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A Group Music Therapy Method to Promote Mentalization Skills in Clients with Narcissistic Personality Disorder

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Abstract

This paper investigates the development of a group music therapy method by adapting elements of mentalization-based treatment (MBT) to help clients with narcissistic personality disorder (NPD). A prominent characteristic of NPD is a deficiency in empathy. The fostering of empathy and emotional awareness forms the basis of MBT. Music therapy offers a means to explore these skills on a nonverbal level. This work is even more impactful in a group setting. Unfortunately, there is a dearth of literature specific to music therapy and NPD. Furthermore, despite the availability of writings separately concerning NPD, MBT, group therapy, and music therapy, there is little research synthesizing these topics, indicating that additional study is warranted. At this author's internship placement at a private psychiatric hospital, there was a significant number of residents with high narcissistic traits. Since mentalization theory is one of the hospital's foundational orientations, the development of this method aligned with both the institutional philosophy and the needs of the population. The resulting intervention plan consisted of nonverbal musical dialogues performed by residents and observed by peers. These were followed by verbal discussions guessing at their emotional and relational content. In addition, I incorporated weekly receptive group sessions aimed at deepening connections among residents and building trust in the therapeutic relationship. The results suggest that this intervention indeed facilitated the MBT component of affect elaboration by engaging the group's interest and engendering a variety of interpretations and perspectives.

Keywords: music therapy, narcissistic personality disorder, mentalization-based treatment, empathy, group therapy

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Introduction

Music is a medium par excellence for empathy. In fact, in many ways, it is unmatched by any other medium. When we sing the same song together, we live in the same melody, we share the same tonal center, we articulate the same lyrics, we move ahead according to the same rhythm—moment by moment, sound by sound, through an ongoing awareness of the other, and through continuing efforts to stay together and thereby become one within the experience

—Kenneth Bruscia, Defining Music Therapy

In this paper, I will explore the treatment of narcissistic personality disorder (NPD) using a group music therapy method derived from the mentalization-based treatment (MBT) approach. Narcissism is a normal human trait that, at a healthy level, fortifies one's sense of identity and self-determination. Narcissistic personality disorder is marked by a combination of features expressing multiple forms of unrealistically inflated or deflated self-valuation (Ronningstam, 2016). According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (American Psychiatric Association [APA], 2013), the primary differentiating traits of NPD are "a pervasive pattern of grandiosity, . . . need for admiration, and lack of empathy" (p. 669). The DSM-5 also includes an alternative criteria structure for diagnosing NPD, namely, evidence of dysfunction in two out of the following four areas—"identity, self-direction, empathy, and/or intimacy" (APA, 2013, p. 767), and both grandiosity and attention-seeking behaviors. These are seen as characteristics that fall under the broader trait category of "Antagonism" (APA, 2013, p. 767).

Approaching the diagnosis and treatment of NPD can be delicate because it is not usually a presenting complaint, and the client is often not aware of their symptomology. Clients with NPD rarely have insight into the connection between their disordered, embedded personality traits and their difficulties with relational functioning, mood regulation, or addiction. As a result, many clients with NPD initially seek treatment for conditions such as depression, bipolar disorder, anxiety, substance issues, or deteriorating relationships (Feinstein, 2022; Ronningstam, 2016)—problems that are inextricably intertwined with their NPD. Bilotta et al. (2018) suggested that, particularly with grandiose narcissism, clients may not experience distress from their symptoms due either to pathological defense mechanisms or their flawed self-understanding and understanding of how others experience them. However, according to Ronningstam (2016), such clients do indeed experience symptoms that negatively affect their emotional well-being and interpersonal relationships. In addition, inherent to this diagnosis may be a resistance to accepting it. In her overview of NPD, Ronningstam (2016) noted that "patients . . . strongly oppose being 'labeled' NPD, conceiving it as unfair and prejudicial" (p. 6). Feinstein (2022) warned the therapist that diagnostic transparency must be considered carefully for clients with NPD because it could rupture the therapeutic relationship and impede the building of a trusting alliance.

Of the treatment approaches commonly used to treat NPD, I have chosen to focus on MBT, a foundational approach integrated into the program philosophy at the private psychiatric hospital where I am completing my second-year internship. Mentalization-based treatment is a psychotherapeutic framework that aims to increase the ability for clients to imagine, recognize, and understand both their own mental states as well as the mental states of others. "In essence, mentalizing is seeing ourselves from the outside and seeing others from the inside" (Bateman &

Fonagy, 2016, p. 5). Some of the many issues of clients with NPD include an inaccurate self-concept, a deficit in self-reflective ability, and impaired empathy, also known as theory of mind (DiMaggio, 2021). Therefore, it follows that one of the core problems of NPD is a compromised ability to mentalize. DiMaggio (2021) cited MBT as one of the treatment models that may effectively target some of these issues.

The creative arts therapies offer the potential for a transformative therapeutic experience that cannot be achieved through verbal therapies alone (Bruscia, 2013). Verbal techniques can be characterized by explicit and reflective exploration and processing, whereas non- and preverbal methods can be characterized by implicit and automatic exploration and processing (Bateman & Fonagy, 2016, p. 9). The nonverbal, preverbal, and sometimes verbal modalities of dance/movement, visual art, drama, and music provide access to emotions and relational behaviors in an immediate, embodied way that can both bypass and enhance language.

