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Testing and treatment-by-attitude in psychotherapy for pathological narcissism: A clinical illustration

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Abstract

Pathological narcissism is a personality constellation comprising distorted self-image, maladaptive self-esteem regulation, and difficulties in intimate relationships. Patients with elevated pathological narcissism may not necessarily meet criteria for narcissistic personality disorder, and may seek treatment for a range of mental health concerns across various clinical settings. An understanding of key principles of control-mastery theory (CMT) can help clinicians understand the specific goals and challenges of the individual patient with pathological narcissism, and can illuminate ways in which the patient may work in psychotherapy. This paper outlines how patients with pathological narcissism may engage in testing of their pathogenic beliefs, and how therapists can respond in ways that facilitate the patient's sense of safety and foster psychological work. The role of the therapist's attitude is highlighted as a means for countering pathogenic beliefs associated with pathological narcissism. Clinical material from a single case of time-limited supportive psychotherapy will be used to illustrate these principles and associated therapeutic processes. Insights from CMT regarding pathogenic beliefs and the patient's plan for addressing them can help to explain how therapy works or does not work for patients with pathological narcissism.

KEYWORDS
case formulation, control-mastery theory, identity, narcissism, psychotherapy

1 | INTRODUCTION

1.1 | Pathological narcissism

Individuals who suffer from narcissistic difficulties may seek clinical services for a range of presenting problems and across various treatment settings. Narcissistic difficulties––commonly referred to as pathological narcissism––may be particularly salient for patients who struggle with identity and self-esteem problems, and among those with entrenched patterns of interpersonal dysfunction. Pathological narcissism is a personality constellation involving distorted self-image and/or maladaptive regulation of self-esteem (Pincus & Lukowitsky, 2010). Individuals with pathological narcissism have difficulty maintaining a reasonably positive and realistic self-image without engaging in maladaptive self-enhancement efforts such as self-concealment, devaluation of others, and excessive grandiose fantasizing (Ronningstam, 2016). While narcissistic vulnerability refers to fragile self-image and shame-proneness, narcissistic grandiosity involves inordinate admiration seeking, inflated self-enhancing fantasies, and other-exploiting behaviors. These domains are often simultaneously present, overlapping with regard to inappropriate entitlement and compromised empathy (Ronningstam, 2016; Wright & Edershile, 2018), and in many cases oscillating in their expression (Gore & Widiger, 2016). At very high levels of severity, pathological narcissism manifests as narcissistic personality disorder (NPD) and bestows significant negative impact upon individuals and those around them (Day et al., 2020; Ronningstam, 2016). However, even below the threshold for NPD, pathological narcissism can be a source of considerable impairment, including interpersonal problems (Cheek et al., 2018), emotion regulation difficulties (Kealy et al., 2020), and psychiatric symptoms (Dawood & Pincus, 2018).

With an absence of efficacy trials supporting specific treatments for pathological narcissism, clinicians have relied on modified versions of traditional psychotherapy models such as psychodynamic and cognitive therapies (see Ogrodniczuk, 2013), combined with principle-based recommendations by experts (Dimaggio, 2022; Gabbard & Crisp, 2018). Clinical strategies may also be informed by research on associated features and mechanisms related to pathological narcissism. Such findings implicate impaired psychological representations of self-in-relation-with-others, including insecure attachment (Kealy et al., 2015), and position narcissistic vulnerability as a particular driver of dysfunction (Dashineau et al., 2019). Patients high in pathological narcissism may thus benefit from therapeutic focus on identity, attachment, and aspects of narcissistic vulnerability such as self-criticism and difficulties in self-esteem regulation. However, constellations of these domains, along with other aspects of narcissistic functioning (e.g., entitlement, grandiose fantasy), can be highly heterogeneous across individuals, reflecting different dynamic adaptations and functions. In this way, efforts to ameliorate pathological narcissism may benefit from theoretical perspectives that account for idiosyncratic patient dynamics––including challenging in-session interpersonal behaviors––within a model of therapeutic process.

1.2 | Control-mastery theory (CMT)

CMT (Silberschatz, 2005; Weiss, 1993) is an integrative relational cognitive-dynamic theory of mental functioning, psychopathology, and psychotherapy that provides a framework for transdiagnostic understanding of the therapeutic process. Developed and empirically tested by Joseph Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group (for an overview, see Silberschatz, 2005), and more recently also by the Control-Mastery Theory Italian Group (see, e.g., Fimiani et al., 2023), CMT offers an integrative perspective on how patients work in psychotherapy to overcome their problems and achieve their goals. The theory is compatible with contemporary hypotheses from evolutionary, cognitive, and developmental psychology (Gazzillo et al., 2020; Leonardi et al., 2022). In contrast to many theoretical orientations in psychotherapy, CMT does not prescribe specific technical interventions and instead seeks to illuminate transdiagnostic therapeutic process factors. An application of CMT to individual cases can potentially help therapists better understand their patients, particularly

when attempting to respond appropriately to patient utterances, attitudes, and behaviors that seem incongruent, confusing, or challenging.

