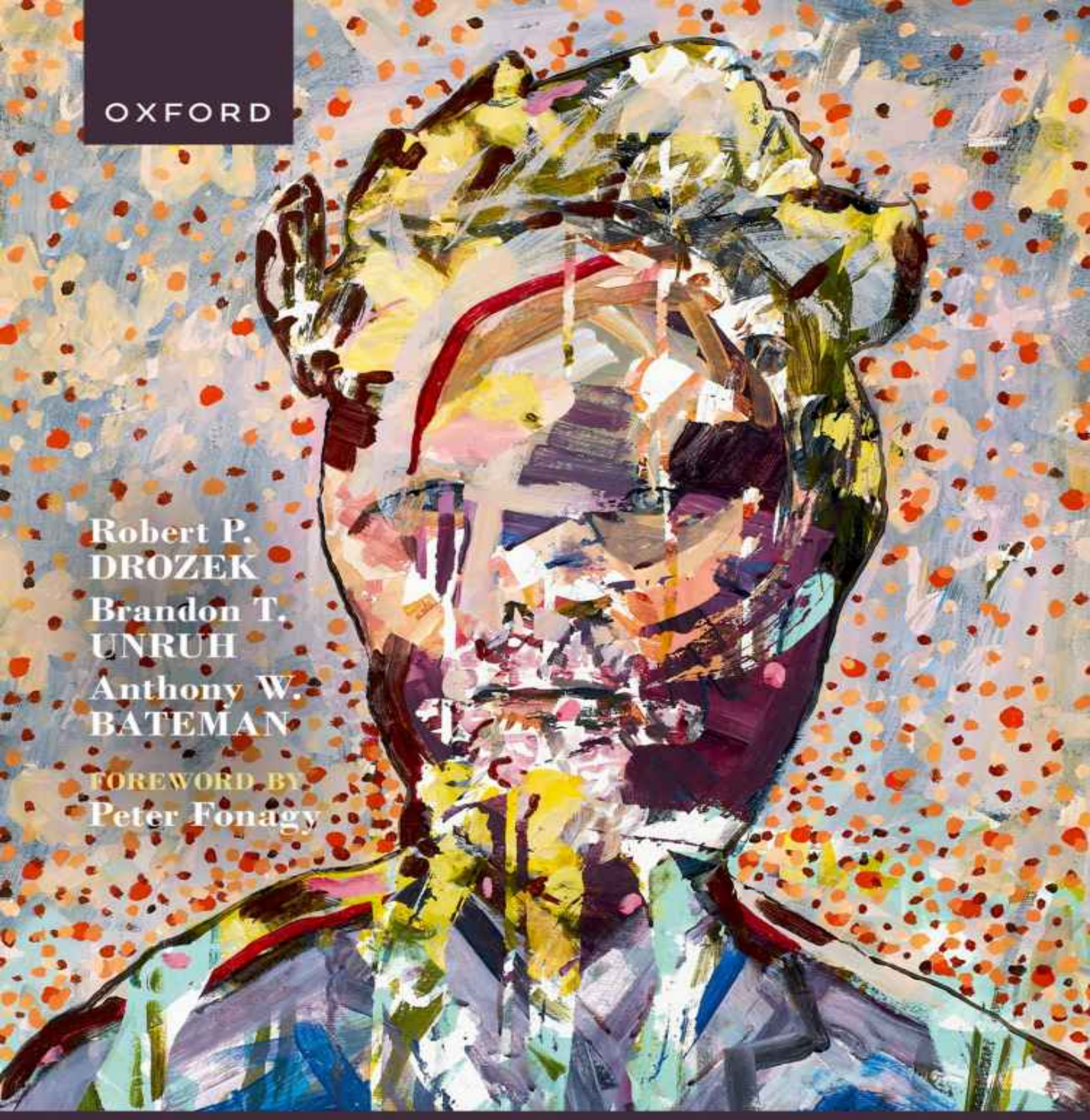

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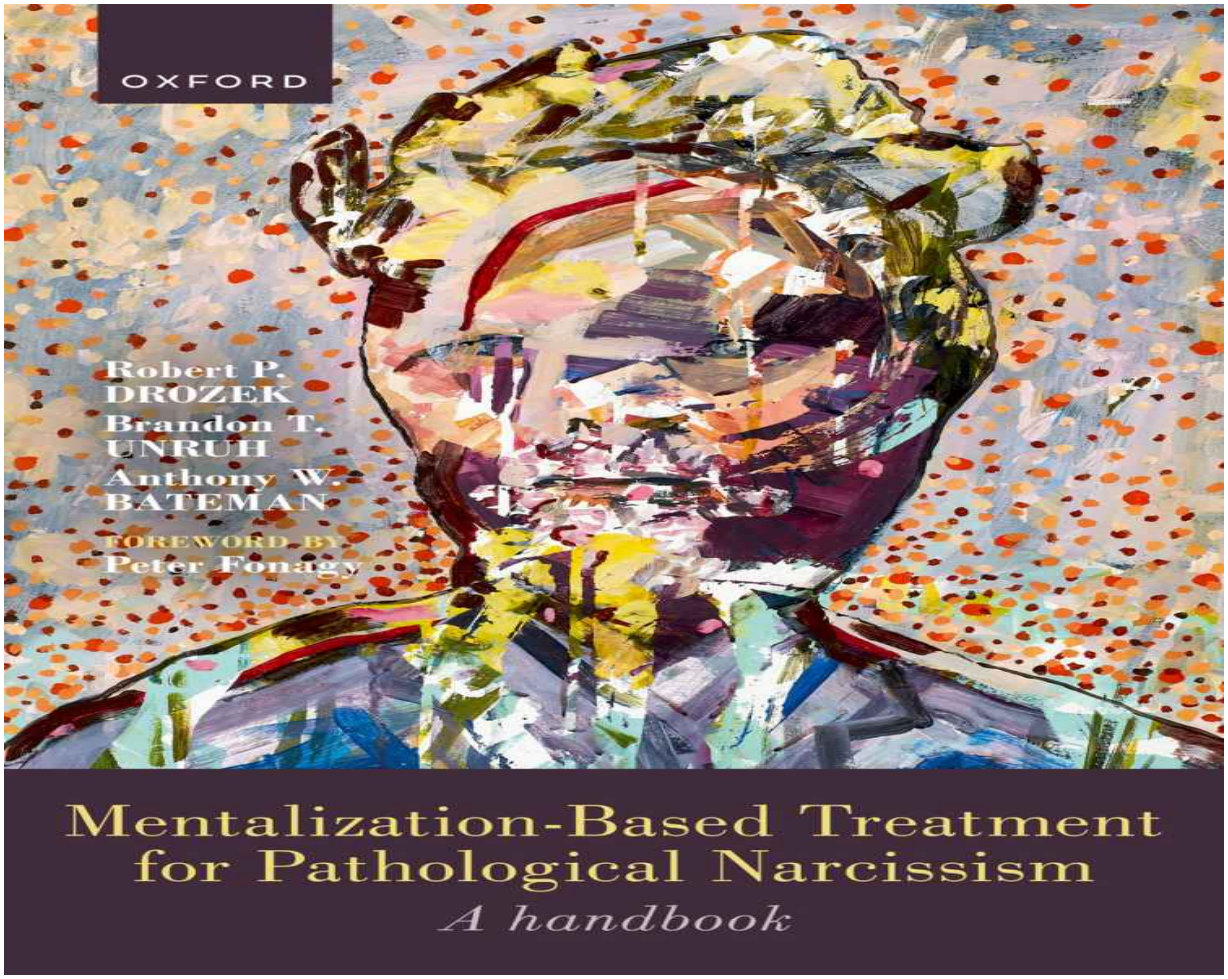
Brandon T. UNRUH
Anthony W. BATEMAN

FOREWORD BY
Peter Fonagy

Mentalization-Based Treatment for Pathological Narcissism

A handbook



Mentalization-Based Treatment for Pathological Narcissism

A handbook

Advance praise for *Mentalization-Based Treatment for Pathological Narcissism: A Handbook*

"*Mentalization-Based Treatment for Pathological Narcissism: A Handbook* fills a critical gap in the clinical literature. This handbook examines the nature of pathological narcissism, carefully outlines an innovative treatment approach, and uses descriptive case material to illustrate the application of mentalization-based treatment (MBT) to address the struggles of these patients. Patients will recognize the expertise in MBT for narcissism, feeling the validation of experience that can be motivating for those who have not felt helped by other approaches."

—**Blaise Aguirre, MD,** DBT trainer, author of *Borderline Personality Disorder in Adolescents* , and co-author of *DBT for Dummies*
Founding Medical Director, 3East DBT Continuum, McLean Hospital
Assistant Professor, Department of Psychiatry, Harvard Medical School

"Now more than ever, psychotherapy needs a coherent and pragmatic approach to the treatment of pathological narcissism. Not only does this groundbreaking book introduce a novel mentalizing intervention for narcissistic disturbances; it also provides clarity about how MBT is more generally implemented, in a practical and user-friendly manner. This book will help any clinician improve their psychotherapeutic interventions with patients who struggle with forming a clearer and more consistent sense of self."

—**Lois W. Choi-Kain, MD, MEd,** Good Psychiatric Management (GPM) trainer, co-editor of *Applications of Good Psychiatric Management for Borderline Personality Disorder*
Director, Gunderson Personality Disorders Institute, McLean Hospital
Assistant Professor, Department of Psychiatry, Harvard Medical School

"It is hard to imagine a book that could bridge so seamlessly the clinical, empirical, and theoretical levels of discourse related to the treatment of pathological narcissism. New students of psychotherapy and practiced clinicians will benefit enormously from the specificity and breadth of various levels of intervention. A book is remarkable when an experienced clinician and a new therapist find genuine help and clarity regarding their treatment of narcissistically disturbed patients. This is that rare text."

—**Steven H. Cooper, PhD,** author of *Playing and Becoming in Psychoanalysis*
Faculty, NYU Postdoctoral Program in Psychotherapy and Psychoanalysis
Training and Supervising Analyst, The Boston Psychoanalytic Society and Institute

"Narcissistic tendencies are on the rise in this modern world of selfies, manicured Instagram pages, constant self-promotion, and other artificial means of increasing self-esteem. This exciting new book explores ways of addressing pathological narcissism, based on one of the best supported methods of addressing similar disorders: mentalization-based treatment (MBT). This book is relevant not just to MBT therapists but also to those interested in interventions from self-compassion to mindfulness, from emotion-focused work to 'third wave' cognitive and behavioral therapy. Comprehensive and well-written, this volume contains interesting and useful ideas on every page. Highly recommended."

—**Steven C. Hayes, PhD,** originator and co-developer of Acceptance and Commitment Therapy (ACT), and author of *A Liberated Mind: How to Pivot Toward What Matters* Foundation Professor of Psychology, University of Nevada, Reno

"Our understanding of pathological narcissism has evolved and is continuing to become more complex and differentiated. Drozek, Unruh, and Bateman's *Mentalization-Based Treatment for Pathological Narcissism: A Handbook* is an excellent example, taking up the challenge of showing us how to work effectively with pathological narcissism. Perhaps the most impressive aspect of this handbook is its clear and direct style, which will make it appealing to seasoned clinicians (who might be familiar with mentalization), as well as to students and early career professionals (who are curious to learn about mentalization)."

—**Elliot Jurist, PhD, PhD,** author of *Minding Emotions: Cultivating Mentalization in Psychotherapy*
Professor of Psychology and Philosophy, The City College of New York and The Graduate Center, The City University of New York

"Integrating contemporary clinical theory and clinical science, this handbook fills an important gap by extending mentalization-based treatment to patients presenting with pathological narcissism. Written in a straightforward and highly accessible style, the book provides clear clinical examples and specific recommendations spanning all aspects of treatment. Most importantly, the narrative easily transports readers into the consulting room. The level of specificity in 'how to' assess and intervene is outstanding, making it an essential resource for clinicians of all orientations who work with these challenging patients."

—**Aaron L. Pincus, PhD,** developer of the Pathological Narcissism Inventory (PNI)
Professor of Psychology, Pennsylvania State University

"This is by far the most up-to-date and comprehensive practical handbook for exploring and treating pathological narcissism. The focus on mentalization as a technique and process opens a remarkable opportunity to engage patients to move from 'reflexive' towards 'reflective' functioning. The authors outline a non-judgmental, systematic approach for recognizing and adjusting strategies for each patient's individual narcissism-related mindset. The detailed clarifying clinical examples make this book exceptionally useful for psychotherapists and clinicians."

—**Elsa Ronningstam, PhD,** author of *Identifying and Understanding the Narcissistic Personality*
Associate Professor of Psychology (part-time), Department of Psychiatry, Harvard Medical School
Psychologist, Gunderson Outpatient Program, McLean Hospital

"Drozek, Unruh, and Bateman illustrate how deficits in mentalization result in grandiosity, emotional vulnerabilities, and empathic deficiencies in individuals with pathological narcissism. Myriad examples of thoughtfully worded interventions bring home the humble, evidence-based, potent, and creative stance of mentalization-based treatment; therapist-readers can immediately bring their suggestions to bear in sessions. Theory, stance, and interventions are folded together in beautifully described, full case examples. This book is a tour de force and a huge addition to the clinical literature on treating pathological narcissism."

—**Charles Swenson, MD,** DBT trainer and author of *DBT Principles in Action: Acceptance, Change, and Dialectics* Associate Professor, Department of Psychiatry, University of Massachusetts Medical School

“Drozek, Unruh, and Bateman have written an essential book for clinicians who are treating, or wish to treat, those with pathological narcissism. Beyond a sophisticated set of treatment principles and techniques, the authors offer a compassionate guide to the often-difficult trajectory of working with someone with this serious disorder. This book is a must-read for anyone working with this intriguing, complex, and common group of patients.”

—**Mary C. Zanarini, EdD,** author of *In the Fullness of Time: Recovery from Borderline Personality Disorder* Director, Laboratory for the Study of Adult Development, McLean Hospital
Professor of Psychology, Department of Psychiatry, Harvard Medical School

Mentalization-Based Treatment for Pathological Narcissism: A Handbook

A Handbook

Robert P. Drozek
Brandon T. Unruh
Anthony W. Bateman

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To Margaret Donnelly, for showing me another way.
—R. P. D.

Foreword

Peter Fonagy

It is indeed a heartwarming and substantial privilege to be asked to read and introduce this book, which is one of the most exciting examples of the continuing expansion of the mentalizing family. I will divide the space allocated equally to a brief overview of mentalization-based treatment's achievements and then highlight what Bob Drozek, Brandon Unruh, and Anthony Bateman's book has contributed.

While a relative newcomer, the treatment model and theory of mentalization-based treatment (MBT) has acquired a certain standing within the community of psychological treatment approaches and transdiagnostic models of mental disorder. The origin of this work goes back (an unimaginable) 35 years, when we demonstrated for the first time that the security of the parent–child attachment bond at one year of age could be predicted from an interview with a parent regarding their own attachment history prior to the birth of the child. This work, with Miriam and Howard Steele, now both enjoying well-deserved senior positions at the New School for Social Research in New York City, showed that parents' capacity to make sense of their early experiences and relationships in terms of their mental states (e.g., thoughts, feelings, beliefs, emotions, intentions)—a capacity we referred to as "reflective function"—was a critical factor that shaped the quality of care parents provided to their infants and the security of the evolving attachment relationships (Fonagy et al., 1991). This paper, which according to Google Scholar has been cited in 2,800 publications, implied that insecure relationships may be perpetuated from one generation to the next. Further follow-ups by Miriam and Howard found parental mentalizing to have a long-term predictive power (Steele et al., 2016). In collaborative work with Pasco Fearon, we were able to show, using behavior genetic methods, that the transgenerational process was

indeed mediated by social (not genetic) transmission, and could be clearly linked to the quality of care the child received (Fearon et al., 2006).

The idea that patterns of relating are laid down in early life, may be relatively stable over time, and may be passed from one generation to the next is neither original nor new. The specificity with which mentalizing explains this process is however important, when thinking about how mental disorder is generated, and how it may be prevented with thoughtful intervention, thus breaking intergenerational cycles of disadvantage. This book, as does the MBT tradition in general, stands on the three decades' old work linking early experiences, mentalizing, and unhelpful patterns of organizing attachment representations that generate clinical outcomes. Much of the translational work that followed the original studies based at the Anna Freud Centre (celebrating its 70th birthday in 2022) adopted the developmental framework in which the capacity to mentalize was seen as a developmental achievement partially ensured by the capacity of the child's caregivers to provide a reflective environment able to build robust mentalizing capacity in the child. The model was described in a hurriedly written book published twenty years ago, brilliantly edited by Dr. Elizabeth Allison. With over 8,500 citations, the book became highly influential, laying out the central hypothesis that attachment-related trauma impairs the development of mentalizing. This subsequently leads to the patterns of emotional dysregulation and self-disturbance that are characteristic of borderline personality disorder (BPD) and related difficulties (Fonagy et al., 2002).

The relationship between attachment and mentalizing would not have had true clinical impact but for the work of an extraordinary clinician, Professor Anthony Bateman, one of the authors of the present work. The novel framework for psychological therapy, on which I had the privilege of working with Anthony, had a transformational impact on practice. In the United Kingdom and internationally, this approach underpinned the development, evaluation, and professional application of effective mental health therapies for several different psychological issues that threaten the health and well-being of adults, adolescents, children, and families (Bateman & Fonagy, 2010). The research, which evaluated the suitability and effectiveness of the mentalizing approach in personality disorder and other client populations where attachment and mentalizing difficulties are considered important (e.g., adolescent self-harm, children in foster care,

depression), has all been based on the principles of treatment which Anthony Bateman's work established for individuals with BPD (Bateman & Fonagy, 2006).

The principles of MBT technique, brilliantly illustrated in the present book, are not all that Anthony has brought to the MBT tradition. Accessibility is perhaps the most important of these. Some of it goes back to the practical constraints that drove the original development of the intervention. Anthony Bateman, in almost his first clinical leadership role, inherited a psychodynamic partial hospital program (the Halliwick Day Hospital), where clinical capacity for specialist intervention was far exceeded by clinical need—a situation still not uncommon in public mental health settings in the United Kingdom. His task was deceptively simple: to create a theory-grounded intervention for individuals with severe (almost exclusively borderline) personality disorders that would have therapeutic value, and could be administered with minimal training by individuals who had not been psychotherapeutically trained, but had experience in treating severe mental health problems through their training in nursing, social work, occupational therapy, psychology, and even psychiatry.

MBT, as established by Anthony Bateman, remains remarkable for taking a non-stigmatizing approach toward a client group who suffer more from stigma linked to their mental health condition than perhaps any other, giving hope to patients by promoting kindness and understanding—the concepts that lie at the heart of mentalizing. Perhaps it is this considerateness that makes MBT relatively easy to implement with clinical groups who have often become suspicious as a result of the many disappointments they have experienced with support previously received.

The approach Anthony, with some support from me, has developed turned out to be massively successful both clinically, and in terms of popularity (Bateman & Fonagy, 2004). It combined our psychoanalytic understanding of personality and its disorders with understanding gleaned from the rapidly developing neuroscience of social cognition (Frith & Frith, 2003). Inspired by developmental psychology and neuroscience, a set of interventions were created that helped clinicians understand the atypical thinking of those with a diagnosis of personality disorder, providing simple rule-based interventions to address these in a way believed to be beneficial to the individuals concerned (Bateman & Fonagy, 2006).

Half a dozen randomized controlled trials showed robust benefits of MBT relative to treatment as usual for BPD and associated problems (Bateman & Fonagy, 1999 , 2001 , 2009 , 2013a , 2019b ; Bateman et al., 2016 ; Robinson et al., 2014 , 2016). It is easy to forget that Bateman's work established MBT as the first therapy to offer clear evidence of lasting patient benefit, including at five- and eight-year follow-up (Bateman et al., 2021 ; Bateman & Fonagy, 2008). The evidence confirmed that those receiving treatment enjoyed a more fulfilling and gratifying quality of life, in terms of reduced use of services and greater likelihood of being involved in full-time education or employment.

Mentalizing as a psychotherapeutic approach continued to grow under Anthony Bateman's stewardship (Bateman & Fonagy, 2012 , 2019a), as did the developmental neuroscience from which it drew some of its inspiration. But the two fields continued to develop separately to enrich our understanding of development, cognition, and psychopathology. Only relatively recently has neuroscience reached out to the clinical mentalizing researchers to establish common understanding (Gilead & Ochsner, 2021). In the meantime, MBT grew as a treatment approach. In collaboration with the Anna Freud Centre, Anthony Bateman oversaw the provision of professional training to practitioners around the globe to incorporate this research-based intervention into the widest range of practices. Over 15,000 practitioners from 36 different countries have received training in one of the MBT family of interventions, with demand for training places continuing to outstrip supply. MBT training centers have been established in seven European countries and three North American locations, and training sessions have been held in all the nations of the United Kingdom, as well as the United States, Austria, Finland, Japan, Italy, the Netherlands, Germany, Chile, Spain, Hong Kong, Sweden, and Canada. While both Brandon Unruh and Bob Drozek have contributed significantly to this training effort, it is Anthony Bateman's remarkable energy that has ensured that the dissemination of MBT has been so extensive. In a recent follow-up survey of practitioners who received training in MBT interventions, 87% of the almost 300 who responded reported that MBT had been "very useful" or "extremely useful" to their practice. 89% reported that MBT had been "very beneficial" or "extremely beneficial" to their patients.

The MBT family is growing. The thinking around clinical practice now belongs to a large and growing community of clinicians and researchers

advancing our understanding of both mentalizing as a developmental process and its challenges in clinical groups. The MBT community's thinking is remarkably coherent, linking attachment and mentalizing to social functioning, and coupling these with the core elements of MBT practice. MBT's thinking has impacted the development of a range of psychological treatments. Mentalizing has become a word used by clinicians practicing many modalities, and it is perhaps unsurprising that giant clinician treatment developers claim MBT to be a subspecialty within their own preferred way of working. Both Aaron Beck and Salvador Minuchin have suggested that MBT, on closer inspection, was a development of cognitive behavior therapy and systemic thinking respectively. The developers of MBT have never aimed to develop a new "school" of psychotherapy. We consider MBT to be a set of techniques perhaps more comfortable within the common factors approach than as a member of a family of psychotherapies, or as a specialist orientation of its own. MBT clinicians and researchers, encountering clinical problems and using the basic ideas of the original model, have developed adaptations that are manualized. These adaptations were evaluated in randomized controlled trials where possible, disseminated to the broadest number of potential practitioners, and supervised by experienced trained clinicians in the subspecialty.

And this brings us to the most recent addition to the family: MBT for pathological narcissism, or MBT-N. MBT-N is an ingenious, creative, and brilliant adaptation of the theoretical and practical principles of MBT which genuinely advances the value and relevance of the MBT approach. To restate in summary form, the two conceptual advances that drive MBT-N are (1) the concept of the narcissistic alien self, and (2) the novel concept of the me-mode.

The approach advanced in Drozek, Unruh, and Bateman's book extends substantially and helpfully the clinical model of the alien self. Those familiar with the work will recall that the internalization of a non-contingently related mirroring figure can create a vulnerability for instability within the self-representation of the child. The self is constituted from interpersonal interaction experiences with others, as suggested by dialectic philosophical tradition as well as interactional social psychological and psychoanalytic models. If early mirroring is absent or inaccurate, the child, looking for a representation of its subjective experiences in the

outside world, internalizes an absence or worse still a hostile representation into the experiencing self. The self then includes within itself a representation of the other, which is nevertheless felt to be a part of itself—albeit an incongruent part. As mentalizing is helpful in creating coherence, the alien self remains a vulnerability rather than a pathology. The propensity for disorder becomes evident at times when the illusory coherence of the self is lost, as is likely to occur when there is a breakdown in mentalizing. At these moments, the incongruence of the self becomes painful, and the fragmentation is experienced as an existential threat.

We have argued that incongruence of this kind is acutely distressing, and is commonly managed by identifying a person in the social environment who can be nudged or manipulated into adopting representations that belong to another (alien) self—historically, the caregiver inaccurately mirroring the self. With trauma history (as is common in borderline personality disorder), internalization of an abusive and destructive figure into the self structure creates an experience of sometimes indescribable self-hatred. The individual's self-hatred can only be managed through identifying a vehicle incorporating hostility toward the individual in the social world—someone who adopts the attitudes of hatred and creates a relationship of persecution with the (now serially victimized) object of maltreatment. Distressing and uncomfortable as these solutions often turn out to be, they are preferred to the alternative of internal persecution and instability in self-experience.

Of course this model would not explain the typically grandiose and superior attitude of the individual with pathological narcissism (PN). Drawing on developmental literature, Drozek, Unruh, and Bateman identify the high prevalence of inaccurate but positive interactions between parents and those who come to be at risk of developing PN. This creates an analogous but different challenge for self-organization in these individuals. There is incongruity in the self structure but this feels alien because it is inappropriately, unrealistically, and excessively positive. The discomfort of incongruity—its existential threat—is the same, but the alien part is not hateful but excessively loving. Extrusion (projection) still has to happen to save the self, but it comes with a loss of positive experience, as the extruded part of the self is loving rather than critical (as in BPD). Although finding external individuals to idealize (the vehicle for this excessively positive

stance) is a recognizable feature of PN, it is the exaggerated value placed on the self which defines the disorder.

The brilliant insight guiding the model of treatment described in this book is a recognition that the kind of extrusion or projection described in BPD can easily be observed in narcissistic personality disorder (NPD), except that the incongruent parts of the self are placed into the self-image rather than the external object. It is the self-image that becomes the vehicle for the alien self, bringing with it relief in terms of increased coherence, and also validation in terms of self-admiration and (inauthentic) pride.

To make this simple idea work, the authors needed to bring in a second ingenious extension to the basic MBT theory. They distinguish between the *I-mode* and the *me-mode* , two developmentally sequenced categories of experience related to the self. The I-mode, defined by philosophy of mind as the source of identity, remains unchanged—the sum total of agentive self-experience. This is the sense of experiencing that James recognized as the golden thread of sameness that continues from infant behavior through childhood, and remains a core aspect of the human mind across the lifespan: a sense of coherence and stability gifted to us (we maintain) by mentalization. As James (1890) wrote, “The mind can always intend, and know when it intends, to think of the Same. This sense of sameness is the very keel and backbone of our thinking” (p. 235). This sense sameness is located within the I-mode. The I-mode, which contains agency, of course requires coherence. This is why incongruent components that would compromise coherence of action need to be projected. However, externalizing positive and favorable components of the self into the external world opposes the pleasure principle, or the principle of reinforcement learning. In common parlance, we might say, it does seem rather a shame, particularly for individuals who for biological or social reasons are struggling with enduring problems of self-esteem.

The solution which the authors suggest is both elegant and compelling. Where better for a person with fragile self-evaluation to place such an inconvenient but pleasing aspect of self than into the me-mode, the representational structure which William James memorably named “self as object”? In the current model, the me-mode is a self-representational structure based on the experience of the self in the social context. It is an object that is described or narrated, rather than an entity that is validated by its coherence and action, and consequently the I-mode is unable to tolerate

incongruity. The me-mode belongs to a developmentally later stage, when the capacity to construct an identity based on self-narrative emerges (McAdams, 2008 ; McAdams et al., 2004). By creating a story and a set of meanings around personal attributes, we create meaning around events in our lives. We interconnect past, present, and expected experiences that collectively generate a unit of experience around William James' (1890) "self as object" or "me." PN is not different in having a me-mode. It is what the me-mode contains that differentiates PN.

The me-mode is the separate individual a person refers to when talking about their personal experiences that feels sustainable over time. Of course it changes as the narrative alters, but normally we deal with that through the usual flexibility that mentalizing offers us. It is most likely that the me-mode comes to fruition as part of or after puberty, when the demand for autonomy and the need to relate to and learn from peers becomes dominant (Debast et al., 2017). After the emergence of the metacognitive capacity sufficient to create an integrated, evolving, coherent story of the self in interaction with the social world, the individual becomes able to represent themselves to others, drawing together their significant life experiences (Adler et al., 2016 ; McAdams, 2008). The me-mode is a narrative identity that is more ideographic, dynamic, and contextual than the I-mode can be, because self-agency demands coherence. You cannot do two things at the same time, for example going at once left and right. Or you can, but the result can be unattractive. As a narrative, the me-mode is therefore in most of us more malleable to change—to change in psychotherapy, or perhaps even more likely, through other social experience such as changed relationships (McLean, 2017).

Not so for the individual with pathological narcissism. If the me-mode is a vehicle for a projection which safeguards the coherence of the I-mode, such luxury cannot be afforded. In a person whose modification of their representational self structure was enforced by the need to maintain coherence in the I-mode, any change in representation signals the return of the extruded object back into the self. This gives rise to incongruence and existential anxiety. For the BPD patient who creates a persecutor externally and repeats again and again their history of maltreatment and exploitation, there is no option of withdrawing the projection without generating the hatred within the self, with self-harm and suicidal intent. The same challenge faces the person with NPD. They cannot change. The grandiose

self-love has to be part of their personality, even if it ill-fits the reality of their life. For them, the flexibility of the me-mode representational structure is unavailable.

The dispositional traits characteristic of pathological narcissism are within the I-mode, but the story the person weaves around these occurs in the representational context, which demands a certain degree of mentalizing to ensure coherence. Limitations in mentalizing will impact on narrative coherence, threatening well-being and explaining clinical referral for the broad range of reasons which Drozek, Unruh, and Bateman hypothesize (Lind et al., 2019 , 2020). When fully functioning, the me-mode—James' self-as-object representation—effectively distracts, preoccupies, and relieves from the disruption of self-experience threatened by incongruity within the I-mode. When mentalizing fails, the threat to self-cohesion becomes real, and pre-mentalistic modes of thinking come to dominate the me-mode. As the authors suggest, at this point, the individual may no longer be able to distinguish the me-mode from the I-mode. When in the concreteness of psychic equivalence, the person no longer experiences the representational self as a construction, but as a reality. The person imagines their representation (their self-image) as having properties of an agent to guide as opposed to narrating action, and they will appear to all observing them as grandiose. Escape to pretend mode may be a solution. It is tempting to think that narcissistic pathology is the me-mode in "pretend I-mode."

All this of course is new thinking which this book proposes, along with a step-by-step comprehensive guide to helping individuals manage these problems, and to navigate the issue of self-evaluation and self-esteem. The breakdown of mentalizing causes a conflation of the representational and the agentive mode, whereby the person feels crushed by their self-representation, as if it were an aspect of physical reality. But the model brings a very clear and, once again, brilliantly insightful goal to the treatment. Recovering mentalizing does not need to confront the exaggeratedly positive self-experience which has caused difficulties in self-coherence in the first place. The goal is the recovery of mentalizing that enables the representational me-mode to act as container for the inflated sense of self-worth. In representational me-mode, the self-narrative can be adjusted to contain both high self-worth and the exigencies of life circumstance, which might at times challenge this assessment. The therapy, as in the treatment of borderline personality disorder, is not focused on

altering the alien self. The mental economy of self structure is likely to make that a fruitless exercise. It is aligning alien parts of the self with a coherent self-representation that is the challenge for therapy, but one which the authors make abundantly clear the patient needs to achieve themselves.

What the book offers is an exquisite, brilliantly written, highly astute set of guidelines on how to manage the recovery of mentalizing with patients whose narcissism is pathological. The inset boxes, the tables, and the case histories reflect the authors' vast and almost unique experience in navigating these patients through the crisis that has caused the collapse of mentalizing. This crisis creates conflicts between the person's lived life and their imagination (their fantastic self-narrative), which they cannot by themselves bridge. As described in the book, the trigger for the collapse of mentalizing is an inconsistency (which the person cannot reconcile) between their experience of themselves and the world's experience of them. Normally the discrepancy, like cracks in plaster, can be papered over by mentalizing, finding sometimes ingenious solutions for fitting square pegs into round holes. The internal or external conflicts that compromise this process and increase emotional arousal have to be negotiated in the mind, but also outside, in the social world. The cognitive and emotional content of the me-mode is often the focus of psychotherapeutic approaches, be it from a cognitive behavioral or a psychodynamic tradition. The authors suggest an alternative: a process-oriented approach where the therapist is committed to engaging the patient in activities that validate their view of the world, without generating unnecessary conflict and endangering their capacity to mentalize. In this process, the separation of the I-mode and me-mode is achieved without dramatically altering either. However, changes will invariably arise through the emergence of more balanced mentalizing that ceases to rigidly prioritize the self over the other, or indeed the other over the self.

I consider MBT for narcissism to be a major innovation. It clarifies the multilevel nature of self structure, interfaces it with mentalizing, and offers what may turn out to be vital help for individuals whose chronic struggle with self-esteem leaves them vulnerable to depression, self-destructive acts, and sometimes suicidality. The book also opens an opportunity for us to work with, and try to understand, a group of individuals who have previously perhaps received inappropriate treatment from MBT practitioners. The increased subtlety of the MBT approach described here

enables us to respond accurately and contingently, in a gentle and marked mirroring manner. This is ultimately what we hope for from the MBT approach in general—not quite a school of therapy but perhaps more than a set of randomly assembled techniques, somewhere in between. Perhaps a tradition?

Acknowledgments

We want to acknowledge a host of friends, colleagues, and organizations, without which this book would never have come to be. MBT for narcissism was largely developed in the Mentalization-based Treatment (MBT) Clinic at McLean Hospital. Established in 2011 under the guidance of MBT originators Anthony Bateman and Peter Fonagy, the Clinic has grown and thrived due to the commitment and generosity of John Gunderson, Lois Choi-Kain, Joe Flores, Shauna Dowden, George Smith, Mary Zanarini, Michael Hollander, Amy Gagliardi, Diane Bedell, and Joseph Gold. We are bolstered and enlivened by our staff, Ashley Beaulieu, Caleb Demers, and Geoffrey Liu. We thank the scores of residents and trainees who have volunteered their time and energy over the years to provide specialized, insurance-based care to patients in critical need of their help. Perhaps most importantly, we are indebted to our patients, who have been genuine partners in helping us learn how to adapt MBT to the unique challenges of pathological narcissism.

Before any words were ever written about MBT for narcissism, Elsa Ronningstam has long encouraged us to formulate and advance our ideas: "We need a therapy geared toward reflectiveness in the treatment of NPD!" At Oxford University Press, Martin Baum has consistently championed our vision for the book, with responsiveness and cheer. On both sides of the pond, our MBT training structures have served as an essential "home base" that have enabled us to advance and disseminate the nuances of this model. In the Gunderson Personality Disorders Institute at McLean Hospital, we recognize Lois Choi-Kain, Ellen Finch, Gabs Ilagan, Evan Iliakis, Julia Jurist, Grace Murray, and Vy Ngo. At University College London, we appreciate the contributions made by our colleagues to the ongoing research on mentalizing. At the Anna Freud National Centre for Children and Families, we acknowledge the continued work of all the staff who enthusiastically and efficiently support the teaching of MBT to clinicians.

Bob Drozek

Many of these principles were initially developed and "road tested" in the MBT for Narcissism psychotherapy group at McLean Hospital. I am thankful for the past and current members of that group—for letting me be a part of your journey, and for your courage and resilience in facing the most treacherous of all endeavors: evolving your sense of self. In the Massachusetts General Hospital/McLean Adult Psychiatry Residency Program, I have had the good fortune to supervise the PGY3s in the Addiction Psychiatry rotation. You have long highlighted the need for a streamlined, "step-by-step" process of elaborating patients' emotional experiences, which bolstered me to systematize the affect elaboration strategies outlined in this book. I am privileged to collaborate with my colleagues in the Division of Alcohol, Drugs, and Addiction at McLean, and especially in the Law Enforcement, Active Duty, Emergency Responder (LEADER) program, where we have applied these ideas in a different context, with the highest of stakes. Hilary Connery, Patty Diaferio, Kate McHugh, Rachel Tester, and Ruth Reibstein—I love working with you all.

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Brandon Unruh

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Anthony Bateman

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He has authored, co-authored, and edited 17 books, including *Mentalization-based Treatment for Personality Disorders: A Practical Guide* (2016), and *Introduction to Psychoanalysis, Second Edition* (2021). He has published numerous book chapters, and over 150 peer-reviewed research articles on personality disorders and the use of psychotherapy in psychiatric practice.

PART 1

MENTALIZATION AND PATHOLOGICAL NARCISSISM

Part 1 examines the relevance of pathological narcissism (PN) within contemporary culture and psychotherapy practice, as well as the potential utility of mentalization-based treatment (MBT) in treating PN. The construct of mentalization is introduced, and the main principles and applications of MBT as a modality are outlined. Utilizing research on parenting styles, attachment patterns, and empathy in PN, the authors propose a theory of PN that centers on impairments in mentalization.

1

Introduction to Pathological Narcissism and Mentalization-based Treatment

As a clinical and theoretical construct, narcissism is currently receiving an unprecedented amount of attention. Multiple authors have highlighted the relevance of narcissism to broader "self-focused" patterns in contemporary culture (Lunbeck, 2014 ; Malkin, 2015 ; Twenge & Campbell, 2009), and the term "narcissism" is now employed liberally in discussions of celebrities, reality television, social media, "selfie" culture, and political figures. Within psychology, research on narcissism has proliferated exponentially over the past several decades. According to the database PsychInfo, while only around a dozen empirical papers on narcissism appeared before 1980, several hundred studies on narcissism are now published every year in peer-reviewed academic journals. This research has revealed that narcissism is not simply an annoying personality trait, but a valid psychological construct with real public health costs. Narcissistic personality disorder (NPD) has a lifetime prevalence of 6.2% (Stinson et al., 2008), and narcissistic traits are associated with a range of debilitating psychosocial challenges, including affective instability (Fava et al., 1996 ; Stinson et al., 2008 ; Tritt et al., 2010); substance use disorder (Coleman et al., 2017 ; Echeburúa et al., 2007 ; Preuss et al., 2009); vocational impairment (Schwarzkopf et al., 2016); violence and aggression (Lambe et al., 2018); corruption (Julian & Bonavia, 2020); lethality from suicide (Blasco-Fontecilla et al., 2009 ; Giner et al., 2013); and dysfunction and distress in interpersonal relationships (Cheek et al., 2018 ; Miller et al., 2007 ; Ogrodniczuk et al., 2009).

As other authors have noted (Caligor et al., 2015 ; Ronningstam, 2005), pathological narcissism (PN) encompasses a wide array of psychological, emotional, interpersonal, and functional challenges. In popular culture, the term "narcissist" calls forth something of a caricature: the arrogant, self-

involved man who spends most of his time bragging about himself and devaluing others. *"It's all about him." "He thinks he's always right."* In everyday clinical practice, clinicians regularly encounter more three-dimensional, sympathetic examples of narcissism: the perfectionistic, insecure college student who spends all of his time on his schoolwork, seriously considering suicide when he is unable to meet his rigid standards for himself; the physician struggling with frequent interpersonal conflicts with colleagues and supervisors, becoming defensive and argumentative whenever she receives constructive feedback; the poised, well-dressed advertising executive plagued by obsessive ruminations about her attractiveness, wealth, and how other people in the office are seeing her and her work; the military veteran with alcohol use disorder and depression, which he attributes to a long history of mistreatment by others—getting fired from his job, his wife divorcing him, and his adult children refusing to speak to him.

What links these diverse sorts of patients to each other? While different theories answer this question from different perspectives (see Campbell & Miller, 2011), a significant body of empirical literature frames PN in terms of an excessive reliance on *narcissistic self-enhancement* , understood as internal and interpersonal efforts "to increase the positivity of one's self-concept or public image" (Wallace, 2011 , p. 309; see also Grijalva & Zhang, 2016). On this view, across its various manifestations and subtypes, PN is marked by the tendency to seek out and amplify internal and external factors that augment the person's sense of self-esteem, while simultaneously avoiding and minimizing those factors that diminish the person's sense of self-esteem.

Despite our increased understanding of narcissistic challenges, therapists treating these patients often feel poorly equipped to the task. Patients with PN are notoriously "difficult to treat," often dropping out of treatment precipitously (Campbell et al., 2009 ; Ellison et al., 2013), and leading therapists to experience a range of uncomfortable emotional states in themselves, including frustration, boredom, and inadequacy (Tanzilli et al., 2017). The psychotherapy literature on PN provides little assistance along these lines. With no randomized controlled trials completed to date, this literature consists of mainly of case reviews, theoretical formulations, and quantitative evaluations of clinical reports (Dimaggio et al., 2008 ; Kernberg, 1975 ; Kohut, 1977). Apart from some recent exceptions

(Diamond et al., 2022 ; Weinberg & Ronningstam, 2020), authors discussing PN tend to approach these topics at a high level of abstraction, articulating broad therapeutic principles that leave significant ambiguity about how to actually implement the approaches in question. Clinicians thus may understand patients with PN better, but they still feel quite uncertain about what to actually *do* when they are sitting with these patients: what to say, how to guide the sessions, and how to respond to the confusing and often frustrating difficulties that occupy these patients.