At my internship site, there was an opportunity to address narcissistic traits by improving interpersonal functioning, reducing problem behaviors, and increasing self-awareness through the primary curricula of dialectical behavior therapy (DBT) and the institutional lens of mentalization. I worked in the executive transitional living program, a $75,000 out-of-pocket 28-day residential program for professionals recovering from substance-use and mood disorders. Unlike residents in more restrictive programs, residents in the executive program were offered special privileges, such as the use of personal electronic devices, a private chef, private bedrooms and bathrooms, and permission to conduct business while in treatment. These privileges attracted a self-selecting, wealthy clientele who valued special treatment and who often fit the diagnostic criteria for NPD.

Music therapy sessions were part of an intensive treatment schedule of at least five sessions each day, including individual and group psychotherapies, process groups, psychoeducation, cognitive-behavioral therapy (CBT), DBT, art therapy, and psychodrama. The DBT program functioned as a unifying concretization of the program components because it taught clients practical skills and strategies for mindfulness, interpersonal effectiveness, emotional awareness, distress tolerance, self-validation, and validation of others. In my position as a music therapist, it was my job to be conversant with all the program components and weave the topics and directives from other groups into my music therapy sessions. A bonus of my position as an intern was the opportunity to observe my clinical population in multiple structured settings and more informally in the milieu. Therefore, my unique positioning allowed for a broad context to inform my planning and learning—an ideal environment for developing and testing new methods.

To create an opportunity to design and test a method, I proposed and received permission to add a second weekly music therapy session to my schedule at the executive program. I then offered one session per week of established, curriculum-specific music therapy and one session per week of pilot interventions. In this way, I could provide program consistency, build rapport, enhance group cohesion, and have the continuity required to develop and refine my mentalization-based intervention ideas. I have shared my experiences and discussed my impressions in the following sections.

One could argue that studying treatments for NPD in a predominantly White, high socioeconomic status (SES) population diverts attention from populations most in need of support. Hadley (2013) cautioned researchers against complicity with the “dominant narrative” (p. 379). In my view, there are parallels between narcissistic pathology and resistance to

recognizing one's unearned privilege among members of the dominant culture. There exists a natural correlation between unacknowledged privilege and a deficiency in empathy. The focus on developing a group music therapy method to promote mentalization skills in clients with NPD may be an opportunity to contribute in a small way to the overall disruption of the social schema of the dominant culture. According to Ronningstam (2016), NPD has gained acceptance as a disorder that adversely impacts the safety and quality of interpersonal interactions on all levels and in all environments, including personal relationships, work cultures, and the greater structures of social and legal systems. Also, MBT may pose fewer barriers to access for clients experiencing financial challenges and reach beyond only those of privileged socioeconomic status. Drozek (2020) pointed out that MBT is more cost-effective than some other methods employed to treat personality disorders, and in addition, it can be administered with less clinical training. If MBT is both effective and inexpensive, then it could be an efficient and dynamic approach in an inclusive community setting. Ultimately, throughout the research and development process, I have strived to remain mindful of my own privilege and implicit biases, my cultural sensitivity, and my capacity for mentalization as a competent therapist (Hadley, 2013).

Literature Review

The purpose of this paper is to design a group music therapy method derived from mentalization-based treatment (MBT) to treat clients with narcissistic personality disorder (NPD). This literature review encompasses research into: (1) the presentations and treatment of NPD, (2) the philosophy and application of MBT, (3) the suitability of group therapy to treat NPD, and (4) writings about the use of MBT as adapted to the music therapy modality. While research discussing NPD, MBT, group therapy, and music therapy is plentiful, research

integrating and synthesizing all these topics together is not available. Therefore, the review will include articles that cover each distinct area as well as articles that may provide some synthesis of one or more of these topics.

Pathological Narcissism and Narcissistic Personality Disorder

Much literature regarding pathological narcissism (PN) and NPD addresses common traits, potential underlying causes, and treatment recommendations. The foundational models of NPD, one based on defensive behaviors and the other based on skill deficits, were developed by Kernberg (1975) and Kohut (1971), respectively. Other models have been developed as well, including a mentalization model (Feinstein, 2022). While there are many common or overlapping symptoms among different types of personality disorders, it is the deficiency or dysfunction in empathy rather than grandiosity that better distinguishes it from other personality pathologies. According to Ronningstam (2016):

> Studies have shown that people with NPD can notice and understand others' internal states and feelings but may not be able to emotionally engage and respond to them. In other words, people with pathological narcissism or NPD have compromised and fluctuating empathy, but they do not lack empathy. (p. 10)

As noted in the previous section, PN and NPD are more complicated than the expected surface displays of grandiosity or attention-seeking—it is their underlying mechanisms that bear examination. Cascio et al. (2015) offered an apt description of NPD, articulating the seemingly contradictory traits of grandiosity and vulnerability, by using the term "defensive self-enhancement" (Cascio et al., 2015, p. 335). Also of interest is the behavioral feature of "interpersonal antagonism" (Lecours et al., 2013, p. 130), which is discussed in the alternative criteria for NPD in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition

(DSM-5) (American Psychiatric Association [APA], 2013) as being significant alongside the primary feature of grandiosity (Lecours et al., 2013, p. 130). Recent writings have suggested multiple, distinct presentations of NPD that sometimes do not include grandiose behaviors. "There is general consensus that there are three different types of NPD: (1) the thick-skinned, grandiose/malignant; … (2) the thin-skinned, fragile type; … and (3) a high-functioning/ exhibitionist type" (Feinstein, 2022, p. 539).