CMT can contribute useful perspectives to understanding and working with patients with narcissistic difficulties, since their clinical presentations can vary widely and are often cited as perplexing or difficult (Ronningstam, 2016). Moreover, behaviors among patients with pathological narcissism can vary in their meaning and motives, with therapist responses being experienced differently by different patients (Gabbard & Crisp, 2018). One patient, for example, could experience a therapist's silence as rapt attention to their captivating narrative, while another might see it as a reflection of the therapist's disengagement. CMT highlights the motives behind patients' idiosyncratic behaviors in therapy, linking these with clinicians' emotional reactions, and suggesting particular therapist response options according to an individualized understanding of such phenomena (Gazzillo, Kealy, et al., 2022). Indeed, individuals with pathological narcissism are often seen as "pulling" for certain interpersonal responses (Gabbard & Crisp, 2018), and CMT conceptualizes these interactions as potentially therapeutic opportunities. Thus, especially given limited consensus regarding the treatment of pathological narcissism, clinical work with this population may particularly benefit from the insights of CMT on therapeutic processes.

CMT begins with the premise that individuals are fundamentally motivated to adapt to their environments, solve their problems, master their traumas, and pursue healthy developmental goals. Unfortunately, efforts to adapt to adverse circumstances and relationships during the developmental period often become solutions that have maladaptive consequences for adult living. According to CMT, the need to adapt to early adversity may lead to the development of beliefs that help the child make sense of and navigate their world and their relations with important others by associating the pursuit of healthy goals with dangers for the self, for important others, or for important relationships. For example, a child who experiences a parent's explosive rage and hostility toward their attempts at self-assertion may form a protective belief that self-assertion will cause maltreatment from others. If parents' hostility is chronic, this child may develop the belief that he is bad and deserving of maltreatment to preserve a good image of the parent and to protect himself against painful conclusions that the parent is overwhelmed or fundamentally hostile. Reinforced over time through repeated experience, pathogenic beliefs subsequently exert a constricting influence on one's pursuit of adaptive and appropriate developmental goals. As an adult, the child in our example may become socially inhibited ("it is dangerous to show who I am"), prone to excessive anger (out of an identification with the angry parent), and may have difficulty feeling relatively positive and deserving ("I am bad and it is wrong to feel worthy"). Pathogenic beliefs are often held outside of awareness both because they tend to be unpleasant, grim, and associated with inimical experience and because they are often implicit and procedural (Gazzillo, 2022). Given the threatening nature of pathogenic beliefs, various defenses or coping mechanisms may be mobilized––and entrenched in cognitive, affective, and behavioral patterns––to repress or compensate for them. Aspects of pathological narcissism may thus be viewed as expressions of pathogenic beliefs and of the defensive and compensatory strategies used to protect the individual from their full impact.

CMT suggests that patients seek to work in psychotherapy to disconfirm their pathogenic beliefs to pursue the developmental goals obstructed by them (Gazzillo et al., 2019). These goals will differ from one patient to the next, and may not be consciously presented by the patient as an explicit treatment goal. Yet CMT posits that patients are unconsciously motivated to overcome their pathogenic beliefs and pursue their evolutionary-based goals, despite this being a difficult task given that pathogenic beliefs are often implicit and have been developed to prevent retraumatization. Patients can make progress if they can experience safety in the form of experiences and relational "atmospheres" (Gazzillo, 2022) that disconfirm their pathogenic beliefs (Fiorenza et al., 2023) because safety facilitates the constructive emergence into awareness of pathogenic beliefs (*control* over defensive/coping processes) and associated traumas (*mastery* of the trauma), allowing for psychological working through and personal growth. CMT asserts that patients actively––even if unconsciously and idiosyncratically––work to achieve such experience in psychotherapy. Indeed, the patient is viewed as having a "plan," even at an implicit level of cognition, for assessing the veracity of their pathogenic beliefs in the service of potentially overcoming them. A patient may work on their plan through insights shared by the therapist, through the therapist's attitudes as experienced by the

patient, or through the therapist's relational responses toward the patient. According to CMT, various configurations and combinations of these processes may be useful so long as they disconfirm the patient's particular pathogenic beliefs and support their pursuit of adaptive goals. Moreover, the patient may engage in behaviors aimed at directly testing their pathogenic beliefs in their interactions with the therapist.

