that he also felt angry that I "left him hanging," an experience I validated because he is not a psychologist and not expected to interpret testing data. I wondered aloud how I missed his experience of feeling alone, unsure, and angry, and Lee described that he "is used to it so it wasn't a big deal." I asked if being "used to it" was similar to being "numbed to it." He agreed, and I wondered aloud how numbing his feelings affected what just occurred. Lee explained, "Not being real keeps you in the dark." Pausing and feeling as though we were "on the observation

Cd	#	Or	Loc	Loc #	SR	SI	Content	Sy	Vg	2	FQ	P	Determinants	Cognitive	Thematic	HR	ODL	R-
I	1	@	W				(H),Cg	Sy			o		Mp,V		PER	GH	(RP)	Opt
	2		D	2			H				u		Ma,r			GH		
	3		W				NC				u		FD		AGC			
II	4	@	W			SI	(Hd)				o		mp	INC1	AGC	PH	ODL	Pu
	5		W				(H)	Sy		2	o		Ma		MAP	GH		
	6		D	3			A				o		F					
III	7		D	7			A				o		F					
	8		D	1			H,Cg	Sy			o	P	Mp			GH		
	9	v	D	7			A				u		F					
IV	10	@	W				(H)				o	P	Mp,FD			GH		
	11		D	3			Ad				u		F		AGC		ODL	
	12		W				A				o	P	F					
V	13	v	W				A				o		F	DR1	PER,AGC			
	14		W				NC				o		FD	DV1	MOR			
	15		W				A				o		F		PER,MOR		ODL	
VII	16		D	1			(H),Ay,Cg				o	P	r			GH		
	17		D	4			A				u		F					
	18		D	3			A				u		FMp		AGC,MAP			
VIII	19		D	5			NC				-		V					Pu
	20	@	D	1			A				o	P	FMp,r		AGC			
	21		D	4			(Hd)				u		Mp		MOR	PH		
IX	22		W				Hd,An,Cg	Sy			u		FC			PH		
	23		D	1			A			2	o	P	F					
	24		D	9			NC				u		F					
X	25		D	4			A			2	-		FMp		AGC			
	26		D	2			A				o		FC		AGC			Pu

Figure 2. Lee's R–PAS code sequence. R–PAS code sequence reproduced from the Rorschach Performance Assessment System™ (R–PAS™) Scoring Program (© 2010–2015) and excerpted from the *Rorschach Performance Assessment System: Administration, Coding, Interpretation, and Technical Manual* (© 2011) with copyrights by Rorschach Performance Assessment System LLC. All rights reserved. Used by permission of Rorschach Performance Assessment System LLC.

Table 3. Rorschach narcissistic variables.