In 2016, Ronningstam released a comprehensive guide to all aspects of NPD, titled NPD Basic: A Brief Overview of Identifying, Diagnosing and Treating Narcissistic Personality Disorder. Ronningstam discussed both the DSM-5 formulations of NPD, variations of presentation, common traits, common co-occurring disorders, and treatment strategies. For example, according to Ronningstam (2016), impaired empathy, along with the dialectics of grandiosity versus vulnerability and perfectionism versus shame, is evidenced by inconsistent patterns of grandiose presentation, poor self-esteem, and underlying fears of worthlessness, failure, and powerlessness. Ronningstam (2016), however, did not include MBT as one of the recommended treatments in this publication.

Feinstein (2022) noted that a therapist should be alert to resistance from a narcissistic client due to difficulties accepting the need for help and a wariness of the perceived power differential between a client and therapist. Weinberg and Ronningstam (2020) offered treatment recommendations, including client-directed, concrete goals, psychoeducation, promoting agency, creating a safe environment to explore vulnerabilities, prioritizing an ongoing, collaborative therapeutic alliance, employing therapy contracts, and immediately addressing treatment-interfering behaviors. In addition, they cautioned against ignoring countertransference, getting into power struggles, challenging or indulging the client's grandiosity and vulnerability, over-

empathizing, or missing significant points of client history that may have informed their self-esteem (Weinberg & Ronningstam, 2020).

In 2021, Dimaggio discussed guidelines for the treatment of PN and NPD based on specific areas of challenge. Many of their treatment goals aligned with Weinberg and Ronningstam's (2020) guidelines, including prioritizing a solid therapeutic alliance with clear boundaries regarding behavioral expectations and respectful discourse while offering empathy and validation to the client (Dimaggio, 2021). Like Weinberg and Ronningstam (2020), Dimaggio (2021) also emphasized the importance of a therapy contract outlining clear treatment goals and co-constructed by client and therapist. Finally, Dimaggio (2021) advocated resourcing client strengths, promoting self-reflection, and increasing awareness of others.

Mentalization-Based Therapy

The most common verbal therapy methods used for the treatment of NPD include psychoanalytic psychotherapy, transference focused therapy, schema therapy, metacognitive interpersonal therapy (MIT), dialectical behavior therapy (DBT) (Dimaggio, 2021; Ronningstam, 2016), psychoanalysis, cognitive-behavioral therapy (CBT), (Ronningstam, 2016), clarification-oriented psychotherapy, and mentalization-based treatment (MBT) (DiMaggio, 2021).

Clients with NPD are, to an extent, deficient in their mentalizing capabilities. "Patients with NPD are able to describe others' thoughts and emotions from their own point of view but find this difficult when someone else's mental state differs from their own" (Simonson & Euler, 2019, p. 358). These statements may suggest that MBT as a treatment method for NPD warrants investigation. However, it is important to note that, according to Bateman & Fonagy (2019), research supporting the application of MBT to NPD is currently insufficient to provide adequate evidence as to its effectiveness. According to Feinstein (2022), "MBT may be especially

interesting to investigate for NPD because of its ease in implementation and flexibility, as well as the significant difficulty patients with NPD have with accurately perceiving (and being empathic with) the minds of others" (p. 537).

Group Therapy and Narcissistic Personality Disorder

Clients diagnosed with NPD can benefit from a group therapy setting. Yalom (2005) pointed out that for clients with NPD, group therapy can provide a more significant opportunity for growth and insight compared to the limited relationship exposure and experience of individual therapy. "In the group . . . the client is expected to share time, to understand, to empathize with and to help others, to form relationships, to be concerned with the feelings of others, to receive constructive but sometimes critical feedback" (Yalom, 2005, p. 422). In addition, group therapy can provide here-and-now intrapersonal and interpersonal experiences for the narcissistic client in a safe, supportive environment, fostering greater socio-emotional awareness of self and others (Dvorkin, 1998; Ronningstam, 2016; Yalom, 2005).

Unkefer and Thaut (2005) discussed the benefits of using group music therapy, particularly instrumental improvisation, as a viable method for increasing emotional awareness and improving interpersonal effectiveness. "Music… is a powerful therapeutic resource for emotional expression and reality-based socialization" (Unkefer & Thaut, 2005, p. 65). In a 2014 case study, Strehlow (2014) described mentalization work with clients with mood and personality disorders in a group setting. Strehlow used several techniques to assess mentalization capabilities and promote skill development. For example, in one exercise, a client selected instruments for each group member. Both the client's choices and the group members' responses to those choices provided fertile ground for discussing and sharing how group members experienced themselves and each other (Strehlow, 2014). As noted by Unkefer and Thaut (2005),

"the group functions as a laboratory…for practice of feeling expression, socially appropriate behavior, sensory-and reality-ordered behavior, and task mastery leading to better self-esteem" (p. 186).

Music Therapy and Personality Disorders

Unfortunately, there is a dearth of literature specific to music therapy and NPD. There is only one case study available, Austin (1992). It describes the use of dyadic instrumental and vocal improvisation to address narcissistic injury in a client studying to be a dance therapist. The treatment goal was to help the client experience and understand their emotions to gain insight into their sense of identity and their maladaptive relational patterns. "The music was often able to penetrate the 'wall' she constructed to protect herself against further injury" (Austin, 1992, p. 783). The client's goal was to begin deciphering their internal experience and its relationship to their external experience. Through their work, "the woman began to uncover, explore and accept devalued parts of herself" (Austin, 1992, p. 743).