In this book, we will attempt to employ the principles of mentalization-based treatment (MBT) to develop a comprehensive approach for understanding, assessing, and treating patients with pathological narcissism (Drozek & Unruh, 2020). MBT is an accessible, easy to learn, and resource-sensitive therapeutic approach that is second only to dialectical behavior therapy (DBT) in empirical support for treating borderline personality disorder (BPD; Cristea et al., 2017 ; Oud et al., 2018 ; Storebø et al., 2020 ; Witt et al., 2021). The term "mentalization" refers to the fundamental psychological capacity to "read," access, and reflect on mental states (e.g., thoughts, emotions, desires, attitudes) in oneself and other people. As a psychotherapeutic treatment, MBT works to strengthen patients' ability to initiate and maintain mentalizing under circumstances of emotional and interpersonal stress, resulting in increased stability in patients' emotions, relationships, behaviors, and overall sense of self (Bateman & Fonagy, 2017). The core tenets of MBT have already been elaborated elsewhere (Bateman & Fonagy, 2016 , 2019a), illustrating its broad applicability to personality disorders, eating disorders, posttraumatic stress disorder, and substance use disorders, among other psychiatric and psychosocial challenges. Rather than supplant Bateman and Fonagy's more comprehensive formulations, we hope to tailor and refine these insights to address the unique challenges associated with narcissism.

We approach this task with significant experience in the practice and training of MBT. Anthony Bateman is one of the developers (along with Peter Fonagy) of MBT, having spearheaded much of the research and writing that has established MBT as a leading psychotherapy for personality disorders. Brandon Unruh is the founder and director of the MBT Training Clinic at McLean Hospital, and a trainer of MBT through the Anna Freud Centre in London. Robert Drozek serves as a therapist and supervisor in the MBT Training Clinic, also serving as a trainer of MBT through the Anna

Freud Centre. As we have gained increased experience facilitating and supervising the treatment of patients with PN, we have come to regard MBT as a useful intervention.

Our interest in narcissism developed somewhat accidentally, through our experience treating patients with BPD in the MBT Training Clinic. Part of the Personality Disorders Service at McLean Hospital, the clinic currently stands as the only outpatient clinic in the United States providing standardized, systematic, insurance-based individual and group MBT. Over the years, we began to notice a certain subgroup of patients presenting for care. While these patients often had experienced some level of success and stability in their lives, they ultimately encountered a significant life disruption—interpersonal challenges at work, disruptions in relationships, change in financial status—that precipitated their difficulties with depression, anxiety, and suicidality. Given the characteristic interpersonal hypersensitivity associated with BPD (Gunderson, 2014), this understandably led referring providers to see them as having "borderline personality disorder."

However, whereas patients with BPD tend to be overly *seeking* of attachment with others, these patients exhibited much more self-reliance, selectiveness in interpersonal relationships, and at times, avoidance and isolation from other people. They seemed to crave connectedness, but they did so more *indirectly* , namely by making insightful comments, sharing about past successes, and in the context of therapy, being the "star patient." While patients with BPD struggle extensively with emotional dysregulation, these patients often seemed more *disconnected* from their emotions. They had extensive insights about themselves and their histories, which they were happy to share, but they struggled to access and express their emotions in an authentic, rich way.

As these treatments unfolded, we gathered a more complex picture of these patients and their challenges. We observed tendencies toward defensiveness, argumentativeness, superiority, entitlement, externalization, self-centeredness, and aggression, as well as empathic deficits, especially when their self-esteem was threatened by others. Thankfully, we were treating these patients during the renaissance of empirical research on narcissism (Campbell & Crist, 2020), which includes studies showing a striking symptomological overlap between BPD and a certain subtype of narcissism referred to as *vulnerable* NPD (Miller et al., 2010 ; Pincus et al.,

2009). As we digested the vast and growing empirical literature on PN, we began to understand that this subgroup of patients was likely better understood through the lens of narcissism. Similar to the treatment of BPD, we started to directly give the NPD diagnosis to patients: reviewing diagnostic criteria, exploring relevant symptoms from their history, and providing psychoeducation about this widely misunderstood and stigmatized construct (see Chapter 3). To our surprise, patients were usually *grateful* for this information. “This explains me in a way that nothing else ever has. I don’t like the *word* narcissism, but I just feel so relieved that I finally know what has been going on with me.”

Following in the footsteps of other modalities for treating PN (Diamond et al., 2022 ; Gabbard & Crisp, 2018), we began applying the principles of MBT to address these patients’ unique challenges, with surprising effects: they tended to get better, in a manner that differed from their previous experiences in treatment. Functionally, patients reported decreased avoidance, improved work performance, and fewer interpersonal conflicts with other people. More internally, they described decreased depression and anxiety, improved ability to empathize with other people, and an increased sense of self-esteem and self-worth. Heartened by this progress, we started an MBT psychotherapy group specifically for patients with PN, where members had the opportunity to learn more about the diagnosis, and to engage in mutual sharing and reflection around their shared challenges with self-esteem and interpersonal instability.

Admittedly, these gains are anecdotal and highly provisional. However, they have led us to consider the possibility that MBT’s principles could have genuine utility in helping patients with pathological narcissism. This book represents our efforts to distill our clinical experience with these patients, in a pragmatic way that is accessible for the practicing clinician. We offer this volume as a usable handbook which might shed some light on how to treat these patients: how to structure the treatment; “what to do and say” in response to patients’ characteristic challenges; and how to facilitate sessions—and the treatment as a whole—in order to maximize the potential for real and enduring change. By clearly outlining our specific techniques and interventions, we try to formulate our proposals in a manner that lays the groundwork for future empirical investigation and clinical applications.

MBT for narcissism: The rationale

Why think that MBT might work for narcissism? Given the aforementioned symptomatic commonalities between BPD and vulnerable NPD, as well as MBT's established efficacy in treating BPD, there is value in considering the potential utility of MBT's techniques in addressing the symptoms and traits of PN. Similarly, recent research supports the efficacy of MBT in treating antisocial personality disorder (ASPD; Bateman et al., 2016), a diagnostic category with a similar mentalizing profile (e.g., involving concreteness, alexithymia, and empathic deficits) as NPD. In the absence of evidence-based treatments for PN, an approach yielding benefits for multiple neighboring diagnoses merits consideration as a candidate treatment. Furthermore, in an 18-month trial of outpatient MBT, MBT was more effective than generalist treatment for patients with greater Axis II comorbidity, including comorbid BPD and PN (Bateman & Fonagy, 2013a). This suggests that MBT may have particular efficacy for those whose BPD is embedded within other personality problems, including narcissism.

Furthermore, as we explore in detail in Chapter 2 , patients with PN exhibit significant and pervasive challenges with mentalization. Research shows that PN is associated with impairments in empathy (Urbonaviciute & Hepper, 2020)—involving difficulties mentalizing others—and alexithymia (Fan et al., 2011 ; Jonason & Krause, 2013)—implying troubles mentalizing oneself. Consistent with the aforementioned tendencies toward self-enhancement, patients with PN also often overestimate their mentalizing abilities (Ames & Kammrath, 2004 ; Duval et al., 2018 ; Ritter et al., 2011). One recent study found that reduced generosity was mediated by reduced perspective-taking abilities in narcissism (Böckler et al., 2017), raising the interesting possibility that inhibited mentalizing could be related to the typical "selfishness" associated with PN. More anecdotally, in clinical work with patients with PN, we regularly see many of the transdiagnostic "mentalizing impairments" that MBT targets, including overly rigid and certain views of Self and Other (*psychic equivalence mode*); tendencies toward concreteness and externalization (*teleological mode*); and problems with intellectualization and disconnection from emotions (*pretend mode*). If these challenges with reflectiveness are part of the characteristic symptom profile in PN, it is reasonable to utilize a treatment approach that directly addresses those challenges.

Along similar lines, one recent study discovered that deficits in mentalizing mediate the relationship between childhood trauma and narcissism among adolescents (Duval, Ensink, Normandin, & Fonagy, 2018). In the event that mentalizing impairments are part of the "pathway" for the development of narcissism, strengthening patients' mentalizing could impact the impact the severity of narcissistic pathology.

Finally, improvements in reflective function and mentalization appear to be important mechanisms of change for personality disorders, including in samples of patients with comorbid BPD and PN (Diamond, Clarkin, et al., 2014 ; Diamond, Levy, et al., 2014 ; Diamond et al., 2013). One important recent study confirms the correlation between PN and mentalizing deficits (Euler et al., 2022), also finding that the capacity to mentalize mediates the relationship between PN and outcomes in psychotherapy. The authors propose: "Enhancing the capacity to mentalize might thus be a promising endeavor in the treatment of patients with pathological narcissism" (p. 288). These conclusions are consistent with research suggesting that mentalized affectivity—the capacity to access one's own emotions while simultaneously reflecting on them—mediates the connection between PN and the capacity for self-compassion (Goodwin & Luchner, in press), a trait that is often compromised in PN (Barry et al., 2015 ; Kramer et al., 2018). In light of all of these findings, we suggest that there could be significant value in utilizing MBT to understand and address the symptoms of pathological narcissism.

Introduction to mentalization-based treatment

The construct of mentalization was originally formulated by Peter Fonagy in psychoanalytic terms in 1989 (Fonagy, 1989). Fonagy then collaborated with Anthony Bateman to manualize and research MBT in the United Kingdom in the 1990s, publishing the first randomized controlled trial on MBT for BPD in 1999 (Bateman & Fonagy, 1999). The first MBT treatment manual was released in 2004, and subsequent editions have followed (Bateman & Fonagy, 2006 , 2016), further developing MBT's technical strategies in light of its expanding evidence base and clinical applications. At present, MBT's focus has expanded far beyond personality disorders, with randomized controlled trials conducted on a wide range of

clinical challenges, including substance use disorder (Philips et al., 2018), addiction among mothers (Suchman et al., 2017), eating disorders (Robinson et al., 2016), depression (Jakobsen et al., 2014), and adolescent self-injury (Rossouw & Fonagy, 2012).

MBT's efficacy has been illustrated in partial hospitalization programs (Bales et al., 2015 , 2012 ; Bateman & Fonagy, 1999 ; Laurenssen et al., 2018 ; Smits et al., 2020); outpatient treatment (Bateman & Fonagy, 2009 , 2013a ; Bateman et al., 2016 ; Jørgensen et al., 2013); and group-based protocols (Bo et al., 2019 , 2017 ; Griffiths et al., 2019). Studies suggest that the positive outcomes for MBT are significant and wide-ranging, including reduced depressive symptoms, decreased suicidality and self-injurious behavior, less inpatient usage, and improved social and interpersonal functioning (Bateman & Fonagy, 1999 , 2009). These gains are durable, with follow-up studies suggesting that progress is maintained 5–8 years after the conclusion of treatment (Bateman & Fonagy, 2008 ; Bateman et al., 2021).

When investigating an 18-month day hospital MBT program for patients with BPD, Bales and colleagues (2012 , 2015) similarly illustrated that MBT results in decreased symptomatic distress, suicidality, self-harm, and care consumption, as well as enhanced self-control, identity integration, responsibility, social cooperation, and stability in relationships. In the treatment of patients with comorbid BPD and ASPD (Bateman et al., 2016), MBT led to diminished anger, hostility, paranoia, and frequency of self-harm and suicide attempts, as well as improvement of negative mood, general psychiatric symptoms, interpersonal problems, and social adjustment.

The reach of MBT is ever-expanding. Clinicians and researchers have begun to develop more novel adaptations of MBT, including short-term MBT (Juul et al., 2022 , 2019); virtual MBT in the context of the COVID-19 pandemic (Fisher et al., 2021 ; Ventura Wurman et al., 2021); and integration of MBT with other evidence-based psychotherapies for BPD, such as DBT (Edel et al., 2017 ; Swenson & Choi-Kain, 2015) and Good Psychiatric Management (Unruh et al., 2019). Similarly, MBT is being applied to address non-clinical problems as well, including law enforcement violence (Drozek et al., 2021), parents undergoing divorce (Hertzmann et al., 2016), children in the foster system (Midgley et al., 2017), bullying in schools (Twemlow et al., 2005), and families of patients with BPD

(Bateman & Fonagy, 2019b). In these ways, MBT has emerged as an empirically informed treatment approach that targets transdiagnostic mentalizing processes across a wide range of clinical, psychosocial, and cultural challenges.

What is mentalizing?

Access to and accurate reading of mental states in self and others is the core of mentalizing. We are all more or less good at it, and the process serves us well as groups of human beings engaging in constructive and progressive affiliation. It gives us the sense of who we are, how we feel, who others are, and what we are like together. Mentalizing helps us understand motives and what lies behind action. It allows us to undertake joint tasks and participate in group interactions in which an individual's role and function is shared by all and, most importantly, accepted by them. We "read" each other. A sense of belonging is generated; loneliness and isolation are vanquished.

Of course mentalizing can go wrong, be inaccurate, or lack balance. So self-correction when misunderstandings occur is a key aspect of our mental flexibility and success at mentalizing. Just as we right ourselves when we stumble physically, we do so mentally. Without flexibility and reflection, individuals insist on their perspective as *the* perspective, rigidifying the process and forcing others to think as they do, or believe what they believe. Conflict and relational inequality result, and relationships may become strained, if not broken.

Mental states are by definition imaginary and infinitely creative, and so anything can happen. Things are not as they seem. We fool ourselves and can be fooled by others. We can trick ourselves and others unwittingly, but it is also possible to make someone believe something for our own selfish purposes. This can be done clumsily and without guile, the other person quickly realizing the misunderstanding. But it can be also done with cunning and charm; the person experiences unwarranted trust and becomes vulnerable to exploitation and manipulation. The accomplished trickster is an example of another truth about mentalizing. We can be "too good" at aspects of mentalizing and exploit that talent for our own ends, while being unable to use other aspects effectively for constructive social relationships.

Where does the information come from that allows us to imagine what is going on in our own and others' minds? Mostly it is based on external observation: the body suggests what is beneath, tone of voice speaks louder than words as someone says they are "fine" when it is obvious they are not. Our assumptions about someone else are commonly accompanied by a question about the mind beyond ("You seem tense. Are you OK?"; "What are you looking at me like that for? Don't you believe me?") to confirm or disconfirm our working hypothesis. This is named the internal/external polarity of mentalizing (see Chapter 13). When the poles are in balance and being used appropriately, interactions take on a reciprocity of "serve and return." It is only when the ball hits the net do we stop for a moment and check out a potential misconception, before continuing.

The healthy development of mentalization

The overall aim of focusing on mentalizing in treatment is to increase patients' effective deployment of mentalizing in social interactions, allowing them to establish themselves effectively and constructively in their social world. To kick-start this process, we structure treatment in such a way that mentalizing is encouraged, and mental states become something of interest for patients (see Chapters 4 & 5). As treatment advances, patients gradually progress along what might be understood as a "developmental trajectory" of mentalizing, which parallels the healthy development of mentalization throughout the lifespan: from I-mode, to me-mode, to personalized me-mode, and ultimately to we-mode. We offer these conjectures as a potentially useful heuristic, rather than any definitive statement. In everyday experience, these modes often blur together quite seamlessly, shifting continuously in a manner that is dynamic, non-linear, and always sensitive to interpersonal context.

I-mode: Focus on internal states in self

A young child develops a sense of their own mind, and later other people's, through early experiences of caregivers accurately recognizing, mirroring, and responding to the child's emotions. These interpretations or responses to the child help them to build a sense of who they are, and to acquire a sense of personal agency. *I have active presence in the world. My*

experiences matter, are of interest to those around me, and can make things happen. These reflections allow the child to build a set of representations of internal states often called "secondary representations." As people around us decipher and delineate who we are, we attain a coherent sense of self, or "self-representation." Selfhood, rather than being all about individuality, is an intrinsically social phenomenon.

The sense of an "I" ideally grows into a robust and coherent representation, arising from the accumulated integration and synthesis of sensory information pertaining to the person. Under optimal combinations of nature and nurture, this process generates an embodied sense of personhood, with continuous and stable contact with the surrounding world. Individuals who have not had the benefit of such secondary representations may develop a less coherent self-representation, building a "not-I" that feels foreign and alien (see Chapter 2). This may include people who have been exposed to responsive care but, for a complex range of possible reasons, have not been able to benefit from it.

We gradually become more or less confident about our own thoughts and experiences. This level of confidence about our self-states forms the basis of all other aspects of mentalizing. Confidence in personal mental states refers to our subjective beliefs about the validity of our thoughts and judgments, irrespective of objective accuracy measures. *This is my inner experience. This is as I am and what I think.* But mentalizing of self is dynamic, so we update or change our assessment, either because our interpretation of ourselves seems incorrect or unproductive, or because feedback from social interaction suggests modification. Rejection, acceptance, productive interaction with others—all create change in our self-experience. "Having talked to you, I feel rather differently about it now." Being impervious to such influence leads to isolation and loneliness. Dissonance between how we see ourselves and how others see us is a threat and cannot be tolerated.

Patients with PN often feel *too* sure about their self-states, expecting others to see them as they see themselves. They may fail to engage in learning about their own states through the mind of others. Their mind becomes focused on self, and there is little time for assessing others' mental states. I-mode becomes dominant, with no room for me-mode. The "I" is asserted, and the person becomes overconfident in themselves and their inner experience. In the case of vulnerable PN, patients may lack

confidence in reading states of mind altogether, relying extensively on other people to determine their own thoughts and feelings. Without confidence in their own mental states, or in their ability to read others, patients remain vulnerable and dependent on other people.

At a more moderate level, there can be benefits to this sort of humility. When people mentalize adaptively at lower levels of certainty, they seek more information from others or conform to a consensus view, thus contributing to a form of "collective mentalizing" in relationships. In this way, the person fits in and becomes a team player, rather than a self-centered loner.

Me-mode: Reading others' mental states

While accuracy is obviously important when considering others' mental states, excessive confidence in our interpretations is also an important driver of difficulties. For example, high confidence may be paired with significant inaccuracy and insensitivity. Those with high confidence are likely to overestimate their own ability to mentalize, while also underestimating others' ability to recognize mental states accurately. Individuals with high confidence may be projecting their own minds, rather than seeing the mind of the other person as an independent and differentiated entity. Continuing to interact with the other person as having an identical mind alienates the other, who feels increasingly misunderstood. A responsive feedback loop should change our understanding of someone else when mismatches occur, but all of us can ignore signals that contradict our original assumptions.

In everyday interactions, recognizing and respecting someone's current social role helps to see things from their perspective. But reading others' mental states at a more complex level requires an understanding of their history and current context. If we are to understand someone else and compare their experience with ours, an effort has to be made to set aside our own mind. This shift from our perspective to someone else's perspective (while still maintaining our own) is sometimes thought of as a flexible move from I-mode to me-mode mentalizing.

"Me" refers to the self-as-object—the self as defined by others' depictions. Or rather, these depictions are seen and felt but experienced *as if* they were the self—the "I" as described by William James (1890) . By

definition, the “me” is context dependent. It is, after all, a function of the immediate social environment that is ever-changing, making self-experiences originating from within the “me” inherently precarious. In the right context, me-mode is comfortable and self-affirming. However, when the environment changes, me-mode may become unstable, and reliance on I-mode experience is necessary to maintain mental safety. Like other approaches, MBT distinguishes the “me” from the “I” discussed earlier (Drozek, 2015). Of course, a dominant “me” (a context-dependent self-experience) can obscure and eclipse “I” experiences. In circumstances that compromise the integration of the “I” (e.g., genetic vulnerability, adversity, deprivation), the “me” becomes the primary determinant of self-experience, leaving the individual potentially encountering the emptiness of their existence if others ignore them.

In the treatment of PN, this distinction between “I” and “me” is essential to bear in mind. As clinicians, we need to assess the extent of the dominance of I-mode functioning, as well as its relationship with me-mode functioning. Patients with PN may rely exclusively on I-mode mentalizing processes, as me-mode is too variable and creates dangers. Alternatively, thin-skinned patients with PN may rely excessively on me-mode and personalized me-mode mentalizing (see below), requiring admiration from others and constant mental support. I-mode function is rudimentary and fails to create a continuous sense of self.

Furthermore, sudden changes in risk may not be preceded by the obvious warning signs which are typically found in patients with BPD, who often become increasingly emotionally dysregulated and demanding as their “I” fragments. In PN, the “I” can go from “one-hundred to zero” with shocking immediacy, based on perceived changes in interpersonal context. What may appear to be a small slight to an outside observer becomes an existential insult to patients with PN (see Chapter 2). Predicting risk becomes almost impossible. The incongruity in representations of the socially dependent “me” is so stark that the I-mode collapses.

Personalized me-mode: Reading others’ mental states about self

How do others see me, and am I differentiating this from how I see myself? This can be called *personalized* me-mode. This mode refers not simply to our ability to apprehend other people’s minds and their complex workings

(i.e., as indicated in the aforementioned me-mode), but also to the capacity to recognize others' mental states *about ourselves* : how other people experience us, as well as how they think and feel about us. Too often individuals cloak how others see them with their own self-experience. This can work to enhance self-esteem as much as to undermine it. Overinflated self-image and excess self-confidence are applied to how a person thinks other people see them, and so the person feels good about themselves irrespective of how other people view them in reality. Conversely, negative self-experience (e.g., the shame or self-loathing in avoidant PD, and sometimes ASPD) can infiltrate experience of all interactions with others. Since the person's own sense of shame leads them to believe that others are judging them negatively, the person naturally retreats from relationships as much as possible.

In MBT, we develop an image of patients' patterns of attachment-seeking and avoidance in relationships. We do this by exploring examples of when patients' personal expectations are met, and when they are not met (see Chapter 3). This may expose the chinks and vulnerabilities in the armor of narcissistic function, and patients can then decide if the fault lines need repair. Recognizing one's own weakness is not easy for anyone. The vulnerabilities are best characterized as *exceptional sensitivities* , so that the exposure does not undermine self-esteem. Patients with vulnerable PN may engage better when other people empathically validate them, rather than directly challenging them. In contrast, empathic validation with grandiose PN will have little effect because patients are impervious to others, having created a bubble of self-importance that isolates them. Patients in that state experience little need for others' affective understanding of their mental states. Instead, they often over-recruit their cognitive processing systems to buttress their sense of self-esteem, independent of their immediate social context.

We-mode: Co-mentalizing and epistemic trust

As human beings, we are tuned into each other. We need to share our inner states and let others know our underlying beliefs, goals, thoughts, and feelings. In so doing, we build a shared mind and generate common goals, from infancy to adulthood through attachment processes that underpin the evolution of mentalization. Sharing mentalizing with others leads to more

confidence about our own mentalizing. When we take into account the inferred inner states of others, a shared reality is achieved, building social bonds. Taking the perspective of others whom we respect, and adjusting the communication between people toward a mutual understanding or "shared reality," maintains friendships and triggers cohesion in relationships.

When this co-mentalizing is achieved, a particular subjective experience of social cognition is generated, referred to as "we-mode." The we-mode—also described as relational mentalizing in MBT (see Chapter 12)—is an interpersonal experience of being attuned to someone else, where intentional states are shared with a common purpose (Gallotti & Frith, 2013 ; Higgins, 2021). The we-mode generates trust, which in turn opens up the pathway for learning from the trusted source. *You make me feel like a person with my own struggle. So I listen to you.* The aim of restoring mentalizing in MBT, or any other treatment modality, is then in the service of reopening the possibility of experiencing we-mode, initially with the clinician and ultimately with other people in patients' lives outside the treatment situation. The experience of epistemic match gives rise to an ability to learn from social interaction. There is an inherently relational aspect to we-mode—a sense of both agency and belonging that arises from an experience of jointness, connectedness, and shared intentionality.

On this view, we-mode is directly related to the notion of *epistemic trust* , which has emerged as a key explanatory and clinical construct in the treatment of patients with personality disorders, and in the psychotherapy process more generally (Fonagy & Allison, 2014 ; Fonagy et al., 2015). Fonagy and colleagues (2019) define epistemic trust as "openness to the reception of social communication that is personally relevant and of generalizable significance" (p. 71). Through use of ostensive cues (e.g., eye contact, turn-taking, interested tone of voice, use of the person's name, accurate empathic reflections), we communicate to other people that we are seeing them and engaging with them as unique individuals, thus enabling them to feel like our communications are credible, meaningful to them, and applicable beyond the specific interaction. In this way, epistemic trust might be seen as a foundational dimension of we-mode, in which both parties are able to flexibly "take in" and collaboratively utilize the mental states of the other.

It is important to note that we-mode is not tantamount to a merger of minds. The self with its full sense of agency remains important. A self

routinely subverting itself for a joint purpose by fusing with another mind creates an illusion of we-mode that is only achieved by a surrender or distortion of oneself. True we-mode is not an abdication of an awareness of separate mental states. Rather, we-mode involves holding in mind the idea that others are separate "agents or persons just as real as oneself" (Tomasello, 2016 , p. 56), with whom we momentarily share an understanding that supersedes our individual perspective. Indeed, the benefits of we-mode accrue from separate minds joining together to focus on a shared object. In this way, joint attention brings new knowledge and perspectives that a single mind cannot hold (Tomasello, 2019). In clinical treatment, we-mode allows joint reflection *on* the relationship while simultaneously engaging *in* the relationship. In Chapters 11 & 12 of this volume, we consider techniques and strategies geared toward engendering a form of we-mode experience in the therapeutic interaction.

Unsurprisingly, we-mode function is a problem in PN. The imbalances in lower levels of mentalizing, referred to in MBT as the polarities of mentalizing, prevent higher level affiliative processes from developing (see Chapter 13). Patients with PN struggle to build shared goals with others, or to generate a sense of mutuality that transcends a single person's experience. At an experiential level, patients thus remain alone and isolated —a painful place indeed.

Core processes of MBT

MBT is a semi-structured treatment targeting patients' challenges with mentalizing in interpersonal relationships. Although it was first developed for the treatment of BPD, MBT is applicable to all patients that have mentalizing vulnerabilities associated with psychiatric illness. In this book, we review in detail MBT's technical strategies for the treatment of pathological narcissism (see Chapters 5 –12). Prior to delving into specific techniques, we will summarize the broad therapeutic principles that undergird our approach. These principles serve as a framework for our primary focus on mentalizing, helping us to deliver interventions that stimulate patients' capacity to reflect on mental states in Self and Other.

Managing anxiety

Any anxiety destabilizes mentalizing, and so our first principle is to manage patients' level of arousal (Chapter 5). Mentalizing improves initially with increasing anxiety until a tipping point is reached, beyond which the chance of effective mentalizing decreases rapidly. Leaving anxiety untethered is likely to trigger a "fight or flight" response in patients. In the case of vulnerable PN, anxiety may be all too obvious, with patients desperately craving recognition and avoiding panic by "performing" in a manner consistent with our preferences. With other patients with PN, emotional states and attachment needs may be deactivated, leading to the problem of over-controlled mentalizing—an excessive reliance on cognition over affect (see Chapters 8 & 13). We thus work to integrate patients' mentalizing and arousal, so that they function harmoniously rather than clashing with each other.

Empathic validation

In MBT, we intervene initially using contingent and marked responses of empathic validation to facilitate a "we-ness" organized first around seeing things together from patients' perspective. Human beings are sensitive to the existence of contingencies between their behavior and environmental events; they are equally attuned to their own mental state intentions, and how other people respond to these intentions. Contingency detection in interpersonal relationships is crucially involved in the progressive development of an awareness of affective states: identifying one's own reaction is only possible through the contingent response of the other. More specifically, our contingent reflections of patients' expressions while struggling to mentalize play a central causal role in stimulating emotional self-awareness and self-control in patients. While this is a central aspect of mentalizing, most patients require scaffolding and support. As reviewed in Chapter 6 , we operate within a framework of empathic validation of patients' experience as the foundation for all other interventions.

Democracy, equality, and collaboration

When implementing MBT, we work with patients to identify and plan the goals, priorities, and focus of treatment (see Chapter 4). We are equal partners in the therapy, and we collaborate to build increasingly salient personal narratives and understanding. Openness to different perspectives is

at the heart of mentalizing, along with humility, ordinariness, and lack of pretense. In terms of mental states, we are "equal" with patients. Neither person has a more valid experience of interactions and their associated mental processes than the other, and both have the capacity to misinterpret experience. Understanding mental states should be a joint and collaborative process. At a dynamic level, equality of mind states and the requirement to consider each other's mind states is a two-way process. We are necessarily focused on patients' minds, and patients have to be equally focused on *our* minds. *Why does my therapist say that? Where is that coming from? What does it mean about me?*

The importance of power differentials in the therapeutic setting needs consideration. Feeling weaker (e.g., through help-seeking, shame, or a sense of inferiority) or stronger (e.g., through educating, self-aggrandizement, or superiority) in an interpersonal dialogue is inimical to mentalizing, since both states almost inevitably bring relational imbalance. Accordingly, when working within an MBT frame, we are open and willing to self-disclose (see Chapter 11). By explicitly accounting (and being accountable) for our own thoughts and feelings, we help patients to "level up" or "level down" in the interaction, thus establishing the conditions for adaptive reflection.

Another aspect of "democratization" is engaging with patients as *conversational partners* . Some patients present with a general tone of supplication, while others show constant malediction, pursuing a style of interaction that undermines equality. By sharing the interactional experience from our own point of view, patients can begin to consider the effects they may have on other people. This also enables *us* to stabilize our own mind through verbalization and activation of explicit mentalizing. In MBT, it is thus essential for us manage our own low mentalizing in the therapeutic relationship. For example, we might momentarily become defensive with patients, and then we can express this state and retrieve mentalizing. Or our mind might go blank, and we are uncertain about how to respond—this is a common reaction to ineffective mentalizing by patients. Here we simply share *this* state of mind: "You know, I am not sure what to say about that. You have stumped me there. Help me think about it. You were saying . …"

Authenticity and the not-knowing stance

Equality links with what MBT refers to as the “not-knowing” or inquisitive stance (see Chapter 5). We can never fully know the contents of another person’s mind, or even of our own mind, for that matter. Since mental states are subjective, they can never be fully knowable. The not-knowing stance is an authentic attitude of curiosity about what is unfolding in another person’s mind. Thoughts and emotions can feel like a part of us, and sometimes can feel alien and imposed, almost with a life of their own. They can overwhelm. The MBT focus on mental states involves getting to know them, taming them and managing them so they serve our interactions and life constructively.

The not-knowing stance arises from an interpersonal perspective. It considers the reciprocity of mental states, and is rooted in the idea that minds can change minds. We maintain the same attitude toward our own mind as we do toward patients’ minds. We avoid taking an unduly privileged position in relation to our own mental states, and we are tentative in the way that we comment on our own constructions (see Chapter 11). The not-knowing stance includes mental playfulness, using imagination and humor to facilitate the joint project of understanding the complexity of minds. Thoughts and feelings are serious because they can change the world (they generate action), but they are also transitory, which gives them a provisional quality of flexibility and transformation. Above all, the not-knowing stance is the most effective avenue for exploring problems with patients hand-in-hand—or better still, mind-in-mind—so that no one has to go into dark and dangerous places of their mind alone. When employed skillfully, this stance promotes the we-mode of shared intentionality.

Stimulating patients’ own reflectiveness about mental states

In all MBT sessions, the primary therapeutic aim is to stimulate patients’ reflectiveness about mental states in themselves and other people (see Chapter 5). We thus work to ensure that the clinical process moves from low mentalizing toward more effective mentalizing. This usually involves a “serve and return” between us and patients—the reciprocity of back and forth dialogue without premature conclusion. In order to facilitate this, we tend to follow a handful of principles:

Recognize ineffective, low-level mentalizing, and work to address it;
Do not "take over" mentalizing for patients;
Do not attempt to mentalize non-mentalizing discourse;
Do not engage in vacuous, superficial mentalizing.

None of these recommendations are easy to follow. As clinicians, we are often "tricked" into seeing patients' intellectualized communications as authentic psychological insights, especially when they take the form of subtle hyper-mentalizing (see Chapters 2 & 8). We tend to have more robust reflective capacities and are well trained in psychological understanding, making it tempting to "take over" for patients by delivering our own mentalized constructions. It is natural to support, offer help, and provide alternative perspectives and solutions for patients' challenges. However, this will not rekindle patients' mentalizing or force them to exercise and develop their mentalizing muscle. Indeed, it does the opposite, encouraging them to be dependent on others' reflectiveness and thereby reducing their own sense of agency. So we desist from doing the mentalizing for patients, instead working continuously to trigger patients' mentalizing, and then to help them maintain it.

Exploring relational processes

Translating mentalizing of self and other into more complex representations of the therapeutic relationship is used to stimulate higher levels of mentalizing. Within the MBT model, knowledge of self and other are complementary but interdependent. We learn about ourselves from others, and knowing ourselves helps us to "put ourselves in the other person's shoes." In PN, this process is out of balance: joint relational processing is one-sided, with mentalizing problems often manifesting in a reduction in self-knowledge and unstable self-representations.

Another form of mentalizing involves developing a sense of agency and ownership over our own actions (see Chapter 7). This begins with ensuring that representations of both self and other are activated, separated, and differentiated within affective experience, and when possible processed at the level of "we-mode" discussed earlier. We-mode in the clinical interaction is distinct from the individualized perspective of either patient or clinician. An inherently relational representation, we-mode is actively promoted in MBT in a number of ways, including collaboratively

developing patients' written MBT formulations (Chapter 4); prioritizing empathic validation (Chapter 6); working explicitly not only with the mind states of patients, but also with our own subjective experiences (Chapter 11); and examining interpersonal processes in the therapeutic relationship itself: the alliance, its ruptures, and joint intentionality between ourselves and our patients (Chapter 12).

Conclusion: An outline for the book

We offer this book as a practical guide—a "handbook," as the title suggests—for the treatment of pathological narcissism. We hope that these strategies will be useful for clinicians and therapists practicing in a range of different clinical settings: hospital-based systems, community health care centers, group practices, as well as "solo" private practices in the community. For the sake of clarity and parsimony, we focus specifically on individual therapy techniques, reserving a discussion of additional adaptations of MBT for PN (e.g., group therapy, psychopharmacological intervention, clinical case management) for future work. As mentioned earlier, group therapy in particular carries an immense clinical value for patients with PN, given the opportunities for identification, mutual sharing, interpersonal learning, altruism, and considering "other perspectives" about themselves and how they engage in their relationships. The principles reviewed here serve as the backbone for our general therapeutic approach for working with patients with narcissistic challenges, which we then tailor to different delivery formats and contexts.

In our view, MBT offers a range of advantages in the treatment of PN. From a clinical perspective, MBT's supportive and non-authoritative posture—involving the "not-knowing" stance, empathic validation, reinforcement of positive mentalizing, and therapists accepting responsibility for enactments (see Chapter 5)—is particularly well-suited to navigating narcissistic patients' interpersonal vulnerabilities. In our experience, colder or more "neutral" approaches, in which therapists see themselves as merely describing or interpreting internal processes from a position of relative authority, are often too emotionally activating for these patients, resulting in increased rigidity, unnecessary power struggles, and treatment drop-outs.

In contrast, MBT's stance can cultivate a warmer and more egalitarian therapeutic climate, in which narcissistic patients feel emotionally and interpersonally safe enough to reflect on subjective states in Self and Other in more flexible, authentic, and expansive ways. At the same time, MBT's engaged and proactive therapeutic style—involving active questioning, structuring of sessions, development and pursuit of clear goals, and focused explorations of internal and interpersonal processes—enables therapists to actively address patients' key problem areas, and to consistently direct the therapeutic relationship toward change and functional improvement.

MBT also affords practical benefits in treating PN. As Choi-Kain and colleagues (2016) observe, MBT constitutes a common-sense, easy-to-learn, and resource-sensitive approach to the treatment of personality disorders. Compared to more complicated models like DBT and Transference-Focused Psychotherapy, MBT requires less training, and is accessible for clinicians with minimal formal training in the provision of therapy. Furthermore, in our experience, MBT tends to be a highly *inclusive* treatment approach. Originally validated among lower-income populations with complex psychosocial situations, MBT is flexible and highly responsive to a range of presenting problems, placing minimal requirements on patients' eligibility and appropriateness for treatment. Finally, MBT—comprising straightforward, easy to operationalize principles that provide clear guidance about "what to do when"—offers considerable potential for empirical validation, a point that is particularly important given the current paucity of empirically validated treatments for PN.

With these ideas in place, we can sketch out a roadmap for the structure of the book, which will enable readers to navigate the upcoming chapters. For ease of reference, we refer to our approach as "MBT for narcissism," abbreviated simply as MBT-N. To begin, in Chapter 2 , we synthesize the developmental theory of MBT with empirical research on PN to propose a **mentalization-based model of pathological narcissism** , which frames the core challenges of PN in terms of deficits and vicissitudes of mentalization. This theory serves as the theoretical foundation for the remainder of the book, informing all of our recommendations regarding the assessment and treatment of PN.

Chapter 3 covers the **assessment and diagnosis of pathological narcissism** , examining the clinical importance of diagnosis-giving in the treatment of PN. We review how to conduct a detailed assessment of PN,

and we offer guidelines for explicitly discussing the diagnosis with patients. In Chapter 4 , we outline the **structure and aims** of MBT-N. Here we develop a novel conception of mentalization, first described by Drozek and Henry (2021) and referred to as the *domain-based* theory of mentalizing. While none of the facets of this theory are wholly original, this model has the advantage of usefully organizing the diverse usages of the term "mentalizing" that appear throughout the MBT literature. On this view, mentalizing tends to focus on three broad domains of human experience: the *content* of mental states (the "what"); the *context* of mental states (the "why"); and the *process* of how we relate to those states (the "how"). This tripartite conception allows for a nuanced assessment of patients' strengths and challenges with mentalizing, also suggesting clear principles of intervention that are entirely consistent with the existing technical guidelines of standard MBT (Bateman & Fonagy, 2016). This conception is especially useful for new learners of MBT, and particularly well-suited for the treatment of PN, where clinicians can often feel overwhelmed and confused about "what to do when."

With this framework in place, we consider key aspects of the structure of MBT-N: detailing the aims of the therapy; establishing the shared priorities for treatment; conducting an assessment of patients' mentalizing across the aforementioned three domains (e.g., content, context, process); developing and delivering a written mentalization-based formulation; and orienting patients to therapy sessions (Chapter 4). Chapter 5 describes the **therapeutic stance and clinical principles** of MBT-N. Employing the domain-based model of mentalizing as a guide, we highlight the broad trajectory of interventions in MBT-N: first exploring and elaborating the content of mental states in Self or Other; then helping patients place these mental states within a broader context; and finally addressing any forms of non-mentalizing (e.g., excessive certainty, concreteness, or emotional disconnection) that have become apparent during the previous explorations. Throughout this process, we are continuously monitoring patients' mentalizing, tailoring our interventions to their reflectiveness in the current moment, and utilizing "judicious praise" to encourage and reinforce patients' mentalizing gains.

We elucidate the structure of sessions in MBT-N, also introducing the concept of *experiential contexts for mentalizing* as an essential technical tool in the treatment of PN. Prior to attempting any mentalizing

interventions, we need to explicitly identify the specific experiential context that will serve as the shared point of focus in the subsequent discussion. This helps us steer clear of the pernicious "pretend mode" that is endemic to PN (see Chapters 2 & 8), while engaging in dialogue that is authentic, meaningful, and geared toward functional progress.

The next several chapters expound upon our techniques for stimulating reflection in each of the different domains of mentalizing. Chapter 6 examines **content-focused interventions** in PN: clarification, affect elaboration, and empathic validation. In different ways, these strategies are all geared toward helping patients represent the "what" of their experiences. Given the importance of alexithymia and emotional disconnection in PN, we devote considerable attention to expanding the repertoire of affect elaboration strategies in MBT. To clarify the often murky and confusing process of helping patients reflect upon their own feelings, we propose a streamlined *affect elaboration interventional pathway* , also delineating techniques for exploring vulnerable emotions, examining other people's subjective experiences, and intervening "when all else fails" in these exploratory efforts.

In Chapter 7 , we review **context-focused interventions** in PN, or techniques that prompt patients to consider the relationship between their mental states and the other aspects of their experience—namely events, behaviors, and other psychological processes. Patients with PN often feel victimized and "done to" in interpersonal dynamics, struggling to acknowledge their own contributions to the scenarios in question. We thus extensively develop *behavior-focused techniques* in MBT-N, which work to mobilize patients' own sense of agency in relationships. We also introduce the distinction between *nascent and evident emotions* , enumerating a range of interventions that help patients mentalize affective processes that are more dissociated and unformulated in their experience.

Chapters 8 through 10 survey **process-focused interventions** in MBT-N: techniques that address problems in the *process* of how patients relate to mental states in themselves and others. MBT designates these challenges as "non-mentalizing modes": **pretend mode** , or disconnection from authentic subjective experience; **psychic equivalence mode** , or excessive certainty, rigidity, and confidence; and **teleological mode** , or difficulties with externalization and concreteness. These chapters offer detailed descriptions of the clinical manifestations of these modes in PN. We summarize

interventional strategies for stimulating reflection in these areas of stuckness, including suggestions about how to respond “when all else fails” with these techniques.

Here we formulate the construct of *teleological self-esteem* (see Chapter 10), in which patients base their self-worth on visible or extrinsic factors (e.g., attractiveness, appearance, possessions, success, effective behavioral performance). We highlight techniques for targeting this core problem in pathological narcissism. As patients become more curious and reflective about their teleological expectations for themselves, they experience greater flexibility, resilience, and coherence in their sense of self.