1.3 | Testing in psychotherapy

Observing reality and testing one's beliefs about reality are normal activities––often engaged in at an implicit level (i.e., without conscious organization)––that help people make sense of and adapt to their world. In psychotherapy, the patient observes and tests whether sufficient safety will allow for the lowering of defenses, the emergence of insight regarding their pathogenic beliefs and traumas, and the pursuit of their adaptive goals. Testing can occur through the patient conveying a narrative to the therapist, making an interpersonal demand of the therapist, adopting a specific attitude, or behaving in ways that seem contradictory or challenging and which may evoke confusion or difficult feelings in the therapist. The patient may, for instance, behave as though a pathogenic belief is true, to see whether the therapist will explore and undermine the patient's adherence to it (*testing by compliance*). Or the patient may take a position contrary to a pathogenic belief to evaluate the therapist's support for doing so (*testing by noncompliance*). While testing the patient may also position the therapist in a role parallel to that of a traumatizing figure in the patient's development (*transference test*), hoping that the therapist will not respond to them as the traumatizing figure of their past, or in a role similar to the patient as recipient of traumatizing experience (*passive-into-active test*), hoping that the therapist will not be as upset by their behavior as they were by the behavior of the traumatizing figure of their past. A further possibility is that the patient, in a passive-into-active test by noncompliance, will treat the therapist as they would have liked to be treated by caregivers, hoping that the therapist will benefit from this behavior, thereby legitimizing the patient's thwarted developmental needs. The degree to which the therapist "passes" a patient's tests (i.e., responds appropriately) holds great significance for therapeutic progress. The patient observes the therapist's responses to testing activity to evaluate the degree to which the therapist can support the patient's developmental goals and disconfirm pathogenic beliefs. In this way, testing in psychotherapy is regarded not merely as a manifestation of psychopathology, but rather as an (unconsciously) motivated attempt at seeking experiences that will facilitate safety and pave the way for further psychological work (e.g., insight regarding pathogenic beliefs, mastery over traumas, pursuit of adaptive goals). Moreover, in addition to actively testing a pathogenic belief, the patient may observe for evidence of whether the therapist's overall attitude is compatible with his or her plan (i.e., implicit/unconscious motivation) to disconfirm pathogenic beliefs that inhibit adaptive development. Referred to as "treatment by attitude" (Sampson, 2005), the patient may keenly attempt to discern whether the therapist is either supportive of or in opposition to the patient overcoming maladaptive patterns and developing new experiences of self and others.

From the perspective of CMT, therapeutic progress is enabled according to the degree to which the therapist's responsiveness is aligned with the patient's plan (Gazzillo, Dimaggio, & Curtis, 2021), comprising adaptive goals, the pathogenic beliefs that impede the pursuit of goals, and the traumas or adverse experiences that were adapted to through the formation and reinforcement of pathogenic beliefs. The plan concept also encompasses the kinds of testing strategies, corrective emotional experiences, and insights that the patient might use to advance therapeutic progress. Numerous research studies suggest that it is possible to reliably formulate the patient's plan on the basis of the first 2–10 sessions of a psychotherapy, and that the therapist's communications and responses which pass the patient's tests and support their plan are predictive of immediate and long-term improvements in the patient (see Fimiani et al., 2023; Silberschatz, 2017). CMT advocates for a uniquely personalized formulation of the patient's plan as a starting point for understanding how a particular patient may work in therapy, including the ways in which they may test their pathogenic beliefs, and as a potential guide for treatment (see Curtis & Silberschatz, 2022).

2 | CASE ILLUSTRATION

2.1 | Clinical context

The following case illustration was selected from a sample of young adults who received brief psychotherapy for distress related to identity concerns. The case was selected for this clinical illustration on the basis of the client's elevated scores on a measure of pathological narcissism.

2.2 | Method

The case was selected from a sample of 88 young adults (aged 18–25) who participated in a research study regarding brief psychotherapy for identity distress. Participants responded to advertisements on social media regarding the possibility of receiving free counseling for distress related to identity concerns. Interested participants were screened by a trained research assistant to ensure eligibility, based on moderate distress in at least one identity domain or mild distress across multiple domains, and to rule out exclusion criteria such as acute suicidality, psychosis, or severe substance misuse. Following informed consent, these participants were then randomized to either 12 weekly sessions of brief psychotherapy or a waitlist/usual care control condition of equivalent duration, followed by 12 weekly sessions of brief psychotherapy. Therapy was conducted by graduate-level trainees and delivered online through the Zoom videoconferencing platform. The treatment was a conversational, supportive therapy based on personalized case formulations developed by individual clinicians, who received weekly supervision regarding principles of CMT. Thus, intervention decisions were guided by principles of CMT reflected in therapists' own individualized case formulations regarding each client's identity-related goals and pathogenic beliefs. Psychiatric diagnoses were not provided and disorder-specific interventions were not encouraged, though were not proscribed if considered appropriate to an individual client's formulation.