There is a fair amount of literature researching the application of music therapy techniques to the general category of personality disorders. In a pilot study testing the efficacy of music therapy in treating personality disorders, Hannibal et al. (2019) described the ability of music therapy and music experiencing to address both implicit and explicit processing at the same time. However, samples for such studies rarely included a significant number of, if any, participants with the NPD diagnosis. On the other hand, borderline personality disorder (BPD) is usually well represented. Borderline personality disorder has also been the sole subject of several music therapy studies (Kenner et al., 2020; Foubert et al., 2017; Strehlow & Lindner, 2016). According to Feinstein (2022), several effective BPD therapies have begun to be adapted for the treatment of NPD, including MBT.

Music Therapy and Mentalization-Based Treatment

There are studies researching the application of MBT to music therapy (Hannibal & Schwantes, 2017; Strehlow, 2014; Strehlow & Hannibal, 2019). In a 2017 case study, Hannibal and Schwantes sought to "describe and unfold how we can understand what happens in music therapy from an MBT perspective" (p. 2). They explained their choice of MBT both because it is so widely used for personality disorders and because there are so few collaborations between the music therapy field and the MBT model. Some of the key MBT elements they felt translated well to music therapy included interactions in the 'here-and-now,' the 'not-knowing stance,' and the relational presence and actions of the therapist (Hannibal & Schwantes, 2017). Strehlow and Hannibal (2019) examined the effects of improvisational techniques on increasing mentalization capabilities, concluding that "musical improvisation is a medium that can facilitate therapeutic change in … implicit relational patterns" (p. 338).

The literature reviewed thus far affords a frame of reference for the purposes of this paper. It organizes some of the key features and treatment goals for NPD and then synthesizes those goals with the concept of MBT. It has provided a basis for choosing group therapy as a preferred setting for the treatment of NPD. It has also provided information about MBT-informed music therapy methods to date, creating a starting point for the development of my method.

Method

My goal was to design a method to address the needs of the population in the executive transitional living program at the hospital, including techniques targeting narcissistic personality disorder (NPD) traits. "Mentalization refers to the ordinary imaginative activity of understanding mental states (e.g., thoughts, emotions, desires, attitudes) within oneself and others" (Drozek,

2020, p. 178). Imaginative was a keyword that helped to inspire the development of my method by narrowing the focus to simple musical interactions aimed at stimulating the residents to wonder and empathize. My approach aligned with a mentalization technique called "affect elaboration" (Drozek, 2020, p. 188), which simply describes techniques designed to increase emotional awareness and facilitate a deeper experiencing of emotion (Feinstein, 2022). Specifically, I wanted to explore an intervention that might improve the residents' capacity to mentalize by prompting them to consider the possibilities of multiple perspectives regarding a singular, shared experience, much like Strehlow's intervention described in the previous section.

Strehlow (2014) expressed that "music therapy is . . . suitable for pointing out alternative perspectives, because music is always experienced uniquely and individually by itself" (p. 12). I followed Strehlow's line of reasoning and developed an intervention consisting of nonverbal dyadic musical conversations to stimulate imaginative interpretations of characters, emotions, stories, and context. This intervention was relational and dependent on the group having reached what is known as the working phase, when the cohesion and engagement of group members can facilitate significant therapeutic progress (Yalom, 2005).

Instead of focusing purely on one intervention, I designed a framework—a weekly treatment schedule consisting of two music therapy sessions supplemented by my observations of group sessions in other modalities and information shared bi-weekly by the collaborative multidisciplinary team. My intention was to synthesize what I learned to help me better understand the residents and continue to build trust and rapport in preparation for the final intervention of the week, nonverbal musical conversations. Group music therapy sessions were scheduled on Mondays at 10:00 a.m., the first session of the week, and Fridays at 3:00 p.m., the last session of the week. The groups could be as small as three residents and as large as eight

residents. Often, clients were absent due to private clinician appointments. After some trial and error, I developed a consistent plan for sessions on those days.

Observations of Other Modalities

Over the course of the week, I tried to attend at least one therapy session per day with other facilitators to observe the group's dynamics in different modalities, identify continuing issues and themes, and build a deeper rapport with the residents. I found attending psychodrama sessions especially helpful. Residents attended psychodrama three times per week. The work they did was informing and, at times, intense. For example, sometimes, residents reenacted past traumatic events to process them in the safe space of the therapy group. Often, residents improvised simulated conversations with their partner, child, or even a work colleague to practice expressing authentic emotions and imagining the mental states and perspectives of others. My method was influenced by some of the simulated conversations I observed in psychodrama sessions.

Every Monday and Wednesday, I participated in rounds with the rest of the clinical team. On Mondays, the entire treatment team met and interviewed each resident in the house for about ten minutes. This was a time for residents to express any concerns, ask questions, and share how they were doing with the entire team. On Wednesday afternoons, the treatment team met virtually without the residents to discuss each case and ensure everyone was updated. All these experiences during the week helped me form a more holistic understanding of each resident, which allowed me to be more prepared for music therapy sessions.

Receptive Sessions

Materials for Receptive Sessions

iPhone and JBL Flip 5 Bluetooth Speaker.