Throughout these chapters, we underscore the most common clinical challenges that are likely to arise in the treatment of patients with PN, providing practical recommendations about managing these problems in everyday clinical practice (Chapter 13). One central issue involves how these patients approach interpersonal relationships, which can involve difficulties with rigidity, stubbornness, dismissiveness, argumentation, self-centeredness, misrepresentation, disconnectedness, and empathic deficits. These patterns inevitably play themselves out with the therapist as well, and so we devote two chapters to **mentalizing the therapeutic relationship** . We highlight the “don’ts” of mentalizing the relationship in PN, as well as what we dub **auxiliary relational techniques** , which we employ in specific circumstances that arise in interpersonally focused work with patients (Chapter 11). Applying the domain-based model of mentalizing to the therapeutic dynamic itself, we describe the comprehensive **interventional pathway** for relational mentalizing (Chapter 12). This pathway involves a more mutual, detailed examination of the bidirectional processes unfolding in the dyad, as well as strategies for tackling the core mentalizing deficits that fuel patients’ interpersonal challenges. To illustrate these ideas, we present and discuss the transcript of a psychotherapy session where therapist and patient attempt to work through a relational disruption in the treatment.

As in all treatment manuals, these chapters outline general principles that we have found effective in helping our patients. However, as any practicing therapist readily understands, such principles can never fully reflect the complexity and messiness of everyday therapeutic practice. Therefore, in Chapters 14 through 16 , we share several detailed case studies of our work with patients with PN. These examples will hopefully further demonstrate

what it looks like to utilize the principles of MBT-N with three-dimensional human beings, on a moment-to-moment basis in sessions and also over the course of a longitudinal psychotherapy.

Chapter 1 contain excerpts from Drozek, R. P., & Unruh, B. T. (2020). Mentalization-based treatment for pathological narcissism. *Journal of Personality Disorders* , *34* (Supplement), 177–203.

2

A Mentalization-based Model of Pathological Narcissism

In this chapter, we propose a conception of narcissism that centers on impairments in mentalization—that is, difficulties in the individual's capacity to "read," access, and reflect on mental states in themselves and others. We start by reviewing the distinguishing features of pathological narcissism (PN). Then we consider the possible developmental pathway for different types of PN, as well as the problems in mentalizing that we see as central to PN.

Symptoms and characteristics of pathological narcissism

Clinicians, researchers, and theoreticians approach the topic of narcissism from a range of different perspectives, reflecting their idiosyncratic concerns and priorities. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) frames PN in terms of difficulties with grandiosity and self-importance (American Psychiatric Association, 2022 , pp. 760–764), as evidenced by at least five of the following nine criteria:

A grandiose sense of self-importance
Preoccupation with fantasies of success, power, brilliance, beauty, or ideal love
Belief that one is “special” and unique
Need for excessive admiration
A sense of entitlement
Patterns of interpersonal exploitation
Empathic deficits
Difficulties with envy
Arrogant behaviors or attitudes.

As has been widely recognized (Pincus et al., 2014), this constellation of symptoms tends to emphasize the more “overt” or “grandiose” dimensions of PN. In the social-psychological literature, researchers tend to distinguish between grandiose and vulnerable forms of PN: “Grandiose narcissism primarily reflects traits related to grandiosity, aggression, and dominance, whereas vulnerable narcissism reflects a defensive and insecure grandiosity that obscures feelings of inadequacy, incompetence, and negative affect” (Miller et al., 2011 , pp. 1013–1014). Cain and colleagues (2008) review the various terms used to describe these more “vulnerable” portrayals of PN, including covert, shy, thin-skinned, hypervigilant, compensatory, masochistic, and contact-shunning (p. 641). This broad spectrum of narcissistic challenges is largely reflected in everyday clinical practice, where we regularly encounter patients who struggle with unique admixtures of arrogance, dismissiveness, insecurity, and attention-seeking.

In light of the above, it is not immediately obvious what constitutes the defining feature of narcissism—those core characteristics that are common to *both* grandiose and vulnerable PN, while still allowing for their distinct presentations. For the past two decades, the literature on PN has remained largely fractured, involving a range of different measures, theories, and phenomenological descriptions of narcissism (Campbell & Miller, 2011 ; Miller et al., 2016 ; Ogrodniczuk, 2013 ; Wright et al., 2013). However, as researchers have gained increased understanding of the symptomatology of narcissism, a consensus has begun to emerge that narcissism fundamentally involves difficulties with *self-importance and self-centeredness* : “Entitlement, self-centeredness, and self-importance are core phenotypic attributes of narcissism that are consistently linked to quite diverse presentations of narcissistic personality” (Krizan & Herlache, 2018 , p. 9).

This particular description of PN is consistent with the empirically validated and highly influential five-factor model of personality disorders, which serves as the basis for the new alternative model for personality disorders in the DSM-5-TR (American Psychiatric Association, 2022 , pp. 881–901; see Oldham, 2015). Along these lines, while elevated traits of antagonism (e.g., self-centeredness, entitlement, self-importance) are central to narcissism in general, grandiose PN involves elevated traits of antagonism *plus* extraversion (e.g., exhibitionism, attention-seeking), and vulnerable PN involves elevated traits of antagonism plus neuroticism (e.g., anxiety, resentment, self-consciousness; Crowe et al., 2019 ; Krizan & Herlache, 2018 ; Miller et al., 2017 ; Wright & Edershile, 2018).

These findings are consistent with the Alternative Model for Personality Disorders in the DSM-5-TR, in which narcissism is framed in terms of the traits of grandiosity and attention-seeking, both of which are manifestations of antagonism (American Psychiatric Association, 2022 , pp. 887–888). The subtypes of narcissism can thus be distinguished by different forms of impairment in the areas of identity, self-direction, empathy, and intimacy. For example, in the area of identity, patients with grandiose PN exhibit inflated and exaggerated self-appraisals, while patients with vulnerable PN display deflated or vacillating self-appraisals. Or in the domain of empathy, grandiose PN involves impairments in the ability to recognize and identify with others' feelings, whereas vulnerable PN involves an excessive focus on others' thoughts and feelings, "but only if perceived as relevant to self" (p. 887).

In terms of the assessment and measurement of PN, one instrument deserves special attention for our purposes here. The Pathological Narcissism Inventory (PNI) is a valid and reliable self-report measure of narcissism, which is adept at capturing the clinically relevant expressions of narcissism that we see in everyday clinical practice (Edershile et al., 2019 ; Pincus, 2023). As we will discuss in the next chapter, the PNI is especially useful in the evaluation and formulation of PN, perhaps most importantly by helping clinicians distinguish between patients' vulnerable versus grandiose traits of narcissism. See Box 2.1 for the PNI's description of these traits (Pincus, 2013).

Box 2.1 Grandiose and vulnerable narcissism in the Pathological Narcissism Inventory

Grandiose narcissism —Maladaptive processes of self-seeking and self-enhancement

Grandiosity: Preoccupation with power, greatness, and receiving admiration and recognition from others
Exploitativeness: Interpersonal tendencies toward manipulation and self-centeredness
Self-sacrificing self-enhancement: Employs altruistic acts to bolster self-esteem

Vulnerable narcissism —Dysregulation in emotions and self-esteem in response to failures of self-enhancement

Contingent self-esteem: A sense of self that is highly dependent on external sources of recognition and achievement
Hiding the self: Avoidance of vulnerability (e.g., dependency, imperfections, personal needs) in relationships
Devaluing: Indifference to others who do not provide admiration; shame around one's own desires for recognition
Entitlement rage: Anger when self or others fail one's entitled expectations

Of note, all of the above literature views narcissism along dimensional rather than categorical lines, considering the extent to which individuals exhibit symptoms and tendencies that tend to be associated with PN. Accordingly, throughout the book, rather than focusing on PN as a clinical diagnosis, we consider pathological narcissism, or "narcissism" for ease of reference. This approach enables us to utilize the growing body of research on narcissism within social/personality psychology, which as we will see, lends support for a mentalization-based formulation of narcissism. This method coheres with recent research supporting transdiagnostic and dimensional models of psychopathology (Haslam et al., 2012 ; Kotov et al., 2017), as well as studies suggesting that narcissistic symptomatology "does not reflect a narcissist category but rather a continuum of narcissistic pathology" (Aslinger et al., 2018 , p. 496; see also Foster & Campbell, 2007). This outlook has the potential to expand the utility of mentalization-based treatment for narcissism's (MBT-N) interventions, which here will be used to target psychological and interpersonal traits and processes associated with

narcissistic symptomatology, regardless of whether or not patients meet full diagnostic criteria for narcissistic personality disorder.

Mentalizing and the development of pathological narcissism

Bateman and Fonagy's (2016) clinical theory of borderline personality disorder (BPD) is based on the developmental model of mentalization proposed by Fonagy, Gergely, Jurist, and Target (2002) in their landmark work, *Affect regulation, mentalization, and the development of the self* . On this view, under optimal developmental circumstances, the caregiver provides sufficiently contingent, marked mirroring of the child's primary emotional states. *Contingency* implies a basic congruence between the caregiver's mirroring and the child's actual emotional experience, while *markedness* refers to the exaggerated "as if" quality of the mirroring, which differentiates it from the caregiver's realistic emotional displays. When the caregiver consistently mirrors the child in this way, the child "sees himself" in the mind of the caregiver, internalizes this, and thus acquires "a secondary, cognitively accessible representation of his primary emotional state" (p. 192). [1] These mentalized affect/representation units ultimately serve as the building blocks for the development of the child's sense of self: "Unconsciously and pervasively, with her behavior the caregiver ascribes a mental state to the child that is ultimately perceived by the child and internalized, permitting the development of a core sense of mental selfhood" (p. 286).

However, when the caregiver insufficiently mirrors the child, the child internalizes representations of the *caregiver's* subjective states rather than his own. This leads to a tragic sense of disconnection from the child's own primary emotional experience, along with a psychological structure that Fonagy and colleagues (2002) call the *alien self* : "A fault is created in the construction of the self, whereby the infant is forced to internalize the object's state of mind as a core part of himself" (p. 320). In addition to generating feelings of fragility and discontinuity, since the child's caregivers are often experienced as persecutory and attacking, "the child comes to experience himself as evil and monstrous" (p. 198). Since such a self-state is psychologically intolerable, the person must employ psychological and behavioral processes of *projective identification* that are the hallmark of BPD—the evacuation of badness outside of the self and onto other people.

This process is not motivated by a desire to manipulate others, or to actualize an internalized object relationship; rather, it can be seen as a desperate effort to ensure the survival of the self, "the need to establish the basic continuity of self-experience" (p. 420).

In their seminal text mentioned earlier, Fonagy and colleagues (2002) make a brief reference to PN that has the potential to serve as the foundation for a more robust conception of narcissism. They suggest that, whereas caregivers in BPD usually display congruent but unmarked mirroring, caregivers in PN are more likely to display marked but non-contingent mirroring—the caregiver's mirroring is *about* the child, but "this mirrored state is incongruent with the child's actual feelings" (p. 11). While the child might *appear* to represent subjective states, "the self will feel empty because it reflects the activation of secondary representations of affect that lack the corresponding connections within the constitutional self" (p. 11).

This formulation has support in the contemporary developmental literature on PN. Research has linked narcissism with a range of aversive childhood experiences, including physical abuse (Cohen et al., 2014), verbal abuse (Johnson et al., 2001), sexual abuse (Grover et al., 2007), emotional and physical neglect (Hengartner et al., 2013), and emotional abuse (Carr et al., 2013 ; Neumann, 2017). It is reasonable to assume that, in the context of such abusive and neglectful dynamics, the caregiver is not sufficiently mirroring the child's internal states.

Fonagy and colleagues' (2002) theory also finds support in the research on parenting styles associated with narcissism. Research shows that both grandiose and vulnerable narcissism are associated with parental indulgence and permissiveness (Barry et al., 2007 ; Capron, 2004 ; Horton et al., 2006 ; Miller & Campbell, 2008 ; Ramsey et al., 1996 ; Watson et al., 1992 ; see also Cramer, 2011 ; Segrin et al., 2013). Of particular relevance here is the concept of *parental overvaluation* , understood as "parents' belief that their own child is more special and more entitled than other children" (Brummelman, Thomaes, Nelemans, Orobio de Castro, & Bushman, 2015 , p. 666). This tendency predicts the development of narcissism in children (Brummelman, Thomaes, Nelemans, Orobio de Castro, Overbeek, et al., 2015 ; Otway & Vignoles, 2006). Interestingly, Brummelman, Thomaes, Nelemans, Orobio de Castro, and Bushman (2015) found that parental overvaluation is elevated among more narcissistic parents, suggesting that "[n]arcissists are habitually inclined to enhance themselves, and they might

try to do so by holding inflated perceptions of their child's traits, behaviors, and accomplishments" (p. 674).

Research has also shown that the parental tendencies toward psychological control and coldness are associated with vulnerable narcissism in particular (Barry et al., 2007 ; Capron, 2004 ; Horton et al., 2006 ; Miller & Campbell, 2008 ; Miller et al., 2010 ; Otway & Vignoles, 2006 ; Ramsey et al., 1996 ; Thomaes et al., 2008 ; Watson et al., 1995 ; see also Cramer, 2015). Psychological control "constrains, invalidates, and manipulates children's psychological and emotional experience and expression" (Barber, 1996 , p. 3296), often by employing guilt, shame, coldness, and withdrawal of love. This research has led Horton (2011) to suggest that grandiose narcissism and vulnerable narcissism might have related but distinct developmental etiologies (p. 186).

With these findings in mind, we can attempt to synthesize Fonagy and colleagues' (2002) theory of mentalization with the existing developmental literature on PN. As noted earlier, Fonagy and colleagues hypothesize that PN results from *marked but non-contingent* mirroring. Parental overvaluation would likely exemplify this pattern. The mirroring would be "about" the child, but since the affective display significantly reflects the caregiver's *own* fantasies and needs for self-esteem, it would not accurately reflect the child's actual subjective experience. This overvaluation would emphasize qualities such as strength, confidence, and behavioral aptitude, while undermirroring vulnerable emotions such as sadness, insecurity, and longings for closeness. This type of mirroring leads to the development of the *narcissistic alien self* : a secondary representation of the caregiver overvaluing the child, which since it fails to map onto the child's own primary affective states, would lead to a profound sense of emptiness and discontinuity in the self (see Figure 2.1). Whereas in BPD the person addresses this experience by projecting a sense of badness onto others ("I'm not bad—you are"), in PN, the person responds by projecting the sense of goodness or perfection onto *the self* ("I'm amazing, or at least I am better than you are"). Borrowing from the empirical literature on PN, we refer to this as the mechanism of *self-enhancement* (Wallace, 2011), a complex intrapsychic and interpersonal process that functions to restore and maintain a sense of continuity and self-coherence.

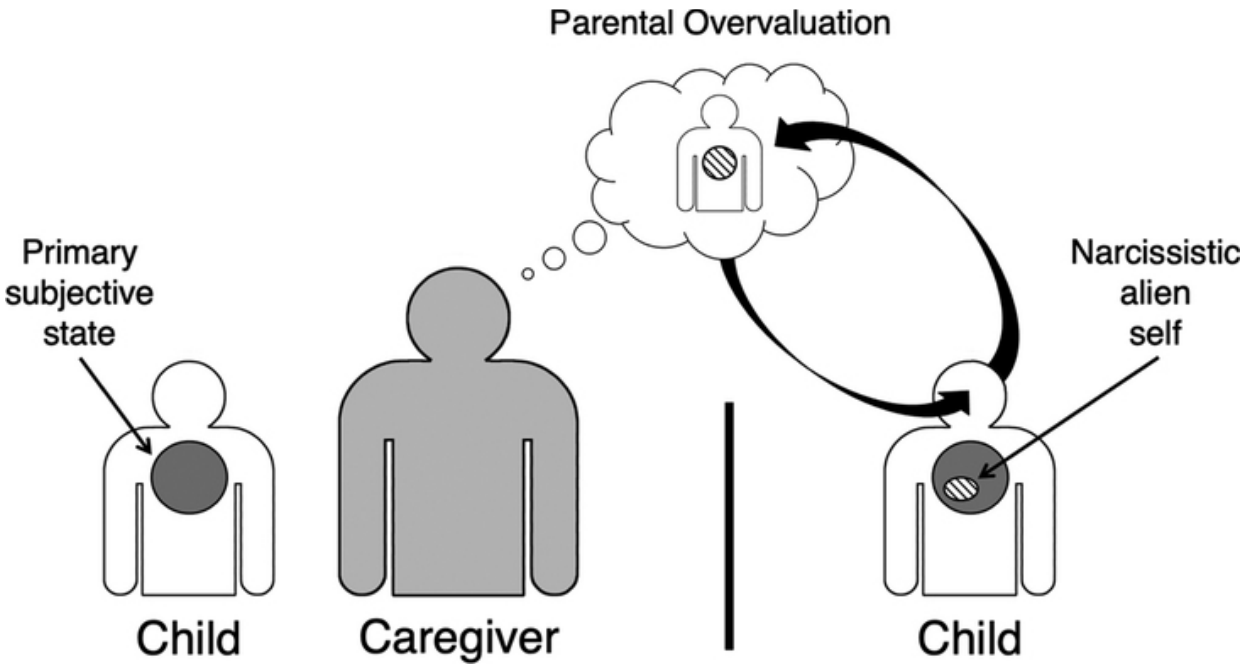

Figure 2.1 The development of the narcissistic alien self. By overvaluing the child, the caregiver provides marked but non-contingent mirroring of the child's primary subjective state. The child internalizes an image of the caregiver overvaluing them as part of the self. This results in the narcissistic alien self, which fails to reflect the child's primary subjective experience and thus generates a profound sense of self-discontinuity.

When the caregiver employs strategies of psychological control, the child would internalize an image of the caregiver as overvaluing *and* shaming the child (Otway & Vignoles, 2006), which the child addresses by mixed processes of self-enhancement and, as in BPD, projection of the badness outside the self. Such processes explain the specific presentation of vulnerable narcissism, where patients are more likely to experience "anger, aggression, helplessness, emptiness, low self-esteem, shame, avoidance of interpersonal relationships, and even suicidality" (Pincus & Roche, 2011 , p. 32). On this formulation, a developmental antecedent of PN in general might be parental overvaluation, whereas the addition of parental psychological control could predispose the person to vulnerable narcissism in particular. This hypothesis, which requires further empirical consideration, is consistent with research showing significant overlap between the constructs of BPD and vulnerable PN (Euler et al., 2018 ; Miller et al., 2010).

A mentalization-based model of pathological narcissism

Consistent with Bateman and Fonagy's (2016) model of personality disorders, we conceptualize PN as a combination of three factors: (a) attachment-related inhibition of mentalization, (b) the re-emergence of non-mentalizing modes of experience, and (c) the constant pressure to actualize the aforementioned narcissistic alien self. Let us consider each of these elements in turn.

Attachment-related inhibition of mentalization

Multiple studies have linked personality disorders with insecure attachment (Levy et al., 2015), and this finding has been replicated with PN in particular (Meyer et al., 2001 ; Ahmadi et al., 2013). Specifically, PN appears to be related to avoidant attachment strategies (Ahmadi et al., 2013 ; Popper, 2002), whereby people protect themselves from disappointment by avoiding close involvement with others, as well as detachment strategies, which involve excessive self-focus and insensitivity to others. In addition, grandiose narcissism has been associated with secure and dismissive attachment (Dickinson & Pincus, 2003), and there is substantial empirical literature linking vulnerable narcissism with attachment anxiety and avoidant tendencies (Dickinson & Pincus, 2003 ; Otway & Vignoles, 2006 ; Smolewska & Dion, 2005 ; see also Rohmann et al., 2012).

In light of this research, we predict that PN would be associated with what Bateman and Fonagy (2013b) call a *mixed* attachment profile (p. 598), consisting of some combination of attachment deactivation strategies (i.e., emotional distancing) in order to cope with interpersonal distress, along with an unstable form of attachment hyperactivation, whereby the person seeks proximity and connection with others largely *indirectly* , by pursuing admiration, grandiosity, and achievement. On this view, in the context of attachment situations that stimulate or threaten their needs for positive valuation, people with PN would be more at risk for various forms of inhibited mentalizing, including constrained access to their own subjective states, especially those involving perceived vulnerability, weakness, and shame; narrower and more superficial perceptions of other people's subjective states; and impairments in what Fonagy and colleagues (2002) call *mentalized affectivity* , which involves accessing and experiencing subjective states in ourselves while simultaneously reflecting on them in a flexible and nuanced way (Jurist, 2005 , 2018).

These hypotheses are supported by the social cognitive literature on PN, which suggests that people with PN have biases toward expressing feelings of anger and entitlement (Dimaggio et al., 2008), along with difficulties representing more "vulnerable" emotional states, such as sadness (Bouizegarene & Lecours, 2017), shame (Watson et al., 1996), insecurity (Myers & Zeigler-Hill, 2012), and dependency upon others (Pincus et al., 2009). In addition, research associates PN with decreased empathic capacities (Hepper et al., 2014 ; Leunissen et al., 2017 ; Watson et al., 1984), decreased ability to recognize emotions in others (Fossati et al., 2017 ; Marissen et al., 2012), and impairments in identifying and describing emotions in oneself (Fan et al., 2011 ; Jonason & Krause, 2013)—all deficits that possibly have a neurological basis in narcissism (Fan et al., 2011). Our proposals also find support in the observation that PN involves cognitive empathy with impaired *emotional* empathy (Jonason & Krause, 2013 ; Ritter et al., 2011 ; Wai & Tiliopoulos, 2012)—that is, patients "know" what another person is feeling but cannot *feel* what that person is feeling. As noted in Chapter 1 , one recent study found that reduced generosity was mediated by reduced perspective-taking abilities in narcissism (Böckler et al., 2017), suggesting that inhibited mentalizing might play a role in the typical "selfishness" associated with PN.

Re-emergence of non-mentalizing modes

When mentalizing is inhibited in PN, patients are more likely to regress into modes of psychic experience that chronologically antedate the full development of mentalization, which Bateman & Fonagy (2016) dub *psychic equivalence mode* , *pretend mode* , and *teleological mode* (Chapter 2). See Box 2.2 for common examples of these non-mentalized forms of experience in PN.

Box 2.2 Non-mentalizing modes in pathological narcissism

Psychic Equivalence Mode

Grandiose beliefs about oneself, achievements, talents
Sense of the self as different, superior, separate from others
Idealization of specific others (e.g., spouse, colleagues, friends)
Devaluation of other persons, groups
Rigid convictions about others' actions, qualities, or beliefs, often seeing them as unequivocally wrong/incorrect
Sense of self as bad, worthless, weak, "a failure"
Self-judgments about certain qualities, emotions, desires
Emotions of shame, embarrassment, humiliation

Teleological mode

Intense desires for tangible success, achievement, possessions
Need for visible attention, admiration, approval from others
Ruminations about social/work performance and appearance
Focus on others' "wrong," "unjust" behaviors
Assumption that such behaviors imply lack of care, respect, etc.
Need to respond behaviorally (e.g., retaliation, avoidance) when hurt or wronged
Use of others for own ends
Self-esteem based on external factors (e.g., validation, competition)
Self-harm in response to loss of visible symbols of "Self"

Pretend mode

Over-reliance on cognition, intellectualization, jargon, rationalization
Monologues and excessively detailed, inconsequential narratives
Apparent disconnection from emotions and desires
Beliefs about the self do not correspond to one's actual behaviors, presentation, life circumstances
Patient uses psychological language but cannot elaborate on meaning, context
Cognitive understanding of others without emotional empathy
Dissociation of more vulnerable emotions and desires: sadness, insecurity, desires for attention, etc.

In *psychic equivalence mode* , thoughts and emotions (e.g., about Self, about others) do not *feel like* thoughts and emotions—they feel like "reality," such that patients are unable to consider alternative perspectives or viewpoints. This state is marked by rigidity, certainty, and extreme confidence about one's own beliefs (see Chapter 9). Fonagy and Target (2005) have proposed that narcissistic grandiosity is often experienced in psychic equivalence mode, and Lecours and colleagues (2013) suggest that "shame and helplessness" in PN fall into this category. In *teleological mode* , mental reality is significantly determined by the external world: physical actions, observable qualities, and visible events and circumstances. The fantasies and aspirations associated with PN are usually teleological and "extrinsic" in nature (Abeyta et al., 2017), involving visible signifiers of achievement, prestige, admiration, and attention from others (see Chapter 10). This also results in a primarily teleological sense of self in PN (see pp. 223–228), where self-esteem is based on "domains requiring external validation," including social recognition and competition with others (Zeigler-Hill et al., 2008 , p. 769).

In *pretend mode* , thoughts and beliefs are disconnected from authentic subjective experience in Self and Other. Patients *appear* to be discussing something psychologically meaningful, but further inquiry reveals the subtle signs of pretend mode, including overreliance on jargon, intellectualization, circularity, and dissociation of affect (see Chapter 8). In our view, pretend mode is a central yet underappreciated clinical phenomenon in PN, a proposal that is consistent with Fonagy and colleagues' (2002) hypothesis that marked but non-contingent mirroring from caregivers predisposes patients to this disorder: the child internalizes marked representations, but these representations do not correspond to genuine affects. The impaired emotional empathy associated with PN also falls into this category. While patients seem able to "represent" the emotional states of another, they can struggle to affectively resonate with those states, especially when patients feel like the other person is threatening their sense of self-esteem and self-worth.

The narcissistic alien self

When these non-mentalizing modes ascend in psychic experience, patients with PN encounter an increased sense of discontinuity and fragmentation, thus facing pressure to actualize what we have called the *narcissistic alien*

self . In these moments, patients engage in strategies of narcissistic self-enhancement, understood as intrapsychic and interpersonal efforts “to increase the positivity of one’s self-concept or public image” (Wallace, 2011 , p. 309). These strategies constitute the effective projection of the narcissistic alien self (Figure 2.2), resulting in a momentary sense of self-continuity. According to MBT-N, this projection is not motivated by the impulse to actualize an internalized object relationship (Diamond et al., 2022); to regulate self-esteem, agency, and identity (Campbell & Foster, 2007 ; Morf & Rhodewalt, 2001 ; Roche et al., 2013); or to defend against vulnerability (Ronningstam, 2005). Rather, it is driven by the real and desperate need to maintain a sense of continuity and self-coherence, and thereby to ensure the survival of the self.

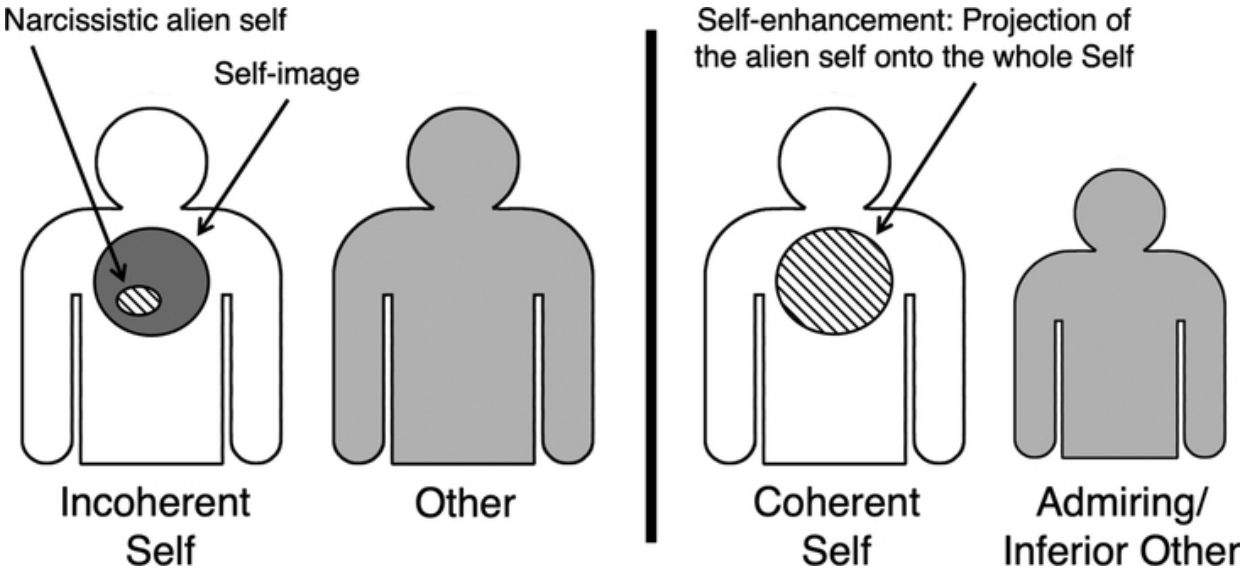

Figure 2.2 Projection of the narcissistic alien self. Through internal and behavioral strategies of self-enhancement, individuals with PN actualize the narcissistic alien self and achieve coherence within their sense of self. In order for individuals with PN to experience a sense of self-continuity, the other person needs to be experienced as admiring or inferior.

In PN, such self-enhancement unfolds internally, for example when patients remember past successes (Robins & Beer, 2001), overvalue their own traits and abilities (Grijalva & Zhang, 2016), and fantasize about success, power, admiration, and ideal love (Raskin & Novacek, 1991). As has been widely documented, such processes also play out interpersonally, for example when patients pursue attractiveness (Vazire et al., 2008), recognition (Wallace & Baumeister, 2002), admiration (Back et al., 2013 ;

Wurst et al., 2017), professional success (Grijalva et al., 2015), material wealth (Pilch & Górnik-Durose, 2017), fame (Southard & Zeigler-Hill, 2016), relationships with high-status people (Seidman, 2016), and the maintenance of power in their relationships (Campbell et al., 2002 ; Wilson et al., 2017).

Of particular relevance here is the idea that patients with PN do not pursue self-enhancement simply to experience themselves as "good" or "valuable"; they seek such enhancement to experience themselves as better or superior to others (Campbell et al., 2000 ; Krizan & Bushman, 2011). On this view, other people can be seen as *vehicles for the projection of the narcissistic alien self* . Therefore, when other people inevitably respond non-contingently to patients with PN (e.g., by ignoring, insulting, criticizing, abandoning, outshining, or failing to admire patients), they are interfering with said projective processes. This results in the characteristic retaliation and aggression associated with PN (Brunell & Davis, 2016 ; Lambe et al., 2018), which MBT-N sees not merely as a defense against vulnerability or shame, but as a desperate and psychologically necessary attempt to maintain a sense of self-coherence. When implementing or even fantasizing about such attacks, patients are actualizing their sense of power and superiority, thus allowing for the successful projection of the narcissistic alien self.

Conclusion

The foregoing formulation says little about the "contents" of the mind in PN. Consistent with MBT's theory of borderline and antisocial pathologies (Bateman & Fonagy, 2016), we have offered what might be called a *process-oriented* conception of narcissism, emphasizing the "stance" taken by narcissistic patients toward mental states (e.g., thoughts, emotions, desires) in themselves and others. Accordingly, when conceptualizing PN from the perspective of MBT, we are not only interested in *what* our patients are feeling and wanting; we are especially curious about *how* they are relating to their own psychological processes: the circumstances that activate them, their challenges with psychological rigidity and disconnection, and the ways in which they seek to maintain and regain control over their own minds. These considerations serve as the foundation for how we approach assessment and formulation of patients with PN.

Chapter 2 contain excerpts from Drozek, R. P., & Unruh, B. T. (2020). Mentalization-based treatment for pathological narcissism. *Journal of Personality Disorders* , *34* (Supplement), 177–203.
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1 When discussing Fonagy and colleagues' (2002) theory in this section, for the sake of clarity, we follow their pronoun usage in the work in question (i.e., she/her/hers for the caregiver, he/him/his for the child). However, throughout the rest of the book, we follow the American Psychological Association's recommendations for bias-free language and gender inclusivity: employing the person's self-identified pronouns when referring to specific individuals; and using the singular "they" when referring to generic individuals whose identified pronouns are not directly relevant to the context.

PART 2

BEGINNING THE TREATMENT

Part 2 reviews the early phases of mentalization-based treatment for narcissism. The authors outline how to complete an assessment of pathological narcissism, as well as how to give the diagnosis to patients in experience-near, collaborative, and patient-specific terms. The domain-based theory of mentalizing is introduced, which informs the technical interventions for the remainder of the book. Core strategies are illustrated for establishing shared treatment priorities; assessing patients' strengths and vulnerabilities in mentalizing; developing an MBT formulation; and orienting patients to therapy sessions.

3

Assessment and Diagnosis of Pathological Narcissism

In this chapter, we review the process of assessing and diagnosing patients with pathological narcissism. We consider how to conduct a detailed assessment of pathological narcissism (PN), and then we offer guidelines for explicitly discussing the diagnosis with patients, as a useful step before starting a mentalization-based treatment.

The importance of diagnosis-giving in MBT for narcissism

Openly discussing the personality disorder diagnosis is an initial component in all of our evidence-based therapies for borderline personality disorder, and is now being increasingly recommended in the treatment of narcissism as well (Hersh et al., 2019 ; Weinberg et al., 2019). This proposal generates feelings of anxiety and concern for many therapists, who worry about upsetting patients, disrupting the therapeutic relationship, and unnecessarily "pathologizing" patients with a personality disorder without much therapeutic benefit. Why not just provide patients with the treatment, and bypass all of the stigma and baggage associated with narcissism?

Hersh and colleagues (2019) have explored the various therapeutic advantages associated with discussing narcissism directly with patients, including showing respect for patient autonomy; obtaining informed consent for treatment; strengthening the therapeutic alliance; decreasing treatment drop-outs; providing psychoeducation on the existing scientific knowledge about PN; and gaining clinical justification for directing patients' focus away from comorbid conditions (e.g., depression, anxiety) unlikely to respond to non-PD interventions.

From the perspective of mentalization-based treatment for narcissism (MBT-N), there are several other important reasons for explicitly discussing narcissism with patients. In MBT, we would not advocate treating patients "behind their backs." If we believe that a patient struggles with PN but never disclose that, then we would essentially be "hiding" a significant part of our minds from the patient, even as we are trying to help the person with those very challenges. This approach is inherently anti-mentalizing. It obscures our genuine opinions (the "what"), it ignores the context of the treatment as a whole (the "why"), and it contributes to a sort of "pretend mode" that disconnects us and our patients from our authentic thoughts and feelings (the "how"). These forms of duplicity can generate confusion and suspicion in patients, also leading to pernicious disruptions in the treatment relationship when inevitably patients' understanding of their challenges depart from our own understanding of these challenges.

Diagnosis-giving also sets the stage for what we suggest is the most helpful therapeutic stance in treating patients with PN—namely, actively working to validate their perspectives while also sensitively introducing our own discrepant perspectives into the therapeutic dialogue (see Chapters 9 , 10 , & 12). When working with these patients, we are often keenly aware of the potential for discrepancy and "otherness" to destabilize them, and so it is tempting to just sit back and align with patients' own viewpoints. By withholding the PN diagnosis at the outset of treatment, we run the risk of inadvertently bolstering relational processes (e.g., self-centeredness, interpersonal sensitivity) that could be a focus of mentalizing in the therapy. In contrast, by discussing the diagnosis in a collaborative manner that simultaneously reflects patients' perspective *and* our perspective, we model the mutually reflective stance that we are attempting to encourage in the therapy.

Lastly, the narcissism diagnosis serves as the foundation for stimulating self-reflection throughout the course of the treatment as a whole. Patients with PN often tend to be quite externally focused, finding it difficult to reflect on their own contributions to their challenges, and instead attributing these challenges to other people's perceived failings. In contrast, the PN diagnosis implies that there is a vulnerability *in the person* , not just circumstances outside of them. When patients are able to see the potential relevance of the diagnosis to their difficulties, this vulnerability provides the collaborative rationale for the treatment approach, which actively works

to address these problem areas through the lens of mentalizing. In this way, the diagnosis serves as something of a "mentalizing anchor" in the treatment, to which clinicians can return when patients inevitably get stuck in unhelpful forms of non-reflectiveness:

> "It sounds like he really disrespected you, and so you had to 'tell him off' in order to defend yourself. But this also reminds me of what we've been talking about lately, where you get so caught up in fighting against the injustice that you lose touch with your own emotions in the situation. Can you tell me a bit about what that made you feel, to have him speak to you in that way?"

In our experience, framing the treatment in terms of PN helps to establish and maintain the reflective space for patients to begin to consider their own contributions to their relational challenges.

Assessment of narcissism in MBT-N

Suppose that we believe our patient struggles with the symptoms of PN, as outlined in the section "Symptoms and characteristics of pathological narcissism" (pp. 23–26). How then do we proceed to establish the narcissism diagnosis in MBT-N? Consistent with MBT-N's employment of contingent yet marked interventions (see Chapter 6), we tend to avoid making categorical proclamations about patients' personalities (*"You definitely have narcissistic personality disorder"*), which would problematically emphasize *our* perspective over patients' subjective experience of their own lives. Instead, we attempt to facilitate an exploratory, collaborative process with patients that simultaneously reflects patients' self-experience as well as our own ideas about how to organize and understand the various elements of that experience. By focusing our discussion around the idiosyncratic traits of PN that patients possess, we increase the chance that patients will feel "seen" by us as unique individuals, in a manner that they find personally meaningful, and hopefully helpful. This approach is also consistent with the dimensional approach to understanding personality pathology, which has significant empirical support for personality disorders in general and narcissism in particular (Aslinger et al., 2018 ; Kotov et al., 2017).

In working toward a diagnosis of PN with patients, we recommend focusing on three broad areas: patients' experience of their presenting

problems, psychosocial disruptions, and narcissistic processes (Box 3.1). Consideration of these sectors provides us with the information that we need to explicitly frame patients' challenges in terms of narcissism, while also laying the foundation for developing a collaborative MBT formulation of patients' impairments in mentalizing, as we will review in Chapter 4 .

Box 3.1 Key facets of establishing the narcissism diagnosis in MBT for narcissism

Exploration of patients' experience of presenting problems—depression, anxiety, interpersonal conflict or estrangement, anger issues, addiction, etc.
Consideration of psychosocial arenas (e.g., family, work, friendships), with an eye toward functional challenges and their precipitants
Examination of narcissistic processes: narcissistic expectations, self-enhancement processes, and disruptions in self-esteem
Delivery of the diagnosis in experience-near, patient-specific terms

For the purposes of illustration, we will review some basic steps for eliciting information about these areas when meeting with patients who are new to treatment. Such discussions, however, are thoroughly non-linear and "messy." In talking about themselves and their challenges, patients are likely to provide information that at once falls into several of the aforementioned categories. Throughout the conversation, we thus recommend *listening* for this information, privately taking note of it in the moment, and then returning to it later to invite further elaboration and discussion.

Patients' perspective on presenting problems

We usually start by asking some open-ended introductory question well-known from most general psychotherapies, such as "What brings you in today?" or "It sounds like there have been some challenges lately. Can you talk a bit about what has been going on?" Our aim here is to understand how patients understand themselves and their difficulties, to apprehend the areas causing them distress, and to identify where patients locate the *source*

of their troubles. While many patients clearly situate their challenges within themselves ("I've got a lot of anger issues"; "My wife is going to leave me if I don't make a change"; "I've been extremely depressed since I lost my job"), there can be significant variability along these lines. In cases where patients offer primarily externally focused descriptions of their problems ("Everything has gone downhill at my company since we got a new CEO"; "My wife has severe OCD, and it has really impacted our whole family"), we inquire further about the *impact* of these external factors on patients (*"How has that affected you, to have to work with someone who is so manipulative?"* ; *"This sounds extremely stressful …"*). In this way, we work toward a more psychologically elaborated understanding of patients' problems, without having to contradict patients' own self-experience at the outset of treatment.

Box 3.2 Steps to elicit patients' perspective on presenting problems

Ask open-ended questions.

"What brings you in today?"
"Tell me a little about yourself."
"It sounds like there have been some challenges lately. Can you talk a bit about what has been going on?"
"What are you hoping to get out of treatment?"

When patients are focused on external factors, directly inquire about emotional experience.

"What has your mood been like lately?"
"With all of these things going on, how have you been feeling?"

Avoid challenging patients' viewpoints, or offering own perspective.
Summarize and empathically validate patients' perspectives and emotions.

By obtaining this information, we will be best situated to frame the diagnosis in a manner that feels relevant to patients, and that relates most directly to patients' own goals for themselves. At this stage of the process, we would not attempt to challenge patients' formulations, or to share our own perspective about the matters at play. Instead, we simply work to help

patients elaborate their own viewpoints and feelings, summarize what we are hearing from them, and empathically validate the emotional states patients are expressing (Box 3.2).

Discussion of the psychosocial landscape: Functioning and precipitants

With this understanding in place, we ask more targeted questions about the relational context of patients' lives, most notably family relationships, work, and friendships. Rather than approach these topics from an abstract perspective, it is most helpful to ask descriptive, matter-of-fact questions about these areas, such as "What do you do for work?" or "Tell me about your family situation." In most cases, patients will naturally proceed to discuss relevant disruptions in these arenas ("My ex-wife will not follow the custody agreement"; "I tell it like it is, but that has gotten me into trouble sometimes"). Here we invite further elaboration, with an eye toward eliciting specific descriptions of patients' behavioral patterns in interpersonal relationships. By and large, we avoid asking general or "abstract" questions about such matters (*"What tends to trigger you?"* ; *"How do you respond to interpersonal conflict?"*). As discussed in Chapter 2 , patients with PN regularly fall into pretend mode processes, where they can share their *ideas* about themselves and others in overly abstract and vague ways, often reflexively minimizing information that might disrupt their sense of self-esteem (see also Chapter 8). While such narratives are useful in apprehending patients' broader beliefs about Self and Other, we must also help patients move beyond them, in order to collaboratively develop a clearer picture of the actual relational circumstances in which patients' challenges take shape.