Of the 88 participants, seven were excluded from selection for the present report due to dropping out before treatment. The present case was selected for descriptive analysis due to the client's pretreatment score on an abbreviated version of the Pathological Narcissism Inventory (SB-PNI, Schoenleber et al., 2015) being the highest of the sample, indicating a substantial degree of self-reported narcissistic difficulty. The client had been assigned directly to treatment, to a 44-year-old female therapist who was a graduate student in counseling psychology. For the present illustration, the following self-report measures were used to indicate outcome from pretreatment to posttreatment, and at 3-months follow-up: (1) the patient's self-described objectives for therapy, each rated in terms of how severely disruptive each problem was over the preceding month (Battle et al., 1966; Kealy et al., 2019); (2) the Identity Distress Survey (Berman et al., 2004) regarding distress across several identity domains; and (3) the Borderline Symptom List-23 (Bohus et al., 2009) regarding symptoms associated with borderline personality disorder and identity disturbance, such as emotional distress and self-destructive urges, experienced over the preceding week.

While the therapist developed a working formulation to guide treatment, our research group also created an independent formulation, based on the Plan Formulation Method (Curtis & Silberschatz, 2022), to facilitate descriptive analysis of the case, including within-session therapeutic processes. A team of seven psychotherapists with expertise in CMT developed this plan formulation collaboratively following the completion of therapy, based on video recordings of the first two sessions.

2.3 | Presenting problem and client description

The client, Jessie, was a 23-year-old female graduate student in English literature. Before commencing therapy Jessie independently indicated the following therapeutic objectives, rating each one in terms of how severe and disruptive the problem associated with each objective had been over the past month:

1. I want to be able to self-regulate my emotions. At present, I find it impossible to calm myself down without receiving reassurance and support from my loved ones, which sometimes leaves me in extended distress if they aren't immediately available to talk to me; *extreme severity*.
2. I want to have a sense of self beyond how I believe others see me. At present, I cannot conceptualize myself beyond what my loved ones tell me about myself; *considerable severity*.
3. I want to learn how to enjoy time spent by myself. At present, I spend all of my time alone feeling lonely and missing my loved ones, waiting until I can spend time with them again; *extreme severity*.

In addition to identifying these goals, she endorsed distress in several identity-related domains using the Identity Distress Survey (Berman et al., 2004), particularly regarding long-term goals, career choice, friendships, values or beliefs, and group loyalties.

With regard to pathological narcissism, Jessie scored 4.67 on the SB-PNI, indicating average responses in the *moderately* to *very much like me* range across PNI items. Her score was more than 1.5 standard deviations above the mean score within the sample. Thus, she strongly endorsed statements reflecting both narcissistic vulnerability (e.g., "I am preoccupied with thoughts and concerns that most people are not interested in me") and narcissistic grandiosity (e.g., "I often fantasize about being recognized for my accomplishments"). However, in her first session with the therapist, Jessie stated that she thought she had borderline personality disorder before describing her difficulties with emotion regulation and their impact on her relationship with her boyfriend.

2.4 | Case formulation

The following plan formulation was developed by the research team following therapy completion, to facilitate descriptive analysis for the present illustration:

> The patient is a graduate student in English literature who started her therapy by stating that she thinks she might suffer from borderline personality disorder. Her primary goals are to more effectively regulate her emotions (particularly sadness, anxiety, and self-loathing), to understand herself better, to dissociate less, to be more comfortable being alone, and to be less anxious when separated from her friends and loved ones.
>
> Several pathogenic beliefs impede her from achieving these goals. First, she is convinced that she is a very damaged, disturbed person who cannot regulate dysphoric moods or emotions on her own (i.e., she suffers from self-hate). Second, she saw her mother as a very weak woman who needed her protection. She believes that if she had put her needs in the foreground and had been less preoccupied with the needs of the people she loves, these people would have been deeply hurt (i.e., she experiences omnipotent responsibility and separation guilt). It is also likely that she believes that having more in life than her mother had would be hurtful (i.e., she may be susceptible to survivor guilt).
>
> The patient's pathogenic beliefs stemmed from several traumatic childhood experiences. She and her mother were abandoned by her father, who apparently suffered from severe mental illness, when the patient was a baby. Her mother seemed unable to maintain a stable, appropriate attachment with her. The patient experienced her emotional needs being seldom recognized or prioritized. She felt her mother did not support or promote her autonomy and self-esteem. The patient's experience growing up was that her mother depended on her and that she had to be mother's caretaker. It is likely that the patient's presentation reflects a powerful compliance with the implicit message of this

dynamic: that she herself does not deserve care and that her needs are of little importance; along with an unconscious identification with her mother, whom she experienced as weak, needy, and relationally impaired.