Receptive Method

On Monday mornings, I used a receptive method by inviting the residents to share preferred music and listen reflectively together. Receptive music therapy is passive in that clients are not actively musicking (playing music). Instead, it consists of interventions where clients listen to, or receive, music. Group receptive sessions can promote emotional expression and connection while enhancing positive social interactions via supportive listening and reflective group discussion (Bruscia, 1998).

Receptive sessions took place in the living room of the executive program residence. Everyone sat in comfortable chairs and sipped their morning coffee or tea. I used Spotify on my personal cell phone for these sessions and connected it to my JBL Flip 5 Bluetooth speaker. I invited each resident to talk about how they were feeling after the weekend and share a song with the group—a song that reflected what was on their mind or how they were feeling about their experience in the program. The purpose of this intervention was to welcome new residents, orient the group for the week to come, provide an opportunity for residents to listen to each others' selections in a supportive and reflective way, and build group cohesion. It was also an opportunity for me, as the facilitator, to assess the emotional positioning of each resident and meet them in their space. I observed the levels of engagement and empathy among residents by noticing each resident's interest in sharing and ability to tolerate listening to music chosen by others.

Instrumental Improvisation Sessions

Materials for Instrumental Sessions

Djembes, tubano, tambourine, castanets, maracas, frame drums, bongos, agogo bells, HAPI drum, guiro, egg shakers, cabasa, rainstick, iPhone, piano, JBL Flip 5 speaker.

Group Improvisation Method

Friday music therapy sessions were for instrumental improvisation. We met at 3:00 p.m. in the group room. In this room, I arranged the chairs in a circle. Next, I set up an assortment of percussion instruments as listed above. The piano was also in this room, and I kept it turned outward diagonally toward the group and located myself on the bench to be part of the circle. Instrumental improvisations strengthen group cohesion, help residents practice mindfulness, and facilitate nonverbal communication and respectful social interactions (Bruscia, 2014). They can also foster a sense of playfulness and humor, which is a wonderful way to mark the end of the week for a group in residential treatment.

To begin the session, I invited everyone to choose an instrument and explore sound-making with that instrument. Then I introduced the idea of group improvisation. I explained that we would be making music with our instruments and that there was no right or wrong way to play the music. I explained that I would start with a rhythm and that everyone could join in when they were ready, playing however they felt they wanted to play. This first improvisation was a warm-up and usually lasted about two minutes. Afterward, we talked about how it felt to play together and shared anything we noticed about the experience, either internally or externally.

After verbally processing the warm-up improvisation, I invited the group to try a second improvisation. Residents could keep their current instruments or try new ones. The second time, I asked for a volunteer to get us started. During this improvisation, I invited each resident, in turn, to perform a short solo. This second improvisation lasted about five minutes and ended in a similar manner to the first improvisation. Afterward, we talked about how it felt to improvise together for a second time and whether the group noticed any differences between the two improvisations. I did not require any residents to play a solo if they were uncomfortable.

Dyadic Improvisation Method

Following the group improvisation experiences, I shared with the group that I was working on mentalization-based treatment (MBT) techniques for music therapy. I asked them to take turns in dyads and have a conversation using the instruments of their choice. I explained that one person would play 'hello,' and their partner would play 'hello' back. Then, each partner could say things to the other, creating a musical conversation. After they finished, I asked the other residents to share their observations and guess at the conversation's emotions, characters, and story. Finally, I invited the playing dyad to communicate their intentions regarding the interaction and describe their experiences of playing together.

Results

Six music therapy sessions were held over the course of five weeks. There were twelve participants in total. The group's makeup was different in every session due either to new arrivals, recent departures, or individual appointments with other clinicians. The group membership completely turned over between the first and final sessions. Sessions were approximately 50 minutes long. I recorded session notes in the hospital records system immediately following each session, and I delineated my impressions and interpretations in my journal.

Observations in Receptive Sessions

At the beginning of every receptive session, I invited residents to verbally share their current emotional states. For example, on Monday mornings, some residents concentrated on their hopes and fears for the week to come, while others focused on the past weekend's events. Sometimes, residents mourned a perceived loss of momentum over the less-structured weekend and wished to process their feelings. Some had enjoyed visiting with family or friends, and

others might have experienced family conflicts or disappointments. Some had spent the weekend acclimating to the program, while others prepared for their upcoming discharge. If there had been recent admissions or discharges, the group would have experienced some shifts in dynamics and roles.

When sharing a song, I asked each resident to explain their reasoning for their song choices—such as a match for their mood, an association with a memory, or an insight related to their target issues. For example, one of the participants had a pattern of choosing songs reflecting their emotional state regarding their marriage. When feeling discouraged, they shared songs like "I've Forgotten You" (Vincent, 2005) and "Talkin' to Myself" (Lonesome River Band, 2000). When feeling hopeful, they shared "Harvest Moon" (Young, 1992) on more than one occasion. One resident reflected on their experience of unconditional love from their dogs while listening to "Love Travels" (Mattea, 1997). Another resident, when sharing for the first time, requested "Lovely Day" (Withers, 1977), which reminded them of happy Sunday afternoons with their family, granting the group a small window into their personal life. Finally, while processing a deeply impactful individual therapy session, one of the residents shared "Same Mistake" (Blunt, 2007), a song about being one's own worst enemy and repeating destructive choices despite knowledge of the potential consequences.