Variable	Rationale	Scoring example
<i>Reflection (r)</i> (Blais, Hilsenroth, Castelbury, Fowler, & Baity, 2001; Meyer et al., 2011; Weiner, 2003)	Provides a response containing an object and its symmetrically identified mirror image or reflection	"A woman looking at herself in the mirror."
<i>Personal Knowledge Justification (PER)</i> (Meyer et al., 2011)	Refers to personal knowledge (most often private and not shared with examiner) or experience to justify or bolster a response	"It looks like a boomerang because I've used them before and that's what they look like."
<i>Expanded Personal Reference (EPR)</i> (Meyer, Gritti, & Marino, 2014)	Expansion of PER that includes seeing one's self in the card, putting one's self in the response in some way, linking one's self to the percept (e.g., "Everything is about me")	"Very nice colorful clothes. I always dress up in colors, and the walls of my house are all red and blue."
<i>Omnipotence (OMP)</i> (S. Cooper & Arnow, 1986; S. Cooper, Perry, & Arnow, 1988)	Makes claim to unrealistic powers, influence, inflated worth, and so on, often in an attempt to deal with powerlessness or worthlessness, which are denied	"You might do better doing the pictures first (points to location sheet) and from these you could easily write down what I saw."
<i>Idealization (IDL)</i> (Berg, 1990; S. Cooper & Arnow, 1986; S. Cooper, Perry, & Arnow, 1988; Lerner & Lerner, 1980)	Describes unrealistically all good, powerful, beautiful, or desirable objects to protect oneself against bad objects or gratify one's own narcissistic needs	"Jesus Christ"; "A crown, a king's crown"; "These tests are amazing, you must have learned so much about me. I know you can help me."
<i>Exhibitionism (EXH)</i> (Wagner, 1965)	Provides responses that encompass percepts engaged in activities performed for the benefit of an audience or describes objects designed for display	"Skating"; "Dancing"; "Playing an instrument"; "A ballerina"
<i>Magic (MAG)</i> (Meyer, Gritti, & Marino, 2014)	Magical figures and objects associated with magic	"A witch"; "A wizard"; "A magic bottle"
<i>Elevated Mood States (EMS)</i> (S. Cooper & Arnow, 1986; S. Cooper, Perry, & Arnow, 1988)	Identifies positive affective states (fun, pleasure, happiness) in percepts or in himself or herself	"I know I'm going to enjoy this because I'm in such a good mood"; "Two people dancing to exhaustion"
<i>Narcissistic Devaluation (NDV)</i> (Meyer, Gritti, & Marino, 2014)	Narcissistically invested or embellished objects are alsodevalued, dismissed, denigrated	"A stupid giant"; "It looks like a wizard wearing a dunce cap"
<i>Narcissistic Deflation (NDF)</i> (Meyer, Gritti, & Marino, 2014)	Objects are missing a key part of their identity or possess deflated or impotent parts or are described as dying, decaying, deteriorating, or eroding; instances when a sentient object would likely feel ashamed of itself if it were on display	"A deer with a broken antler"; "A bird without wings"; "A giant with tiny limp arms"
<i>Narcissistic Denial (NDN)</i> (Meyer, Gritti, & Marino, 2014)	Denies or minimizes the impact of perceptions connected to weakness, vulnerability, inferiority, and so on	"This person is not desperate"; "It looks like a girl crying. She's not really crying, probably just acting."

Note. Adapted from Meyer, Gritti, and Marino (2014). © Gregory J. Meyer. Adapted by permission from Gregory J. Meyer. Permission to reuse must be obtained from the rightsholder.

deck” looking back together (Finn, 2007), we agreed and connected around a pattern wherein his “confidence shines, but his struggle stays in the dark.” In the traditional TA model, the intervention session(s) are separate from summary and discussion session(s), but in an attempt accommodate time constraints associated with an inpatient unit, Lee and I took a short break to reconvene to continue the summary and discussion.

Session 3 continued: Summary and discussion

The C/TA model deliberately avoids the term *feedback session* due to the implication of a unidirectional flow of information from assessor to patient, a feedback style rated as less satisfying and influential than more collaborative and involved feedback styles (Finn, 2003; Goodyear, 1990; Hanson, Claiborn, & Kerr, 1977; Rogers, 1954). Instead, C/TA encourages a summary of the assessment via a discussion of the patient's unfolding subjective experience with relatable language that also incorporates the quality of interaction between patient and assessor. Fidelity to this model requires time that is not always available in an inpatient setting. Therefore, the following discussion summary with Lee might have sacrificed “experience-near” exploration while using more assessor-driven explanation and education than what is recommended by C/TA.