Broadly speaking, the therapist can help disconfirm these pathogenic beliefs by seeing the patient as a capable, intelligent, thoughtful, lovable woman with many appealing qualities (i.e., adopting a stance that counters self-hate). Conveying the attitude that the patient's self-regulatory difficulties are not her fault and instead likely stem from the challenging circumstances of her childhood would also be extremely helpful.

Several potential testing strategies were also identified as part of the plan formulation process (see Table 1). While not an exhaustive list, these potential tests were inferred from early clinical material, thereby allowing for examination of the therapist's interventions in terms of their compatibility with the patient's plan.

2.5 | Course of treatment and outcome

Jessie attended all 12 sessions offered in this brief psychotherapy study. To illustrate the role of testing as the patient's way to establish safety and disconfirm pathogenic beliefs, we focus our descriptive analysis on selected segments from three sessions reflecting early (session 3), middle (session 7), and late (session 11) portions of the treatment.[1]

Session 3

Jessie began this session by telling the therapist about recent despairing feelings, experienced in regard to her relationship with her boyfriend. She presented with markedly sad affect and obliquely alluded to suicidal ideation.

Pt: I'm not doing very well.

Th: Okay. I'm glad you're here. [pause]

Pt: It's just really hard with my partner right now, and he keeps telling me things are going to get easier soon and it just never happens—and I've been so scared for such a long time. [pause] I said last time I wouldn't kill myself and I still feel that way but being with him is so hard right now and, and just, I don't know what's going to happen if things don't get better soon.

Th: Okay, that's lot to deal with right there. And so do you feel right now, like you're at risk to kill yourself?

Pt: No.

Th: Do you want to talk to me about what happened?

Pt: It's just so hard to see him in person, right now––he has really bad depression… So we just need so much space and he's just not ready to be in a relationship like this and he's trying but it's just—he says I'm asking for way too much and I'm not asking for nearly as much as I need.

The patient went on to describe some of the challenges of not getting to spend much time together, due to living far apart and having different work and school schedules. She then indicated that she reluctantly decided to accompany him on a holiday with his family, as the alternative of not having contact with him for a few days would be too difficult for her to manage.

Pt: I'm going to be with his family for an entire week, and I don't know how that's going to go because I'm already just in a really bad place, and it's really hard for me to be okay around them when I'm like this. But I can't not go because, like 1 day without talking to him like I just, I just start breaking down—I really need support right now and he's not going to have internet access at the campsite for 4 days and I can't handle that… it's just I don't know for sure and so that's really scary not knowing how it's going to turn out…

Th: Yeah, not knowing if you're going to get your needs met, not knowing if you're going to be able to get the support you need and care for yourself… I'm sorry that this hurts so bad right now.

TABLE 1 Selected pathogenic beliefs and testing strategies in Jessie's plan formulation.

	Transference testing		Passive-into-active testing	
Pathogenic belief	**Compliance with the belief**	**Noncompliance with the belief**	**Compliance with the belief**	**Noncompliance with the belief**
I am neither strong, capable, nor lovable (Self-Hate)	The patient will describe herself or act as a weak, uncapable and/or unlovable person, hoping that the therapist will not believe this is true	The patient will describe herself or act as an intelligent, capable, and/or lovable person, hoping that the therapist will believe this is true	The patient will behave as if the therapist is incapable, weak, or unlovable, hoping that she will not be too upset by this behavior	The patient will support the therapist's self-esteem, hoping the therapist will appreciate this
If I put my needs in the foreground, and not the needs of the people I love, they will be deeply hurt	The patient will put in the foreground the needs of other people, hoping that the therapist will help her put her own needs first	The patient will put her own needs in the foreground, and will neglect other people's needs, hoping that the therapist will support her in doing so	The patient will try to make the therapist feel guilty if she does not sacrifice her needs for her, hoping that the therapist will not feel guilty or overly worried for her	The patient will support the right of the therapist to satisfy her needs, hoping that she will appreciate this behavior.
If I have more in life than others/my mother, I would hurt them/her (Survivor Guilt)	The patient will not try to do anything to improve her life situation or will sabotage her attempt to do so, hoping that the therapist will intervene and support her right to a more satisfying life	The patient will try to do the best that she can to have a life that is better and more satisfying than her mother's/therapist's, hoping that the therapist will support this	The patient will attempt to make the therapist feel guilty when she sees her as powerful and satisfied, hoping that she will not be upset by this	The patient will appreciate and support the ability of the therapist to have a satisfying life, hoping that the therapist will appreciate this