Song choices often provided evidence of growth and therapeutic progress. For example, in their first session, a resident shared "Romeo and Juliet" (Dire Straits, 1991), relating the lyrics to their frustration at the deterioration of their marriage and their partner's disdain for them, despite their commitment to being a good partner. Their stance was akin to that of a victim. Two weeks later, the same client shared "Roar" (Perry, 2013). After listening to the song numerous times, they said that they suddenly experienced an epiphany that the word 'roar' was a message

of empowerment to take charge, self-advocate, and exercise their agency. As they listened, they felt motivated for the upcoming week of therapy and were ready to look at their life from a new perspective.

When inviting each resident to share music, I observed who offered to go first and who required prompting. There were always a few residents who arrived at the Monday morning group with more than one song ready to share, and sometimes it was necessary to ask them to hold off and give others a chance to be heard. If a resident declined to share, I wondered if it were due to discomfort in sharing or an inability to identify or express their current state of emotion. Sometimes the answer was simply that a resident could not think of a preferred song, especially if they felt that they were being put on the spot. In those cases, I came back to them later in the session and made it clear that sharing was optional.

When facilitating verbal discussion between song selections, I noted which residents offered supportive comments and which offered statements indicating a self-focus. I also noticed that when residents shared music that did not show attunement to the group, the comments from peers were far fewer and less substantial. In one of the early receptive sessions, I witnessed a beautiful moment of altruistic peer support. When one resident (who had a cognitive deficit) was unable to retrieve the title and artist of the song they wanted to share, their peers patiently asked questions until they were able to guess the correct song, which was “Wonderful Tonight” (Clapton, 1977). Once the music began, the client’s body relaxed, and they were able to sing along despite their word retrieval problems. After listening, they wiped tears from their face and shared that they had been thinking about happy times with their partner. It was an emotional moment of connection for the entire group, who had assisted in holding space for their peer.

I was interested to know what about each piece stood out to the residents, such as the instrumental sound, the lyrics, or something more specific. Often, comments revolved around lyrics and their relatability, and sometimes comments were made about the emotions evoked by the music itself. For example, in one session, the group listened to two versions of "Fly Me to the Moon" (London, 1963; Sinatra, 1964). The group enjoyed comparing the swing style of Sinatra to the bossa nova style of London, noticing the different moods and emotions evoked by each recording.

I observed each resident's postures and motor activity while listening to assess for interest and emotional reactivity. I was especially interested in whether residents appeared to be actively engaged in listening or whether they appeared distracted or talked with each other while music was playing. For example, one resident might lean forward and appear to be listening intently, and another be sitting straight but fidgeting, perhaps having difficulty tolerating the music. Sometimes the fidgeting indicated that a resident was displaying hypomanic symptoms. Once or twice, a resident leaned back and fell asleep while the music was playing. I did not know whether the person was bored, resistant, or tired. In these instances, I practiced taking a mentalizing stance to imagine more than one possible reason for the behaviors I witnessed.

I was sensitive to any signs of potential trauma responses that I could not anticipate in advance of playing a song. I also made it clear at the beginning of each session that if anyone felt discomfort from a song selection, we did not need to listen to it. Likewise, residents were encouraged to choose music that did not focus on problem behaviors, glorify substances, or reflect on suicide or self-harm. If a resident had appeared uncomfortable or upset during a song, I would have checked in to see if they needed to leave the room for a moment. Fortunately, this did not occur during any of my sessions. One of my clients was able to tell me, in advance, of an

artist that they expected would trigger them. I was able to bear that in mind in the event that someone requested a song from that artist, planning, after validating their first choice, to invite a second choice as a substitution.

Finally, I looked for clues relating to the flow of the session and the sequence of song choices to see if they revealed evidence of attunement or detachment. I considered whether the series of songs told a story or represented a common theme. In one session, I noticed that residents were tuning in to each other's choices and sharing representations of their most significant relationships. First, a resident shared "Something in the Way She Moves" (Taylor, 1968), saying that there was a time when their partner represented the subject of the song. They were hoping they could get back to a place of lifting each other up instead of tearing each other down. It was in this session that songs such as "Harvest Moon" (Young, 1992) and "Wonderful Tonight" (Clapton, 1977) were offered, as mentioned previously, to communicate feelings about primary relationships. At the end of this session, one of the residents shared a specific live version of "Your Smiling Face" (Taylor, 1977) because it was a recording they enjoyed listening to in the car with their child. Here, the pattern shifted slightly, with a few potential imaginings of the client's mental state. The first was the possibility that they were not quite as tuned in as other residents. The second was the possibility that they considered their relationship with their child, not their partner, to be their most significant relationship. A third explanation could have been that this resident was able to recognize music as a relational activity and a point of connection with their child, which was significant to them in the context of the session.

Sometimes song choices appeared to lack personal meaning or seemed utterly incompatible with the choices of other residents. For example, one Monday morning, a resident arrived in the middle of the group after a series of songs and discussions that were quiet and

reflective. They then asked to share an instrumental swing recording by the Boilermaker Jazz Band that was incongruent with the preceding choices. Although their peers offered positive comments, the session appeared to have lost its direction and focus. Another time, a resident asked to share a song that had been used in a title sequence for a television show. They had come into the session ready to share that song, having thought about it for a few days. The other songs shared in this session were “Roar” (Perry, 2013), “I Will Always Love You” (Houston, 1992), and “Lovely Day” (Withers, 1977). The lyrics of their song choice, “Nemesis” (Clementine, 2015), were cautionary and spoke of karma and the inevitability of consequences. The animated visual accompanying the title sequence symbolized isolation, instability, competition, and conflict. This song choice felt disconnected and oppositional, perhaps antagonistic, and it engendered little discussion. It could have been a helpful song from a therapeutic standpoint in the proper context with a relevant directive.