Along these lines, it is most useful to ask for specific examples of patients' problems in relationships, as reviewed in Box 3.3 . So we might ask, "What are the things your boss does that you find really problematic?" Or: "Could you tell me about a recent example of an argument you had with your wife?" At this stage of the interview, the ideal discussion involves patients sharing specific examples of their difficulties in interactions with other people, in something of a "he said, she said" format: "She just started criticizing my work on the project, saying that it really was not at the level she was expecting. So I told her that she clearly did not know what she was

talking about, and that the only reason why she has this job is because her father owns the company. She did not like that one!”

Box 3.3 Techniques for elaborating functional challenges and triggers

Avoid abstract questions, encouraging straightforward descriptions of relational processes.
Ask open-ended, domain-specific questions.

“Tell me a bit about your family situation.”
“How have things been going at work?”
“Outside of your family, whom do you interact with?”
“What does your life look like on a daily basis?”
“How do you spend your time?”

To elicit functional challenges, ask closed-ended questions about conflict and difficulties.

“So things have been a little tense at home?”
“It sounds like your boss has a lot of problems. What are the things that he does that really get under your skin?”
“I see, so you and your *[significant other/boss/friend/parent/child]* end up getting into these really intense back-and-forths. Could you give me a recent example of this?”
“This seems really important. Could you walk me through this: what did she actually say that affected you, and what did you say in response?”

Work to elicit multiple examples of functional difficulties across psychosocial contexts, listening for

Functional challenges: argumentativeness; dismissiveness; criticism of others; controlling behaviors; withdrawal and avoidance; dishonesty or misrepresentation; addictive or compulsive behaviors; interpersonal rigidity; self-centeredness; lack of empathy
Triggers for functional problems: criticism from others; lack of recognition; perceived injustice; having less power or status than other people; others ignoring or abandoning them; feeling dismissed, insulted, ignored, or misunderstood by others

Articulate common themes in the areas of functionality and relational triggers.

Relational trigger: *"So it sounds like you are quite focused on issues of justice, and it really affects you if you feel like someone else is being taken advantage of."*
Functional challenge: *"I am wondering if this is something of a pattern for you: if you feel like people don't appreciate you enough, you end up avoiding them and thinking a lot about how problematic they are."*

Collaboratively revise formulations based on patients' feedback and reflections.

As patients offer these examples, we listen for two main areas of content: patients' functional challenges in relationships, and the triggers for (or precipitants to) these challenges. See Box 3.3 for common examples of these processes in pathological narcissism. Once patients have shared several specific examples, if we start to notice a "theme" across examples, we cautiously try to articulate that theme and invite patients' reflections on it:

> "Based on everything you are saying, it sounds like it really impacts you when people talk down to you *[attachment-related trigger]* , and you tend to respond by criticizing them *[behavioral response]* , to make sure that they know they cannot treat you that way. What do you think of that?"

We offer these ideas to patients not to try to convince them of our perspective, or to ascribe any specific meaning to the patterns in question. Rather, we simply attempt to observe commonalities across patients' different descriptions, using patients' own language and staying as close as possible to their experience. We explore patients' responses to these ideas, reconsidering and revising our formulations based on their feedback: "I see, so it is not just about people TALKING down to you … You can tell that they are LOOKING down on you, and that is what makes it feel so intolerable."

Exploration of narcissistic processes

Thus far we have explored patients' subjective understanding of their challenges, as well as the more "objective" interactions unfolding between patients and other people. The next step involves fleshing out the emotional

and self-esteem related dimensions of such processes, which enables us to relate patients' difficulties to narcissism in particular. Three topics warrant specific consideration here: narcissistic expectations, self-enhancement processes, and disruptions in self-esteem. As we help patients reflect on such processes at the outset of treatment, patients are more likely to see the narcissism diagnosis as something that is personally meaningful to them, and thus to feel motivated to engage in a treatment process to address these challenges.

Narcissistic expectations refer to patients' assumptions about the positive conditions that must be met in order for them (or other people) to have value or esteem. Such conditions can be internal states of patients' (e.g., feeling confident, powerful, or intelligent; the absence of more vulnerable emotions); external facets of patients (e.g., wealth, physical attractiveness, vocational success, social status, effective behavioral performance at work or school); internal states of others (e.g., other people admiring or respecting them); or external facets of others (e.g., sexual attention from others; other people complimenting or praising them; maintaining relationships with attractive, wealthy, or powerful people). As we will discuss further in Chapter 4 , these expectations fall into what MBT refers to as *psychic equivalence* and *teleological* modes—that is, rigid and inflexible forms of thinking that play a powerful role in structuring patients' experiences and emotions.

The shape these expectations take varies significantly across different patients, and different subtypes of pathological narcissism. Patients with vulnerable PN are likely to frame these expectations in "evaluative" terms ("I should be more successful at my job"; "I need to be able to provide for my family—to give them the life that I never had as a child"), or in terms of wishes or desires ("I really want other people to admire me"); whereas patients with grandiose PN are more likely to express these expectations as descriptions or "facts" about themselves ("I have always been more intelligent than my peers, and people get really threatened by that"). While patients sometimes explicitly endorse such ideas, usually these assumptions are only implicit and unformulated in patients' experience, thus underscoring the importance of helping patients to articulate and "put words on" their own narcissistic expectations of themselves.

The first step in elaborating narcissistic expectations involves listening for patients' evaluative language—the ways in which they ascribe positive

and negative value to Self and Other. Positive evaluations often involve terms like “good,” “should,” “ideal,” “right,” or “ought,” but such valuations are often highly idiosyncratic to each patient’s experience (“I felt like a new person when they started me on this new med”; “None of these problems really came up for me in high school”). Negative evaluations involve the negation of such standards, as indicated by terms like “bad,” “wrong,” “should not,” or “unjust,” or more implicit devaluations of Self or Other (“My wife is the one who really needs therapy”; “I just feel so old and unwanted”). Once we notice such evaluations, we invite elaboration about their content (“*It sounds like you have some real concerns about your physical appearance … could you say more about that?*”). We explore patients’ affective states related to these standards (“*How did that make you feel about yourself, when she told you how much she looked up to you?*”), gradually working to explicitly “link” patients’ specific narcissistic expectations to their sense of self-esteem (“*You seem to care a lot about how people see you. When they are appreciating you, it really makes you feel good about yourself*”). See Box 3.4 for various techniques for elaborating such processes.

Box 3.4 Techniques for elaborating narcissistic expectations

Move from general self-devaluations to specific expectations of Self: *"You have described yourself as a 'failure' several times. It sounds like you have really specific standards for yourself, of who you need to be in order to NOT be a failure?"*
Move from specific self-devaluations to particular expectations of Self: *"You seem to have a lot of insecurities about your physical appearance, and how you present to other people. I'm gathering that this is something that is really important to you?"*
Ask open-ended questions about ideal life circumstances: *"We've been talking a lot about your challenges. Could you share about a time when things were going best, when you felt most positively about what was happening in your life?"*
Summarize/elaborate narcissistic expectations explicit in patients' narratives: *"You seem to place a lot of value on* [narcissistic factor: work or academic performance/physical attractiveness/intelligence/material success/other people's positive opinions/power and control/helping others]. *Could you say a bit more about that?"*
Explore affective experience related to narcissistic expectations.

"You had been wanting that promotion for so long . … What was it like when it finally happened?"
"How did that make you feel about yourself, when she told you how much she looked up to you?"

Once specific narcissistic expectations have been articulated, explicitly link these expectations to patients' self-esteem.

"Based on what you are saying, it sounds like you base a lot of your self-esteem on how productive and efficient you are at work."
"You seem to care a lot about how people see you: it plays a powerful role in how you feel about yourself."

As discussed in Chapter 2 , *self-enhancement* refers to internal and interpersonal strategies to maintain and bolster patients' sense of self-esteem. Such processes can include bragging; performing effectively (e.g., socially, vocationally, intellectually, sexually); hiding perceived vulnerabilities (e.g., dishonesty, misrepresentation, withholding information); pursuing physical attractiveness; seeking recognition and

admiration from others; competing with others; striving for “success” in specific areas (e.g., work, status, fame, finances, intimate relationships); fantasizing about such success; feeling superior to other people (e.g., by focusing on one’s own positive qualities and others’ perceived deficiencies); and maintaining social power. When patients’ self-esteem is injured or threatened, self-enhancement can also unfold more reactively, as we see with tendencies toward anger, argumentativeness, defensiveness, aggression, withdrawal, and avoidance of whatever factor (e.g., people, situations, emotions, memories, ideas about oneself) is interfering with their self-esteem.

When interviewing patients, we will already have obtained key information about such processes by eliciting experience-near descriptions of patients’ relational experiences, as reviewed in the “Discussion of the psychosocial landscape” section above. To invite further elaboration of these processes, we ask further questions about the shape that the self-enhancement takes: “You’ve mentioned that sexual relationships are really important to you. Could you talk more about what that looks like?” We explore patients’ affective experience of such processes (*“How did that feel, to do such an amazing job on that presentation?”*), and then we synthesize these descriptions in an experience-near way, drawing the explicit connection between patients’ emotional states and their efforts to maintain self-esteem (*“You feel really proud of the family you’ve been able to build. You’ve given them the life that you never had as a child”* ; see Box 3.5). In most cases, patients’ patterns of self-enhancement also lead to negative psychosocial consequences in their lives, for example when their dismissiveness contributes to marital problems, when their defensiveness alienates supervisors, or when their avoidant tendencies lead them to neglect important responsibilities. In such cases, we also invite reflection on those potential negative consequences, for example saying to the patient, “You’ve mentioned that you can get a bit critical of your wife if she doesn’t do things ‘your way.’ Has this affected your relationship?”

Box 3.5 Techniques for elaborating self-enhancement processes

Encourage elaboration on specific self-enhancement strategies already mentioned: *"You've mentioned that sex, and specifically receiving sexual attention from women, is a big part of your life. Could you talk more about what that looks like?"*
Utilize narcissistic expectations to elaborate self-enhancement processes: *"You've said that it is really important to you to make a lot of money. What do you end up doing to work toward that?"*
Explore affects related to self-enhancement.

"How did that feel, to do such an amazing job on that presentation?"
"You started smiling as you spoke about telling your wife off. What came up for you just then?"

When curious about specific self-enhancement processes patients are not mentioning, permissible to ask closed-ended questions in a tentative fashion: *"It sounds like you can get really irritated with your boss, especially when he gives you constructive feedback that feels unfair. Has this ever led to any arguments between the two of you?"*
Invite reflection on connection between self-enhancement and problems with functionality: *"You've mentioned that you can get a bit critical of your wife if she doesn't do things 'your way.' How has this affected your relationship?"*
Once affective states have been articulated, explicitly link self-enhancement with emotional experience and self-esteem.

"It really seems to make you feel good about yourself, to get such positive feedback on your blog posts."
"You feel really proud of the family you've been able to build. You've given them the life that you never had as a child."

With these narcissistic processes now "on the table," we explore the disruptions in self-esteem that are endemic to pathological narcissism. As reviewed in Box 3.6 , techniques here involve elaborating the content and focus of patients' self-devaluations (*"You've called yourself a 'loser' several times throughout this discussion. What were you getting at there?"*); exploring the impact of patients' narcissistic disruptions on their lives and emotions (*"How has this affected you, to have your wife say she wants a divorce after all these years?"*); and inviting reflection on the possible

connection between patients' self-devaluations and their functional challenges already reviewed thus far in the assessment (*"It sounds like you've been feeling really badly about yourself ever since you got laid off. Do you think this played a role in you getting so depressed?"*).

Box 3.6 Techniques for elaborating narcissistic disruptions

Elaborate specific self-criticisms.

“You described yourself as ‘pathetic’ for having to take a medical leave from college. It seems there are some real negative judgments of yourself there?”
“It sounds like whenever you make a mistake at work, you end up beating yourself up quite harshly. Can you say more about what that looks like?”

Explore global devaluations of self.

“You’ve called yourself a ‘loser’ several times throughout this discussion. What were you getting at there?”
“From everything I am gathering, it comes across that you really do not like yourself very much. What is that about for you?”

Explore general impact of narcissistic disruptions.

“How has this affected you, to have your wife say she wants a divorce after all these years?”
“It never occurred to you that they might fire you. What was this done to you?”

Explore affects related to narcissistic disruptions.

Self-focused narcissistic disruption: *“When you are criticizing yourself in that way, how does that affect your mood?”*
Other-focused narcissistic disruption: *“When she starts criticizing you like that, what does that do to you emotionally?”*

Invite reflection on the possible connection between narcissistic disruptions and functional challenges.

“It sounds like it was quite destabilizing to have to change jobs. While you feel extremely confident in your work, you are not used to people monitoring you and questioning you. Do you think this played a role in you getting so depressed?”
“You’ve said that you were ‘humiliated and decimated’ when everyone found out about the affair. Looking back on it, where does the suicide attempt come into all this?”

Giving the diagnosis of pathological narcissism

Once we have explored all of the above topic areas, we are usually in a position to begin to explicitly discuss the narcissism diagnosis. No rules can be laid down about the best way to proceed here. We encourage clinicians to try out different approaches to such discussions, to work toward a stance that feels authentic to them, and personally relevant for the specific patient with whom they are working. See Box 3.7 for a broad method that we have found helpful in working with patients, which synthesizes and contextualizes the information garnered thus far in the discussion.

Box 3.7 Steps in giving the diagnosis of pathological narcissism

Offer introductory comments, obtaining consent to discuss diagnosis.
Contextualize pathological narcissism as an excessive reliance on self-enhancement processes to maintain a sense of self-esteem, which can lead to negative consequences in people's lives.
Review narcissistic expectations.
Discuss self-enhancement processes, as well as the function they serve in maintaining self-esteem and emotional stability.
Synthesize information gathered about functional challenges: [relational trigger] → [narcissistic disruption] → [personally meaningful functional challenge]
Explore patients' emotions and reactions to the diagnosis, inviting reflection on its relevance to their lives.

To transition from the "information gathering" stage to the "diagnosis-giving" stage, we say something like the following.

> "Well, I just want to thank you for sharing so much about yourself today. You have clearly been through a lot, and I appreciate how open you have been in talking about your challenges. In light of everything you have said, I do have some thoughts about a diagnosis that might be relevant for you. Is this something you would be interested in talking about further?"

By approaching the discussion in this way, we are clearly communicating our intention to "shift gears" from focusing primarily on the patient's mind, to sharing about *our* mind—that is, our ideas about the patient's difficulties.

Depending on the specific patient, this will likely heighten the person's feelings of anxiety in the meeting. While of course this discussion has occurred in a professional context, most patients with PN will have some level of concern about what we think of them, along with a wish that we will see them positively, and feel positively about them. By starting the dialogue with positive validation (*"I appreciate how open you have been"*), we begin to alleviate patients' attachment anxieties—an important condition for stimulating mentalizing about their emotionally charged patterns in relationships. Similarly, by securing patients' consent to discuss the diagnosis (*"Is this something you would be interested in talking about further?"*), we affirm their sense of agency in the process, which further regulates patients' attachment system, while also reinforcing their own internal motivation to participate in the discussion.

If patients express an interest in hearing more, we provide a general description of narcissistic challenges, without yet invoking the term "narcissism."

> "Given everything we have been discussing, I do think that many of your challenges could be related to a disorder that we have some experience treating, something I'm not sure has been discussed with you before. This disorder involves challenges in the person's sense of self-esteem. Essentially, the person has extremely strict, often rigid standards for themselves, and usually for other people as well. The person works tirelessly to maintain those standards—in order to feel good about themselves, and also to stay away from those things that might make them feel bad about themselves. But the difficulty is that those standards are so specific, and so narrow, that it becomes nearly impossible for them to maintain, especially in their relationships with other people. And then when they are unable to meet those conditions, they start to experience many of the challenges that lead people into treatment—depression, anxiety, anger, even shame and self-loathing."

As noted in Chapter 2 , pathological narcissism involves a range of different symptoms, some of which are highly consistent with how patients see themselves (e.g., desires for power and recognition, avoidance of vulnerability, anger when others violate expectations), and others that are quite discrepant with patients' self-concepts (e.g., entitlement, exploitation of others, empathic deficits). In MBT-N, we always start by elaborating patients' current experiences of themselves, under the assumption that patients must first feel understood by us in order to meaningfully reflect on themselves and others. The above conception thus emphasizes those more "contingent" facets of PN (e.g., strict expectations for Self and Other, tireless efforts at self-enhancement, dysregulation in response to narcissistic

disruptions), in the hopes that patients will begin to "see" themselves in the formulation and experience a personal investment in the diagnosis and treatment. Accordingly, at this stage of the conversation, we invite patients to share about aspects of this description that resonate with them, discussing any additional examples that illustrate these ideas.

Since the term "narcissism" can feel more aversive and threatening to many patients, we postpone introducing it until patients have had the opportunity to consider, and hopefully identify with, the above description.

> "I should tell you in advance that this diagnosis does have some negative connotations nowadays. This is not how *I* am using the term, but unfortunately it can get a lot of bad press in popular culture. Have you heard the term 'narcissism,' or narcissistic personality disorder?"

Here we give patients the chance to share their feelings and responses to the term, making sure to explore and validate any aversive emotions they might have about being described in this way. "This is very helpful to hear—'narcissism' feels like it is the exact OPPOSITE of who you are as a person. Your problem is that you care too much about other people, usually sacrificing yourself in the process." Or: "So it brings up a lot of shame to be associated with this label. You feel like people would really look down on you if they knew this about you."

Once we have given patients plenty of space to share their reactions, we again elicit permission to proceed with the discussion: "Are you interested in hearing more about your symptoms that might be relevant to this diagnosis?" If patients express a willingness to continue, we proceed to "tell a story" of their difficulties, employing the various elements covered thus far in the interview: narcissistic expectations, self-enhancement, and narcissistic disruptions. The content of this part of the discussion will vary considerably across patients, since our comments will reflect each person's unique history and experiences. For the purposes of illustration, we review part of our conversation with George, a 32-year-old computer programmer who was presenting to treatment to address issues of depression and suicidality, in the context of difficulties in the workplace.

THERAPIST: Based on everything you have said, it seems to me like you have extremely strict—one might even say harsh—standards for yourself. You really value hard work and efficiency, and you expect yourself to perform at an extremely high level. In

particular, work, intelligence, and success seem to serve as the core of your identity. You want to achieve, you want to make a lot of money, and you want others to *see* your talents, and how much you have to offer. *[summary of narcissistic expectations]*

PATIENT: Yeah, that is definitely right. When you say it like that, it makes it sound a little imbalanced. But I've got to admit, that is how I feel.

THERAPIST: Well, from what I can tell, you have worked extremely hard to achieve all of these things. You've worked 80-hour work weeks, sacrificed having a romantic relationship, and volunteered for projects you really did not want to do. And it sounds like there was a time where everything seemed to click. You excelled in your studies; you got this amazing job right out of college; you felt like your boss was appreciating you; and you felt really confident about your skills and efficiency when it came to coding. *[articulation of self-enhancement processes and their impact on affect/self-esteem]*

PATIENT: Exactly, that was the best time of my life, about three years after I got this job. I was 100% on my game, and no one could touch me. I have been trying to get back to that, but I've just been too depressed. I feel like my confidence is too shot, and I'm worried that I will never be able to perform at that level again.

THERAPIST: Along those lines, it seems like it really impacted you to get that new boss. *[starting to identify relational trigger for the narcissistic disruption]*

PATIENT: Yeah, I feel like that was the beginning of the end for me. I was doing so well when Mark was in charge, and Emma is just so incompetent. I hate to say it, but I feel like the only reason why she has that job is because they wanted to hire a woman.

THERAPIST: That's one of the things that really stood out to me when you spoke about Emma. You really don't trust her, and over time you even stopped respecting her. It seems like the tipping point was when she gave you that negative performance

review, which felt inaccurate and unfair *[identifying relational trigger]* . You stopped trying as hard at work; you started missing days; and then it sounds like you started getting really defensive and argumentative with Emma, which is something that would never would have happened with Mark *[describing functional challenges]* .

PATIENT: It never *had* to happen, since he knew what he was doing.

THERAPIST: Right, but what I think came across to me is what a devastating impact this all had on you. *[hinting at personally meaningful functional challenge]*

PATIENT: It did. It destroyed me.

THERAPIST: It sounds like it. You started getting more depressed; you felt anxious whenever you received a new assignment; you began drinking more. And perhaps most importantly, you started feeling extremely bad about yourself—hating yourself for being (in your words) "such a failure," and even considering suicide as a way to end it all. *[further description of personally meaningful functional challenges]*

PATIENT: You're saying exactly what happened. I just can't believe that I ended up here.

THERAPIST: Well, this is what I was talking about with the idea of narcissism. On this view, the problem might not be that you are such a failure, or that you are so insecure that you will never be able to do coding again. The issue could be this pattern you have of basing your sense of self-esteem on these very specific conditions—achievement, intelligence, money, and how other people see you. When you aren't able to attain these things, you end up feeling horrible about yourself, and you need to do whatever you can to get away from these feelings: avoiding work, drinking, and the ultimate escape, even wanting to kill yourself. So thinking about these things in terms of narcissism, that would be the target of treatment—working on your sense of self-esteem, and how you manage that in your relationships.

PATIENT: That's definitely a different way to think about it. A little less harsh, I guess. But I don't even know how I would do this

> any differently. This is how I've been for as long as I can remember . …

If patients would likely identify with the symptoms listed in any of the categorical or dimensional models of pathological narcissism (e.g., the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* [DSM-5-TR] standard diagnosis, the alternative model of narcissism in the DSM-5-TR, the Pathological Narcissism Inventory), we can also review these criteria explicitly with them, inviting them to share examples from their experience that exemplify these criteria. One especially useful approach is to ask patients to complete the 52-item Pathological Narcissism Inventory (PNI), a valid and reliable self-report instrument that measures seven different characteristics of narcissism (e.g., contingent self-esteem, exploitativeness, self-sacrificing self-enhancement, hiding the self, grandiose fantasy, devaluing, and entitlement rage), while also helpfully distinguishing between grandiose versus vulnerable subtypes of PN. Clinicians can easily score the PNI on their own, reviewing and providing written descriptions of the traits that patients endorse to an elevated degree (Pincus, 2013).

For example, after delivering the diagnosis as reviewed above, the therapist might say:

> "This diagnosis of narcissism appears to be supported by this questionnaire you completed. This report suggests that you have some characteristics of what we call vulnerable narcissism, where the person experiences significant emotional instability when their expectations of themselves and others are not met. Please take a look at this sheet, which reviews the four traits that you seem to possess to a greater degree. The first of these is 'hiding the self'—'dependency feels weak and shameful. Conceals needs and concerns from others. Disclosure of imperfections evokes anxiety and is avoided.' Does that resonate with you at all?"

In cases where patients are able to "see themselves" in these more formal criteria, this can confer a degree of legitimacy to the diagnosis, helping patients to understand and internalize the diagnosis in a way that they find personally meaningful and even validating. However, if these presentations are too incongruent with patients' experiences of themselves at the time, it is better to forego this less personal approach and stick to the more individualized presentation of narcissism outlined previously.

Consistent with the standard of care for treating borderline personality disorder (Zanarini & Frankenburg, 2008 ; Zanarini et al., 2018), Hersh and

colleagues (2019) have discussed the potential value of reviewing the epidemiological information about PN upon disclosure of the diagnosis. While such information is currently quite limited, existing data suggest that the prevalence of narcissistic personality disorder (NPD) is 6.2% in the general population, with rates greater for men than for women (7.7% versus 4.8%; Stinson et al., 2008). Among psychiatric outpatients, prevalence rates of NPD range from 1.3% to 17% (Ronningstam, 2009). NPD is highly heritable, with some twin-studies indicating heritability of 71% (Torgersen et al., 2012), or even as high as 79% (Torgersen et al., 2000). Emerging research also suggests that there are neurobiological differences in people with narcissistic traits, including gray matter abnormalities (Nenadic et al., 2015 ; Schulze et al., 2013), as well as neurological correlates to alexithymia and impaired empathy in PN (Fan et al., 2011). In general, PN has been shown to have moderate stability across time (Ronningstam et al., 1995 ; Vater et al., 2014), although some research in a non-clinical sample indicates that traits of PN improve with age (Pulay et al., 2011).

When patients seem interested, we can include this more "objective" information about PN while giving the diagnosis, along with any relevant information on common symptomatology and comorbidity reviewed in the first two chapters of this book. Once we have discussed our own understanding of narcissism and its possible relevance to patients' challenges, we explore patients' emotions and reactions to the diagnosis, inviting them to reflect on its relevance to their experience. As long as patients identify with the traits under discussion, we provide some basic psychoeducation about the treatment of PN.

> "Well, I am glad to hear that you feel like parts of the diagnosis fit for you. When it comes to treatment, unfortunately at this time, there is no specific form of treatment that has been shown to be effective at treating narcissism. To be honest, very little empirical research has even been done on using psychotherapy to help people with narcissism specifically. The good news is that we have several different evidence-based treatments that have been developed for treating borderline personality disorder, which can be seen as a 'close cousin' of narcissism. So within the world of psychotherapy, the approach that has been taken is trying to *adapt* these evidence-based treatments to help people with these challenges in their sense of self.
> One of these approaches is mentalization-based treatment, or 'MBT.' MBT is one of the leading evidence-based therapies for borderline personality disorder, and there is some research showing that it is an effective treatment for helping people who have *both* borderline and narcissistic personality disorders. Are you interested in learning more about this: how we understand narcissism in MBT, and how we go about helping people with these sorts of challenges?"

If patients express an interest in learning more about MBT-N, we proceed to orient them to the broad treatment approach, as outlined in the next chapter.

4

Structure and Aims of MBT for Narcissism

In this chapter, we consider the earliest stage of mentalization-based treatment for narcissism (MBT-N): how to implement the initial sessions, and how to plan a treatment that addresses patients' central challenges through a focus on mentalizing. As discussed in Chapter 1 , our recommendations are based on a specific understanding of mentalization that distinguishes between three distinct but related "domains" of mentalizing: content, context, and process. In our experience, this conception can be especially helpful in organizing our thinking about the complex and often overwhelming challenges patients with pathological narcissism (PN) face. Accordingly, there is value in starting our discussion by exploring this view in some detail.

Domain-based conception of mentalization: Content, context, and process

We define mentalization as the capacity to "read," access, and reflect on mental states in ourselves and other people. As Bateman and Fonagy (2016) explain in *Mentalization-based Treatment for Personality Disorders: A Practical Guide* , mentalization is a dynamic, multidimensional, and neurologically grounded imaginative capacity that serves as the foundation for everyday human experience:

> Mentalizing … is the spine of our sense of self and identity. Seeing oneself and others as agentive and intentional beings driven by mental states that are meaningful and understandable creates the psychological coherence about self and others that is essential for navigating a complex social world. (p. 5)

Rather than recapitulate Bateman and Fonagy's (2016) comprehensive formulation of mentalizing (see Chapter 2 of that volume), we will offer a

streamlined overview of the concept, which we have found useful in assessing mentalizing processes of patients with PN.

Construed most broadly, mentalization can be oriented toward ourselves and toward other people. Within that dimension, mentalizing tends to focus on three basic areas: the *content* of mental states, the *context* of mental states, and the *process* of how we relate to those states. This leads to the six core "domains" of mentalizing, which are outlined in Table 4.1 .

Table 4.1 Domains of mentalizing

	Self	**Other**
"What": The content of mentalizing	Observing and identifying specific mental states (e.g., thoughts, beliefs, emotions, needs, desires, self-states, and attitudes) in ourselves	"Reading" and recognizing specific mental states (e.g., thoughts, beliefs, emotions, needs, desires, self-states, and attitudes) in other people
"Why": The context of mentalizing	Reflecting on the reciprocal relationship between our own mental states and other factors: our history; current situation and context; other psychological processes inside of us; our specific behaviors and broader interpersonal patterns	Reflecting on the reciprocal relationship between other people's mental states and other factors: their history; current situation and context; other psychological processes inside of them; their specific behaviors and broader interpersonal patterns; *our impact* on others' mental states and behaviors
"How": The process of mentalizing	• Flexible and tentative reflection about ourselves vs. rigid and certain convictions about ourselves • Internal, psychologically elaborated experiences of ourselves vs. external, "visible" experiences of ourselves • Curious, engaged experience of our own mental states vs. disinterested, dissociated relationship to our mental states	• Flexible and curious perceptions of others vs. rigid and certain convictions about others • Internal, psychologically elaborated experiences of others vs. external, "visible" experiences of others • Attentive, empathic experience of others' mental states vs. disconnected, uncaring relationship to others' mental states

When we are mentalizing about content, we are interested in the "what" of the mind: the specific thoughts, beliefs, emotions, needs, desires, feelings, attitudes, self-concepts, values, and personality traits that are continuously unfolding inside of ourselves and other people. Within ourselves, this involves what is often called "introspection" or self-reflection. "*What am I feeling or wanting right now?*" "*I think that I felt a*

bit high-strung and irritable in my interaction with that person." "What are my assumptions about this situation?" We can also approach content at a higher level of abstraction, for example when we consider: "*How do I see myself as a person?" "What personality traits am I bringing into my relationships?" "I tend to base a lot of my self-esteem on my professional life—on how successful and productive I am feeling at my job."*

When mentalizing content in other people, we are engaged in "reading," perceiving, and understanding the experiences of others. "*What is she feeling right now?" "I think that he was wanting to spend time with me, and perhaps feeling hurt that I was too busy to see him." "What is my boss expecting of me in this project?"* And then more abstractly: "*What really drives her as a person? What makes her tick?" "He acts like he is so confident and self-possessed, but he seems quite insecure to me."*

Content-mentalizing is perhaps the most foundational form of mentalizing, which is especially central to issues of *identity.* It allows us to feel connected to "who we are" as human beings—what we are feeling, and what matters to us. Similarly, it enables us to see and recognize other people —who *they* are as people, what drives them, and what is important to them. Content-mentalizing can thus be seen as the basis for human connectedness, a capacity that helps us "hold onto" a core sense of ourselves as unique individuals engaged with other unique individuals, all experiencing a wide range of emotions and desires in relation to each other.

When mentalizing about context, we move beyond considering "what" people are feeling to reflecting on the *relationship* between those mental states and other facets of experience. Within ourselves, context-mentalizing can involve reflecting on the relationship between our mental states and our history ("*I might be a bit self-conscious about my appearance* [content] *because I was bullied so much when I was younger* [historical context]*"*); on the connection between our mental states and situational factors ("*Why did I get so sad* [content] *when my wife started being so kind to me* [situational context]*?"*); on the link between some mental state in us and some other mental state ("*I think that it is much more comfortable for me to feel angry with him* [content] *than it is for me to feel hurt and rejected by him* [emotional context]*"*); and on the association between mental states and behaviors ("*I get worried that I am not skilled or intelligent enough for this job* [content], *so I end up procrastinating in my work* [behavioral context]*"*).

We also reflect on the relationship between *other people's* mental states and a broader context, for example considering the relationship between their mental states and their history (*"I suspect that his history of trauma* [historical context] *probably played a role in how angry he is now* [content]*"*); between their mental states and their current situation (*"She has been in a much better mood* [content] *ever since she got that promotion* [situational context]*"*); between their mental states and their other mental states (*"You seem to be really getting really impatient with me lately* [content] … *Are you upset with me about anything* [emotional context]*?"*); between their mental states and their behaviors (*"She has been working 16 hours a day for the past two weeks* [behavioral context]. *That has to be taking a toll on her …* [content]*"*); and between *our* behavior and other people's mental states (*"I've been a lot more 'needy' lately* [our behavior], *and I wonder if they are getting a bit fed up with that* [content]*"*).

Context-mentalizing might be seen as a more "advanced" form of mentalizing, centering largely on issues of *agency.* This type of mentalizing gives rise to an experience of ourselves as intentional, meaning-driven agents—enjoying a sense of continuity across time, influencing and influenced by our environments, and engaging in actions and life pursuits that are expressive of "who we are" as people. We also are able to experience other people as understandable and meaningful, living lives that make sense in light of their history and idiosyncratic personalities. When mentalizing in these ways, we are capable of a sense of mutual responsibility and accountability in our relationships with others, assuming responsibility for ourselves while also experiencing other people as an independent agents in their own lives.

Thus far we have considered what might be seen as the "focus" of mentalizing—the content of mental states in ourselves and others, and the broader context of those states. But mentalizing can also be approached from the perspective of *process* , that is, *how* the person relates to those different areas of mind: flexibly versus rigidly, psychologically versus concretely, and authentically versus disconnectedly (Bateman & Fonagy, 2016 , Chapter 4). Given the importance of process-related considerations in pathological narcissism, it is worth considering these categories in some detail.

"Good mentalizing" is usually associated with openness and flexibility. This attitude stems from what MBT refers to the *opacity* of mental states.

Since we lack any direct access to mental states in ourselves or others, we have no basis for confidence or certainty about "what" people are feeling (content), or "why" they are feeling that way (context). We thus remain in what MBT calls a "not-knowing stance" toward mental states, which involves a perpetual spirit of humility and tentativeness (see Chapters 1 & 5). With ourselves, we recognize that there are psychological processes unfolding within us of which we are unaware, and that all of our "perspectives" are irreducibly shaped and influenced by our own psychologies. With other people, we maintain a sense of cautiousness about what we "know" about other people's thoughts and feelings, along with an openness to being corrected in our viewpoints.

By definition, good mentalizing is also associated with attentiveness to internal, psychologically elaborated processes in ourselves and others, rather than strictly on the external and "visible" aspects of experience. These visible states include actions, physical appearance, facial expressions, life situation, financial status, physical objects, and social or vocational roles, among other things. When mentalizing effectively, we are always *considering* such factors (e.g., when we try to imagine why another person took a certain action), but we are perhaps most interested in the *invisible* dimensions of experience that we are here calling mental content. Within ourselves, we are not simply focusing on our actions, status, or appearance; we are looking inward and considering our own thoughts, emotions, and desires. Similarly, with others, we are not only thinking about *their* appearance, behavior, or life situation; we are trying to see the world from their perspective—attending to what they might be feeling, what they might be wanting, and what this could be "about" for them.

Finally, good mentalizing involves authentic connectedness with mental states in ourselves and others. In all of the above domains, we can "think about" psychological processes without fully engaging with them in an affectively grounded, embodied way. In contrast, mentalizing involves feeling genuinely curious about our own subjective worlds, while also *accessing and inhabiting* our emotions and desires in the present moment. With other people, we are actually *interested* in their internal states, and we are able to empathize with (and genuinely care about) what they are thinking, feeling, and wanting.

These process-related considerations are central to issues of closeness and intimacy. When we are more flexible and "not-knowing" in our

thinking, we can maintain a reflective distance from our own initial perceptions. This opens up the imaginative space for us to think about ourselves in new ways, and to be changed and influenced by the experiences of others. When we are focused on the psychological dimensions of experience, the world expands into a complex, multifaceted terrain. We become psychological beings engaged with other psychological beings, which allows us to relate to others in deeper and more meaningful ways. And when we are actually *accessing* emotions and desires, we can finally feel our feelings, share feelings with others (Stern, 2004), and genuinely care about people and what they are going through. This all has a dramatic impact on our capacity to connect with others. When other people feel like we understand them, that we are interested in them, and that we genuinely care about them, they are much more likely to want to be close to us, and to engage with us with authenticity and emotional depth. On this view, effective mentalizing serves as the foundation for closeness, intimacy, and mutuality in our relationships.

Aims of MBT for narcissism: "Reflect rather than reflex"

As in any form of MBT, MBT-N works to strengthen patients' capacity to mentalize—that is, to flexibly, adaptively, and authentically reflect on mental states in Self and Other (Box 4.1). Put simply, we are trying to help patients "reflect rather than reflex"—a promising candidate for the motto of MBT for narcissism. While MBT for borderline personality disorder tends to focus on circumstances under which patients' mentalizing is likely to be disrupted (e.g., functional impairment that occurs in the context of emotional or interpersonal instability), given the prevalence of more "static" mentalizing deficits in PN (e.g., longstanding rigid beliefs about Self, pervasive pretend mode processes, global challenges with empathy and dismissiveness), MBT-N tends to focus *both* on context-dependent and more stable impairments in mentalizing. By targeting these processes in patients' mentalizing of themselves and others (see "Domains of Mentalizing" in Table 4.1), MBT-N works to address patients' challenges in their sense of Self, while also ameliorating their difficulties in interpersonal relationships.

Box 4.1 Aims of MBT for narcissism

The aim of MBT for narcissism is to help patients "reflect rather than reflex"—
to flexibly, adaptively, and authentically reflect on mental states in Self and Other.
Focuses on both context-dependent and more global impairments in mentalizing
In orienting patients to the aims of MBT-N, therapists

Introduce patients to the construct of mentalizing and its relevance to personality disorders
Discuss the relevance of mentalizing to narcissism in particular, especially in the areas of self-esteem, and standards/expectations of Self and Other
Provide psychoeducation on how MBT-N addresses patients' unique challenges elicited in the assessment and diagnosis phase
Collaboratively explore, elaborate, and address patients' reactions and concerns about the topics under discussion

Along these lines, if patients are expressing an interest in learning more about MBT-N, we usually start by introducing patients to the construct of mentalizing and its relevance to personality disorders:

> "As a treatment, MBT centers on the idea of mentalizing. Mentalizing is our ability to 'read,' access, and reflect on mental states in ourselves as well as other people. Mental states are essentially all of the invisible stuff that goes on inside of us all of the time: our thoughts, emotions, desires, and attitudes. When we are mentalizing other people, we try to understand what they are feeling, to consider why they are feeling that way, and also to really *care about* (and empathize with) what they are experiencing. We are also able to do that same thing with ourselves—to look inward and be curious about what we are feeling, to consider what that is about for us, and to *access and experience* our emotions and desires in a real and authentic way.
>
> MBT proposes that people with personality disorders are able to mentalize, and often to mentalize quite well. The issue is that, in certain areas and at certain times, this ability can get disrupted. When people with personality disorders experience strong emotions, or when things get more intense or complicated in their relationships with other people, they can struggle to adaptively reflect on their own thoughts and feelings, and the thoughts and feelings of others. This 'difficulty reflecting' can cause trouble in how they feel about themselves, and in their ability to have close, stable relationships with others."

Once these broad conceptions have been explained, we usually review the relevance of mentalizing to pathological narcissism, tailoring our comments to the patient's unique challenges already considered in the assessment and diagnosis phase. For example, in the case of the patient George discussed in Chapter 3 , the therapist might say:

> "So with narcissism in particular, the person can struggle with mentalizing specifically in the areas of their *standards and expectations* , which as we discussed, can often be quite strict and even harsh. This comes up especially in the area of self-esteem—in what conditions have to be met for the person to feel good about themselves. They can often have very strong opinions about how *other people* should be, which can lead to trouble in their relationships.
> In your case, George, we have seen how you have extremely specific standards for yourself: you need to be productive, you need to be exceptionally intelligent, you need to make a lot of money, you need to have a high-status job, you need *other people* to see you in a positive light. As we have discussed together, you base a lot of your self-esteem on those standards. If you can meet them, then you feel good about yourself. But if you *fail* to meet them, then you hate yourself, and you feel ashamed.
> In MBT, we would focus much of the treatment on these standards and judgments of yourself, trying to help you become more reflective about them. So rather than just automatically assume that you need to meet all of these conditions in order to be valuable, we would want to strengthen your ability to reflect on these processes: how you get there, how it impacts you, other potential ways to experience yourself, and all of the other emotions and desires that might be unfolding inside of you that you might be missing. We find that, as people develop the ability to reflect in these ways, they tend to feel more stable and connected to themselves, and ultimately to develop a stronger sense of self-esteem.
> You've also shared about some other ways that you can get pretty stuck. You've struggled a lot with avoidance; drinking alcohol to try to manage your feelings; considering suicide; and getting defensive and argumentative, especially when you feel like people are unfairly criticizing you. We would want to direct attention to these processes in MBT, helping you to 'hold onto' your mind in these moments—to access a wider range of your emotions; to identify and question your beliefs and impressions about things; and to consider *other people's* thoughts and feelings, which sometimes can get lost in the shuffle in the midst of these interpersonal conflicts. As you are able to reflect in these ways, you will start to experience a greater sense of agency, and this leads to increased stability in your behaviors and relationships."

Having outlined our own understanding of the aims of MBT-N, we invite patients to share their reactions to what we are proposing (*"How does this all sound to you?"* ; *"Do you have any questions about what I've said so far?"* ; *"What comes up for you as I describe the treatment?"* ; *"Does any of this feel at all relevant to you?"*), helping them to explore and elaborate these feelings and addressing any concerns that might arise. We also answer any questions about MBT in particular at this point: the theory, the evidence base, and its potential applicability to the patient's unique challenges. In contexts where additional treatments are being provided in addition to

individual therapy (e.g., psychopharmacology, group therapy), we discuss the aims and focus of these protocols, and how they support the primary aim of strengthening patients' mentalization. If patients express an interest in trying MBT-N, then we proceed into the initial phase of the treatment.

Early stages of treatment

The preliminary stage of MBT-N follows the broad steps outlined in the original MBT treatment manual: developing a safety plan, collaboration with other treaters, and providing more intensive psychoeducation about MBT in either a group or individual format (Bateman & Fonagy, 2016 , pp. 147–170). Here we focus on three components that have special importance in MBT-N: establishing treatment priorities; assessment and formulation of mentalizing; and orienting patients to the structure and focus of sessions.