To begin discussing Level 1 findings, questions that encourage a collaborative dialogue were integrated into our conversation about “main symptoms,” such as whether Lee felt that I or the testing process had wrongfully depicted him, what he found to be clear and helpful, how he made sense of the test data, and whether the results were different based on his current situation. Lee denied having depression and anxiety, to which I agreed, while showing no elevations on the associated MMPI–2 and MCMI–III scales. Lee acknowledged being addicted to the sleep aid, to which I also agreed and mentioned the elevated drug dependence MCMI–III scale. As the conversation stalled, I added that instead of struggling with sadness and worry, his responses on the MMPI–2 indicated a tendency toward optimism, resiliency, and thoughtfulness, as well as more “physical” than “emotional” symptoms (e.g., a loss of drive and energy, headache, gastrointestinal irritation, general aches and pains, concentration and thinking difficulties). Lee wholeheartedly agreed with these descriptions and expressed enjoyment inspecting the clinical scales on the MMPI–2. I remember Lee's comment, “sounds about right so far,” as an approving nod to see what else was discovered by the assessment.

C/TA deters the use of psychological jargon or DSM–5 symptom counts, as pathologizing clinical terms might not add to, and perhaps even take away from, explanations that use clear, concrete, and experience-near language. However, I knew that on inspecting his medical record after hospital discharge, Lee would see his diagnosis of NPD without support and further explanation. Therefore, a major task of the summary and discussion was explaining NPD in a useful way that encouraged Lee to explore this side of himself with me, rather than numbing a criticized experience and rejecting this explanation.

Using a helpful resource for describing personality styles in more understandable, useful, and humane terms (Oldham &

Morris, 1995), I began by explaining how everyone's personality develops out of necessity to successfully adapt to stress. I explained that the testing data suggest a “self-confident personality helps <him> cope with going into it alone and not knowing for sure.” This resonated with Lee, who commented, “That's fair,” and we then agreed on other self- words that encompass several of his attributes, including self-made, self-propelled, self-reliance, self-asserting, self-esteem, and self-starter (Oldham & Morris, 1995, p. 86). Lee elaborated on these attributes, explaining how his proactivity and self-assurance led to occupational success, wealth, and “being able to rise above some shitty circumstances.” I wholeheartedly agreed, adding that “rising above” might require numbing any painful emotions that accompany “shitty circumstances.”

I asked Lee, “But what about when things get extraordinarily shitty? What happens then?” We discussed how under extreme stress, these self- words take a desperate and unhealthy turn, as in self-aggrandizing, self-preoccupation, selfish, and self-destructive (Oldham & Morris, 1995, p. 87). I distinctly remember Lee repeating these words aloud, chuckling while he said, “Yeah, you sound like my ex-wife.” I asked Lee to mentalize or consider his ex-wife's mindset that motivated her statements. Lee insightfully linked instances when he would disconnect from his family to work or vacation alone, leading his wife to attack his character as “narcissistic” and “cold.” I asked if Lee imagined me thinking the same about him, especially if we had ended the assessment after the recent intervention. Perhaps due to our growing alliance and his increasing personal insights from inpatient treatment and assessment, Lee expressed new understanding, stating, “That is what I do, when I act like that I know people see me that way, but I guess it is just a show.” I asked Lee to help me understand what it was like to be seen “that way” as best as he can without “numbing” or “not being real with me.” Lee described anger, confusion, and “just wanting to leave, drive away.”

Nodding in agreement, I showed Card I of the Rorschach, repeating his responses of a caped wizard, a stealth fighter, and a devil's mask. The imagery of these magical, impenetrable, and powerful percepts were related to his ability to detach from reality and rise above. Also on Card I were dancers watching themselves in the mirror, illustrating his enjoyable self-image directly following periods of self-doubt (the wizard who “couldn't tell if he was a good or bad guy”). I added that this wizard's suspected “potion” was self-destructive and might cause him serious harm. Seemingly amazed by the congruency of his Rorschach responses and current self-descriptions, Lee admitted, “I'm baffled that I haven't killed myself driving on this stuff.” I shared his concern, and asserted that he is not invincible, or above the law, but the fact that he risks grave consequences signals “extraordinarily shitty circumstances” and desperately self-confident coping. I shared the elevated scales on the MCMI–III and explained it was consistent with NPD and acting out. I briefly discussed Greek mythology, wherein Narcissus was a young man who was made to fall in love with his own reflection in a pool of water, loved no one else, but could not embrace this watery image and yearned for real connection. Perhaps this mythological tale provided enough distance, and perhaps ego indulgence, as Lee identified with the disconnection, loneliness, and emptiness. Thus far, Lee

remained engaged and open to the discussion session and did not display defensiveness or a rejection of the findings.