At other times, receptive sessions furthered group cohesion even when the song selections were light and playful. For example, it was warm and sunny on the day of our final receptive session, so the group met outside on the patio. The songs reflected a need to celebrate the coming of Spring and let off steam on a Friday afternoon. These more social, relaxing choices included songs like “Sittin’ on the Dock of a Bay” (Redding, 1968) and “Hotel California” (Eagles, 1977). Residents even joked that the psychiatric hospital setting represented their very own Hotel California, and their use of humor furthered the atmosphere of fellowship. Listening to these kinds of songs together fostered genuine bonding and cohesion.

Observations in Group and Dyadic Instrumental Improvisation Sessions

In our whole-group improvisations, I looked at both group dynamics and individual behaviors. I usually initiated the first group improvisation in our instrumental sessions. One of

the residents often volunteered to initiate the second group improvisation. Sometimes the group ended improvisations organically as a unit, and sometimes I gestured to the group to slow down, reduce volume, and let the music fade away. The second improvisation often had a different quality and energy—people tried different rhythms, listened to each other, and worked together better. Sometimes, the residents would remark that the second improvisation felt more comfortable and that they felt the group was working together more than during the first improvisation.

I wondered if a resident's choice of an instrument might indicate their emotional state or the type of stimulation that could fulfill a need or restore emotional balance. For example, in one resident's first session, they chose maracas and a tambourine, and their playing reflected an energy and excitement that suited their instrument choices. Another resident, who at first had been reluctant to play any instrument at all, came into their second session and went straight for the green djembe. They were comfortable with this instrument and played it almost continuously throughout the session. They chose the same drum for the remainder of their sessions.

I also noted whether residents changed instruments during sessions or from one session to another. For example, one of the residents chose a djembe for their first dyadic improvisation. After surprising themselves and the rest of the group with loud expressions of anger in their conversation, they decided never to use the djembe again. Instead, they used a soft, gentle HAPI drum for the remainder of their improvisational sessions. A resident newer to the group began by choosing the cabasa and participated with hesitancy and some frustration at the difficulty they had communicating with the instrument. After that session, they made different instrument choices, usually picking hand drums. Still another client tried new instruments for each session due to their curiosity and enthusiasm for making music.

When playing, I observed the residents to determine who was focused on themselves and who was attending to and interacting with the rest of the group. One resident, who often arrived late, chose a djembe in their first session, experimenting with sounds on all the instrument's surfaces and using various tools to strike it. Instead of entraining and playing with the group, they focused all their attention on their own sounds and rhythms. Their eyes were focused downward. In another session, they chose a rain stick for one of the group improvisations, making sounds with mallets, sticks, and hand taps. They unselfconsciously explored different ways to make sounds with the rainstick and appeared to have tuned out what was happening in the rest of the group. In addition, they were aggressive in their sound-making, almost damaging the instrument. This same client also presented as antagonistic and oppositional in their dyadic conversations.

I looked for mirroring, matching, dominance, playfulness, connection, and confidence levels. One resident struggled with the lack of structure and definition in free improvisation and imaginative interpretation. While playing, they looked to me for guidance, often mirroring and matching my rhythms and patterns. When asked to share their interpretations of dyadic improvisations, they often were unable to come up with any ideas.

Some residents were uncomfortable with the exposure of playing solos. However, others felt a sense of achievement when playing their solo. One resident could not play a solo at all during their first instrumental session; they were frozen in fear and looked like they wanted to escape the room. However, like the previous client, they gained confidence as the sessions progressed. By the time they arrived at their final session, they had become a leader in the group. Another resident showed excitement when invited to play a solo during their very first session.

They were creative and uninhibited during their solo, pretending their maracas were directing airplanes to their jetways.

After the group improvisations, residents experimented with dialoguing in dyads while others worked on mentalizing by interpreting their conversations. During dyadic improvisations, I functioned as one of several group observers. I was interested to see who might initiate each conversation, whether the quantity of conversation was balanced or lopsided, whether one dyad member appeared to dominate the other, and whether the residents appeared to be listening to each other.

I tried to get a sense of the power differential and the roles the partners were embodying, such as friends, family members, romantic partners, or parent/child. One resident tried to communicate in both of their dyads and had difficulty being heard. For another resident, both of their conversations were short, and they were viewed both times by others as communicating dismissal and a desire not to engage with their partners. For the resident who often arrived late and focused inward, their dyadic improvisations were characterized by a lack of both eye contact and natural pauses to allow their partners to speak. Instead, they took a dominant and overbearing stance and played long soliloquies with varied rhythms and sounds. Their partner provided uniformly short responses and appeared to lose interest in the conversation after a short while.

I looked for emotional expression, reflective listening, and a sense of play. One of the residents showed unexpected emotion when using the djembe in their first dyadic conversation. They, surprisingly, played angrily and loudly as though emphasizing a point and asserting themselves. This was unusual for them because they usually interacted in a timid, passive way. In response, their partner played the maracas in a conciliatory posture, as though trying to diffuse

their anger and help soothe them. In the end, the initiating participant concluded with a soft, slow phrase that they explained was intended as an apology to their partner. Other residents interpreted the more delicate playing as a defeat or loss of energy, both reasonable guesses. The experience of discovering their anger through music became a point of emotional access for this resident, which was further explored in their individual therapy.