Establishing shared treatment priorities

The first step in MBT-N involves collaborating with patients to explicitly identify the shared priorities for the treatment itself (Box 4.2). While treatment priorities might seem like a tedious and mundane component of psychotherapy, they play a crucial role in the effective treatment of narcissism. As discussed in Chapter 2 , patients with PN are especially prone to pretend-mode functioning. They can talk extensively about their insights and ideas, while remaining subtly disconnected from their own emotions and desires, and also from important aspects of external reality, including the needs and experiences of others (see Chapter 8). Psychotherapy with these patients can proceed endlessly, with patients saying similar things in slightly different ways over an extended period of time, all without enacting real changes in their lives. Treatment priorities serve as an essential anchor in MBT-N, the place to which we can always return in order to reorient the treatment toward meaningful dialogue.

Box 4.2 Establishing shared treatment priorities in MBT for narcissism

Treatment priorities must be fundamentally collaborative, reflecting patients' own goals for therapy as well as therapists' perspective on important areas of clinical focus.
Can involve four different spheres: emotions, identity, interpersonal relationships, or functionality
Useful questions include

"What are the most important difficulties you would like to address in treatment?"
"What would you like to prioritize in our work together?"
"What are your goals for therapy?"

When patients and therapists encounter discrepancies in their treatment priorities, therapists attempt to stimulate a mentalizing process around these matters, where both parties seek to understand the mental states of Self and Other in a flexible, thoughtful, and emotionally engaged way.

Consistent with MBT's emphasis on "two minds in the room," treatment priorities must reflect (a) patients' own goals for therapy, along with (b) our perspective on important areas of clinical focus. In establishing the narcissism diagnosis, we have already gained some sense of patients' understanding of their presenting problems. Such problems usually fall into four broad psychosocial spheres: emotions, identity, interpersonal relationships, or functionality. *Emotional* challenges are mood or feeling states that cause difficulty for patients, such as depression, anxiety, or anger issues. *Identity-related* challenges are impairments in patients' sense of self-esteem, such as grandiosity, self-hatred, or contingent self-esteem—that is, the tendency to base one's self-worth on external factors (e.g., vocational success, intelligence, attractiveness, other people's admiration). *Interpersonal* challenges could involve difficulties in specific relationships (e.g., with romantic partners, work colleagues, children, parents), or broader interpersonal tendencies (e.g., argumentativeness, withdrawal and avoidance, dishonesty, empathic deficits) that cut across multiple relational contexts. Finally, *functional* challenges are miscellaneous difficulties that do not overtly concern other people and yet interfere with patients' ability to function effectively in their lives (e.g., addiction, suicidality, social isolation).

To elicit patients' personal goals for treatment, we ask open-ended questions about patients' challenges. "What are the most important difficulties you would like to address in treatment?" "What would you like to prioritize in our work together?" "What do you see as the most pressing problems in your life, that you'd like to work on here?" We can also frame our questions in more solution-focused terms, underscoring what patients want to *gain* from the treatment. "What are your goals for therapy?" "What are you hoping to achieve in our time together?" "How would you know that this treatment is successful?"

In asking these questions, we are not attempting to specify "how" patients might progress in these areas, for example by outlining concrete objectives, behavioral strategies, or skills training protocols. Rather, we are simply seeking to clarify two to three broad areas of patients' experience that they find most pressing and important, which are clear and understandable enough to serve as the focus for a structured treatment. There is a wide variety of ways that patients express such goals. Whereas some patients articulate their goals in terms of the amelioration of problems ("I want to feel less depressed"; "I need to fix my marriage, or my wife is going to leave me"), others frame goals in more "positive" and affirmative terms ("I want to get a more stable sense of self-esteem"; "I have to get my act in gear and finally finish college"; "I would like to finally start dating again"). In MBT-N, we care less about the exact format of these goals than about whether patients are identifying an area of life that feels personally meaningful and relevant to them as individuals.

As mentioned earlier, priorities for treatment should reflect patients' goals *and* our viewpoint on patients' challenges. In instances where we are in full agreement about key areas of focus, we transparently communicate that to the patient:

> "So it sounds like your primary goal is to work on your suicidal thinking, and also to improve your relationship with your wife, so that you are arguing less and communicating more effectively with her. I think that it makes a lot of sense to focus on those areas in the therapy. Your suicidality has gotten quite a bit worse lately, so it seems like a good idea to prioritize that. You have also shared about how important your marriage is to you. I understand why you want to do whatever you can to strengthen it."

When patients do not mention an area of their lives that strikes us as particularly pressing, we raise the issue in a curious but non-authoritative manner, inviting them to reflect on the importance they ascribe to the issue

in question. “You stated previously that you have been getting into arguments with your boss, whenever he gives you any constructive feedback. Is that something you would ever like to work on in therapy?” Or: “I know that you’ve become quite socially isolated since the divorce, and that you really want to improve your relationships with your friends and family. Would you want that to be incorporated into your treatment goals?” By asking such questions, we hope to stimulate a collaborative, reality-oriented inquiry into the various dimensions of patients’ experience, so that patients can consider for themselves their relative levels of motivation to address these matters in treatment.

In general, we tend to follow patients’ lead in establishing treatment priorities. By tailoring the therapy to patients’ own goals, we increase the chance that they will experience the treatment as personally and uniquely meaningful to them. The main exception to this occurs when patients are reluctant or unwilling to work on an area that we see as central to their safety, functionality, or overall well-being. For example, a patient wants to work on his relationship with his wife, but he is not willing to address his suicidal thinking and behavior: “If she leaves me, I am definitely going to kill myself, so there really is no point in talking about the suicide stuff.” Or a patient has the goal of addressing her anxiety and perfectionism at work, but she does not want to consider her amphetamine addiction.

Here we start by empathically validating patients’ position, then proceeding to share our own concerns in a “marked” manner—that is, articulating our perspective simply as *our* feeling state, without trying to argue, persuade, or change patients’ minds. So we might say:

> “I appreciate that your suicidal thinking is not a priority for you right now. Your main focus is your marriage, and you want to keep suicide as a back-up plan in case things don’t work out with your wife. *[empathic validation of the patient’s perspective]*
> Personally, I feel more concerned about the suicide, especially since recently you have gone quite far down that road, such as stockpiling your medications. This worries me, and I don’t think I would feel OK providing you with a treatment just focusing on your marriage, where in the background you really are at risk of hurting yourself. *[sharing own perspective in a marked manner]*
> So for me, if we were to proceed into a treatment together, it would be important to have ‘decreasing your suicidal behavior’ somewhere in the treatment goals.”

After sharing our view, we then explore patients’ own thoughts and feelings about our communication (*“Any thoughts about this?”* ; *“What comes up for you as I share this?”*), with the aim of each person considering the

mental states of Self *and* Other in a flexible, thoughtful, and emotionally engaged way.

Patients can sometimes respond to these discussions by being more dismissive of our viewpoint, for example by reassuring us, or telling us that we *shouldn't* be concerned about the issue in question. Rather than getting into a content-based debate about the importance of the issue, we empathically validate patients' perspective, then inviting reflection about the interpersonal process unfolding around these matters:

> "You really think that I should not be concerned about your amphetamine use. Not only is it not a problem, but it helps you to focus, and to stay motivated in the areas of your life that are really important to you. *[empathic validation]*
> The challenge is that, even though you think there is no reason for me to be concerned about your use, *I* still feel that way. That creates something of a dilemma for us in the treatment: you are not worried about this issue, and I feel like I can't in good conscience ignore it. What is your sense of where that leaves us?" *[inviting reflection about the interpersonal process in the dyad]*

In most cases, patients are able to understand the rationale for prioritizing issues of safety and functionality. They often share some of their own concerns about the topic, and they are usually willing to include such challenges in the formal treatment priorities.

In those rare cases where, even after engaging in this exploratory process, patients are definitively *not* willing to work on the area in question, we are obliged to "plant our feet" and decline to proceed further in the treatment under these conditions. The reasons for this are ethical as well as therapeutic. From an ethical perspective, we have a responsibility to promote patients' safety and well-being, and we are obligated to structure a treatment consistent with that. From a clinical perspective, it is precarious to build a therapeutic relationship in which we negate or suppress our core concerns, especially when those involve patients' safety and functionality. This could create challenges later in the relationship, as instability in these areas inevitably arise, and we lack any therapeutic "buy in" from patients to address the matter. It also contributes to a relational dynamic which is especially unhelpful in the treatment of PN, where patients' perspective occupies inordinate space in the therapeutic relationship, and the needs and concerns of other people are ignored or dismissed. In contrast, by ensuring that treatment priorities reflect *both* parties' viewpoints, we work toward building a therapeutic relationship based on collaboration, mutuality, and

the validity of multiple perspectives. These are the conditions we find most effective in the treatment of PN.

Assessment of mentalizing

At this point in our work with patients, having completed the assessment reviewed in Chapter 3 , we will have a great deal of information about patients' lives and experiences. The next step is to translate our understanding of patients into the explicit framework of mentalizing. In Chapter 4 of *Mentalization-based Treatment for Personality Disorders* , Bateman and Fonagy (2016) review a range of different techniques and measures that can be utilized to assess patients' mentalizing processes. By and large, these strategies center on identifying patients' capacities to flexibly consider mental states in themselves and others (i.e., the "good mentalizing"), while also recognizing the ways in which such capacities can become more limited or constrained (i.e., the "non-mentalizing"), either under specific circumstances or more globally across patients' lives.

Employing the domain-based conception of mentalizing reviewed earlier in this chapter, we consider these strengths and vulnerabilities through the lens of *content* , *content* , and *process* . We tend to avoid directly inquiring about these capacities, for example by asking the patient, "How well are you able to 'read' other people's thoughts and feelings?" Consistent with the self-enhancement processes associated with PN, patients with PN are liable to overestimate their mentalizing abilities, and it can be difficult for them to recognize how they are being non-reflective, especially when they are in the midst of the non-reflective process itself. Rather, we simply ask patients questions about their experiences in relationships (Chapter 3). As they are speaking about these experiences, we "listen" for their unique mentalizing capacities in these areas, summarized in Table 4.1 : the ways in which they recognize and identify mental states in themselves and others (the "what" of mental states); their ability to reflect on the broader context of such states (e.g., history, current situation, behaviors, other mental states; the "why" of mental states); and their ability to relate to such states with flexibility, psychological mindedness, and emotional connectedness (the "how" of mental states). Throughout these discussions, we can regularly ask questions about the areas in question (*"Do you have any sense of why he said that to you?"* ; *"What role do you think you're playing in this*

dynamic?” ; *“How confident are you that she is really trying to undermine you?”*), which enables us to further ascertain patients’ strengths and weaknesses along these lines.

In Chapter 2 , we reviewed some of the mentalizing challenges most commonly associated with pathological narcissism. In the context of a treatment relationship, we are called upon to examine each patient’s unique difficulties with mentalizing, which again can be seen through the lens of content, context, and process (see Table 4.2). From the perspective of *content* , patients can struggle to identify “what” they are thinking and feeling, either in general or when it comes to specific mental states (e.g., certain emotions, particular desires or attitudes). They become confused and “draw a blank” when asked to consider other people’s mental states, often overlooking important motives and emotions unfolding in others. Patients also draw inaccurate or incomplete conclusions about mental states in themselves and others, then proceeding to take actions based on these unhelpful assumptions.

Table 4.2 Domain-specific problems in mentalizing

	Self	Other
Content-related problems	• Confusion about specific mental states (e.g., thoughts, beliefs, emotions, needs, desires, self-states, attitudes) in ourselves • Drawing inaccurate conclusions about our own mental states • Tendency to "miss" or ignore particular mental states in ourselves • Difficulty identifying and "putting words on" certain mental states in ourselves • "Biases" toward identifying some mental states in ourselves, while neglecting others	• Difficulty "reading" or understanding mental states in others • Drawing inaccurate conclusions about others' mental states • Tendency to "miss" or ignore specific mental states in other people • Difficulty identifying and "putting words on" certain mental states in others • "Biases" toward identifying particular mental states in other people, while neglecting others
Context-related problems	• Feeling unsure about "why" we are feeling a certain way • Difficulty identifying situational/environmental factors (e.g., interactions with others, recent events) that might be influencing our mental states • Trouble recognizing other psychological factors (e.g., specific thoughts or emotions) that could be impacting our mental states • Challenges understanding the connection between our mental states and our behaviors—for example, how our feelings affect our behaviors, or how our behaviors impact our moods/emotions/desires • Tendency to focus on our discreet behaviors, and to "miss"/fail to recognize our broader patterns in relationships (the latter of which implies continuity of mind) • Problem understanding the impact of past events on our mental states—how our unique histories have led to our specific personalities, attitudes, sense of self, patterns of thought and feeling	• Difficulty identifying situational/environmental factors (e.g., interactions with others, recent events) that might be influencing others' mental states • Trouble recognizing other psychological factors (e.g., specific thoughts or emotions) that could be impacting other people's mental states • Challenges understanding the connection between others' mental states and their behaviors—for example, how their feelings affect their behaviors, or how their behaviors impact "how they feel" • Problems recognizing how **we** are often the context of other people's mental states—the effect that our feelings/behaviors/interpersonal patterns have on how other people feel, and thus how they relate to us • Difficulty understanding the impact of past events on others' mental states—how their unique histories have led to their specific personalities, attitudes, sense of self, patterns of thought and feeling

	Self	Other
Process-related problems	*Rigid and overly certain (psychic equivalence mode):* • Rigid thinking or beliefs about ourselves: positive or negative evaluations of ourselves; rigid depictions of our own characteristics, emotions, qualities, or actions; rigid standards or expectations for ourselves; predictions about our future • Powerful emotions directed toward Self: debilitating sadness about our circumstances; shame and humiliation; panic and anxiety about our future • Intense desires and urges related to ourselves, our feeling states, our circumstances • Rigidly held experiences of self or identity • Miscellaneous mind states felt to be overwhelming or "too real"—traumatic or painful memories, certain somatic or bodily experiences	*Rigid and overly certain (psychic equivalence mode):* • Rigid thinking or beliefs about others: positive or negative evaluations of others; rigid depictions other people's characteristics, emotions, qualities, or actions; rigid standards or expectations for others; predictions about other people's future experiences • Powerful emotions directed toward other people: anger and rage at others; anxiety about what other people might do, think, feel; sadness and loss about others' behavior, mind states, or circumstances • Intense desires and urges aimed at other people's mental states—need for others to think, feel, or want certain things • Tendency to base our own mental states (e.g., emotions, desires, interest, self-states) on our perceptions of others' mental states
	Concrete and external (teleological mode): • Significant focus on visible aspects of self: actions; physical appearance; financial status and possessions; tangible success; achievement in vocational, academic, or social realms • Tendency to allow these visible factors to significantly determine our mental states (e.g., emotions, self-esteem) • Propensity to base our mental states (e.g., emotions, self-esteem) on our behavioral "performance" in specific areas (e.g., work, school, family and personal relationships) • Need to engage in specific observable behaviors (e.g., avoidance, retaliation, attention-seeking, competition, dishonesty, self-harm) when emotionally or interpersonally triggered	*Concrete and external (teleological mode):* • Significant focus on visible aspects of others: actions; physical appearance; financial status and possessions; tangible success; status in vocational, academic, or social realms • Tendency to interpret others' mental states (e.g., thoughts, emotions, desires) largely utilizing these visible factors • Propensity to base our own feelings toward others (e.g., emotions, desires, interest, valuations) primarily on these concrete factors

	Self	Other
	Disconnected and dissociated (pretend mode):	*Disconnected and dissociated (pretend mode):*
	• Lack of interest or curiosity in our own mental states (e.g., thoughts, emotions, desires) • Apparent detachment from our own mental states • Overreliance on cognition, abstractions, intellectualization, jargon, rationalization about ourselves • Disconnection from/ minimization of certain objective facts about our lives: our actual behaviors, presentation, circumstances • Difficulties elaborating on the intended meaning of our own language	• Lack of interest or curiosity in other people's mental states (e.g., thoughts, emotions, desires) • Empathic deficits: difficulties resonating with, caring about, and being motivated by other people's mental states • Overreliance on cognition, abstractions, intellectualization, jargon, rationalization about other people • Detached communications: monologues, self-centeredness, self-focused attention • Disconnection from/ minimization of certain objective facts about other people's lives: specific behaviors, interactions, life circumstances

In the area of *context* , patients are sometimes hindered in their ability to reflect on the *relationship* between their mental states and other factors. They do not readily recognize how various internal and external factors (e.g., situations, relationships, other emotions, their own behaviors) impact how they are feeling, and they can "miss" the impact of their feeling states on how they engage with their own lives. Similarly, patients can struggle to understand the impact of these contextual factors on other people's mental states, including the fact that *they* are often the context for others' feeling states. They can thus often fail to appreciate the role that they are playing in creating the relational scenarios that regularly cause them such distress.

When it comes to *process* , patients can endorse rigid and overly certain experiences of themselves and others, which MBT refers to formally as *psychic equivalence mode* (see Chapters 2 & 9). These mind states can take various shapes, including inflexible thinking or beliefs (e.g., positive or negative evaluations of oneself or others, rigid depictions of reality, standards or expectations for Self and Other, predictions about the future) about different topics (e.g., behaviors, emotions, qualities, tendencies, history, circumstances, future, value, or oneself as a person); powerful emotional states (e.g., anger or rage toward others, fear that some event might occur, shame or humiliation about "who they are" as people); intense desires (e.g., need for another person to see them in a specific way, urge for

particular qualities or desires in oneself, longing for some relationship or dynamic); rigidly held experiences of self or identity (e.g., some self-concept, self-image, or sense of self-esteem); and miscellaneous mind states that are felt to be overwhelming or "too real" (e.g., traumatic or painful memories, certain somatic or bodily experiences). In addition, patients can also extensively base their *own* mental states (e.g., self-esteem, sense of well-being, feelings of shame or humiliation) on their perceptions of others' mental states, which can result in significant challenges with emotional and interpersonal instability.

Patients can also experience their lives in overly concrete and "visible" ways, a form of non-mentalizing that MBT refers to as *teleological mode* (see Chapters 2 & 10). This includes focusing extensively on concrete aspects of Self or Other (e.g., actions, physical appearance, financial status and possessions, achievement); significantly relying on external factors in order to interpret others' mental states; basing their feelings about Self or Other (e.g., emotions, desires, self-states, interest, valuations) on these visible things; endorsing a sense of self-esteem that rests extensively on external factors (pp. 223–228); and feeling compelled to engage in specific observable behaviors (e.g., avoidance, retaliation, attention-seeking, competition, dishonesty, self-harm) when emotionally or interpersonally triggered.

Finally, patients can often take a more disconnected or dissociated stance toward mental states in themselves and others, which MBT describes as *pretend mode* (see Chapters 2 & 8). On the most basic level, this can involve a lack of interest and curiosity about mental states in themselves and others, along with a tendency to ignore and minimize aspects of reality (e.g., certain feelings, behaviors, circumstances) that are likely to disrupt their sense of self-esteem. Patients deploy lots of "language" (e.g., ideas, abstractions, jargon, intellectualizations) that initially appears insightful, but they simultaneously appear to be disconnected from their own emotions and desires. Patients often struggle to elaborate on the meaning of these articulations, and further exploration reveals that patients' communications often do not reflect important aspects of their actual life circumstances. Similar forms of emotional disconnection play out in patients' relationships with others, where patients can exhibit self-centeredness (e.g., monologues, self-focused attention) and difficulties empathizing with, caring about, and being motivated by other people's mental states.

Developing and delivering the mentalization-based formulation

Having acquired a deeper understanding of patients' strengths and challenges with mentalizing, we synthesize this information into a written assessment of patients' mentalizing capacities, which MBT refers to as a *mentalization-based formulation* (Box 4.3). As Bateman and Fonagy (2016) explain, the formulation models the mentalizing stance employed throughout the course of the treatment (pp. 157–162). While the formulation can be articulated from either the third- or second-person point of view (e.g., he/she/they vs. "you"), it tends to be written to and *for* patients, avoiding extensive jargon and using patients' own words as much as possible. Consistent with MBT's "not-knowing stance," the ideas in the formulation are framed as non-authoritative hypotheses rather than definitive proclamations. We use tentative language and offer examples from patients' experience, thus clearly marking how we are arriving at our perspectives. At the same time, the formulation is written at a somewhat higher level of abstraction than traditional therapeutic discourse, utilizing specific examples to illustrate more general patterns in patients' difficulties with mentalizing. We tend to revisit and update the formulation once every three months, to reflect patients' progress, continued challenges, and new understandings arrived at through the therapeutic work (Bateman & Fonagy, 2016 , pp. 161–162).

Box 4.3 Key points about the mentalization-based formulation in MBT for narcissism

The mentalization-based formulation is a written assessment of patients' mentalizing capacities, synthesizing therapists' impressions about patients' strengths and vulnerabilities in reflecting on mental states.
Written *to and for* patients, from either the third- or second-person point of view
Is simultaneously abstract and specific, utilizing specific examples to illustrate more general patterns in patients' difficulties with reflection
The formulation fulfills several different functions in MBT-N.

Serves as a therapeutic tool for stimulating reflection throughout treatment, especially during moments of refractory non-mentalizing
Helps to establish the therapist's mind as an important factor in the treatment, laying the groundwork for a relationship based on mutual consideration of multiple perspectives
Functions as a mentalizing treatment plan in the therapy, offering ideas about how patients can work on their challenges

The formulation fulfills several different functions in MBT-N. First, it serves as a crucial aid in stimulating reflection around patients' core areas of vulnerability. By highlighting each patient's unique challenges with reflectiveness, the formulation helps patients to anticipate and recognize those challenges as they are about to unfold in everyday life. Since these ideas are framed at a sufficient level of abstraction, patients ideally recognize the relevance of the patterns we are describing to their lives more broadly, having an experience of, "Yes, I *do* experience these sorts of things, and I can think of examples of this in my life and relationships." As the treatment unfolds, when patients invariably "get stuck" in their characteristic forms of thinking, we are able to invoke the formulation as a therapeutic tool to encourage greater reflection about the circumstance in question. For example, we might say:

> "It sounds like you are thinking about skipping the holidays with your family, since it was so unacceptable how they treated you last year. This makes me think about something that we discussed in your MBT formulation, where you can sometimes engage in avoidance and withdrawal when you feel like you have been mistreated and disrespected by others. Could this pattern ever be relevant to this recent conflict with your family?"

Secondly, the formulation establishes the therapist's mind as an important entity in the therapeutic process at the outset of the therapy. One of the most common hazards in the treatment of narcissism is an imbalanced therapeutic relationship, where patients' minds occupy "too much space" in the room, and therapists only communicate the parts of themselves that support patients' own self-concepts. This does not serve patients, since they are being deprived of the opportunity to practice mentalizing *other* minds—an area where they often struggle in their relationships outside of therapy. In contrast, the formulation offers an example of *optimally titrated otherness* . By utilizing patients' own words and experiences, it is highly contingent to their subjectivity, and so patients often feel "seen" while reading the document. And yet by offering a snapshot of the therapist's understanding of patients' personal vulnerabilities in mentalizing and personal relationships (e.g., regarding excessive certainty, concreteness, or emotional disconnection), the formulation is clearly *marked* as coming from the therapist's independent mind. In this way, the formulation lays the foundation for a therapeutic relationship oriented around mutuality, cooperation, and reciprocal consideration of multiple perspectives.

Finally, the formulation serves as something of a "treatment plan" in an MBT treatment—our effort to articulate our own ideas about how patients can work on the challenges with which they have been struggling. However, rather than outlining prescriptions at the level of content (e.g., *"Do this particular thing …"* ; *"Think in this specific way …"* ; *"Have this particular insight about yourself …"*), the "how" of MBT always involves mentalizing: remaining alert to the triggers for non-mentalizing, recognizing the shape that these forms of non-mentalizing take, and working to become more reflective about relevant mental states in those moments. In this way, the formulation shines a spotlight onto key markers in patients' mentalizing landscape, so that when they come across those markers in their lives, that will remind them to reflect rather than reflexively react. This enables patients to "hold onto their minds" in moments of unrest, which enables new forms of experience to progressively unfold for them.

Structurally, the MBT formulation synthesizes much of the information we have gathered in the evaluation and early treatment planning stages thus far: demographic information; patients' functional challenges and goals; strengths in mentalizing; triggers for emotional and interpersonal

disruptions; and difficulties with mentalizing in the areas of content, context, and process. We highlight context-dependent mentalizing difficulties (e.g., increased rigidity in response to criticism, decreased empathy specifically with authority figures), as well as more categorical or "global" deficits (e.g., consistent challenges with alexithymia, general tendencies toward psychological concreteness). See Box 4.4 for a template of important information to include in the formulation, directing the reader to areas in the present volume that discuss these areas further.

Box 4.4 Template for the mentalization-based formulation

Introductory statement summarizing

Demographic information
Patient's view of presenting problems (p. 40)
Patient's functional difficulties (pp. 41–43)
Patient's treatment goals and, if different, shared treatment priorities (pp. 61–64)

Strengths in mentalizing

Summarize the patient's strengths in mentalizing in the domains of content, context, and process (pp. 54–58)

Triggers for emotional dysregulation

Summarize the triggers or precipitants to the patient's functional difficulties (pp. 41–43)

Challenges with mentalizing

Content-related challenges

Summarize the patient's impairments reflecting on psychological content in Self and Other (pp. 65–68)

Context-related challenges

Summarize the patient's deficits reflecting on the context of mental states for Self and Other (pp. 65–68)

Process-related challenges

Rigid and overly certain

Describe the patient's problems with psychic equivalence mode (pp. 30–31, 65–68, 195–198)
Include any internally focused narcissistic expectations discussed in the evaluation phase—ways in which the patient bases their sense of self-esteem on internal facets of Self and Other (pp. 43–45)
Include all internal self-enhancement processes, discussed in the evaluation phase (pp. 45–47)
Include internal narcissistic disruptions reviewed in the evaluation phase (pp. 46–47)

Overly concrete and visible

Describe the patient's struggles with teleological mode (pp. 30–32, 65-68, 210–214, 223–228)
Include any externally focused narcissistic expectations discussed in the evaluation phase—ways in which the patient bases their sense of self-esteem on visible facets of Self and Other (pp. 43–45)
Include all behavioral, interpersonal, or visibly focused self-enhancement processes, discussed in the evaluation phase (pp. 45–47)
Include external narcissistic disruptions reviewed in the evaluation phase (pp. 46–47)

Disconnected or dissociated

Describe the patient's challenges with pretend mode (pp. 30–32, 65–69, 181–183)

Implications for the therapeutic relationship

Hypothesize about how the patient's troubles with mentalizing could manifest themselves in the therapeutic relationship, including relevant relational processes that might play out between therapist and patient
Consider how therapist and patient might respond to these issues as they arise

Summary and further recommendations

Summarize the most important non-mentalizing process reviewed in the formulation: [Trigger] → [Non-mentalizing experience] → [Behavioral challenge]
Offer two to three explicit prescriptions about mentalizing targets for the treatment—ways in which the patient could try to practice positive mentalizing around the aforementioned mentalizing difficulties

Several sections warrant further explanation. For therapists learning MBT for the first time, one common question involves the distinction between psychic equivalence and teleological modes, and how to describe each mode in the formulation. Both modes are characterized by rigid, inflexible, and emotionally intense forms of experience, so how do we distinguish them from each other? In everyday life, psychic equivalence and teleology can overlap considerably, often fueling and influencing each other in complex ways. For the purposes of the formulation, we place all rigid forms of experience involving *visible* factors under teleology ("Overly concrete and visible"), and rigid forms of experience that do *not* overtly involve visible processes under psychic equivalence ("Rigid and overly certain").

For example, utilizing information gathered during the evaluation phase, in the "Rigid and overly certain" section, we describe patients' internally triggered narcissistic disruptions (i.e., self-criticism or self-attack related to the violation of some subjective standard), as well as the ways in which the patient bases their sense of self-esteem on internal facets of Self and Other (e.g., other people's positive views of them, the presence or absence of certain emotions or desires in oneself). In the "Overly concrete and visible" section, we describe patients' externally triggered narcissistic disruptions (e.g., self-criticism relate to job loss, physical appearance, or others failing to explicitly communicate admiration or respect); overt self-enhancement processes (e.g., bragging, pursuing recognition, arguing, avoidance, misrepresenting oneself); and the ways in which the patient bases their sense of self-esteem on visible facets of Self and Other (e.g., wealth, physical attractiveness, vocational success, social status, relationships with powerful people).

In the "Implications for the therapeutic relationship" section, we consider how patients' unique challenges in mentalizing are likely to manifest

themselves in our clinical interactions with the patient. Here we make sure to cover (a) the possible shape of the non-mentalizing, (b) our own potential contributions to any such processes if relevant, and (c) recommendations about how both parties might respond to such challenges as they crop up. By explicating these possibilities in advance, we increase the chance that patients will be able to meaningfully reflect on such processes if and when they arise later in the work. As we will discuss further in Chapters 11 and 12 , this helps to establish the therapeutic relationship as an important venue for patients working on their difficulties in relationships—a "training ground" of sorts where they can practice utilizing the principles of mentalizing to open up new possibilities for mutuality and connectedness with other people.

We conclude the formulation with the "Summary and further recommendations" section. As should be clear from the above, the formulation includes a wealth of information about patients' diverse strengths and challenges with mentalizing. The final section provides something of a "bite-sized nugget" of the formulation, something accessible that patients can carry around with them as they move throughout their lives. Elsewhere in the MBT literature, Bateman and colleagues (2019) refer to such summaries as *relational passports* (pp. 105–108). Here we shine a spotlight on one non-mentalizing process that is most relevant to patients' treatment priorities and functional challenges, then offering two to three "mentalizing prescriptions" about how the patient might begin to work on the difficulties in question. In our experience, it is common for patients with PN to reflexively "lose themselves" to the non-mentalizing processes that tend to dominate their experience. By itemizing a handful of clear recommendations about alternative ways to respond in these moments, the formulation helps patients internalize a "meta-framework" for how to maintain and regain a reflective stance toward mental states in themselves and others.

There are a range of ways that therapists can deliver the formulation to patients for the initial reading, including giving it to patients the week in advance, or having patients read and discuss the formulation in the session itself. One approach we have found useful is to ask patients to arrive 30–60 minutes prior to their scheduled appointment, so that they can read the formulation immediately before the session. This enables patients to have personal space to reflect on the contents of the formulation. Patients with

PN are often extremely sensitive to other people's views of them. Even when thoughtfully and sensitively written, reading the formulation can be an acutely vulnerable experience, triggering emotions of insecurity, shame, and defensiveness. It is often too overwhelming for patients to undergo this process in front of another person, limiting their ability to "take in" and metabolize the ideas in the formulation itself. At the same time, by having an appointment soon after the reading (e.g., rather than a week or a day later), we are able to seize on any emotions generated by the formulation in real-time, and hopefully to address any misunderstandings and non-mentalized reactions before they take significant hold in patients' experience.

Prior to patients reading the formulation, we explicitly frame this process as an opportunity for joint mentalizing.

> "This formulation is my effort to synthesize all of the things you have been talking about over the past several weeks, and to think about these things through the lens of mentalizing—your strengths and challenges reflecting on mental states in yourself and other people. There is nothing definitive about what I am writing about here. It is just my best effort to say something about your mentalizing, and to offer some ideas about how we might work on these issues in the treatment.
> Your job will be to try to reflect on the things that I am saying in the formulation: what feels relevant to your experience, what confuses you, things you might disagree with, and the feelings that come up for you as you are reading it. Once you are done, we will talk about all of these reactions, and we can think together about what this all means for your treatment moving forward."

In discussing with patients afterwards, we follow Bateman and Fonagy's (2016) broad guidelines for mentalizing the formulation: exploring and empathically validating patients' reactions; considering patients' reasons for any disagreements with what we have written; and editing and revising the written document as appropriate (pp. 161–162). We are especially attentive to patients' emotional responses to the formulation, actively eliciting these and remaining ready to tentatively inquire about potential connections between patients' feelings and the broader mentalizing patterns reviewed in the formulation. See here for an example of these explorations with George, the computer programmer we have been discussing in the past two chapters.

THERAPIST: So it sounds like you felt a bit insecure when I was writing about some of your challenges with rigidity and argumentativeness. You mentioned that it made you worried that I was seeing you in sort of a negative light? *[attempting affect elaboration]*

PATIENT: Well, I know you wouldn't do that. You're much too professional for that.

THERAPIST: I appreciate that, but what were you getting at when you were expressing those concerns?

PATIENT: I mean, I know you would never let your personal opinions interfere with your professionalism. But you are still human, and I am sure you have your own judgments about me and how I was treating everybody at work. And I'm obviously aware that I was being a pretty big asshole. I'm not proud of that.

THERAPIST: I see: "not proud." Can you say more about what the feeling is there? *[continued pursuit of emotions]*

PATIENT: I mean, it's embarrassing, it's humiliating. But that's not the person that I want to be anymore. That's why I am in treatment; that's what I'm here to change.

THERAPIST: Well, I really appreciate you putting words on all of these things. It seems like reading the formulation brought up a lot of feelings for you: maybe shame and embarrassment about how you behaved at work, but also some concerns about how I might see you, that I might be judging you in some way. *[empathic summary and validation]*

PATIENT: Yeah, exactly.

THERAPIST: I see. Well, I should say that I'm not conscious of judging you significantly about your challenges at work. I think that I feel more concerned for you, and to be honest, maybe a bit worried that this could all keep happening, and it could lead you to lose your job. *[sharing own subjective experience in the therapeutic relationship]*

PATIENT: I mean, you probably should be worried about that. I'm not out of the woods yet, and I only have one strike left before they fire me.

THERAPIST: Before we shift gears, I just wanted to touch base about these concerns about me judging you negatively. That makes me think about that pattern we have been discussing, where you can become really worried about how others see you, and that can affect how you end up feeling about yourself. Do you think these concerns about me could be relevant to that pattern in any way? *[inviting reflection about the possible parallels between patient's response to the formulation and patterns identified in the formulation]*

PATIENT: Well, I wasn't really thinking about it like that, but I guess it is sort of the same thing. It's like, when other people are telling me that I am on my game, I feel really good. But as soon as they start to doubt me or question me, I get really insecure, and then ultimately I start to get pissed off at them. I mean, I wasn't really feeling pissed off here, but the insecurity is the way that this usually starts out.

Here, the therapist has helped the patient to elaborate his emotional response to reading the formulation, which lays the groundwork for the patient reflecting in real-time on a broader challenge in mentalizing that is directly relevant to his treatment goals.

See below for a sample MBT formulation from George's treatment. For the purpose of illustration, this exemplifies a more comprehensive formulation. As Bateman and Fonagy (2016) explain, clinicians should feel free to tailor the level of detail in the formulation to the needs and cognitive style of the particular patient, providing distilled and summarized versions when necessary (p. 161).

Mentalization-based Formulation for George

George is a 32-year-old man presenting to treatment to address his challenges with depression, suicidal thinking, and interpersonal conflicts at work. George sees his difficulties as stemming from his conflictual relationship with his current supervisor, which led him to engage in a range of avoidance strategies, such as procrastinating on his assignments, missing work, and drinking alcohol in order to manage his feelings of depression and anxiety. His goals for therapy are to feel less depressed and suicidal, to improve his performance at work, and to decrease his arguments with his supervisor.

Strengths in Mentalizing

When he is not emotionally activated, George can be curious about his own emotional states, and also attentive to the nuances of other people's experiences. He is especially able to access feelings of anger and irritation, and to reflect on the broader context of relational/environmental processes that are contributing to these feelings in him. He is also attuned to emotions of anger, annoyance, and stress in other people. In the context of close relationships (e.g., with his mother and sister, with his best friend Peter), he is often able to genuinely empathize with the other person—to care about and be motivated by others' needs and feelings.

Triggers for Emotional Dysregulation

George has several different "triggers" for his emotional activation, including

Receiving negative or constructive feedback about his coding work (e.g., from supervisors, from colleagues)
Receiving more "neutral" or apathetic responses to his work (e.g., not hearing back from his boss after he submits a project)
Feeling confused about how to proceed in a work project, or believing that he has "done a bad job" at some assignment
In his personal relationships (e.g., with his mother, sister, or past girlfriends), feeling like the other person is ignoring him or disregarding his preferences

Challenges with Mentalizing

Content-related difficulties:
George often struggles with identifying his own emotions and desires, finding it quite confusing to articulate those things. Especially when he is angry with another person, it is challenging for George to recognize some of the more vulnerable feelings in himself, such as insecurity, shame, and desires for attention. He is also likely to "miss" such emotions in other people when he is angry with them, instead interpreting their actions largely in terms of "anger"-related motives (e.g., frustration, impatience, desires to control). In his relationships with others, while George can be attuned to people's feelings about him (e.g., judgments, criticisms, overall interest), he can be less attentive to their mental states that are not directly related to him.
Context-related difficulties:
George can struggle to understand the broader context of mental states, in some of the following ways:

Focusing on the details of specific conflictual situations, often without considering his broader interpersonal approach in these scenarios

In the heat of the moment, rarely reflecting on the possible role of his feelings of insecurity in his tendency to antagonize and criticize other people

Not often considering the role that his own actions might play (e.g., argumentativeness, rigidity, missing work) in contributing to other people's coldness and criticism toward him

Process-related difficulties:

Rigid and overly certain:

The tendency to base his sense of self-esteem and self-worth on other people's positive opinions of him

Strong feelings of conviction that he is "right" and "accurate" in his judgments of other people, especially concerning their actions that he sees as unjust or immoral

Intense feelings of shame and humiliation, centering on his belief that he is bad or "weak" in some way. (George is especially vulnerable to such feelings when he feels like others are seeing him in a negative light.)

Overly concrete and visible:

An extrinsic, externally focused sense of self-esteem, where George's sense of self is based largely on productivity, intelligence, financial status, vocational success, and other people's explicit validation of him

The tendency to focus extensively on visible aspects of everyday experience (e.g., work responsibilities, other people's behaviors and comments), without reflecting as much on mental states in these situations

When he feels insulted or disrespected, feeling the need to engage in certain visible behaviors (e.g., arguing with others, avoiding work, drinking alcohol, planning suicide) in order to manage his emotional states

Disconnected or dissociated:

Employing lots of words, insights, and language about himself (e.g., intellectualization, sharing ideas), while not fully accessing his emotions and desires in the moment of speaking
Ignoring or minimizing aspects of his life and experience that might make him feel bad about himself (e.g., his perceived “failures” at work, other people’s successes, emotions in himself that he judges as “weak”)
Problems empathizing with other people and seeing things from their perspective, especially when he is absorbed in some work project or endeavor, or if he is angry at someone for what he sees as unjust/unfair treatment

Implications for the Current Treatment

These challenges with mentalizing could have a range of implications for the present therapy. When discussing his difficulties, George can often communicate in a highly intellectualized and cognitive fashion, sharing his ideas and psychological insights about himself without saying much about his other mental states (e.g., emotions, desires) in the situation. It will be important for George to begin to notice these moments himself, and to actively work to “put words on” his feelings in a meaningful way. There could also be value in me interrupting George in these dialogues, to help him reorient toward his internal world.
As mentioned above, George’s sense of self-esteem can rely extensively on other people’s positive opinions of him. This is likely to play out in our relationship as well, as he has already expressed his strong desires to “excel” and “do a good job” in therapy. One risk in this process is that, if George ever feels criticized or disrespected by me, this could trigger his feelings of insecurity, shame, and possibly even anger. It will be useful for George to try to identify these processes in the therapy, so that we can help him to access a wider array of his emotions as they arise in real-time, and to reflect more deeply on his tendency to base his self-esteem on factors outside of himself.

Summary and Future Recommendations

When George feels criticized or disrespected in his relationships with others, he can become highly focused on how “ignorant” and “misinformed” their perspectives are. He then proceeds to engage in behaviors (e.g., defensiveness, argumentativeness, criticism of others, avoidance, drinking alcohol, planning suicide) that can further alienate people from him.
Based on the above, I suggest three mentalizing targets for George’s engagement in the present therapy:

Decreasing the frequency of George's core behavioral challenges, and helping him to reflect on the various mental states surrounding such behaviors
Developing increased flexibility and tentativeness re: his negative judgments of other people, while considering the possible validity of others' perspectives
Improving George's ability to experience his own emotions and desires in the present moment, especially the more vulnerable emotions that he struggles to access when he feels angry and upset with other people (e.g., insecurity, shame, desires for approval)

By helping George to mentalize—*that is, to "read," access, and reflect upon* —these processes as they play out between himself and others, we might help George to develop a richer, more flexible, more emotionally grounded experience of himself and other people in his life.

Orienting patients to the therapy sessions

Having developed a working draft of the formulation with patients, we proceed to explicitly orient them to the work of the therapy sessions themselves (Box 4.5). Many patients with PN are accustomed to largely unstructured appointments with therapists, where they free-associate around whatever topic is on their mind at the time, thus getting caught up in pretend mode processes that are unhelpful for them. By transparently sharing our ideas about how patients can best utilize the sessions, we begin to acculturate them to a new format of treatment, which is exploratory while still being structured and focused. This helps to set patients' expectations about "what they are in for," decreasing the chance of disappointment and frustration with a more structured clinical approach. In addition, this orientation enables patients to utilize their time in sessions most efficiently, while focusing them toward meaningful goals and treatment priorities—an important condition for stimulating a genuinely reflective process in psychotherapy.