The therapist then asked Jessie to revisit the question of whether she might be at elevated risk for suicidality, and proceeded to review a crisis safety plan that included the use of crisis telephone and chat services. The patient duly responded to such questioning and reassured the therapist that she would be okay. On one level the therapist's expressions of sympathy and concern about suicide potential may be seen as responsible acts of rapport-building and risk management. However, in light of the plan formulation for Jessie, this segment of the session can be regarded as the patient's use of testing. By presenting herself as overly troubled and incapable of managing a separation from her boyfriend, the patient may have been testing pathogenic beliefs related to self-hate––her sense of being weak and incapable. At the same time, she was probably also proposing a passive-into-active test by compliance, by acting as her mother used to act with her when she was a child, hoping that the therapist would not be too disturbed and preoccupied by this behavior (i.e., that the therapist would act as a role model for her). In testing this way, the patient may have unconsciously "hoped" that the therapist would at least explore, if not highlight, the patient's resilience and capacity for independence without being too worried about her (since Jessie affirmed she was not actively suicidal). Such testing can be viewed as the patient asking "Will you see me as too pathological, or as capable and able to take care of myself?" and "Will you become overly worried by me as I was by my mother?" The therapist's overt ministrations likely did not "pass" this testing sequence, leaving the patient less able to feel safe and work constructively on her pathogenic beliefs. Indeed, following this sequence, the patient's affect presentation became a confusing mixture of sadness and laughter as she reiterated phrases like "It's just so scary."

Later in this session, the patient described having difficulties with her boyfriend's mother. She also continued to present herself as deficient and in need of bolstering from others like her boyfriend ("I don't have a sense of self without him") or the therapist ("If I didn't have this appointment today, I wouldn't have been able to get out of bed today"). The therapist subsequently commented on her yearning for connection having been longstanding, throughout Jessie's childhood. The patient's affect became more stable as she began to reflect.

Pt: I remember I felt like nobody really wanted to spend time with me. That's all I ever wanted…

I think my mom was so codependent on me growing up…I never knew good boundaries. I don't know, like it's just so many things…I fight with him, and then afterwards I don't know what I should apologize for; I don't know if I'm pushing too much or not enough; I don't know if I screwed up or if he's screwed up…and then I just end up just feeling so compelled to just take the blame for all of it. I never know if what I'm asking for is too much or not.

Th: So, all relationships are hard, but what seems clear is that what you asked for as a kid—your needs should have been met. And you deserved to have them be met. And so it makes sense that it's so confusing…when you came to learn that early on…

Pt: I've never lived in the moment—I just always taught myself to always be looking ahead…

In this segment, the therapist presented the view that Jessie's difficulties with separations and uncertainty may stem more from early experiences than from a fundamental deficiency in her as a person. This attitude was compatible with what our independent plan formulation proposed would be helpful for the patient. As such, these comments from the therapist seemed to restore a degree of safety. Thus, the patient consequently gained greater control over her affect in the session and began to describe a different aspect of her difficulties.

Session 7

At this mid-point in her therapy, Jessie began the session by indicating she had been having a difficult, up-and-down week, though without presenting herself as overwhelmed and unable to manage. She described having had some positive days with her boyfriend before becoming angry with him over an incident she experienced as a breach of trust.

Pt: You know I can't get angry and I've never been angry around him, but yesterday I was really angry and today I'm really angry, and I'm so sad… I just yelled for a few minutes… I just don't know what to do. I want to pass over it but what happened was like a big violation of trust.

Th: Yeah, so when someone breaks our trust it makes a lot of sense, we'd be pretty angry. And really sad. I welcome you to share with me what it was, if you feel comfortable.

Jessie went on to describe her discovery of her boyfriend's secretive communications with another woman. She felt that in these communications he had negatively compared her in a way that evoked considerable insecurity regarding her attractiveness to him. She also experienced this as a betrayal, and expressed angry feelings toward her boyfriend.

Pt: So I have to trust him. And it's so hard to trust to begin with, and just having this massive reason in my face to not trust him is so hard. And this anger is not great to be feeling.

Th: I'm really sad that this happened to you, you don't deserve to be treated this way at all. But I'm glad that you got angry.

Pt: The problem is it's still so hard to be angry at him—like I'm just doing that stereotypical thing of being angry at her [the other woman]…

The therapist validated Jessie's right to have strong feelings about the incident with her boyfriend. This was compatible with the patient's effort to overcome her self-image as person without importance who cannot or should not be bold and focused on her needs. In presenting her anger, Jessie was likely evaluating whether the therapist would help her feel entitled to her reaction and support her in addressing the scenario (*transference test by noncompliance*).

Pt: I kind of feel like most of the trust that I had is still there. It's just suspended in midair and the base is gone, and whether we can repair this is whether we can slide a new base into that space before the rest of it collapses.

Th: Yeah, that's a pretty clear visual and I think, from what I understand it's like this experience really kind of kicked your feet out from under you. As much as you have the awareness of like, "Okay, I have some elevated reactions sometimes"—and that makes a lot of sense with your early experiences—there was something that you were like "okay but not this". And then this idea of "Do I want to rebuild…Can this be different? Because I want and deserve to be in a partnership where I get to feel safe".