In another dyad, a resident playing the green djembe played energetically and dramatically. They experimented with sound-making on different parts of the drum. Their partner responded using the cabasa with a lighter tone and in shorter bursts. Residents had many different guesses about the interaction, including a fight with a resolution at the end, a passionate rendezvous, or a flirtatious encounter. One observer had an imaginative take on this improvisation—they described a scene in which John Lennon and Paul McCartney were arguing about what song to sing and then playing in synchrony once in agreement. The first player shared that they were acting out war with soldiers and cannons, joking that their partner must undoubtedly have been doing the same. Their partner shared that on their part, they felt that they were playing like a child, trying to get their partner's attention and saying, "Look at me!" with the cabasa. It was clear the players and the observers were having distinctly different experiences of the same musical content.

In all the dyadic conversations, I tried to discern if a story or narrative was unfolding. Two residents performed a steady, purposeful, harmonious conversation with consistent eye contact in our final improvisation session. Some peers interpreted the conversation as a couple having a conversation about what to do together and coming to an agreement. Some thought it was a flirtatious exchange, with one partner setting boundaries and the other partner pushing them. The partners then revealed that, in general, they were both expressing gratitude to each

other for the bonding they had experienced in the program together. They also claimed to have been making plans for their first round of golf together post-discharge. Their intentions matched, even if the details did not match exactly.

Ultimately, I wanted to discover how the other residents experienced each dyad and how dyad partners experienced each other. If one interaction led to more than one interpretation, the groundwork for considering multiple perspectives was laid. All residents were open to these activities and participated fully in playing and communicating their observations. They provided feedback that they enjoyed these experientials and looked forward to doing them again. The interactions in the final instrumental session evidenced the group's growth in imagination, curiosity, and elaboration of their observations.

Discussion

The purpose of this paper was to investigate a treatment method to address symptoms of narcissistic personality disorder (NPD) by integrating components of mentalization-based treatment (MBT) with group music therapy techniques. This writer examined literature discussing NPD, MBT, group therapy, and music therapy and synthesized salient elements to construct the method, which aligned with the theoretical orientation of the treatment site, mentalization, and applied to the population being observed, patients with a high occurrence of narcissistic traits.

Narcissistic personality disorder is a complex diagnosis with varying presentations. Structural theoretical models addressing the characteristics of both grandiosity and vulnerability continue to evolve, and the underlying feature of dysfunctional empathy is a common denominator among them (American Psychiatric Association, 2013; Cascio et al., 2015; Feinstein, 2022; Lecours et al., 2013; Ronningstam, 2016). Researchers have worked to identify

specific areas of need, treatment goals, and therapeutic recommendations for clients with NPD, all of which include objectives to improve empathy (Dimaggio, 2021; Ronningstam, 2016; Weinberg & Ronningstam, 2020). Mentalization-based treatment has at its core the aim of promoting the development of empathy and improving one's understanding of self and others (Bateman & Fonagy, 2016). Mentalization-based treatment can also be an effective way to form a collaborative relationship and promote emotional awareness with narcissistic clients (Bateman & Fonagy, 2016; Drozek, 2020; Lecours et al., 2013). The use of nonverbal techniques supports the exploration of relational awareness, emotional expression, and empathy on an implicit level (Bateman & Fonagy, 2016). Group music therapy techniques build interpersonal connections and invite mindfulness, playfulness, and emotional spontaneity, creating optimal conditions to facilitate mentalization (Hannibal & Schwantes, 2017; Strehlow, 2014; Strehlow & Hannibal, 2019).

The method consisted of a framework that included both receptive and improvisational techniques. These interventions served as components of a semiweekly treatment program consisting of one session of receptive therapy and one session of instrumental improvisation. Observation of the residents in other modalities augmented my readiness and reflexivity to meet them where they were upon arrival at my music therapy sessions. The receptive sessions provided information about the stage of the group and level of group cohesion (Bruscia, 1998; Yalom, 2005) and the cognitive and affective orientations of the residents (Bruscia, 1998).

The objective of the method was to foster mentalization skills by encouraging clients to imagine the mental states of others through observation of their peers' nonverbal, musical representations. The group setting at this writer's internship presented an opportunity to maximize the potential of music therapy work with this population. As Strehlow (2014)

explained, in a group, the "patient not only receives feedback from the therapist, but also the feedback of the patients among themselves is often of inestimable value and stimulates reflection processes" (p. 12). The method allowed the residents to work together as a group, validate each other, and discover for themselves that different people could have completely different intentions and interpretations concerning the same shared experience. This writer hopes that their new awareness contributed to their learning as a piece of their holistic, integrative treatment program.

The specific intervention of conversational, instrumental dyads sparked the residents' imaginations. When they shared their observations, they often surprised each other with differing interpretations. The method promoted discussion and comparison of multiple perspectives, which in and of itself is a worthwhile objective in terms of learning to mentalize, per Bateman and Fonagy (2016). The "overarching principle of mentalizing is to take an 'inquisitive stance' … behavior characterized by an expectation that one's mind may be influenced, surprised, changed, and enlightened by learning about another's mind" (Bateman & Fonagy, 2016, p. 5). This intervention seemingly facilitated mentalization by engendering a variety of interpretations and stimulating curiosity and imaginative exploration. As a result, this method merits further study.

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