Pointing to his original assessment questions, “Why can’t I sleep on my own? What’s wrong with me that I almost kill people on the road? Does this have to do with something in my childhood or something?” I asked Lee to consolidate his understandings thus far. Lee authentically struggled, but effectively described his pattern of numbing his need for help while showing everyone he was “fine,” leaving when things got too difficult, but struggling to feel connected and assured. In an honest moment of need, Lee asked my opinion on whether this pattern relates to the death of his father. I explained that I believed in a continuity of identity, meaning that our life experiences are stored in us, even if they seem emotionally and mentally distant. I continued, “Your profound loss of your father doesn’t hurt now, 39 years later, but when you told me about your prom after his death, you stated that you looked up to the sky outside the dance and [snap] you knew you would be fine.” He agreed. “Well, I think that captures your coping for all these years, leaving people, being alone, and looking to the stars. In many ways, you have become your own star, and you noticed earlier how you see so many stars in these pictures [referencing TAT stories with famous figures]. Even though it comes so unquestionably natural for you, I think being outside, disconnected from others, is not healthy and might answer some of your questions about addiction.”

With several signs of agreement, Lee continued to convey understanding, stating that he “self-medicates to sleep,” insightfully adding how he became addicted during the stressful peak of his divorce. Lee cried for the first time, sharing, “I always talked to my wife in bed and slept fine ... when she left, I was up all night, night after night after night.” His pain, loneliness, and agitation were palpable. We applied these insights to answer his question about sleep and acknowledged the calming support his wife provided for most of his life. While empathizing with Lee, I crossed out my question for the assessment (“How do you remain unaffected by disaster?”), stating that he has, in fact, been quite devastated by disasters, yet takes huge risks with his and others’ lives, desperately trying to hide his pain. His last assessment question came into focus for both of us: “What’s wrong with me that I almost kill people on the road?” We agreed together that what was “wrong” was denying his human vulnerability in favor of numbing with sedatives, as this has led to disconnection and callous risk-taking.

Finn’s (2003) cup and saucer metaphor was shared to gently challenge Lee’s tendency to “go into it alone” while illustrating the need for secure, supportive attachments who are interested in his whole person, not just his invincibility, strength, or success. I encouraged Lee to “outsource your support to those you trust” to decrease the possibility of disconnection, uncertainty, and further addiction. Lee’s smile at hearing this metaphor was refreshing and relaxing for both of us, as we connected around how we helped each other answer the assessment questions. I asked if he felt “stupid to trust this professional,” like he did the last time he received the sedative prescription, and Lee expressed gratitude and “a good feeling because this feels right to me.” Pushing further, I stated, “When your dad died, this feeling of being unsure and going into it alone

became so engrained and familiar that it’s second nature—but not healthy for you and your children.” I asked Lee to practice asking for help on the unit and encouraged him to reconnect with his children when he felt ready, not because they needed something, but because he did. Looking back at this moment in the assessment process, my efforts diverged from the C/TA summary and discussion model, as I gave more direction and advice. Perhaps this was due to the time demands of the session that created a press to wrap it up. Nevertheless, maintaining fidelity to the C/TA model might have solidified this ending with more effectiveness.

Consistent with C/TA, the assessment report is written as a personalized letter structured around the patient’s assessment questions, contrasting with traditional psychological assessment reports formally written for other providers with diagnostic and psychological vocabulary. C/TA encourages mailing this letter to the patient and scheduling a follow-up session after several weeks. Accommodating the inpatient setting and practical limitations conducting a follow-up, I met with Lee the following day to read the letter together and conduct an immediate follow-up to answer any additional questions. Although the effects of an immediate letter review without follow-up have not been studied, this inpatient adaptation might have decreased C/TA effects by shortening the time to process the assessment results and preventing the ability to check progress after reentering daily life to address associated obstacles or relapse. I did not include a copy of the assessment letter in this article to preserve confidentiality, but the letter summarized our feedback in a structure similar to a variety of examples in TA case studies (Finn et al., 2012; Fischer & Finn, 2014).