Pt: I've always told him that's the one deal breaker—if you ever cheated on me, that would be it. And I was very clear with him, if you ever do something like that, I'm not putting up with it… I believe if this happened again, I would have the strength to break up with him.

This sequence further indicates the therapist's attitude of fundamentally supporting the patient's nascent sense of deservedness and boldness in looking after herself. In what may be viewed as reflecting increased safety, Jessie went on to elaborate further on her efforts to tolerate uncertainty and invest her trust in her relationship.

Session 11

By this latter part of the therapy, Jessie's interaction with the therapist had developed to become more conversational, reflective, and collaborative. Compared with early sessions, her affect was relatively stable. Jessie introduced the theme of her mother demanding attention and support, often in awkward ways, and Jessie's attempts to create some distance for herself. She reflected on harboring feelings of guilty responsibility toward her mother: "It just hit me—she's so difficult to deal with, why am I still in that place of like 'I don't deserve these nice things?'" Furthermore, Jessie expressed concern about being identified with her mother, recognizing similar tendencies toward desperately seeking attention and validation to compensate for bad feelings about herself. She and the therapist focused collaboratively on her irrational guilt and feelings of unworthiness.

Pt: I guess I don't know how to give myself validation.

Th: And so, what then is kind of underneath that—what is needing to be validated?

Pt: I guess I just I want to know that I'm worthy of good things.

Th: Okay. So if we think about that, sometimes that behavior [seeking validation] kind of comes out in you because at the core you're trying to fight against, you know, an old belief of "I'm not good enough".

Jessie then reflected on her lonely adolescent years when she struggled to make friends with others and concluded that she must be uninteresting. As the session progressed, she explored aspects of her relationship with her mother, with the therapist commenting on how she may have developed pathogenic beliefs about

undeservedness, suppression of her emotional needs, and omnipotent responsibility. The therapist was inquisitive in facilitating this exploratory work, while also directly expressing attitudes aimed at countering Jessie's self-hate and supporting her right to feel strong and capable.

Pt: I feel like that's sort of a missing piece, like I just don't believe in my personality enough… I worry that I won't be enough. In the future, I worry that somebody would need more than me, like I'm not a big enough thing by myself and I want to be a big enough thing. I want to believe in myself that much, and it's just—I'm not sure how to do that.

Th: I think you are really enough… and maybe some of the tricky part is trusting that the environment is going to be safe enough for you to be who you are…

Pt: I always want to have actions I can take, like this will lead to that, but I think I might just have to have patience and kind of see that I'm enough over time rather than being able to do something that says "oh now I'm enough"—but that's hard for me…

Th: You know, when you take up space and be yourself, and let's say in our context I'm able to respond in a way that signals to you "hey, we're good," that kind of allows you to expand more and hopefully take up more space—and feel more empowered to say "yeah, I'm enough".

The therapist also responded with enthusiasm and support regarding Jessie receiving an academic award and planning to pursue additional graduate training, allowing Jessie to further use her attitude to work on beliefs that she should not be strong or have a better life than her mother.

2.5.1 | Outcome and prognosis

The objectives in the context of Jessie's treatment were to reduce distress related to identity concerns, particularly as reflected in the patient's specific individual goals. The Identity Distress Survey includes seven identity domain items, each scored from 1 (*disagree strongly*) to 5 (*agree strongly*). At pretreatment, Jessie's average score was 3.57 across these seven items. At posttreatment, her average score was 2.57. This decrease in identity distress was largely maintained at follow-up 3 months later, with a score of 2.71. Regarding distress related to Jessie's three main personal treatment goals (outlined above), her average score decreased from 4.67 at pretreatment (*considerable* to *extreme severity*) to 2.33 and 2.0 at posttreatment and follow-up, respectively (*minor severity*). Similarly, her average score on the Borderline Symptom List-23, scored from 0 (*not at all*) to 4 (*very strong*), decreased from 3.83 at pretreatment to 2.04 at posttreatment and 2.47 at 3-months follow-up. Taken together, these results indicate modest reduction of identity distress and associated emotional and behavioral symptoms, along with moderate improvement in Jessie's personal goals concerning self- and emotion regulation. Jessie maintained her academic functioning throughout her involvement in therapy and indicated plans to undertake further graduate education. However, given the pernicious nature of self-hate at the core of narcissistic vulnerability, Jessie would likely benefit from additional treatment to address further aspects of pathological narcissism.