Box 4.5 Orienting patients to sessions in MBT for narcissism

Patients with pathological narcissism are often accustomed to unstructured appointments with therapists, which risk encouraging unhelpful pretend mode processes.
By explicitly orienting patients to MBT-N sessions, we acculturate patients to a more structured treatment. This helps to decrease patient frustration, increase efficiency, and orient patients toward reality-oriented goals.
Orienting patients to sessions involves

Highlighting key areas of focus in sessions, based on the shared priorities for treatment
Reviewing the process of agenda-setting
Explaining each person's tasks in the therapeutic dialogue: therapists ask questions and shares ideas, and patients work to mentalize themselves and others in the areas under discussion

When orienting patients to MBT-N sessions, we highlight the key areas of focus in sessions, based on the shared priorities already established; we review the process of agenda-setting in appointments; and we explain our respective tasks in the therapeutic dialogue—us asking questions and sharing ideas, and patients intentionally working to mentalize themselves and others in the areas under discussion. For example, continuing with our discussion of the patient George, we might say something like:

> "As you are starting off in the treatment, I wanted to share some information about how our sessions are going to go. In general, MBT sessions are focused on recent moments of emotional or interpersonal unrest—those times throughout the week where people feel upset about something, get into an argument or conflict with someone, or engage in a behavior that tends to cause trouble for them. In your case, George, we've agreed to work on your depression and suicidal thinking; your interpersonal conflicts with people at work; and your challenges with behaviors like avoidance, missing work, and procrastination. So as you are going throughout your week, I would recommend that you remain alert to these sorts of difficulties: times where you felt depressed or suicidal; situations where things got heated between yourself and another person; or times where you engaged in (or really wanted to engage in) any of the avoidant behaviors we have been discussing. Try to keep track of these situations as they come up, either just by remembering them, or even making a note of them in your phone, if you think you might forget about them.
>
> When you come to your next session, we'll work together to set an agenda for the session: you'll bring up any challenges you have experienced, and I might have some ideas about what we could talk about as well. And basically we'll spend our sessions trying to mentalize together: thinking about your feelings in these situations, and the feelings of other people; considering how you relate to others, and what that is about for you; and over time, considering areas where you can 'get stuck' in your thinking about yourself and others, so that you can try to become more reflective about those things.
>
> My job will be to ask a lot of questions about these matters, and sometimes to share my own ideas as well. And your job will be to really try to be curious about all of these mental states in yourself and others, and to work to *feel and access* your own emotions in the present moment, while also reflecting on them. As I mentioned before, we find that, by doing this repeatedly in these areas where you struggle, it becomes easier to do this 'in the heat of the moment,' outside of the therapy sessions—to access and think about a wider range of your feelings as they come up for you, while also remaining attentive to the experiences of others. Over time, this can lead to a greater sense of stability in your sense of self, and in your relationships."

With these ideas in place, we are we are well-positioned to commence the "mentalizing work" on the shared treatment priorities. Over the next several chapters, we will explore the specific interventions that we utilize in MBT for narcissism, in order to optimally facilitate a mentalizing process.

PART 3

THE THERAPEUTIC APPROACH

Part 3 presents in detail the therapeutic approach in mentalization-based treatment for narcissism (MBT-N). Starting with an overview of MBT's broad therapeutic stance, the chapters outline the domain-based trajectory of interventions in MBT-N: first exploring the *content* patients' mental states; then considering the broader *context* of these states; and finally addressing any challenges in patients' *process* of relating to mental states. Utilizing these ideas as a foundation, the authors propose therapeutic strategies for mentalizing the therapeutic relationship in MBT-N, in order to help patients address their interpersonal challenges inside and outside of the therapy.

5

Therapeutic Stance and Clinical Principles

In this chapter, we review the main elements of our therapeutic approach in mentalization-based treatment for narcissism (MBT-N). We start by considering what is often called the "therapeutic stance"—the broad clinical attitude that cuts across the specific techniques we are employing at any given moment. We then explore strategies utilized within each session in order to optimally facilitate a reflective process: following a trajectory of interventions, establishing a shared point of focus in sessions, and working with patients to develop and implement a collaborative agenda for appointments.

Core features of the therapeutic stance in MBT for narcissism

In their treatment manual *Mentalization-based Treatment for Personality Disorders: A Practical Guide* , Bateman and Fonagy (2016) describe the overall "stance" that MBT clinicians take throughout the treatment. We refer readers to Chapter 6 of that volume for the most comprehensive illustration of this stance, which we wholeheartedly endorse for the treatment of narcissism as well. In summary, MBT's broad clinical approach involves

a primary focus on mental states;
a sense of humility or “not-knowing” about what we can ever discern about such states;
an overall attitude of authenticity, transparency, and ordinariness with patients;
active engagement and structuring of sessions;
a continuous attentiveness to patients’ arousal and mentalizing in the present moment, and an effort to tailor interventions to patients’ current state;
acceptance of and interest in “differences in perspectives” between ourselves and our patients;
and a ready willingness to explicitly “own” our own mistakes, misunderstandings, and interpersonal contributions in the treatment.

Throughout this book, we will have much more to say about the role of these various approaches in MBT-N. At the outset, we will underscore three facets of MBT’s stance that have special relevance to the treatment of narcissism: the not-knowing stance; active structuring of sessions; and management of patients’ arousal levels in sessions (Box 5.1).

Box 5.1 Key features of the therapeutic stance in MBT for narcissism

MBT’s therapeutic posture involves authenticity, humility, active structuring of sessions, a primary focus on mental states, interest in “different perspectives” between therapist and patient, and a ready willingness to take responsibility for one’s own interpersonal contributions and mistakes.
Central features of the therapeutic stance in MBT-N include

A “not-knowing” or inquisitive approach
Active and engaged structuring of sessions
Continuous monitoring and management of patients’ arousal levels

MBT’s therapeutic approach has been referred to as the “not-knowing” stance: “a sense that mental states are opaque, and that the therapist can have no more idea of what is in the patient’s mind than the patient and, in fact, probably will have a lot less” (Bateman & Fonagy, 2016 , p. 186). From the perspective of MBT, it is impossible to ever fully know the contents of

another person's mind, or even the contents of one's own mind. This leads to a position of relative humility, where we eschew "interpretations" and authoritative declarations about the meaning and content of patients' experiences. Instead, we approach the therapeutic interaction with a sense of curiosity and tentativeness, attempting to stimulate a process of mutual reflection in which both parties are seeking to understand mental states (e.g., thoughts, emotions, desires) in themselves and the other person. We avoid definitive and confident language about mental states (*"You clearly feel …"* ; *"The reason why you did this is …"*), instead asking questions about patients' experiences (*"How did you end up feeling when you learned you did not get the job?"* ; *"What do you think was so upsetting to you in that interaction?"*), and offering marked qualifications about our own ideas and impressions (*"It sounds like that made you feel …"* ; *"I am gathering that …"* ; *"From my perspective …"* ; *"I am wondering if . . ."*).

This not-knowing, inquisitive approach holds central importance in MBT for narcissism. Given the self-enhancement processes associated with narcissism, patients with pathological narcissism (PN) are exquisitely sensitive to feeling patronized, controlled, and "talked down to" by others. More authoritative therapeutic approaches—in which therapists see themselves as describing or interpreting internal processes from a position of relative authority and greater "knowing" (e.g., transference-focused psychotherapy, traditional cognitive behavioral therapy)—risk escalating narcissistic vulnerabilities unmanageably in the earliest phases of treatment, resulting in increased defensiveness, power struggles, and treatment drop-outs. In contrast, MBT's inquisitive stance positions us slightly "below" patients in the therapeutic interaction, enabling patients to feel like *they* are the experts on their own experience. In this way, MBT's approach coheres with patients' self-enhancement needs at the outset of treatment, enabling them to feel validated and emotionally safe enough to engage in a reflective process.

MBT's therapeutic stance is also highly active, existing somewhere "midway" between cognitive behavior therapy and traditional psychoanalysis. Whereas therapists working psychodynamically are often less active in their clinical approach (e.g., allowing extended silences, rarely setting agendas for sessions, offering interpretations and observations largely in response to patients' material), MBT therapists are more active and engaged in their therapeutic approach: asking open- and closed-ended

questions (*"What was that like for you, when your boyfriend started criticizing you?"* ; *"In the past, I know that you felt quite insecure at work … could any of that be coming up for you now?"*); directing attention to specific aspects of patients' narratives (*"Could we go back for a moment, and could you tell me a bit more about how that argument with your mother unfolded?"*); and as we will discuss later in the chapter, structuring sessions based on patients' formulations and treatment goals (*"What would you like to put on the agenda today?"* ; *"Personally, I have been curious about where things stand with your urges to drink, and I was wondering if we could check-in about that"*). However, whereas CBT therapists are active in their provision of didactic content (e.g., highlighting cognitive distortions, teaching skills to address problem areas, assigning homework), MBT therapists are primarily active from an exploratory standpoint—that is, by doggedly directing therapeutic attention to the topic of mental states in Self and Other.

This active stance is a crucial component in the effective treatment of narcissism. As we have discussed, patients with PN are especially prone to pretend mode processes, involving emotional disconnection, overly abstract and intellectualized narratives, and extended monologues, without a full regard for the therapist's independent perspective. The active stance of MBT enables us to respectfully direct patients away from such processes, focusing them toward more authentic, meaningful emotional engagement with themselves and other people.

Finally, MBT therapists are also especially attentive to patients' degree of emotional activation in the present moment. The MBT model proposes that, for patients with personality disorders, the ability to mentalize is inversely related to their level of affective arousal (Fonagy & Bateman, 2008). We thus work to help patients remain at something of a "sweet spot" of emotional intensity: emotionally activated enough to be engaged in the interaction, but not so excited or overwhelmed that it becomes too challenging for them to hold onto their reflective capacities. We are continuously monitoring patients' emotional states, in relation to the narrative content under discussion but also in response to our own participation in the therapeutic dialogue. As patients start to move into more intense emotional terrain, we are prepared to employ a range of strategies to "cool things down" in the interchange. We liberally employ empathic validation of patients' experience (*"I think it is really understandable this*

would all be so upsetting to you. You were really looking forward to spending the weekend with your wife, and you had no idea her brother was going to visit"), which allows patients to feel more "seen" and understood by us. We ask more cognitively oriented questions (*"What do you make of her comment to you in that discussion?"*), which enables patients to temporarily shift focus away from emotionally charged content. And we assume responsibility for our own role in patients' emotional disruption (*"I'm worried that I came across as a bit critical back there, and I really didn't mean to …"*), which helps patients feel less blamed and criticized by us. In all of these ways, we work to titrate patients' level of emotional arousal, thus creating an interpersonal climate that is optimally conducive to adaptive mentalizing.

This titration is especially important in the treatment of PN. In his early paper on the treatment of narcissism, Anthony Bateman (1998) , one of the present authors, highlights the tension between patients' more disconnected, self-sufficient mind states and their more emotionally activated, agitated states. Patients operating at either pole are unable to effectively mentalize: they are either disconnected from mental states, or they are rigidly experiencing their perspective as a straightforward "fact," rather than a psychological construction. As Bateman (1998) proposes, patients are most accessible when they are "moving between" these polarities (p. 13). By walking the therapeutic tightrope between "too hot" and "too cold," patients and therapists are able "to develop a shared sense of reality," opening up the pathway for patients to finally develop "a secondary level of mental representation" of subjective states in themselves and others (Bateman, 1998 , p. 23).

Trajectory of mentalizing interventions: Content, context, and process

One of the most challenging facets of helping patients with narcissistic challenges is understanding "where to start" in responding the breadth of information patients bring into sessions. Therapists can end up feeling overwhelmed and inadequate with these patients, leading over time to unhelpful tendencies to appease, argue, disengage, and somehow "try harder" to feel some level of competence in the interaction. MBT-N recommends a stepwise approach to the therapeutic dialogue, which we

organize in terms of tripartite conception of mentalizing we have proposed here: first exploring the *content* patients' mental states; then considering the broader *context* of these states; and finally addressing any challenges in patients' *process* of relating to mental states (see Figure 5.1). While these steps will be examined in detail over the next several chapters, we will first offer a "big picture" statement of the approach, in order to highlight the broader therapeutic principles guiding our specific techniques.

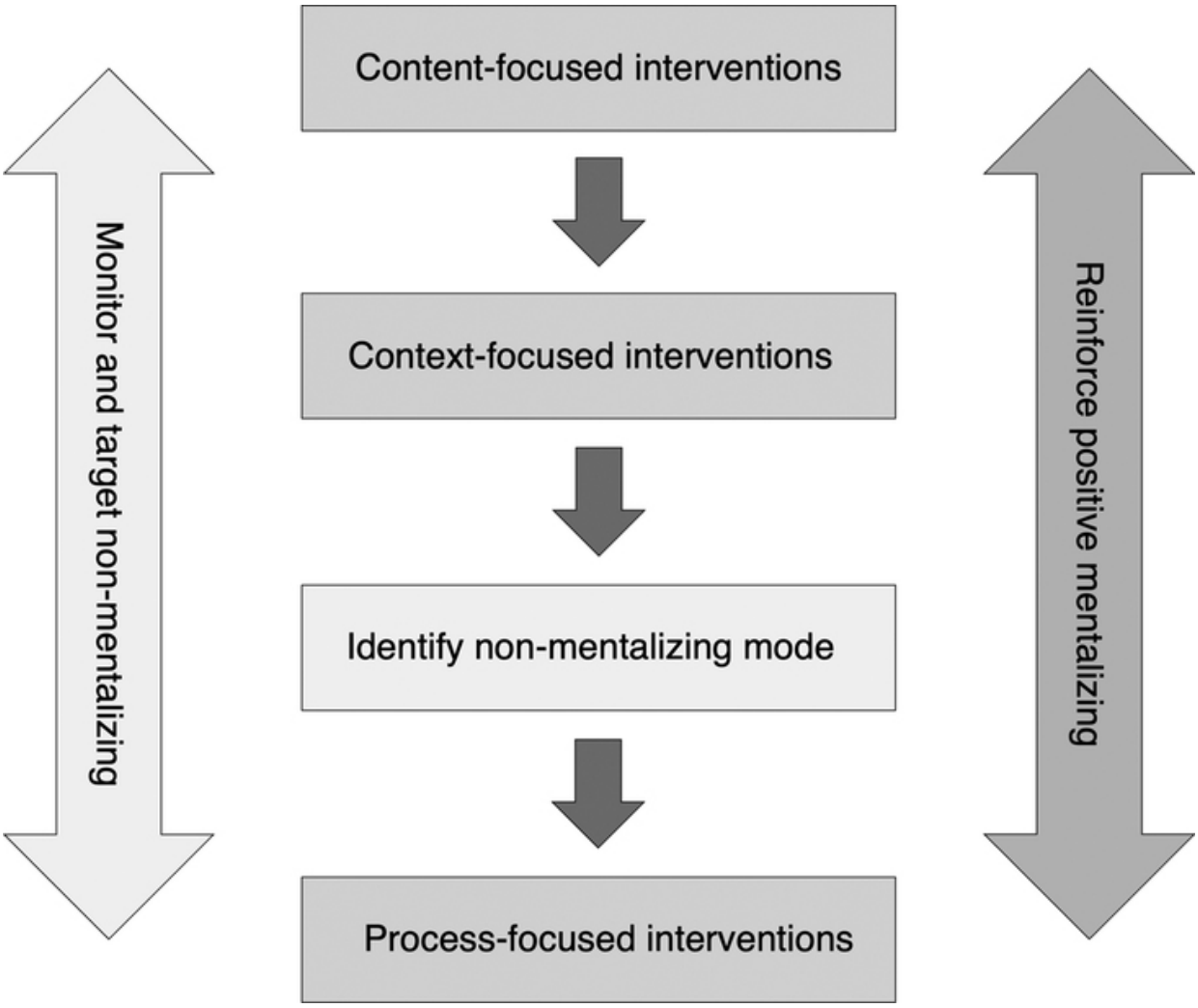

Figure 5.1 Trajectory of interventions in MBT for narcissism. Therapists first explore the content of patients' mental states; then they consider the broader context of these states; and finally they address challenges in patients' process of relating to mental states in themselves and others. Throughout, therapists tailor these interventions to patients' reflectiveness in the current moment, reinforcing progress in mentalizing as it unfolds.

In actual practice, psychotherapy is of course much messier, with techniques blurring together and sessions unfolding in a non-linear way. Nevertheless, we find that, by trying to follow this step-by-step approach, we are much less likely to "outpace" patients' mentalizing abilities in the current moment. This approach also helps *us* to feel more emotionally grounded in the clinical interaction, since we have a clearer sense of where to place our focus, and where we are going with our interventions. See Box 5.2 for a description of the core interventions in MBT for narcissism.

Box 5.2 Core interventions in MBT for narcissism

Content-focused interventions

Help patients to represent the content of mental states in themselves and others, as well as the circumstances under which those states unfold and take shape
Techniques include empathic validation, clarification, and affect elaboration.

Context-focused interventions

Geared toward stimulating patients' reflection about the relationship between their mental states and the broader context of their experiences
Techniques include inviting patients to reflect on the relationship between their mental states and life circumstances; between different emotions; and between these emotions and behavioral/interpersonal patterns.

Process-focused interventions

Address patients' challenges in the process of mentalizing: certainty, concreteness, and disconnection
Techniques for certainty and concreteness include empathic validation; elaboration of patients' perspectives and related emotions; temporarily shifting the focus to a less emotionally charged topic; exploring areas of possible nuance; and cautiously sharing our own feelings and perspectives about the matters at play.
Techniques for emotional disconnection and dissociation include asking for specific examples; inviting reflection on patients' current emotional states; sharing about our own mental states; explicitly "naming" the form of disconnection patients are exhibiting; and ultimately attempting more "challenging" and provocative communications.

Reinforcing positive mentalizing

Employing "judicious praise" to highlight and affirm positive examples of patients' mentalizing in the current moment
Tends to "cut across" all other interventional processes, regardless of the particular mentalizing operation (e.g., content, context, process) under consideration at the time

Content-focused interventions include clarification, affect elaboration, and empathic validation (see Chapter 6). These interventions help patients to identify and represent the content of mental states in themselves and others, as well as the circumstances under which those states unfold and take shape. Consistent with the not-knowing stance, rather than supplying or "filling in" these states (*"You really felt angry at him for saying that to you"* ; *"Clearly you really wanted her to comfort you"*), we try to *elicit and reflect* patients' descriptions of these states (*"When he said that to you, what emotions came up for you?"* ; *"What do you think you were wanting from her at that moment?"*). Clarification involves requesting information about the external details or "facts" of a situation: what happened, who was involved, what was said, and what actions were taken, from patients' perspective. Affect elaboration is a broad family of strategies employed to help patients represent, expand, and deepen their experience of their emotional states: explicitly asking about patients' emotions and desires; inviting further elaboration of previously expressed emotional states; and trying to expand the range of patients' feeling states. Empathic validation is our effort to "put words on" our own understanding of patients' experiences, including their emotions, desires, beliefs, and overall "impressions" of themselves and others in their lives.

Content-focused techniques can be seen as the "foundational" interventions in MBT-N (Drozek & Unruh, 2020). These techniques gradually allow patients to consider a broader spectrum of experiences in the therapeutic dialogue: a more diverse and nuanced set of emotions and desires; a clearer view of their own actions and interpersonal patterns; and a more comprehensive picture of their environments, relationships, and interactions with others. Once all of these processes are "on the table," we can employ *context-focused* interventions. Context-focused interventions are techniques geared toward stimulating patients' reflection about the relationship between their mental states and the broader context of their experiences (see Chapter 7). Examples of such interventions include inviting patients to reflect on the relationship between their mental states and circumstances in their lives ("contextualization of affect"; Bateman & Fonagy, 2006); considering the possible connection between different emotions; and examining the link between these emotions and patients' subsequent behavior patterns. By and large, we only ask patients to reflect on the possible connection between two elements (e.g., "sadness" and an

interpersonal conflict; “anger” and “insecurity”; desires for attention and someone talking extensively in a therapeutic group) when **both elements have already been elicited and elaborated by patients themselves** in the therapeutic dialogue. Consistent with the not-knowing stance, this principle ensures that our own mentalizing is not “jumping ahead” of patients’ mentalizing. If we are ever drawn toward introducing new mental “content” in inviting context-related reflections, we take that as an indication that we need to return to the content-based interventions, in order to invite further descriptions of patients’ lived experiences.

As we implement the above techniques, we begin to notice patients’ forms of non-mentalizing discussed earlier: rigid thinking, excessive concreteness, and psychological disconnection. At this stage of the process, we privately “take note” of the difficulty in mentalizing, proceeding to implement *process-focused techniques* to address the issue in question. In response to patients’ challenges with rigidity and concreteness, we utilize a set of techniques geared toward encouraging patients’ greater reflectiveness (see Chapters 9 & 10): empathic validation; elaboration of patients’ perspectives and related emotions; exploring areas of nuance in patients’ experience; and cautiously sharing our own feelings and perspectives about the matters at play, without trying to change patients’ minds. The aim of all of these interventions is not to “correct” the patient’s viewpoint by bringing it into alignment with some pre-determined vision of reality, but rather “to enhance the patient’s mentalizing by broadening the patient’s perspectives on an event” (Bateman & Fonagy, 2017 , p. 2900).

In response to patients’ difficulties with emotional disconnection and dissociation, we utilize strategies aimed at helping patients more authentically experience emotions and desires in themselves and other people (see Chapter 8). Techniques include shifting the focus away from abstractions to something more specific and reality-based; asking questions about patients’ emotional states in the present moment; sharing about our own mental states in the interaction; explicitly “naming” the form of disconnection patients are exhibiting; and ultimately employing what MBT calls a *challenge*, understood as a surprising, irreverent, often provocative comment that has the effect of “waking patients up” to more authentically access their own emotional states, or to consider the mental states of the therapist.

When working within a particular domain of mentalizing (e.g., content, context, process), we are continuously monitoring the quality and nature of patients' reflectiveness about mental states, in the domain under consideration as well as other domains addressed later in the trajectory (see Box 5.3). This entails assessing for patients' strengths and vulnerabilities in mentalizing. In the domain of content, we ask ourselves: *in what ways is this patient observing and identifying specific mental states (e.g., thoughts, beliefs, emotions, needs, desires, and attitudes) in themselves and others?* In the domain of context, we consider: *to what degree is the patient reflecting on the relationship between mental states and other factors (e.g., situations, behaviors, other mental states)?* In the area of process, we are curious: *where is the patient displaying certainty, concreteness, or emotional disconnection in their experiences of Self and Other? On the other hand, are we seeing any signs of flexibility, psychological mindedness, emotional engagement, and empathy in the patient?*

Box 5.3 Monitoring patients' mentalizing in clinical process

Content-focused mentalizing

In what ways is this patient observing and identifying specific mental states (e.g., thoughts, beliefs, emotions, needs, desires, self-states, and attitudes) in themselves and others?

Context-focused mentalizing

To what degree is the patient reflecting on the relationship between mental states and other factors (e.g., situations, behaviors, other mental states)?

Process-focused mentalizing

Where is the patient displaying certainty, concreteness, or emotional disconnection in their experiences of Self and Other?
On the other hand, how is the patient exhibiting any signs of flexibility, psychological mindedness, emotional engagement, and empathy?

Efficacy of mentalizing interventions

To what degree did that intervention appear to stimulate the patient's reflectiveness about mental states, versus sending the patient into unhelpful forms of non-reflectiveness?

In light of these considerations, we tailor our techniques to (a) address any current challenges in mentalizing in the domain at hand, and (b) enhance patients' reflectiveness about mental states in that domain. After we have employed a particular technique, we attempt to consider its impact on the patient's mentalizing overall: *to what degree did that intervention appear to stimulate the patient's reflectiveness about mental states, versus sending the patient into unhelpful forms of non-reflectiveness?* We discontinue approaches that seem to inhibit mentalizing, and we continue pursuing whatever approaches appear to bolster patients' mentalizing processes. Once we have sufficiently stimulated reflection in one sphere, we are able to proceed into the next domain, and once again to tailor our interventions to address the challenges in reflectiveness we have already begun to observe in this new domain. This continues until we have made our way through the full trajectory of interventions, such that patients are increasingly able to reflect on the content, context, and process of mentalizing—in Self, in Other, or in *both* Self and Other, depending on each patient's unique challenges and the specific details of the circumstances under discussion.

To illustrate these principles, we can consider one example of the shape this trajectory might take.

A patient, Hillary, was sharing about a recent argument with her father, which started when he made a critical comment about the patient's outfit at a family party. The therapist started by utilizing content-based interventions to help Hillary explore the "what" of this experience: what happened, and what she was feeling at various points throughout the party. Hillary was easily able to relay all of the details of the interaction, but she could only identify "anger" and "feeling pissed off" as her emotional response to her father's comment. Privately noting this as a potential problem with content-based mentalizing, the therapist utilized further affect elaboration strategies (pp. 110–135) to help Hillary articulate additional emotions of hurt, embarrassment, and insecurity about what her father thinks of her.

Determining that Hillary seemed to be reflecting more on the content of her mental states, the therapist progressed to helping her consider the broader context surrounding these emotions. Hillary shared that she felt especially hurt by her father because she continues to crave his approval; her embarrassment came from the fact that her father made this comment in front of her cousins, whom she feels have exceptional taste in clothing. Recognizing these reflections as positive examples of "situation-focused" context-mentalizing (pp. 144–147), the therapist noticed that Hillary seemed to be struggling to reflect on her own interpersonal contribution to the argument with her father. The therapist thus utilized techniques for context-mentalizing about behavior (pp. 147–165), and Hillary was able to reflect on her broader interpersonal pattern of becoming argumentative and aggressive whenever she feels hurt and insecure. At the party, this approach made her feel better about herself in the moment, but she worries that it alienated her from her cousins, who seemed to feel anxious and awkward around her afterwards.

At this point in the session, in the therapist's view, Hillary was exhibiting notable improvements in both content- and context-based mentalizing. Throughout the discussion so far, the main "process-based" mentalizing problem that had emerged was Hillary's tendency to rigidly base her feeling states on other people's views of her (psychic equivalence mode), as exemplified in her interactions with her father and her cousins. The therapist and Hillary agreed to focus on this topic for the remainder of the session, with the therapist utilizing process-focused interventions for psychic equivalence (pp. 198–209) to help Hillary move toward greater curiosity and flexibility surrounding these processes.

In this session, the therapist employed a combination of in-session monitoring and tailored clinical techniques to progressively target challenges in mentalizing unfolding across multiple domains of the patient's experience.

Taken together, the above techniques all work toward patiently encouraging patients' mentalization of themselves and other people: considering the content of mental states in themselves and others; understanding the broader context of such states; more authentically experiencing mental states in themselves and others; and thinking more flexibly about areas where they tend to get "stuck." Our aim is simply to shepherd a process in which patients begin to "think about thinking," and to do whatever we can to help this continue for as long as possible during each session. Over time, patients come to internalize this experience of *themselves and us* representing each person's mental states: *"I am considering myself, while also considering you. You are considering yourself, while also*

considering me.” This experience ultimately serves as the psychological template for patients’ burgeoning capacity to mentalize—to remain flexibly and authentically grounded in their own experience, leading to a more cohesive and coherent sense of self; and to flexibly and empathically regard the experiences of others, leading to improved stability and connectedness in their relationships.

One technique deserves special consideration here, given its central importance in the treatment of pathological narcissism: *reinforcing positive mentalizing* . This technique tends to “cut across” all other interventional processes. We employ it liberally and enthusiastically, regardless of the particular mentalizing arena (e.g., content, context, process) under consideration at the time. As we utilize the techniques reviewed above, we hopefully observe positive “in the moment” changes in patients: increased access to a range of affective states, greater cognitive flexibility, improved emotional empathy toward others, and enhanced curiosity and reflectiveness about subjective experiences in themselves and others. When such changes unfold in sessions, we utilize “judicious praise” to highlight and affirm positive examples of mentalizing in patients’ experiences (Bateman & Fonagy, 2016 , pp. 245–247).

Examples of this include inviting further reflection about a more mentalized experience (*“So you are thinking that, in addition to feeling really angry with him, you also felt quite hurt by him. Can you say anything more about that?”*); inquiring about the process of arriving at a new perspective (*“That is a really interesting idea. Could you walk me through how you figured that out?”*); inviting reflection about the impact of mentalization on others (*“It seems like you were really able to be sensitive to what she was experiencing at that moment. What do you think that was like for her?”*); and asking about the impact of positive mentalizing on patients’ themselves (*“Somehow you were able to feel the anger without retaliating against him. How did that make you feel about yourself?”*). Given narcissistic patients’ tendencies to be motivated more strongly by rewards than by punishment (Foster & Trimm, 2008), this technique has special utility in encouraging patients’ progress in treatment. As patients see that we are most interested in and excited by their flexibility and reflectiveness about mental states, they begin to recognize the interpersonal advantages of that flexibility and reflectiveness. Such reinforcement can serve as the

“narcissistic carrot” that invites patients into relational dynamics involving greater reflection and mutual responsiveness.

Establishing and managing the experiential contexts for mentalizing

Peter Fonagy (2021) , one of the developers of MBT, proposes that MBT involves three main elements: the patient’s mind, the therapist’s mind, and some shared picture of reality that both parties can examine together. This conception underscores a core insight about the nature of mentalizing: mentalizing can only occur in relation to some context of experience, which is clear and understandable enough to serve as the focus of joint attention.

This point has crucial importance for the treatment of narcissism, where patients can become untethered from reality-based experiences, often leaving us confused about what is being discussed at any particular moment. By having greater understanding and clarity about the different experiential contexts for mentalizing, we are better equipped to implement the interventions we have been discussing. We propose nine such contexts, organized around *setting* —the specific aspect of reality under discussion— and *chronology* —the time period in which that context is being represented by patients (e.g., past, present, or future). See Table 5.1 for examples of these potential arenas for mentalizing.

Table 5.1 Experiential contexts for mentalizing in MBT for narcissism

		Chronology		
Past	**Present**	**Future**		
Setting	**Outside of sessions**	One or more past events or interactions, involving the patient and/or other people	Ongoing events, circumstances, or interactions in the patient's current life, involving patient and/or other people	Anticipated future events or interactions, involving the patient and/or other people
	Patient's engagement in the therapeutic activity	One or more of the patient's past experiences participating in the therapeutic task	The patient's current experience engaging in the therapeutic task	The patient's anticipated future experience participating in the therapeutic task
	The therapeutic relationship	One or more past experiences in the therapeutic relationship, involving the patient and/or therapist	The current interactional process in the therapeutic relationship, involving the patient and/or therapist	Anticipated future experience in the therapeutic relationship, involving the patient and/or therapist

By and large, patients tend to focus on aspects of reality "outside" the therapeutic relationship. They talk about something that happened since the last session, or they share about some event or experience in the more distant past. They discuss ongoing events in their current lives, such as an interpersonal conflict or some situation unfolding at work. They also share about events or interactions that they expect to happen in the future, or more potential or "hypothetical" future scenarios (e.g., starting a new romantic relationship, saving money to purchase a new home, trying to have children).

Patients can also pause to consider their experience of engaging in the therapeutic activity itself: "I'm getting a bit worked up the longer that I talk about this." They can rewind to reflect on their feelings arising in the clinical work, earlier in the session or in past sessions: "I'm not sure why, but I got extremely sad when we started talking about my relationship with my parents." In addition, patients can "fast forward" and anticipate their future experiences participating in the task of therapy: "We still haven't talked about the divorce. I don't think that is going to be easy for me."

Finally, patients can discuss their "here and now" experiences within the therapeutic relationship: "I think I'm feeling anxious that you might be judging me right now." They can consider earlier moments in the interaction,

or in the history of the relationship: “I felt like you really weren’t listening to me in our last appointment. You were just focusing on your own agenda.” And patients can imagine future events in their interactions with us, reflecting on each person’s potential experience of the situation: “I know that, if I keep being so stubborn, you are going to get fed up with me and not want to work with me anymore. Just like everybody else does.”

With these ideas in place, we can offer a handful of principles about how to approach our interventions with patients with PN (Box 5.4). First and foremost, prior to attempting the interventional pathway reviewed in the previous section, we explicitly identify with patients the experiential context that is serving as our shared point of focus. While sometimes the area of focus is abundantly clear (e.g., the patient shares about a recent argument with a friend, or an upcoming job interview), we are wary when patients want to discuss their broad “ideas” about themselves and other people. “My problem is that I always put other people before myself . …” “My wife is a control freak; it has to be her way or the highway, every time.” “Due to my trauma history, I have learned that I cannot rely on anyone but myself.” Especially in the earliest stages of treatment, when the risk of pretend mode is usually at its highest, we do not attempt to mentalize patients’ abstract formulations about themselves or others. This is likely to just trigger further pretend mode, regardless of how insightful the statements might sound on the surface.

Box 5.4 Key points about experiential contexts in MBT for narcissism

The foundational focus in MBT-N is patients' current reflectiveness about mental states, directed toward Self and Other, considered in a range of different experiential contexts.
Prior to attempting any mentalizing interventions, therapists explicitly identify with patients the experiential context that is serving as the shared point of focus.
MBT-N sessions progress from a "then and there" focus to a "here and now" focus: starting with patients' experiences outside the therapeutic relationship; proceeding to their experience discussing the topic in question; and finally to their experience with therapists in the clinical interaction.
MBT-N prioritizes patients' current affective experience—regularly inviting reflection about their feeling states in the present moment, and any shifts in emotions as they occur in real-time.
When focusing on a particular experiential context for mentalizing, there is value in pursuing the trajectory of MBT-N interventions (e.g., mentalizing content, context, and process) prior to moving on to another context.

So when patients are engaging in this way, we usually respond by first empathically validating the cognitive content of the idea in question (*"I see, so you end up prioritizing other people at your own expense"* ; *"Your wife can be rigid and controlling, and it sounds like that especially plays out between the two of you"* ; *"Your history of trauma has really impacted you, actually leading you away from other people"*), then proceeding to ask further clarifying questions to elicit one or two specific examples of the experience in question. "What's an example of someone you've recently prioritized, to your own detriment?" "What are the things that your wife says or does that you really find the most problematic?" "Could you please tell me about a relationship from which you have recently withdrawn?" Once it is clear which experiential context patients are discussing, we can proceed to utilize the mentalizing interventional pathway on the examples in question, rather than focusing on patients' abstract ideas about themselves or others. At any given moment in the session, if we ever become confused or unclear about which experiential context is under discussion, we can ground ourselves by again asking for specific examples of the experience—this serves to reorient the dialogue toward a shared picture of reality.

When working to mentalize a particular area of patients' experience, we are interested in one primary question: to what extent is the person reflecting on mental states in Self and Other in the context in question? In this way, we are always most interested in patients' *current* mentalizing, even if they are discussing some past or future event (Bateman & Fonagy, 2016 , p. 182). For example, if we are utilizing content-focused interventions (e.g., empathic validation, clarification, affect elaboration) to explore a patient's recent argument with her boyfriend (a past incident outside the therapeutic relationship), we consider the extent to which she is *currently, in the moment of speaking* , reflecting on her feelings and her boyfriend's feelings in that past interaction. If the patient then expresses feeling insulted by something *we* said about the argument with her boyfriend, we can temporarily shift our focus to explore her experience of that interaction with us (a past incident within the therapeutic relationship). Again, in that discussion, we will be attentive to the patient's *current* mentalizing about that earlier moment in the therapeutic dynamic. See Figure 5.2 for a visual illustration of this foundational focus in MBT-N: patients' current levels of reflectiveness about mental states, directed variously toward Self and Other considered in a range of different times and contexts.

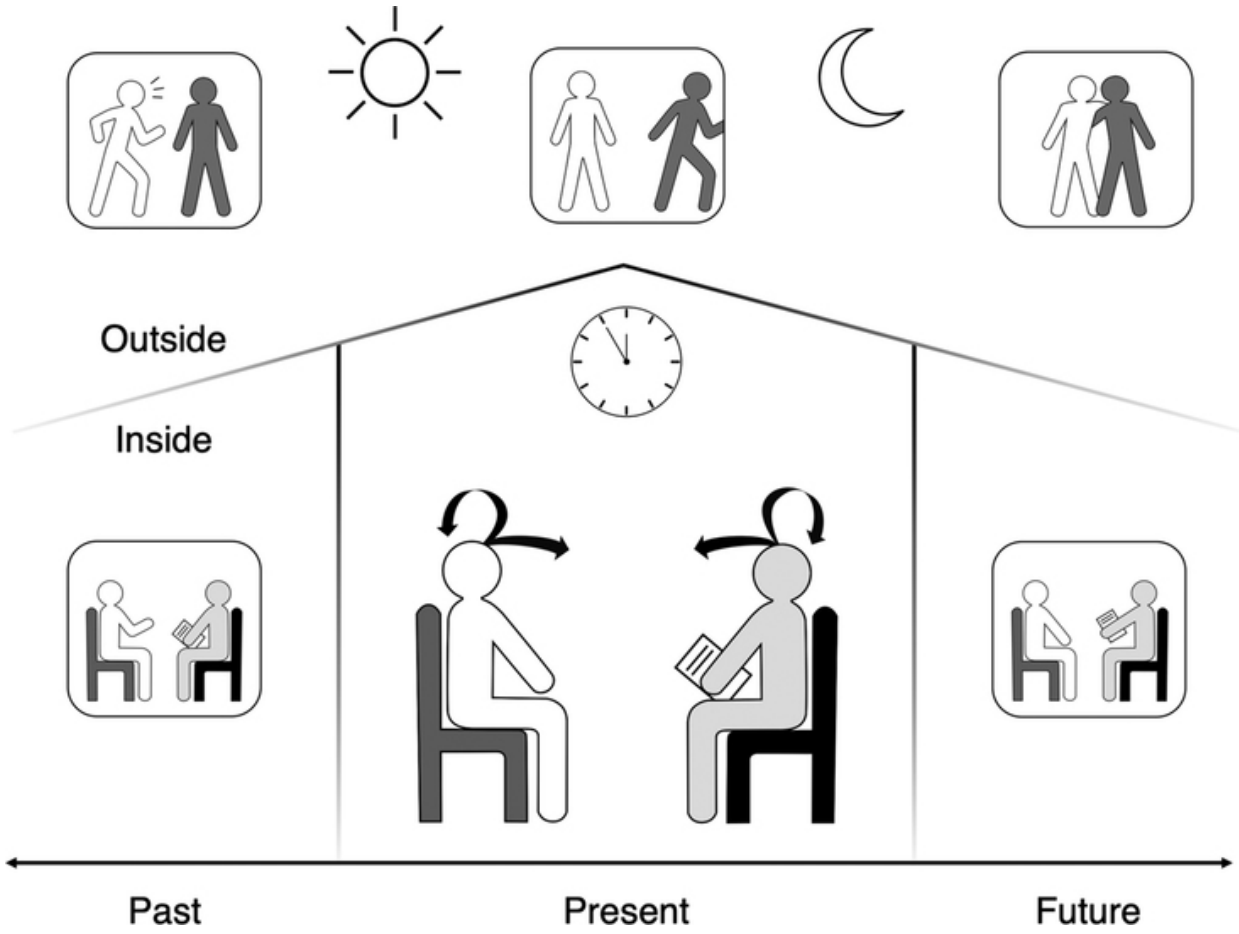

Figure 5.2 Foundational focus in MBT for narcissism: patients' current levels of reflectiveness about mental states, directed variously toward Self and Other considered in a range of different times and contexts.

As Bateman and Fonagy (2016) have explained, MBT sessions tend to progress from a "then and there" focus to more of a "here and now" focus, depending on the quality of patients' mentalizing as well as the intensity of their emotional activation in the current moment (pp. 182–183). Framed in the terms we are proposing here, we start with patients' experiences outside of the therapeutic relationship, proceed to their experience engaging in the therapeutic task, and finally approach their experience *with us* in the therapeutic relationship. This arc tends to follow a progressive escalation in emotional intensity (see Figure 5.3). By and large, emotional intensity increases the closer that our focus moves to the present moment, and the more that it attends to the specific relationship in which we are engaged. In particular, mentalizing the therapeutic relationship is especially stimulating for patients with narcissism, since they are invited to share their feelings *to*

and about the person of the therapist, an authority figure who offers both the gratification and the rejection of their intense self-enhancement needs (see Chapters 11 & 12). By cautiously but persistently nudging patients into areas of heightened emotional intensity, we are helping patients to practice being "in" the emotion while also reflecting on it, and remaining attuned to the emotional states of others—whether those "others" are the other person in the situation outside of the room, or *us* when they are discussing something more immediate to the current interaction.