During the abbreviated review session, Lee and I consolidated moments of insight across the testing sessions with a focus on next steps. He had several questions about continuing individual therapy, which signaled to me a shift from his old story (e.g., “I don’t need others”) to a more flexible and interpersonally interested story (e.g., “Let’s see what others have to offer”). It is an overarching hope for assessors that patients will use gleaned information to “author new identities” (Finn, 2003, p. 126) instead of clinging to past ways in an attempt to preserve pride, ownership, and investment (Finn, 2003; Swann, 1997). I considered Lee’s excitement to learn more about psychodynamic, cognitive, behavioral, and mentalization-based individual psychotherapies as an indicator of his blossoming openness toward change and relational intervention. To capitalize on this period of openness, I also provided Lee with further reading about his personality style (chapter 5 in Oldham & Morris, 1995) and collaborated on locating suitable psychologists in his area for further treatment.

Overall, Lee expressed great benefit from the C/TA process, with comments such as, “I feel like this makes sense to me,” “Thank you for working with me it really helped,” and “I shouldn’t have been so worried about seeing a shrink.” Relatedly, a variety of self-report outcome measures completed by Lee across the inpatient treatment duration showed a general improvement in well-being, functioning, and working alliance. However, C/TA was a complement to a variety of psychiatric, individual, group, and milieu-based interventions, making it difficult to attribute Lee’s expressed benefit solely to the assessment process.

Conclusions

Conducting this modified C/TA approach in an inpatient setting significantly contrasted with my previous inpatient assessment experiences. Beginning with the initial interview, I felt more effective focusing on here-and-now questions for Lee. Answering questions for Lee, instead of a referring provider, led me to feel more invested, interested, and motivated to closely examine testing data with more energy and focus. The inpatient setting assisted in providing the time and space for this level of involvement, as a medical and social history had already been recorded by members of the treatment team. Relatedly, explaining test results to Lee in understandable terms led me to practice empathic phrasing and increase my own professional understanding of the associated psychological phenomenon. Instead of electronically submitting a technical symptom-focused report to another provider, I found myself using this person-centered understanding when describing Lee with other providers involved in his care. These conversations alone seemed to raise the overall compassion and investment in Lee among the treatment team, as we all found ourselves paralleling the collaborative process during consultations. For example, in the days following Lee's assessment I heard him described differently from a "narcissist" and "help-rejecter," to "a lonely man ... who needs help but struggles to ask." In addition, treatment teams on any psychiatric inpatient unit offer a wealth of resources that are unavailable with outpatient C/TA. For example, staff observations of daily self-care and interpersonal behaviors helped supplement assessment data with concrete and current situations. With Lee, working within the inpatient unit allowed us to track his sleep, assess the quality of interactions with other patients, witness his consistent hesitation involving his family in treatment, and observe and encourage times he elicited support from the treatment team.

Although this case was deliberately chosen for its diagnostic clarity and successful outcome, and might not be an exemplary prototype for an inpatient adaptation of C/TA, I also do not believe that there is a "right way" to conduct collaborative assessment. As Fischer and Finn (2014) wrote, "the best way to begin [collaborative assessment] is to expand on the ways you have already found yourself exploring in order to discover 'what in the world' test patterns might have to do with the client's life" (p. 426). The investigatory process of a multimethod assessment, colored with Lee's life and motivated by his quest for self-understanding, proved personally rewarding and professionally invigorating. I hope that this feasible demonstration of inpatient C/TA encourages further investigation of the magnitude of perceived benefits and supports other clinicians therapeutically assessing narcissism.

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