Interestingly, overtly grandiose themes were largely absent from these sessions; most of the concerns Jessie explicitly brought to these sessions pertained to aspects of narcissistic vulnerability such as diminished self-esteem, sensitivity to rejection, and intense needs for validation from others. Narcissistic vulnerability has been posited to underlie grandiosity, with the latter considered a compensatory arrangement to rectify perceived and barely tolerated deficiencies in the self (Gabbard & Crisp, 2018; Pincus & Lukowitsky, 2010). For Jessie, pathogenic beliefs concerning self-hate and omnipotent responsibility may have been more imperative to address during a brief therapy than the grandiose fantasies she endorsed in the pretreatment research assessment. Indeed, from a CMT perspective, many patients may have difficulty feeling safe enough to examine and ultimately reduce compensatory behaviors before a sufficient degree of corrective experience has helped them to disconfirm underlying pathogenic beliefs.

3 | CLINICAL PRACTICES AND SUMMARY

Amelioration of pathological narcissism is generally thought to require long-term or intensive treatment. Nevertheless, improvement in domains relevant to pathological narcissism, such as identity, interpersonal, and emotion regulation difficulties, may be possible in low-intensity or brief treatments, offering significant relief for patients who can utilize them. According to CMT, patients are motivated to work on the pathogenic beliefs at the core of their difficulties regardless of the particular therapeutic context. By understanding a particular patient's pathogenic beliefs––arguably the drivers of defensive and compensatory behaviors associated with pathological narcissism––the therapist can determine appropriate responses to facilitate safety and psychological work. The concept of testing helps to make sense of unusual, provocative, or challenging behaviors and presentations that may arise among patients with narcissistic difficulties. Rather than viewing these exclusively as manifestations of psychopathology, the clinician can consider whether such behaviors reflect the patient's efforts to master their problems and learn something new through testing their pathogenic beliefs. Beyond the treatment context, such testing may be awkward and ill-considered, producing responses from other people that threaten to confirm the pathogenic belief and reinforce the patient's maladaptive self-regulatory patterns. By contrast, the therapist who formulates the patient's goals, pathogenic beliefs, and traumas can attempt to anticipate various possibilities in the patient's testing behavior and respond in ways that signal safety and promote insight.

Especially useful in therapy for pathological narcissism is the formulation of the kinds of attitudes that might disconfirm the patient's pathogenic beliefs. Some patients with narcissistic problems may have great difficulty absorbing the therapist's verbal interpretations, explanations, or suggestions, construing these interventions as painful confirmations of the patient's vulnerability (Shilkret, 2006). In these and other cases where the patient is highly defended against the therapist's overt influence, corrective experiences obtained through the therapist's attitude––attuned to the specific patient's needs and sensitivities––may be the primary mechanism of therapeutic action. Moreover, since patients with pathological narcissism and other personality dysfunctions may test in particularly challenging and sometimes contradictory ways, their therapists might have a greater probability of failing to respond in ways that advance the therapy (Gazzillo et al., 2021). The therapist's consistent expression––through both verbal and nonverbal communication––of attitudes that are compatible with the patient's plan could support the patient's disconfirmation of core pathogenic beliefs even when the therapist misses or fails important tests. Jessie's therapist, for example, showed consistent positive regard and a level of concern for the patient that conveyed respect for the patient's worth and resilience, without involving an undue sense of guilty responsibility. By leaning against beliefs related to self-hate and omnipotent responsibility, this relational stance may have been more pivotal to fostering Jessie's self-regulation than specific tests or technical interventions.

Principles of CMT can help therapists appreciate the pathogenic beliefs associated with narcissistic presentations, understand the idiosyncratic ways in which patients may work to overcome such beliefs, and develop specific attitudes and responses to tests that foster corrective experiences. This can potentially accommodate a variety of technical interventions across a range of treatment contexts and support an integrative approach to therapy for a heterogeneous patient population. Indeed, pathological narcissism has been noted to span considerable diversity in presentations and social functioning (Gabbard & Crisp, 2018). Some patients with narcissistic difficulties may be well organized, high achieving, and affectively stable, while others may experience significant dysphoria and relational turmoil, sharing features with borderline personality disorder. Prescribing the same therapy to all patients with pathological narcissism would be inappropriate. As a theory and set of principles about therapeutic process, however, CMT can highlight how the particular individual patient with pathological narcissism may work most constructively in therapy, guiding therapists regarding the most salient pathogenic beliefs and likely opportunities for safety and corrective experiences. Moreover, even when basing interventions on a structured technical model (e.g., dialectical behavior therapy), therapists equipped with a CMT-informed formulation can anticipate ways in which the patient with narcissistic difficulties might test their pathogenic beliefs in relation to the therapist. Perhaps most importantly, CMT principles can focus the therapist's attention on the patient's needs and sensitivities, thereby promoting optimal relational atmospheres and mitigating negative reactions commonly associated with the treatment of pathological narcissism.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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ENDNOTE

[1] Potential identifying information has been changed to preserve confidentiality, and session excerpts have been edited for brevity and clarity.

PEER REVIEW

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