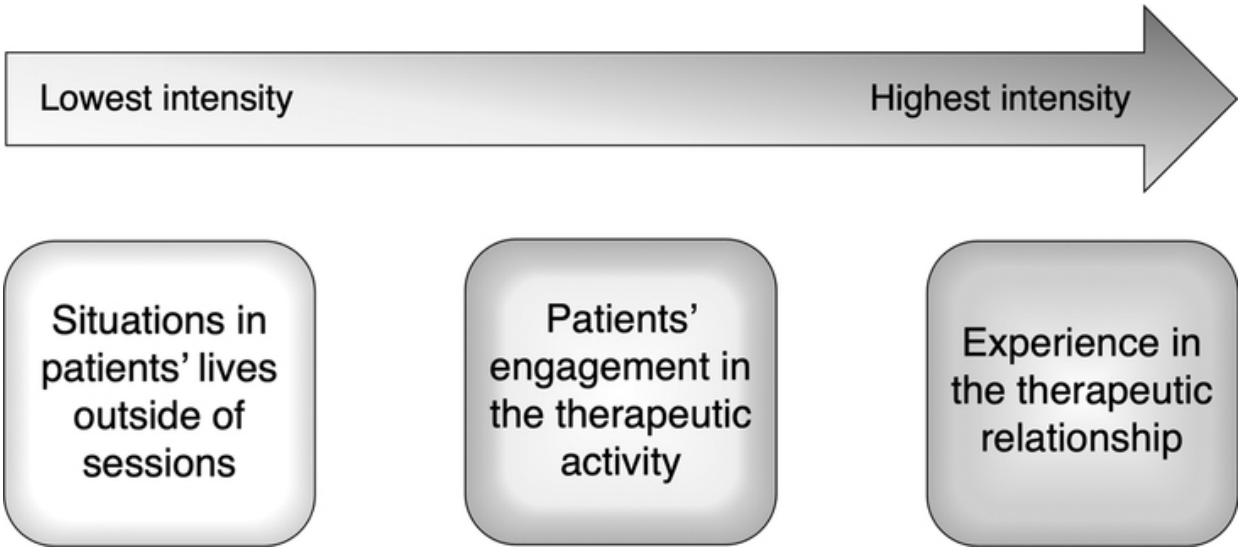

Figure 5.3 Arc of affective intensity of different experiential contexts in MBT-N sessions. By and large, emotional arousal is lowest when patients discuss their lives outside of sessions, higher when considering their engagement in the therapeutic task, and highest when exploring their experience in the therapeutic relationship itself.

As patients discuss these matters, we carefully attend to their current emotional states, especially noticing shifts in those states that occur in response to what they are discussing, or in reaction to our own questions and interventions. Along these lines, we tend to "stop the presses" when patients experience an emotional fluctuation, even if it appears to be subtle, non-verbal, and not explicitly acknowledged by patients. Whereas MBT for borderline personality disorder often diverts patients' attention *away* from intense emotions in order to encourage a reflective process, given the prevalence of alexithymia and pretend mode among patients with narcissism, we are called upon to "strike while the iron is hot" in MBT-N, directing patients' attention to their feelings in relation to the topic under discussion (e.g., past, present, or future). For example, we might observe, "Your tone

seemed to change when you started talking about your ex-wife. Did you notice a difference in how you were feeling at that moment?" Or: "What is coming up for you as you talk about these things right now?" As patients increasingly come to experience and access their own emotional states in the moment, they start to spontaneously represent these emotions without prompting, and to exhibit greater awareness of such state-shifts as they unfold in their relationships outside of therapy.

At any given moment of the session, how do we decide which experiential context will serve as the area of focus? While it is difficult to lay down any definitive rule about this, we can offer some general considerations. As we will review in the next section, the initial area of focus will usually be determined by the agenda for the session, which is structured at the beginning of the appointment based on the shared priorities for treatment. If possible, when focusing on a particular context for mentalizing, we try to pursue the full range of interventions with patients—elaborating and empathically validating mental states, contextualizing these in some way, and finally identifying and addressing some process-related difficulty in reflectiveness—prior to moving on to another context. This allows for what our co-author and MBT co-founder Anthony Bateman (2020) , in his Adherence and Competence scale on MBT, calls greater *extensiveness and depth* in mentalizing exploration.

As the meeting progresses, we actively direct the focus of the session in response to patients' level of emotionality at the time. As we have discussed, we are always working to titrate patients' affective arousal in MBT-N, in order to optimally stimulate mentalizing: "not too hot, not too cold." If patients appear more emotionally disconnected and cognitive, we are thus prepared to shift the focus to a more immediate experiential context, such as patients' emotional experience in the moment, or in their interactions with us (see Chapter 8). Or if patients seem too upset or agitated to meaningfully reflect on the issue in question, we would likely steer clear of more here-and-now topics, instead directing the focus toward some past or present topic "outside the room" that feels more emotionally neutral and less affectively charged for them.

Throughout this book, for the sake of clarity, we will introduce MBT-N's interventions in relation to the first two main experiential contexts: patients' experiences outside of sessions, and patients' experience engaging in the therapeutic activity (Chapters 5 –10). Once we possess a clear grasp of these

techniques, we will consider how to apply them to a more emotionally complex experiential context: the therapeutic relationship itself (Chapters 11 & 12).

Structure of sessions in MBT for narcissism

As mentioned earlier, MBT-N sessions are exploratory yet structured. This means that we do not simply "follow" patients' narratives wherever they might lead, a practice that risks reinforcing many of the non-mentalizing processes (e.g., pretend mode, self-enhancement, focusing on other people's defects, excessive self-focus) endemic to PN. In contrast, we take a highly participatory stance in sessions, working with patients to collaboratively set an agenda for each meeting, and actively managing the session in order to address all items on the agenda (Box 5.5). In the introductory phase of MBT-N, we have already oriented patients to the structure and focus of sessions, asking patients to "keep track" of challenges throughout the week related to the shared treatment priorities, and to come to sessions prepared to discuss these (pp. 79–81).

Box 5.5 Structuring sessions in MBT for narcissism

Sessions begin by asking some general question eliciting patients' ideas about agenda items for the session.

"What would you like to put on the agenda today?"
"Has anything happened over the past week that feels important to discuss?"

Agenda items include two main elements: some specific experience that has a clear connection to the shared treatment priorities, and the focus for mentalizing, understood as some basic "mentalizing question" related to the experience in question.
Therapists work with patients to construct a collaborative agenda for the session, emphasizing patients' personal priorities and incorporating therapists' own ideas about important areas for clinical focus.
Once the agenda is established, therapists utilize the trajectory of mentalizing interventions (e.g., focused on content, context, and process) on each agenda item, progressively working from "then and there" experiential contexts to "here and now" contexts.
Appointments end by therapists summarizing the work of the session: recapping the important topic areas covered, reviewing progress in mentalizing observed, and underscoring areas for future inquiry.

At the start of appointments, after greeting patients, we ask some general question eliciting patients' ideas about agenda items for the session. "What would you like to talk about today?" "What would you like to put on the agenda?" "Has anything happened over the past week that feels important to discuss?" Each agenda item includes two main elements: some experiential context that has a clear connection to the shared treatment priorities (e.g., related to specific challenges in emotions, identity, interpersonal relationships, or functionality; see pp. 61–64); and what Bateman (2020) calls the *focus for mentalizing* (pp. 15–22), understood as some basic "mentalizing question" related to the experience in question.

In general, patients themselves identify the preferred experiential topic:

"I'm considering applying to graduate school, but I'm not sure if that is the best idea right now."
"I don't know why, but I have been really unhappy in my marriage lately, and even started thinking about divorce."
"My boss and I have been getting into lots of arguments this week, so I guess we should talk about that."
"I've been feeling really bad about myself ever since I got a low grade on that test."

In turn, we tend to propose the focus for mentalizing, based on patients' expressed concerns about the topic as well as our own ideas about patients' unique vulnerabilities in mentalizing identified in the formulation. Whereas the experiential topic always involves some specific content derived from patients' experiences, the mentalizing focus is a more open-ended, process-oriented inquiry about some facet of mentalizing. The focus can involve considering the content of mental states (e.g., patients' thoughts, feelings, desires in some situation, or the experiences of other parties involved in the situation); reflecting on the context of such states (e.g., examining situational triggers, or behavioral/interpersonal patterns); or addressing more process-related challenges (e.g., patients' rigid or concrete thinking, or difficulties with dissociation or disconnection).

Synthesizing patients' preferred experiential topic with our proposed mentalizing focus, we then invite patients' feedback about the potential agenda item. We collaborate with patients to arrive at the optimal mentalizing focus for the agenda item, which hopefully reflects both patients' concerns and our ideas about how to best address these, through the framework of mentalizing. Review Box 5.6 for some examples of different agenda items for sessions in MBT for narcissism.

Box 5.6 Sample agenda items in MBT for narcissism

“Going to graduate school—that sounds like an important agenda item *[experiential context identified by patient]* . Would you be interested in looking more at your various feelings about this, and what you might be wanting here *[content-related mentalizing focus]* ?”

“It sounds like you have been feeling really dissatisfied lately with your relationship with your husband *[experiential context identified by patient]* , but you’re not really sure what that is about for you *[context-related mentalizing focus]* . Would you like to spend some time looking at this today?”

“OK, so let’s definitely spend some time considering your recent arguments with your boss *[experiential context identified by patient]* . Maybe we can think about what is coming up for you in these arguments *[content-related mentalizing focus]* , and how you are engaging in them *[context-related focus]* ?”

“Ever since you received that low grade on your test, you’ve been struggling with really intense feelings of shame and worthlessness *[experiential context identified by patient]* . Perhaps we could consider how these feelings end up playing out for you, and how you respond to them *[process-related mentalizing question]* ?”

If patients identify an experiential topic in a more general fashion (“I want to talk about my difficulties with self-esteem”; “My relationship with my mother is completely toxic—she does not care about anyone but herself, and that is never going to change”), we ask clarifying questions in order to elicit specific examples of the problem in question (*“This seems extremely important. Could you tell me about a time over the past week when you felt the worst about yourself?”* ; *“ ‘Toxic’ … that sounds horrible. Has she done anything recently that has really upset you?”*). We do this kindly but persistently, until patients have shared at least one or two examples of the difficulty under discussion. Since the treatment priorities always concern patients’ psychosocial situations in their actual lives, relevant agenda items usually involve some past, present, or future experiential context outside of sessions.

Similarly, patients can sometimes offer agenda items without clearly articulating the emotional meaning of the issue for them. For example, they might describe a situation in a more “reporter-like” fashion (“This happened,

and then that happened … ”; “I said this, and then he said that”). Or they can discuss a series of affectively laden events without specifying the most salient features of the scenario for them. Rather than make our own assumptions about the significance of the issue in question, we ask some open-ended question to elicit patients’ ideas about their particular investment in the matter. “What part of this feels most important to you?” “There’s a lot here … Is there something specific you would like to focus on?” “Clearly this whole situation was quite upsetting to you. Do you have a sense about what made this all so difficult?” This enables us to develop a mentalizing focus that more efficiently targets patients’ unique challenges in the area under discussion, and ultimately that relates most directly to the shared treatment priorities (Bateman, 2020 , pp. 20–21).

We tend to follow patients’ lead in setting the agenda for the session—devoting attention to the topics that they find the most important, and allowing patients to establish priorities for the session. This helps patients to feel like the sessions are personally meaningful to them, and that they possess a sense of agency in directing the process and focus of therapy. We also often have our own ideas about possible agenda items, for example following up on a topic from a previous session; some treatment priority not spontaneously mentioned by patients (e.g., suicidality, excessive substance use, interpersonal conflicts in a specific relationship); or a recent issue that has implications for the viability of the treatment as a whole (e.g., missed appointments, disagreements about the treatment priorities, an interpersonal pattern in the therapeutic relationship that could be interfering with mentalizing; Bateman, 2020 , p. 15). In such cases, we raise the issue in question in a marked way, asking to add the item to the session agenda as well:

> “I know that last week you were feeling extremely stressed out about your performance at work—feeling like you were making a lot of mistakes on your assignments, and even starting to doubt if you were competent enough to do this job. I would love to hear about how things have been going with that. Would you be OK if we added this to the agenda as well?”

In this way, we work with patients to collaboratively construct a list of potential agenda items for the session, summarizing this list and then inviting patients to rank these items in terms of personal importance to them.

THERAPIST: OK, so you would like to consider your anxieties about money, in particular how you’ve been managing these concerns in your relationship with your wife. That sounds like

an important thing to think about, especially given your long-term goal of improving your marriage. You're also up for sharing a bit about how you've been feeling about your job. What would you like to prioritize today?

PATIENT: Well, I guess we can talk about my work first, since there's not much to say and it won't take very long. Then we can have more time for the money stuff, which has really been weighing on me lately.

THERAPIST: Alright, that sounds great. Well, let me know how things have been going at work.

By and large, we try to build session agendas with one to two items per session. This allows for greater depth of mentalizing process for each agenda item, rather than more cursory or superficial "updates" about multiple agenda items.

While patients are usually receptive to discussing topics that we raise for consideration, there are times when patients are more dismissive of our preferences, declining to discuss an issue that we find important. If the topic itself feels more "optional" and not particularly urgent, we tend to defer to patients' preferences. However, if we see the topic in question as having a more pressing importance (e.g., regarding safety, functionality, the therapy itself, or a previously agreed-upon treatment priority), we take such moments as a useful opportunity to mentalize the interpersonal process unfolding in the current interaction.

We start by inquiring further about patients' reluctance to speak about the matter (*"So you really do not want to talk about your recent arguments with your boss. Could you say more about what keeps you away from that?"*), proceeding to empathically validate their perspective (*"I see, so it makes you MORE upset to talk about your boss, and you really don't want to enter into a negative headspace today. I think that's really understandable that you want to stay away from that"*). Without trying to alter patients' views in any way, next we communicate our own experience about the issue in question, including any reasons why it feels more important for us to discuss the topic:

> "While I definitely don't want to make you upset, I have to admit that I've been feeling a bit worried about you lately, ever since you told me that you only have 'one more strike' before you get fired. This probably feels even more pressing to me since you said that you would seriously consider suicide if you ever lose your job. If we don't spend at least a bit of time talking about how things are going at work, I feel like it could be difficult for me to focus on all of the other things that you are wanting to talk about today."

We then invite patients to reflect on the current relational dynamic (*"So where does this leave you?"* ; *"Any reactions to this?"* ; *"In light of this, do you have any sense about how we should proceed?"*), helping them to elaborate their current feelings about the interchange. In most cases, we are able to arrive at some compromise for the agenda that feels acceptable to both parties. If impasses continue to arise surrounding the agenda, we take that as a sign that the shared treatment priorities might need to be revisited and renegotiated (pp. 61–64), or that further mentalizing interventions could be needed to address some non-mentalized process unfolding in the dyad (e.g., patients' rigidity/inflexibility regarding certain feelings or topic areas, patients' dismissiveness toward our viewpoints).

Having collaborated with patients to develop a shared agenda for the session, we are now in a position to utilize the mentalizing interventions reviewed in this chapter: elaborating and empathically validating mental states; contextualizing these in some way; and finally identifying and addressing some process-related difficulty in reflectiveness. As discussed previously, we usually begin with patients' experiences "outside the room" and progress to more immediate experiential contexts (e.g., their experience discussing the topic in question, or in the therapeutic relationship itself). Once we transition to the new experiential context or the next agenda item, we tend to "start over" with the mentalizing interventions we have been discussing: first exploring mental content, then context, then process, and so on. In this way, we gradually move the session through the agreed-upon agenda for the appointment.

MBT-N offers considerable flexibility in structuring sessions, encouraging therapists to follow their own instincts, and to direct the focus of the meeting in a manner that is responsive to patients' evolving experience at the time. At times, a more cursory discussion of a topic is warranted. For example, patients "just want to give an update" about something that has happened since the last session, or time is running short in the appointment, and so we shift the area of focus in order to cover other important topics on the agenda.

As patients share throughout the session, new topics, themes, and pieces of information often emerge, which are not simply elaborations on the current issue and seem worthy of consideration in their own right. Similarly, *we* might have an idea that feels important to pursue further, for example if we notice some similarity between a topic under discussion and some challenge in mentalizing identified previously in the formulation. We simply

make sure to explicitly “mark” these shifts explicit in the therapeutic dialogue, to ensure that patients are aware of our shared focus in any given moment, and that such alterations are arrived at in a collaborative fashion. For example, we might say, “I was actually not aware that you have been researching suicide online recently *[current experience outside the therapeutic relationship]* . Would it be OK if we spoke about this further?” Or: “A few minutes ago, you mentioned in passing that ‘of course I’ll never get married again,’ and it seemed to me like you were tearing up a bit *[past experience engaging in the therapeutic activity]* . Could we talk a little bit about what was coming up for you in that moment?”

As the appointment nears its end, we usually spend a couple of minutes summarizing the work of the session: recapping the important topic areas covered; reviewing patients’ progress in mentalizing (e.g., increased elaboration of mental states in Self or Other, improved contextualization of these states, increased flexibility, improved ability to access emotions and desires); and underscoring any areas for future inquiry. This approach helps to reinforce important areas of progress, while also situating the work of the session within the broader context of patients’ core challenges with mentalizing and overarching treatment goals.

Chapter 5 contain excerpts from Drozek, R. P., & Unruh, B. T. (2020). Mentalization-based treatment for pathological narcissism. *Journal of Personality Disorders* , *34* (Supplement), 177–203.

6

Content-focused Interventions

In this chapter, we explore what we call the *content-focused interventions* in mentalization-based treatment for narcissism (MBT-N): clarification, affect elaboration, and empathic validation. As discussed previously, these techniques are all geared toward helping patients represent the “what” of their experiences. Broadly speaking, “experience” encompasses two distinct but related dimensions: some representation of reality (as lived or imagined by the person), and the person’s unique motivational investment in the representation in question. Clarification elicits these representations of reality; affect elaboration helps patients reflect on their subjective states (e.g., emotions, desires, motives, self-states) surrounding that reality; and empathic validation “reflects back” the evolving image that has been elicited through one or both these techniques (see Figure 6.1).

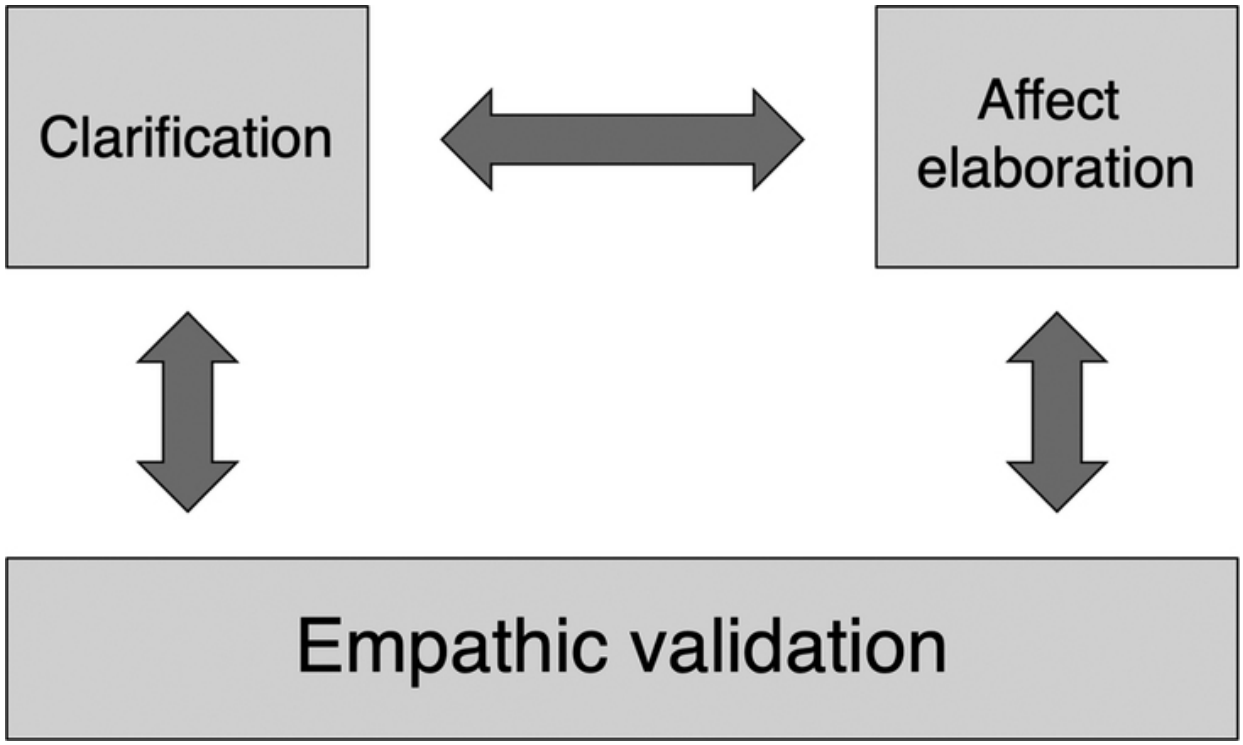

Figure 6.1 Content-focused interventions in MBT for narcissism. Therapists employ clarification to elicit patients' experiences of reality; they utilize affect elaboration to stimulate patients' reflection on their feelings about that reality; and they regularly return to empathic validation to "reflect back" the image that emerges throughout this process.

As discussed in the last chapter, the not-knowing stance cuts across all these interventions in MBT-N. Rather than making assumptions about the content of patients' experiences, we ask questions and invite elaboration about that content. Clarification thus involves inquiring about what happened, rather than presuming what happened. When attempting affect elaboration, we avoid drawing conclusions or making inferences about patients' feelings; we urge patients *themselves* to consider their feelings. And empathic validation entails reflecting back our understanding of what patients are directly communicating, as opposed to sharing our assumptions about what they "must" or "could" be experiencing. We will consider these interventions in turn.

Clarification

Clarification involves requesting information about the external details or "facts" of a situation: what happened, who was involved, what was said, and

what actions were taken, from patients' perspective (Box 6.1 ; Bateman & Fonagy, 2016 , pp. 249–250). On this view, clarification is always oriented toward reality, or at least reality as patients experience it. Among psychotherapists, clarification is often overlooked as a therapeutic technique; it can come across as mundane, pedestrian, and even superficial, especially compared to interventions focused more on emotions and desires. In contrast, we see clarification as one of the most essential techniques in the treatment of pathological narcissism (PN). Since patients' language is so influenced by their self-enhancement needs (e.g., emphasizing information that bolsters the self, minimizing information that undermines the self), their initial descriptions of situations often support a highly narrow range of affective experiences—namely anger, entitlement, and a sense of superiority or separateness from others. When we have a fuller description of what *actually happens* in patients' lives, we are better equipped to help them mentalize a broader range of their emotional experiences. On this view, "good enough" clarification is often a necessary condition for effectively utilizing all the other interventions at our disposal in MBT-N (e.g., affect elaboration, context-focused interventions, process-focused interventions).

Box 6.1 Clarification in MBT for narcissism

Clarification involves requesting information about the external details or "facts" of a situation: what happened, who was involved, what was said, and what actions were taken, from patients' perspective.

Through helping patients articulate a fuller description of reality, clarification serves as an essential step toward patients mentalizing a broader range of emotions in Self and Other.

Clarification can focus on various aspects of reality: current life circumstances; interpersonal relationships and interactions; facts about other people; patients' own behavioral patterns; patients' histories; chronological uncertainties; and broader chains of circumstance in patients' lives.

Therapists should seek out clarification until the situation passes the "picture test," when they have a clear image in their own mind of the scenario in question.

By and large, clarification focuses on experiential contexts outside of sessions, either in the recent or distant past, or in situations unfolding in an ongoing way in patients' lives. While we often ask clarifying questions about some topic patients have already been discussing, we can also invite patients to share about some aspect of reality for the first time. As reviewed in Table 6.1 , clarification variously involves requesting information about patients' current life circumstances; interpersonal relationships; facts about other people; specific interactions with others; patients' own behavioral patterns; visible aspects of patients' interpersonal patterns; patients' histories; chronological uncertainties; and broader chains of circumstance that seem relevant to patients' lives and relationships.

Table 6.1 Clarifying questions in MBT for narcissism

Specific aspect of reality	**Examples of clarifying questions**
Current life circumstances	"Where do things stand with your job applications?" "What is going to happen with your living situation?"
Interpersonal relationships	"Do you have any updates on your relationship with your children?" "You haven't mentioned your boss much lately. How have things been going with him?"
Facts about other people	"What do you know about this person?" "What does your friend do for work?"
Specific interactions with others	"What did your mother actually say to you at that moment?" "Where did you and your professor leave things with each other?"
Patients' own behavioral patterns	"How often were you drinking, prior to starting treatment?" "Could you walk me through a typical day for you: how are you actually spending your time?"
Visible aspects of patients' interpersonal patterns	"What are the specific things your wife does that really upset you?" "How do you respond when your boss gives you constructive criticism at work?"
Patients' histories	"It sounds like you moved around a lot as a child?" "Could you say a bit more about your employment history?"
Chronological uncertainties	"So you told him off before or after he made that comment about your haircut?"
Broader chains of circumstance	"Could you please take me back to when you first started feeling bad—where were you, and what was going on?"

As patients discuss these matters, we continue to ask for further details until the situation or relationship passes what we call the "picture test": *continue to seek clarification until we have a relatively clear image in our*

own minds of the scenario in question, such that we would be able to fully describe the scenario if we were writing a screenplay about it. "He said this specific thing, and then she said that particular thing." Or: "In interactions with each other, she tends to do this, and he tends to do that." Once a situation "passes" the picture test, we can feel reassured that we are considering a shared vision of reality with patients. This significantly decreases the chances of pretend mode dialogue in the therapy, while also paving the way for the affect elaboration techniques that are central in the treatment of narcissism.

It is important to note that, when we are asking clarifying questions about reality, there is often no clear distinction between "facts" and "feelings" in patients' narratives. Patients simultaneously talk about something that happened, what they think about it, and how they feel about it, all these elements often blurring together seamlessly in an inherently messy way. Accordingly, in everyday practice, we often utilize content-focused techniques in a non-linear fashion, as illustrated in Figure 6.1 : first gaining factual clarification about some situation, then elaborating emotions and desires surrounding that situation, and periodically returning to clarify further facts as the scenario becomes progressively more elaborated.

Affect elaboration

As discussed throughout this book, pathological narcissism is significantly associated with alexithymia, understood as the difficulty identifying, experiencing, and expressing one's own emotional states. This can result in a range of challenges for patients: overly cognitive, excessively concrete forms of thinking; a narrow spectrum of affective experience; and a significant sense of disconnection from themselves in everyday life. By working with patients to progressively elaborate their emotions and desires, we help them to lay the essential mentalizing groundwork for the development of a more cohesive, affectively grounded sense of self.

Affect elaboration is a broad family of strategies employed to help patients represent, expand, and deepen their experience of their emotional states. By understanding the various facets of an emotion (see Figure 6.2), we are better equipped to utilize the range of affect elaboration techniques at our disposal in MBT-N.

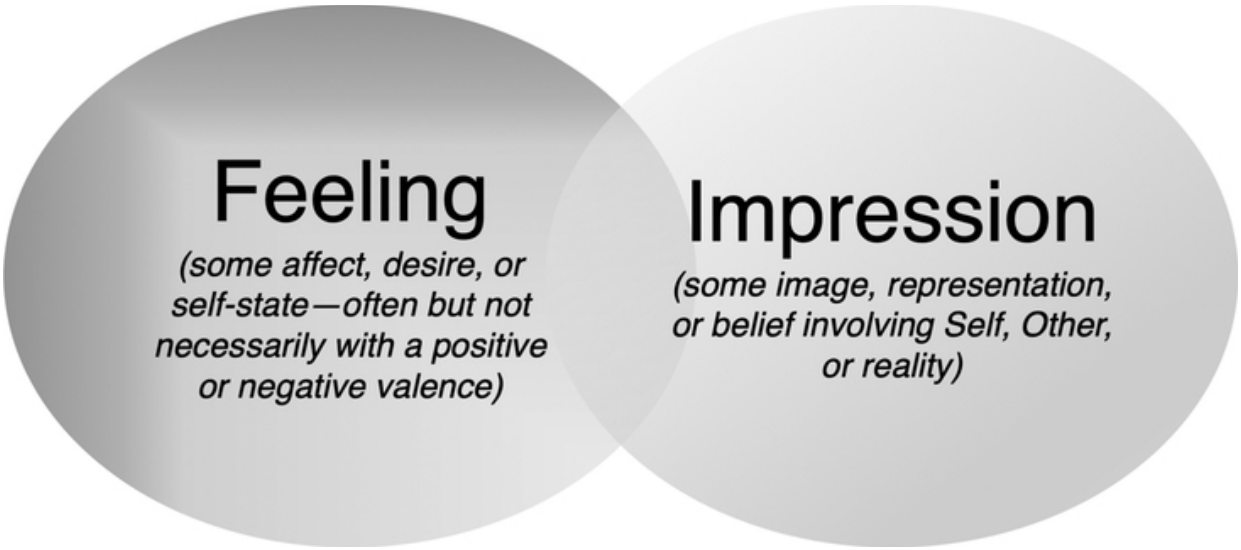

Figure 6.2 The structure of an emotion. Emotions can be understood as encompassing two broad elements: *feelings* , defined as some affect, desire, or self-state, usually possessing some positive or negative valence; and *impressions* , understood as some image, representation, or belief involving Self, Other, or reality.

We can conceptualize all emotions as consisting of two "parts": some *feeling state* , often but not necessarily with some positive or negative experiential valence; and some affectively charged *impression* of ourselves, other people, or the world more generally. As defined here, the feeling is always explicitly psychological and "internal" to the individual's own experience, while also being more affectively oriented and embodied in nature. Examples include affects (e.g., anger, joy, sadness, shame); desires (e.g., wish for attention or approval, urges for concrete things in the world, avoidant impulses); and self-states, or "feelings about oneself" (e.g., pride, self-confidence, self-hatred, feelings of worthlessness). In contrast, impressions tend to be more cognitive or "idea"-like in nature, including appraisals of oneself (e.g., regarding one's own psychology, qualities, or circumstances); views of other people (e.g., regarding others' minds, qualities, or circumstances); and perspectives on the world more generally (e.g., about the nature of events, objects, locations, or reality). See Table 6.2 for examples of possible feelings and impressions that might comprise a more elaborated emotional experience for patients. [1]

Table 6.2 Feeling states and impressions: Examples from clinical practice

Feeling state	Impression
“I’m sad and depressed.”	“I can’t believe that she would leave me like this.”
“I am going to be really anxious at the job interview tomorrow.”	“I feel like this is my only shot, and I do not want to screw it up.”
“I’m feeling pretty insecure and self-conscious right now.”	“I’ve gained a lot of weight since we broke up. I don’t look the way that I used to.”
“I was so angry at him.”	“He never thinks about anybody but himself.”
“I want her to like me, to be impressed with me.”	“I really respect her, and her opinion means a lot to me.”
“I love him so much.”	“He’s always been there for me, no matter what. I just feel really safe with him.”
“I felt completely ashamed and humiliated.”	“Everybody was looking at me, and I had no idea what to say.”
“I just feel so much better lately, actually happy for the first time in a long time.”	“I am finally starting to do well in my life: I’ve got a job, I’ve got a girlfriend, I’m not suicidal anymore . …”
“I felt guilty after our last appointment.”	“You were just trying to help me, and I kind of acted like a jerk to you.”
“I’m really excited about this new guy.”	“I felt connected to him right away, and I think he felt the same way about me, too.”
“At the time, I was pretty hurt by the whole thing.”	“They were just criticizing me, and not really appreciating how hard I was working to get this done.”
“I hate myself. I just feel worthless.”	“I’m 30 years old, and I still haven’t graduated from college.”

In our experience, patients with PN can display significant deficits in spontaneously elaborating a more three-dimensional picture of their emotional lives. At the start of treatment, they tend to communicate mostly impressions of themselves and others, rather than their feelings *about* these impressions. When they do reflect on their feeling states, they often do so in a vague and terse fashion (e.g., “I’m angry,” “I’m upset,” “I’m uncomfortable”), finding it challenging to reflect on the emotional and interpersonal meaning of these experiences for them. In turn, we often miss that these patients are *not* actually reflecting on their emotional states, reflexively filling in the gaps by making assumptions about what patients “must” be feeling or wanting in the scenarios under discussion. By appreciating this distinction between feelings and impressions, we are better attuned to what might be *missing* in patients’ own narratives, and thus better equipped to intervene more efficiently to stimulate mentalizing. With this

framework in place, we can now consider the various affect elaboration strategies in MBT-N.

Affect elaboration inquiries

From the perspective of affect elaboration, the most basic techniques involve asking targeted yet open-ended questions about patients' emotional states. Having already employed clarification to elicit patients' experiences of reality, we then "hold up" that depiction, offering some affect-related inquiry that invites patients to reflect on their emotions and desires in relation to the experience. "When your mother speaks to you in that way *[aspect of reality]* , what is that like for you *[affect-related inquiry]* ?" "What emotions come up for you *[affect-related inquiry]* , as you talk about this *[aspect of reality]* ?" "So you finally ended up telling him off *[aspect of reality]* . What did that feel like for you, to do that after all this time *[affect-related inquiry]* ?" Affect-related inquiries variously focus on broad subjective experience (*"What was that like for you?"* ; *"What is happening inside of you?"* ; *"How might that impact you?"*); affects (*"What were you feeling?"* ; *"What emotions are you experiencing?"* ; *"What was your mood like at that moment?"*); and desires, motives, and impulses (*"What are you wanting right now?"* ; *"What desires do you have here?"* ; *"As you took that action, what do you think you were hoping for?"*). Table 6.3 itemizes examples of these broad techniques, directed toward both past and present experiences inside and outside of the treatment setting.

Table 6.3 Examples of affect elaboration inquiries in MBT for narcissism

		Chronology	
		Past	**Present**
Setting	**Situations outside of sessions**	"What was that like for you?" "When you woke up that morning, what was your mood like?" "What emotions were coming up for you in that moment?" "When _____ happened, do you have a sense of what you were feeling?" "What do you think you were wanting at that time?" "What was happening inside of you, when all of this was going on?" "When they said that to you, how did that impact you?"	"When _____ happens, what is that like for you?" "What do you feel when she says that to you?" "What emotions do you experience there?" "Do you have a sense of what you are wanting in those interactions?" "What does that do to you, when they treat you in that way?" "What has your mood been like lately?"
	Patients' engagement in the therapeutic activity	"Can we go back to when you were describing _____. What emotions were you experiencing right then?" "Something seemed to shift in you as you were talking about _____. Did you notice any difference in how you were feeling at that moment?" "What was that like for you, to be sharing about _____?"	"How are you feeling, as you talk about this?" "Could you try to put words on what emotions are coming up for you right now?" "What is this like for you, to be talking about _____ for the first time?" "Where are you at right now?" "Do you have a sense of what you are most hoping for, as you are talking about _____?" "Where does this all leave you?"

We tend to liberally employ a wide range of these general techniques, flexibly tailoring our approach to patients' specific responses to our questions. When patients are especially cognitively oriented, we often eschew more abstract queries (*"What was that like for you?"*), instead prioritizing interventions that are explicitly focused on affects and desires (*"What emotions were you experiencing?"* ; *"What do you think you want*

from her?"). Throughout these explorations, we remain alert to the broad question: *Is this patient actually responding to the questions we are asking?* In many cases, in response to our inquiries about feelings and desires, patients respond by telling us more about their impressions about the situation under consideration. It is easy to overlook this and just "follow" the new narrative content. In contrast, we find it helpful to plant our feet and continue to express our curiosity about the feelings in question: "But I want to make sure we don't lose this: what EMOTIONS do you think you were feeling at that moment?" This sort of doggedness enables patients to orient toward their *internal* world rather than just external facets of situations. As patients are able to elaborate their emotions about some specific aspect of reality (e.g., some event, interaction, or relationship), we are ready to call attention to some other emotionally salient facet of the scenario, inviting reflection about that new facet (*"Now what about when he called you 'needy'? Do you remember what you felt at that moment?"* ; *"You mentioned before that your partner has been a bit more distant lately. What has that been like for you?"*).

One especially important "aspect of reality" is patients' actions themselves. Patients with PN often engage quite reflexively in their lives and relationships, *reacting* to others rather than thoughtfully considering relevant emotions and desires in themselves and other people. To help stimulate patients' reflection in these areas, we employ affect elaboration techniques focusing specifically on their behaviors in relationships, whether those be situation-specific maladaptive behaviors, broader interpersonal patterns identified in the MBT formulation, or more flexible, prosocial actions that are likely related to healthy mentalizing.

Here the technique involves specifying the action/interpersonal pattern in question, and then offering some affect-related inquiry that invites patients to reflect on their emotions and desires in relation to that behavioral experience. For example, we explore patients' feelings prior to taking the action (*"Before you started drinking that night, what was your mood like?"* ; *"It sounds like there was a time period before you decided to tell him off. What emotions were you experiencing then?"*); during the action (*"What was that like for you, to finally be honest about what was bothering you?"* ; *"How does it feel when you are taking care of her in that way?"*); and after the action (*"How did you feel after giving your presentation?"* ; *"Once you cancelled the date, what emotions came up for you?"*).

The original treatment program of MBT includes several sessions of group psychoeducation on the role of emotions in the treatment of personality disorders (Bateman & Fonagy, 2016 , pp. 303–312). When providing MBT-N in individual therapy, we sometimes find it useful to spend some time reviewing and discussing with patients the basic information covered in those modules: the different types of emotions (e.g., basic versus social, primary versus secondary); the importance of curiosity; the process of mentalizing emotions in Self and Other; and core strategies for emotion regulation. In this way, we can help patients build a meta-cognitive framework around emotions that enables them to appreciate the therapeutic and personal value of working to reflect on affects and desires—in treatment and in their everyday lives.

The affect elaboration interventional pathway

Having asked these initial affect elaboration questions, we proceed to follow a broad pathway for subsequent techniques to help patients further elaborate their emotional states (see Figure 6.3). In response to elaborative questions about their emotions, many patients share their impressions about the issue in question: they describe something that happened (“He just kept yelling at me”); they discuss other people’s qualities and characteristic (“She is extremely self-centered—it always has to be about her”); or they express their beliefs about themselves, other people, or the situation (“He had no right to be talking to me that way”). Here we respond by empathically validating the content of the impression in question, then inviting reflection about patients’ feelings in relation to the impression in question: “I see … so she is quite self-centered. How does that impact you, for her to be so self-involved?” Or: “So he was just yelling and yelling. What emotions were coming up for you in that moment?” If patients share further impressions at this point (“Well, she just doesn’t really care about me anyway, so there’s no point in me even trying to express myself”), we again work to empathically validate their perspective, redoubling our efforts to stimulate patients’ reflection about relevant feeling states: “There’s no point in you even trying … that sounds horrible. But what EMOTION does that bring up for you, to feel like there is no point?”

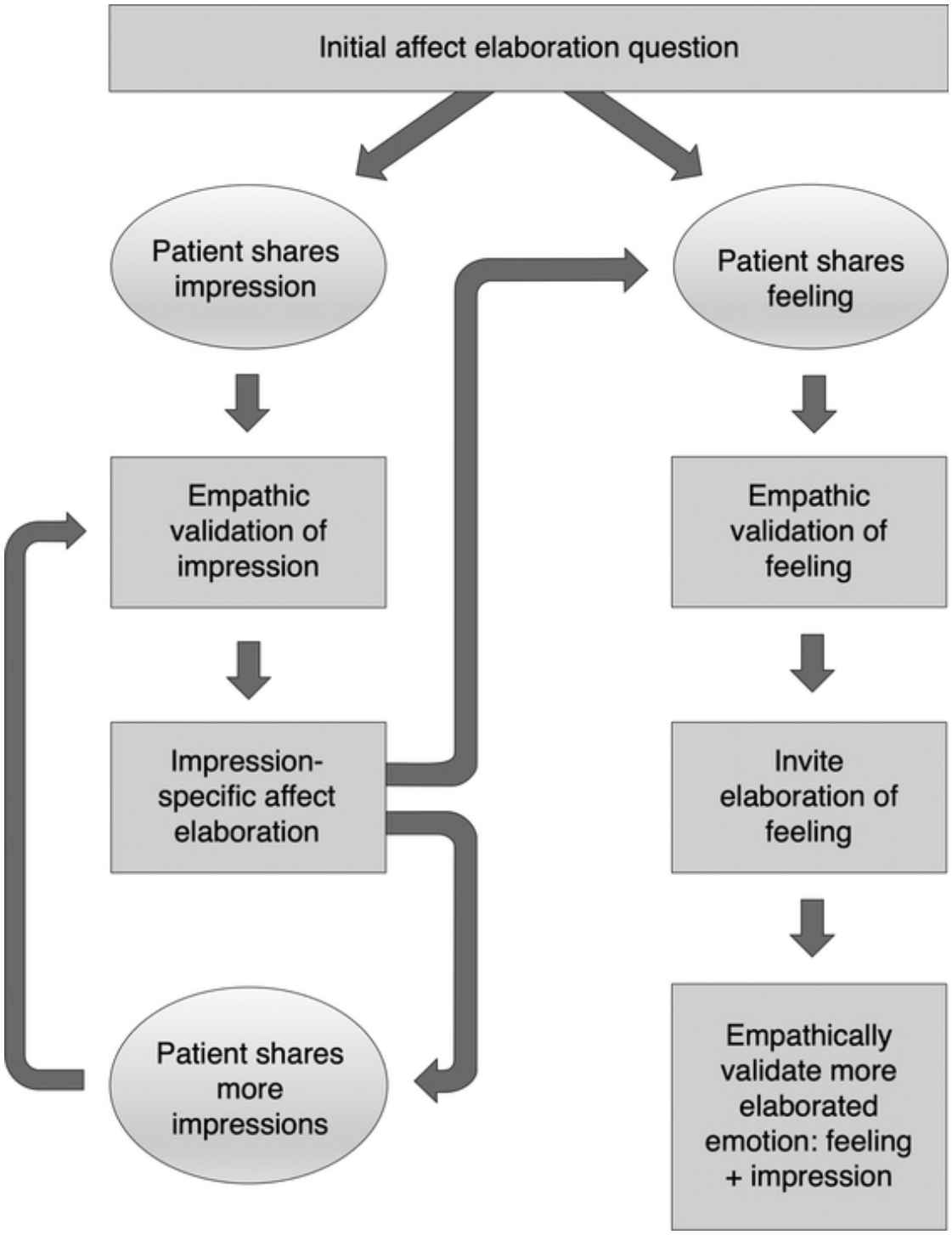

Figure 6.3 The affect elaboration interventional pathway. Therapists start by asking general questions about patients' emotions. When patients share their impressions, therapists empathically validate this and reorient toward internal feeling states. When patients articulate feeling states, therapists invite further elaboration and gradually work with patients to build representations of an increasingly complex emotional experience.

If we are dogged in our pursuit of these feeling states, patients usually end up discussing something that is a bit more "internal" to their experience, such as an affect, desire, or self-state ("I just end up feeling angry, and hopeless"). We become quite excited and curious in these moments, empathically validating these more internally oriented states and inviting further elaboration about them (*"Angry and hopeless—that sounds really important. Can you tell me more about this hopelessness?"*). As patients say more about their various feelings and impressions, we synthesize these states into a little "package" of subjectivity, delivering this back to patients and empathically validating the more elaborated experience that has emerged throughout this process:

> "I really appreciate what you've been able to put words on here. You take your girlfriend to be quite self-centered—she is not able to fully engage with your experience *[impression]* . This makes you feel angry, but it also gives rise to a feeling of hopelessness, since you feel like you're never going to get your needs met in this relationship *[feeling states and related impressions]* ."

In exploring these matters with patients, we utilize a handful of additional techniques to help them gradually expand the spectrum of subjective experiences under discussion (Box 6.2). We privately take note of any moments when patients explicitly or obliquely reference their internal feeling states, especially those that seem more complex, nuanced, or vulnerable than those expressed thus far in the session. We are ready to return to these states later, reflecting them back to patients and inviting further elaboration about them: "Earlier you mentioned you felt a bit 'hurt' when your brother didn't invite you over for the holiday. What was that hurt for you?" Or: "I heard you say 'of course' you wanted that promotion. Could you say more about that—what would have been nice about that for you?" We empathically reflect and summarize these elaborations back to patients, ideally at a level of nuance that matches the complexity reflected in patients' own narratives.

Along these lines, we tend to explicitly distinguish between different emotions, desires, and self-states that arise in the therapeutic dialogue, in order to reinforce patients' enhanced reflectiveness about these feelings. "I see, so in addition to feeling angry with your boyfriend for cancelling on you, you also felt quite hurt by him, like he didn't really want to spend time with you." "It sounds like you are quite anxious about the job interview tomorrow, feeling worried that you will make a bad impression on them. Am

I also picking up some insecurity, the feeling that you are not even qualified to work there?"

When attempting affect elaboration with patients with PN, beware of **pseudo-emotions** —that is, experiences that at first glance *sound* like representations of affects, but are really more externally focused impressions packaged in emotion words. Examples of these include terms like "rejected," "abandoned," "invalidated," "criticized," "controlled," "betrayed," and "disrespected." Such language is extremely common for patients with PN, especially when they are engaged in interactional processes they see as unjust or unfair. The patient might say, "I feel disrespected," but upon further exploration, it emerges that they are articulating their impression "That person disrespected me." If we fail to notice these sorts of constructions, we are likely to assume that patients have elaborated and reflected upon their internal states, while they still remain largely focused on other people's perceived defects.

To address pseudo-emotions, we utilize the basic techniques from the affect elaboration interventional pathway: empathically validating the impression associated with the pseudo-emotion (*"So it was clear that this guy was disrespecting you, and really treating you poorly"*); inviting reflection about patients' feelings in relation to that impression (*"What feelings did that bring up in you, to have him treating you in this way?"*); and ultimately encouraging elaboration of any internally oriented feeling states (e.g., anger, sadness, hurt) expressed throughout the conversation thus far (*"Anger … that seems really understandable. Could you tell me more about that?"*).

Another especially useful affect elaboration strategy involves exploring the reciprocal relationship between affects and desires. By and large, most affects imply the presence of some wish or desire, and most desires (satisfied or unsatisfied) give rise to some affective experience. So once we have helped patients to progressively elaborate a particular feeling state, we can then utilize that work as a starting point to "open things up" further about the experience in question: first by empathically validating the previously elaborated feeling, and then inviting reflection about associated affects and desires.

Box 6.2 Additional affect elaboration techniques

Reflect back previously expressed feeling and invite elaboration.

“Sadness?”
“Loneliness. What’s the loneliness?”
“So there’s a feeling of hurt there. Could you say more about the hurt?”
“Anger. What’s the anger about for you?”
“You mentioned that you are ‘excited’ about this upcoming date. What part of this feels most exciting to you?”

Explicitly distinguish between different emotions, desires, and self-states emerging in patients’ narratives.

“I see, so in addition to feeling angry with your boyfriend for cancelling on you, you also felt quite hurt by him, like he didn’t really want to spend time with you.”

Remain alert to **pseudo-emotions** in patients’ narratives: “rejected,” “abandoned,” “criticized,” “controlled,” “betrayed,” “disrespected.”

Pseudo-emotions sound like representations of affects, but they are really more externally focused impressions packaged in emotion words.
To address pseudo-emotions, empathically validate the related impression; invite reflection on internally oriented feeling states; and encourage elaboration of any affects/desires that emerge throughout this process.

Move from affects to desires.

“It sounds like you have been struggling with a real sense of sadness and loss ever since she broke up with you. Can you put words on what you are hoping for at this point?”
“So you felt like she was looking down on you, and you were really hurt by that. Do you a have sense of how you were wanting her to see you?”

Move from desires to affects.

“You’re expressing a strong desire to tell your father all of the ways that he has failed you. What would that do for you, to finally be able to confront him in that way?”
“So you desperately want them to be more responsive to you, to ‘see you’ as you are, rather than how they want you to be. How does that make you feel, that they are so consistently unable to do that?”

Explore patients' self-focused desires and fears about other people's mental states (e.g., cognitions, emotions, desires).

"What were you wanting her to think about you at that moment?"
"How would you most want them to feel about you?"
"Do you think you had any concerns about what they were thinking of you, or how they were feeling about you?"

For example, after one patient shares extensively about his feelings of anger toward his boss, we might shift the focus to any potential desires in this situation: "We've talked a lot about how angry you are with your boss for not appreciating how hard you've been working. What is your sense of how you might WANT him to be treating you?" Or for the patient who is sharing about her desire for her parents to be more empathically responsive to her, we could inquire about the affective consequences of this: "So you desperately want them to be more responsive to you, to 'see you' as you are, rather than how they want you to be. How does that make you feel, that they are so consistently unable to do that?"

We also explore how patients want other people to feel about *them* . As we have discussed throughout this book, people with PN can struggle with a highly contingent sense of self-esteem, whereby their self-worth is significantly determined by others' views of them. This conditional self-esteem is a significant driver of these patients' emotional and interpersonal instability, as they can struggle with depression, anxiety, and rage when they feel like other people are judging them, looking down on them, or failing to admire them. We thus directly inquire about patients' self-focused desires involving other people's mental states, variously concerning other people's cognitive processes (*"What were you wanting her to think about you at that moment?"* ; *"How do you want him to see you, as a person?"*); other people's emotions (*"How would you most want them to feel about you?"*); or others' wishes (*"Do you have a sense of what you are wanting him to want from you?"*). Along similar lines, if patients are expressing anxiety-related emotions about interpersonal relationships (e.g., fear, worry, concern, insecurity), we can invite reflection about their *worries* about the mental states of others: "Do you think you had any concerns about what they were thinking of you, or how they were feeling about you?"

For a clinical illustration of the above principles, consider the case of Trent. Here the therapist is attempting to utilize the affect elaboration interventional pathway to explore Trent's emotions surrounding a recent argument with his wife. Trent's wife had criticized his driving on a car ride, and then Trent had become defensive and argumentative with her.

THERAPIST: Well, that sounds like it was quite an intense situation: you driving, your wife criticizing your driving, and this whole argument unfolding while you were out there on the road. But could we go back to that moment when your wife first made that comment, telling you that you were being "careless and irresponsible" when you were making that turn *[directing attention to an aspect of reality]* ? What came up for you in that moment *[affect elaboration inquiry]* ?

PATIENT: Well, I mean it's simply not true. I am an extremely safe driver, and I always have been. *[sharing an impression]*

THERAPIST: So you know that what she was saying is not true, since you are such a careful driver *[empathic validation of patient's impression]* . But what EMOTIONS came up for you in that moment, given that she was misportraying you in this way *[impression-specific affect elaboration]* ?

PATIENT: Well, I guess some feelings of annoyance and irritation, like, "Why would you be talking to me in this way?" *[sharing more of an internal feeling state]*

THERAPIST: Absolutely, that makes complete sense: annoyed, irritated, and it sounds like specifically around this idea of how she was speaking to you? *[empathic validation and inviting elaboration of patient's expressed feeling state]*

PATIENT: This is what she does all of the time. Basically whenever people do not meet her very specific standards, she criticizes them and tells them what to do. *[returning to sharing impressions]*

THERAPIST: I see, so this criticism is something your wife can easily fall into, and this time it got aimed directly at you *[empathically validating new impression]* . But I just want to hear more about something you were saying back there, which seemed really important. You said, "Why would you be talking to me in this way?" Talking to you in *what* way, Trent? *[inviting*

elaboration about a possibly more nuanced area of experience]

PATIENT: With such disdain, such superiority. Like she's my boss or something, just telling me what to do. But she's not my boss; she's my wife! I don't tell her what to do, or how to drive. What makes her think she can speak to me in that way?

THERAPIST: Interesting … with disdain and superiority, like she was in a position of authority over you *[empathic validation of new impression]* . How did that make you feel about yourself, for her to be talking down to you like that *[impression-specific affect elaboration]* ?

PATIENT: Definitely not good. *[sharing vague feeling state]*

THERAPIST: What's the "not good"? *[requesting elaboration]*

PATIENT: You can call it whatever you want: worthless, deficient, embarrassed. All of those feelings. *[naming potentially more robust feeling states]*

THERAPIST: Can you say more? *[inviting further elaboration of expressed feelings]*

PATIENT: I mean, you know that I don't like myself very much. I've ruined a lot of things in my life, but I know that I am a competent person, and at the very least, I know that I can drive a stupid car. But when she talks to me like that, it's like she's saying, "Look at you, you can't even do this right." *[sharing affectively laden impression associated with negative feelings about self]*

THERAPIST: Thank you so much for sharing all of this, Trent. Initially you were most in touch with your feelings of anger and irritation, related to the idea that your wife should not be talking to you in such a critical, authoritarian way *[empathic validation of feeling plus impression]* . But as you spoke about this more, it also sounds like you felt like your wife saw you as somewhat incompetent, and this made you feel bad about yourself more globally: worthless, embarrassed, and deficient as a person *[empathic validation of additional feelings and impressions]* .

PATIENT: Yeah, I feel like that hits the nail on the head. I know that I shouldn't let her define me in that way, but I guess I still do . …

By doggedly yet empathically inviting Trent to reflect on his emotional states in this interaction, the therapist helps Trent arrive at a broader representation of his internal experience. As patients are able to consider a progressively wider range of their emotional experiences (e.g., affects, desires, related impressions), they develop an increased ability to notice and reflect on these processes as they unfold outside of sessions. This lays the groundwork for a more grounded, embodied experience of themselves in their everyday lives and relationships.

Affect elaboration of vulnerable emotional states

When utilizing the affect elaboration pathway reviewed above, we often find that patients are drawn to articulate more "power"-oriented emotions (e.g., anger, irritation, resentment, entitlement, and impatience), finding it more challenging to access and represent more "vulnerable" emotional states, such as sadness, shame, insecurity, and dependency upon others (pp. 29–30). These observations are consistent with MBT-N's theory of the narcissistic alien self, whereby the person feels compelled to actualize experiences consistent with their narcissistic ideals (e.g., strength, power, success, superiority, admiration) in order to maintain a sense of self-coherence (pp. 32–33). Accordingly, when practicing affect elaboration in MBT-N, we actively work with patients to expand their "emotional repertoires," such that they are able to increasingly access and represent a broader array of emotions and desires. Patients gradually come to experience themselves in more three-dimensional ways: with strengths and capacities, but also with vulnerabilities, emotions, desires, and needs. This decreases the need for alien self processes, as well as many of the maladaptive tendencies (e.g., aggression, argumentativeness, devaluation of others, avoidance, grandiosity, self-centeredness) associated with such processes.

See Box 6.3 for the specific techniques we have found most useful in helping patients elaborate their more vulnerable emotional states.

Box 6.3 Techniques for elaboration of vulnerable emotional states

Summarize some previously mentioned impression possibly associated with more vulnerable emotions, inviting affect elaboration in relation to that impression.

“You mentioned earlier that she also said to you, ‘You’re a loser and you’ll never amount to anything’ *[impression]* . How did that feel, for her to say that to you *[impression-specific affect elaboration]* ?”
“So it sounds like your professor is a very important person, with the power to make or break someone’s career *[impression]* . Do you have a sense of what you were wanting from him, as he was reading your paper *[impression-specific affect elaboration]* ?”

Provide psychoeducation about the ways that anger can hinder reflectiveness about divergent affective states.

Offer psychoeducation, summarize facets of reality likely to generate more vulnerable emotions, and reorient patients to internal processes.

Explore the emotional relevance of patients’ sense of self, identity, and self-esteem.

“So when your friend was criticizing you in that moment, how did that make your feel about yourself—who you are as a person?”
“It sounds like the divorce has really impacted you. How have you been lately, from the perspective of self-esteem?”
“With all of this conflict with your children, how does that make you feel about yourself as a dad?”
“I know you’ve been feeling much better since you got that promotion. What do you think it says about you, that you were finally able to make this happen?”

Temporarily shift the focus to more “positive,” vulnerable, or nuanced dimensions of patients’ experiences.

Direct patients’ attention to an experiential context where they experienced a broader array of mental states; explore emotions surrounding that context; and then return to the original experiential context for further affect elaboration.

Invoke the parts of patients’ MBT formulations that speak to their challenges reflecting on vulnerable affects, inquiring about the possible relevance of these processes to their current experience.

“In your formulation, we observed that you can sometimes get stuck in a more ‘angry’ feeling state, and you can find it challenging to reflect on your softer feelings, like hurt or insecurity. Could any of that be happening right now?”

Along these lines, the most essential technique involves inviting affect elaboration around the facets of reality that are likely to be associated with more vulnerable feelings. These can include potentially hurtful comments other people make toward them; events or interactions likely to trigger patients’ shame, embarrassment, or sadness; scenarios that inspire patients’ desires for recognition or admiration; or personal qualities or actions that we imagine patients could associate with some form of emotional pain. As patients share about their lives and experiences, we are actively listening for these sorts of impressions, holding them in reserve for when patients get “stuck” in a more two-dimensional representation of their emotional lives. Here we invoke the impression in question, shining a spotlight onto it and inquiring about patients’ feelings in relation to that impression. “You mentioned earlier that she also said to you, ‘You’re a loser and you’ll never amount to anything’ *[impression]* . How did that feel for her to say that to you *[impression-specific affect elaboration]* ?” “So it sounds like your professor is a very important person, with the power to make or break someone’s career *[impression]* . Do you have a sense of what you were wanting from him, as he was reading your paper *[impression-specific affect elaboration]* ?” Without supplying the content of the feelings in question, this approach constitutes a form of “affective focusing” that circumvents patients’ tendency to ignore and avoid those experiences that threaten their self-esteem, thus enabling them to reflect on a wider range of their emotional states.

When we are attempting affect elaboration with patients with PN, one of the most common challenges is their tendency to get stuck in an “anger” loop of affective experience: sharing externally focused impressions about other people’s problematic qualities and behaviors, and only articulating emotions consistent with these impressions (e.g., “anger,” “betrayal,” “disrespected”). In order to help patients step out of this closed, non-reflective system, we explicitly call attention to it, providing

psychoeducation about the ways that anger can hinder reflectiveness about divergent affective states.

> "Have you ever heard the saying that 'anger is a blanket feeling'? It means anger sometimes works like a blanket, covering over other emotions and desires that are a bit 'softer' and more vulnerable. You are talking a lot about what your wife is doing wrong in the divorce, and you are clearly in touch with a lot of your angry feelings toward her.
> But I'm worried that we are missing other feelings you might be having here, which could be relevant to this whole process of getting a divorce, having to move out of the house, and having to be separate from your kids *[summary of impressions possibly related to more vulnerable emotions]* . So bracketing the anger just for a moment, could you say anything about your *other* emotions regarding this whole experience: what you might be feeling, and what you might be most wanting here?"

By summarizing facets of reality likely to generate more vulnerable emotions, and by reorienting patients to their internal processes, we help patients consider a broader spectrum of their emotions and desires. When patients respond by sharing more externally focused content (*"I just feel betrayed … how could she do this to me?"*), we explicitly observe that and try to orient patients to their internal processes: "Yes, betrayal sounds very important, and understandable. But that still feels very focused on your wife and what she is doing wrong. Are there any OTHER emotions you might be experiencing, related to her leaving you, and all of these changes unfolding in your life?"

If patients remain quite outwardly focused even after we have attempted the aforementioned open-ended techniques, we often directly inquire about the emotional relevance of patients' sense of self, identity, and self-esteem. "So when your boss was criticizing you in that moment, how did that make your feel about yourself—who you are as a person?" "With all of this conflict with your children, how does that make you feel about yourself as a dad?" "I know you have been feeling much better since you got that promotion. What do you think it say about you, that you were finally able to make this happen?" This definitive emphasis on feelings "about self" is uniquely effective at directing patients' reflective processes toward internal experience, which is usually more nuanced and vulnerable in nature.

When patients are focusing extensively on more anger-related emotions, another useful technique is temporarily shifting the focus to more "positive," vulnerable, or nuanced dimensions of patients' experiences. As patients reflect on their emotional states in these (related but distinct) contexts, they are often able to return to the original topic area with an increased ability to

reflect on a broader array of mental states surrounding the issue in question. The technique here involves directing patients' attention to an experiential context in which we imagine they might have experienced more variegated mental states (e.g., more positive emotions toward themselves or others; more vulnerable affects, desires, self-states); exploring patients' emotions surrounding that other experiential context; and then attempting affect elaboration again around the original experiential context, in light of the more nuanced emotions that have been mentalized throughout this process. For example, consider the patient Joan, who was feeling frustrated with her supervisor after receiving constructive feedback on her recent performance appraisal. The therapist had been attempting to explore a wider range of emotional states around this situation, but Joan was becoming increasingly upset and agitated as she discussed the matter.

PATIENT: It is complete bullshit. This is not a fair portrayal of my work. I am one of the best salespeople this company has, and he has no right to mischaracterize me in this way.

THERAPIST: Well the more that we talk about this, it really does come across how upsetting this all has been to you, to be misrepresented in this way. *[empathic validation of Joan's current emotional state]*

PATIENT: Definitely.

THERAPIST: One thing that comes to mind for me is that there was a recent time when you were feeling really good about your job, and actually quite positively about your relationship with your boss. *[directing patient's attention to an experiential context where more nuanced emotions were present]*

PATIENT: That was the one time when he wasn't acting like an asshole!

THERAPIST: I remember that. Could you remind me a little bit about what that was like for you? *[inviting affect elaboration on the other experiential context]*

PATIENT: He just was finally being appreciative of me and the work that I was doing. He was complimenting me in staff meetings. He told me that my sales numbers were "off the charts." He even gave me that huge bonus. *[sharing impressions potentially associated with more complex emotions]*

THERAPIST: So he was really recognizing you, and being quite explicit about that *[empathic validation of impressions]* . How did

that make you feel, to finally be appreciated in that way *[affect elaboration inquiry]* ?

PATIENT: I felt amazing. For the first time in a long time, I was actually excited to go to work.

THERAPIST: Can you say more about that “amazing” feeling? *[inviting elaboration on previously expressed emotion]*

PATIENT: I mean, I actually felt good about myself. Like, “I am good at my job, I know what I am doing, and other people can see that, too.” You know how important work is to me, and to finally get that feedback, it was exhilarating. This is what I have been waiting for, and working so hard for.

THERAPIST: I really appreciate you putting words on all of this. You *have* been working so hard for so long, and when you finally received that positive feedback from your boss, it didn’t just make you feel good—it made you feel good about *yourself* . *[empathic validation of more positive emotional state]*

PATIENT: Exactly. I felt proud, and energized.

THERAPIST: Well, this makes me think about what this all must be like for you—to be feeling so validated by him and good about yourself before, and now for him to be telling that you can sometimes be “rude and off-putting” to your co-workers? *[attempting affect elaboration around the original context, in light of newly mentalized emotions]*

PATIENT: I mean, it has been very painful to me, to say the least.

THERAPIST: Painful? *[inviting elaboration about expressed feeling state]*

PATIENT: It has really hurt me, and made me feel pretty insecure. I want to do a good job there, and I don’t want to hear that my co-workers have a problem with me, and don’t like me. What am I supposed to do with that?

By considering her own mental states associated with an affectively gratifying experiential context, Joan was able to temporarily “sidestep” her anger-related emotions, returning to the original topic area with an increased ability to mentalize her more vulnerable feeling states in the situation.

Another technique for elaborating vulnerable emotions involves invoking the parts of patients’ MBT formulations that speak to these matters. When developing patients’ formulations, we highlight challenges in mentalizing likely to interfere with reflection on vulnerable emotions, including the

tendency to “miss” certain emotional states in themselves (in the “Content-related challenges” section); the lack of curiosity about one’s own mental states (in the “Dissociated and disconnected” section); and the propensity to ignore and minimize certain objective aspects of reality (also under “Dissociated and disconnected”; see pp. 69–79). Accordingly, when patients are struggling to reflect in these ways, we can sometimes invoke these parts of the formulation, inquiring about the possible relevance of these processes to the current interaction.

For example, we might say, “In your formulation, we observed that you can sometimes get stuck in a more ‘angry’ feeling state, and you can find it challenging to reflect on your softer feelings, like hurt or insecurity. Could any of that be relevant right now?” Or we could offer:

> “When we were developing your formulation together, we realized that sometimes you can become extremely focused on your judgments about other people, without being very curious about your own emotions and desires in the situation. I am starting to think about that in this situation. You seem quite focused on all your mother’s deficiencies, and I’m not hearing much about *you* in this situation: what you are feeling, and what you are really wanting from her.”

Or we might ask: “Do you remember how we have discussed your tendency to ‘put your head in the sand,’ and ignore the parts of reality that cause you pain and distress? As we talk about your boyfriend, I am noticing you are not mentioning any of the sexual difficulties you two have been having lately. What feelings come up when you consider talking about this?” Since patients have already seen the relevance of the problem in mentalizing to their lives, when we reference that problem in the current area of stuckness, they are often able to “step outside of themselves” and start reflecting on a wider range of mental states in the situation in question.

“If all else fails”: What to do when affect elaboration is ineffective

We have reviewed some of our core affect elaboration techniques—a range of open- and closed-ended questions that invite reflection about the content of patients’ emotional states. While these techniques are often quite effective, we find that some patients can still find it extremely difficult to identify and express their emotions and desires. They struggle to “put words on” their feelings; they focus extensively on concrete details of external circumstances; or they continue to itemize the wrongs and failings of other parties in their lives. Here we consider some interventions that we find

useful for particularly intractable forms of non-reflectiveness about internal processes, summarized in Box 6.4 . We usually employ these only *after* we have attempted the more emotionally oriented techniques considered thus far.

Box 6.4 Techniques for when traditional affect elaboration is ineffective

When patients are consistently sharing impressions rather than feelings, call attention to that process.

“I’m not sure if you’re aware that I have been asking you a bunch of questions about your emotions, but you are not actually sharing about your emotions. You’re just continuing to describe the situation.”
“I have been trying to find out more about your FEELINGS in your relationship with your father, but it seems like you are sharing more of your IDEAS about him, in a more abstract way.”

Empathically validate and invite reflection about patients’ difficulties reflecting on emotions.

“It seems like it’s actually quite challenging to articulate what you were feeling in that interaction. You’re working very hard here, but it all still feels quite confusing.”
“What do you think makes it so challenging to consider what you are feeling here?”

Explore the physical and bodily dimensions of emotional experience.

“Could you say anything about what you are experiencing physically right now?”
“Do you have a sense of where this emotion is located in your body?”
“Looking back on it now, did anything happen in your body as you were starting to get worked up?”

“Filling in feelings”—cautiously hypothesize about affects and desires we can imagine patients experiencing.

“If I were in your shoes, I would probably feel a bit hurt by what he was saying.”
To prevent pretend mode processes, if patients confirm the presence of the hypothesized feeling, invite further elaboration of associated impressions: “Looking back on it now, do you have a sense of what was making you feel so insecure?”

Attempt cognitive elaboration—invite patients to reflect on their cognitions, beliefs, or assumptions in the experiential contexts under discussion

"What went through your mind when she said that to you?"
"You were grimacing there for a few moments. What were you thinking?"
When patients articulate cognitions relevant to their affective experience, we invite elaboration of emotions in relation to the cognition in question: *"It sounds like you have been thinking a lot about your wife, and the way that things used to be in your relationship. How have you been feeling as you think about this?"*

If patients confidently assert that certain emotions and desires (e.g., hurt, insecurity, shame, anger, desires for attention) are definitively *not* present in their experience:

Suspend affect elaboration, and refrain from trying to convince patients that the feeling in question is present.
Empathically validate patients' certainty about the absent emotion: "*You feel quite clear that you have no insecurities about your work performance. This is the one area of your life where you are entirely confident about your skills and abilities."*
"Skip ahead" in the trajectory of interventions, proceeding to implement the process-focused interventions for psychic equivalence: "*What clues you in that you have absolutely no insecurities at work?"*

In cases where we have been asking affect-focused questions ("*How did you feel when she said that to you?"* ; *"What was that like for you?"* ; "*What emotions did that bring up for you?"*), and patients respond by sharing more impressions, we gently call attention to this process, in a manner that is kind rather than critical. "I'm not sure if you're aware that I have been asking you a bunch of questions about your emotions, but you're not actually sharing about your emotions—you're just continuing to describe the situation." "I have been trying to find out more about your FEELINGS about your relationship with your father, but it seems like you are sharing more of your IDEAS about him, in a more abstract way." In our experience, patients are frequently unaware they are not answering the questions we are asking; when we call their attention to this point, they are often then able to re-orient toward their own subjectivity.

If patients continue to struggle along these lines, we empathically validate their difficulties representing their feeling states. "It seems like it's actually quite challenging to articulate what you were feeling in that interaction.

You're working very hard here, but it all still feels quite confusing." Especially when said with a warm and understanding tone, this approach can alleviate patients' anxieties about "failing" at affect elaboration, taking the pressure off the task at hand. If patients are able to recognize their struggles reflecting on emotions, we can also invite reflection about those struggles themselves. "What do you think makes it so difficult to consider what you are feeling?" Paradoxically, when patients are able to become genuinely curious about their problems with mentalizing, they have begun mentalizing! This often opens up the pathway for more meaningful reflection on affects and desires.

As Bateman and Fonagy (2016) observe, another useful affect elaboration technique is inviting patients to reflect on the bodily dimensions of emotional experience: "Identifying feelings and their bodily precursors, then placing them in context, helps to reduce the patient's perplexity and reduces the likelihood that his/her feelings have to be managed through action" (p. 253). This is especially relevant for patients with narcissism, who are often both disconnected from their feelings *and* highly focused on external factors. Along these lines, we inquire about patients' physical experience in the present moment: "Could you say anything about what you are experiencing physically right now?" "Do you have a sense of where this emotion is located in your body?" We also can employ this technique when attempting affect elaboration around past experiential contexts, for example when exploring the emotional antecedents to patients' problem behaviors: "Looking back on it now, did anything happen in your body as you were starting to get worked up?" Since bodily experience exists somewhere "in between" the visible and psychological planes, it can provide a more accessible entry point for patients to begin reflecting on their emotional states.

At times, we also sometimes "fill in" patients' feelings by cautiously hypothesizing about potential affects and desires we can imagine them experiencing. Since our aim in MBT-N is to stimulate patients' *own* reflection about mental states (rather than co-opting the reflective process ourselves), we usually only employ this intervention as a last resort. We start by sharing some tentative hypothesis about patients' feelings, providing as little content as possible about the feelings in question. "If I were in your shoes, I would probably feel a bit hurt by what he was saying." "In the past, I remember that you have actually felt quite ashamed whenever your wife

did not want to have sex with you." "I wonder if you were experiencing any insecurity in that situation?" If patients affirm the relevance of the hypothesized feeling, we then invite them to elaborate on any associated impressions. "Say more: how is the hurt relevant here?" "That seems really important. What do you think the shame is about for you?" "I am glad that you feel like that resonates. Looking back on it now, do you have a sense of what was making you feel so insecure?"

When patients respond by simply restating the emotion without further elaboration ("Well you know, 'ashamed' … what more is there to say?"), we consider the likelihood of pretend mode processes, wherein patients "absorb" our ideas without authentically reflecting on their internal states (see Chapter 8). However, if patients respond by spontaneously expounding on the emotions in question, then we are free to utilize the affect elaboration strategies outlined throughout this chapter. The purpose of such interventions is not to convince patients that they are experiencing any particular emotions. Rather, even when patients are considering "whether or not" they are feeling some emotion, or reflecting on why such an emotion might be absent, they are adopting a more curious stance toward their emotional life, which over time enables them to access a broader array of affective states.

There are times when, no matter how many different interventions we try, patients are unable to say very much about their emotions and desires. While this can be disheartening to the earnest clinician, it is important to remember that this is an expected part of working with patients with narcissism, whose core challenges with self derive (in our view) from deficits in representing their own mental states. When all else fails, one final elaborative technique involves inviting patients to reflect on their cognitions, beliefs, or assumptions in the experiential contexts under discussion. Since cognitive structures are inherently *internal* to patients' psychology, reflecting on them represents a higher level of mentalizing than strictly focusing on external, concrete factors. For patients with alexithymia, such reflection often feels less challenging than identifying emotions, and it can make them more receptive to affect elaboration at a later stage of the therapeutic dialogue.

When attempting cognitive elaboration, we start by asking some open-ended question about patients' thinking, along the lines that we have described with affects and desires. "What went through your mind when she said that to you?" "When you are isolating like that, what do you find yourself thinking about?" "You were grimacing there for a few moments.

What were you thinking?" "You seem to have some strong opinions about what is going on at work right now. Can you put words on that at all?" We empathically validate patients' thoughts and viewpoints here, privately taking note of any process-oriented difficulties with reflectiveness (e.g., certainty, concreteness, disconnectedness) for future attention as we proceed down the trajectory of mentalizing interventions (see Chapters 8 –10).

When patients articulate cognitive impressions that seem potentially relevant to their affective experience, we then invite elaboration of emotions in relation to the cognition in question. "As you imagine going on that job interview, what emotions come up for you?" "It sounds like you have been thinking a lot about your wife, and the way that things used to be in your relationship. Do you have a sense of what you are wanting from her right now?" If patients are then able to give voice to any affects or desires, we can proceed to utilize the affect elaboration pathway reviewed earlier in the chapter. In this way, we help patients move toward a progressively expansive, complex representation of their internal states.

One additional clinical scenario warrants special attention. As we work with patients to elaborate their affective experience, they often express their views that certain emotions and desires are definitively *not* present in their experience. For example, they might confidently deny experiencing feelings of hurt, insecurity, shame, anger, and desires for attention from other people, despite the fact that one would expect such emotions to be present in the scenarios under discussion. While initially this might come across as a deficit in reflecting on the content of mental states (pp. 65–68), in our experience, patients' rigid certainty here usually constitutes a *process-related* problem in mentalizing, which in MBT we see as psychic equivalence mode (pp. 66–68). "I am 100% certain that I am NOT feeling this thing." These forms of certainty are often related to the narcissistic alien self processes discussed in Chapter 2 (pp. 32–33). Especially when the emotions in question contradict patients' ideal views of themselves, such feelings threaten patients' sense self-coherence and self-continuity. At a phenomenological level, these emotions literally *cannot* be present in patients' subjectivity, lest patients descend into an unbearable state of fragmentation, instability, and incoherence in their sense of self.

Therefore, once we recognize such forms of certainty in patients' experience, we suspend our pursuit of the affect elaboration strategies reviewed in this chapter. We also refrain from trying to rationally convince

patients of the presence of the feelings in question. Such strategies usually only lead to unhelpful debates in the treatment, or alternatively to pretend mode compliance, where patients cognitively agree that they "must" be feeling some emotion, but the emotion is nowhere to be found in their subjective world. In contrast, we first empathically validate patients' certainty about the absent emotion. "You feel quite clear that you have no insecurities about your work performance. This is the one area of your life where you are entirely confident about your skills and abilities." Or: "So there is no way that you are feeling angry with your wife about her having the affair. You understand why she did it, and right now you just want to help and support her." We then "skip ahead" in the trajectory of MBT-N interventions (pp. 88–95), proceeding to implement the process-focused interventions for psychic equivalence reviewed in Chapter 9 : exploring patients' process of arriving at their rigid viewpoint (*"What clues you in that you have absolutely no insecurities at work?"*); then examining the consequences of the certainty in patients' experience (*"What is that like for you, to feel so confident about your skills and abilities?"*); and so on (see pp. 198–209). In this way, we help patients gradually work toward a more flexible perspective about their emotional lives, thus opening the door for them to consider a broader range of their internal experiences as the treatment progresses.

Affect elaboration of other people's mental states

Thus far, we have considered therapeutic strategies geared toward stimulating patients' reflection on their own mental states. However, as we reviewed in Chapter 4 , patients also experience difficulties reflecting on the content of *other people's* minds. When asked to ponder others' feelings, they can become confused and "draw a blank." They often overlook important motives and emotions in other people, drawing inaccurate, biased, or incomplete conclusions about such processes. These assumptions then significantly influence how patients experience and approach interpersonal relationships, leading to interpersonal tendencies toward defensiveness, argumentativeness, dismissiveness, and self-centeredness. As we help patients mentalize a greater diversity of other individuals' psychological states, they are able to experience deeper forms of understanding and connectedness with others, opening up pathways for more adaptive communication and interaction.

From the perspective of technique, all the principles we have reviewed for elaborating patients' own emotions can be utilized for elaborating other people's feelings as well (Box 6.5). The most basic technique involves "holding up" some aspect of reality for patients and then offering some affect-related inquiry that invites patients to reflect on the other person's emotions and desires in relation to that reality. "What do you think that is like for your wife *[affect-related inquiry]* , to find out you have been lying about the gambling *[aspect of reality]* ?" "When your friend said that to you *[aspect of reality]* , how do you suspect he was feeling *[affect-related inquiry]* ?" Other-focused affect-related inquiries variously focus on broad subjective experience (*"What do you imagine that was that like for him?"* ; *"How do you think your comment affected your girlfriend?"*); affects (*"When she went silent like that, what do you think she was feeling?"* ; *"What has your father's mood been like lately?"*); desires and motives (*"What do you imagine your wife is hoping for at this point?"* ; *"What do you think your boss is wanting you to do differently?"*); and self-states (*"When you said that to him, how do you think that made him feel about himself?"* ; *"Do you have a read on her sense of identity—how she sees herself as a person?"*).

Box 6.5 Techniques for affect elaboration of other people's mental states

"Hold up" some aspect of reality for patients, and then offer some affect-related inquiry about the other person's emotions and desires in relation to that reality.

"What do you think that is like for your wife *[affect-related inquiry]* , to find out you have been lying about the gambling *[aspect of reality]* ?"
"When your friend said that to you *[aspect of reality]* , how do you think he was feeling *[affect-related inquiry]* ?"

When patients present more two-dimensional portrayals of other people's mental states, utilize techniques for elaborating more vulnerable emotions.

Always start by empathically validating patients' impressions of the other person: *"He really has a lot of animosity toward you, even wanting to get revenge against you."*
Summarize aspects of reality associated with more nuanced emotions in the other individual, inviting reflection on relevant emotions: *"You mentioned previously that your wife was actually crying during the argument* [aspect of reality]. *What do you imagine she was feeling in that moment* [affect-related inquiry]*?"*
Give patients feedback about their two-dimensional portrayals of others, encouraging them to consider a broader spectrum of feelings than initially occurs to them.

Once patients begin reflecting on other people's mental states, utilize the content of these reflections to encourage further elaboration of patients' own feeling states.

Start by empathically validating patients' impressions of the other party's mental state: *"So you feel like your wife was judging you, even looking down on you for having these difficulties at work."*
Inquire about patients' emotional experience of the other's presumed mental state: *"When you felt like your wife was judging you, how did that make you feel about yourself?"*
Ultimately articulate some synthetic statement that "links" the other person's mental state with patients' own emotional experience: *"It sounds like your wife's opinion of you can really impact your self-esteem. When she is seeing you in a negative light, it can make you feel worthless and ashamed."*

When patients proceed to reflect on the other person's internal states, we empathically validate these reflections and invite further elaboration on them: "So you feel like your wife has been sort of sad and withdrawn, and a little irritable with you. Can you say more about the sadness?" We also encourage patients to consider how they arrive at the reflection in question: "What clues you in that your son has been feeling more insecure lately?"

If patients respond by sharing impressions or ideas about the other person ("He's just completely self-absorbed—he doesn't care about anybody but himself"; "This is the same way that my wife's mother is. I think this is just what she learned in childhood"), we empathically validate these impressions as well, redirecting patients' attention to potentially relevant affects and desires: "It sounds like he can be extremely self-centered. When he's all caught up in himself like that, what emotions do you think he's feeling?" "OK, so these patterns go back a long way for your wife. But I'm still curious: what do you think she is most wanting from you, when she is going through this list of the things you have done to hurt her?"

Even when patients reflect on internal dimensions of other people's experiences, they can still sometimes present a highly two-dimensional pictures of the person in question. "She just wants to control me." "They're jealous of me. They can't stand it when anything good happens to me." "He hates me. He was just wanting to get back at me for calling him out." Here we respond by empathically validating patients' experience of the person ("*He really has a lot of animosity toward you, even wanting to get revenge against you"*), then utilizing the various techniques for elaborating more vulnerable emotions. If patients have described any aspect of reality (e.g., specific comments, behaviors, or objective circumstances) possibly associated with more nuanced emotions in the other individual, we summarize that feature and invite reflection on relevant emotions: "You mentioned previously that your wife was actually crying during the argument *[aspect of reality]* . What do you imagine she was feeling in that moment *[affect-related inquiry]* ?" "What do you think it's like for your son *[affect-related inquiry]* to have to say goodbye to you, knowing that he won't be seeing you again for so long *[affect-related inquiry]* ?"

As patients reflect on the internal experiences of the person in question, we flexibly utilize the techniques already reviewed for patients themselves: following the affect elaboration pathway; explicitly distinguishing between different emotions, desires, and self-states that progressively emerge in

patients' narratives (*"I see, so in addition to feeling angry with you, you think she also might have felt somewhat embarrassed. Could you say more about the embarrassment?"*); and exploring the reciprocal relationship between desires and affects (*"It sounds like you think he was feeling hurt by your comment. Do you have a sense of what he was wanting from you in that interaction?"* ; *"So you suspect that she has been wanting you to communicate with her more directly—to stop withdrawing when you get upset with her. What would that be like for her, if you were to be more open about your feelings?"*).

If patients continue to endorse more two-dimensional views of the other person's emotional states, we have a handful of techniques at our disposal. First, we can give patients feedback about their constricted reflectiveness along these lines, using this as a spur for them to consider a broader range of subjective states in the other person.

> "The more that you talk about your mother, she comes across as this aggressive demon who just wants to harm and control you. While I suppose she could be that two-dimensional, in my experience, people tend to be a bit more complex than that, usually experiencing a wide range of feelings and desires—some of them malicious, others more positive. Do you think that your mother might have *any* good motives here?"

If we have already identified these forms of constrained reflectiveness in patients' formulations, we might invoke these parts of the formulation and inquire about the possible relevance of these processes to the current interaction: "In your formulation, we noticed that you sometimes get 'stuck' focusing on how problematic other people are, and you can ignore some of their more positive or vulnerable feelings in the situation. Could any of that be happening as you talk about your boyfriend right now?" As a last resort, we can also tentatively hypothesize about what the other person might be feeling, inviting patients to reflect on what we are proposing: "Personally, I have been wondering if your co-worker might have felt a bit anxious or even afraid, given how angry you were and how you were speaking to her. What do you think about that?" In different ways, all these techniques call attention to aspects of subjectivity that patients might be *missing* in their reflection about others, thus encouraging patients to consider a broader spectrum of feelings than initially occurs to them.

Once we have been able to successfully stimulate patients' reflection on other people's affects and desires, we can then utilize the content of these reflections to help patients further elaborate their own emotional

experiences. Especially for patients with vulnerable narcissism, their emotional states and feelings about themselves can be significantly impacted by their assumptions about the feelings of others. Such processes often unfold outside of patients' full awareness, placing them at risk for more reflexive, impulsive reactions to other people (e.g., defensiveness, argumentativeness, avoidance, attention seeking). As patients recognize their own emotional response to other people's feelings, they start to develop something of a "reflective buffer" that enables them to engage with others in a more agentic, less reactive manner.

From the perspective of technique, we start by empathically validating patients' impressions of the other party's mental state (*"So you feel like your wife was judging you, even looking down on you for having these difficulties at work"* ; *"It sounds like the interview went really well, and that everyone was really impressed with you and your experience"*), then offering some affect-related inquiry about patients' emotional experience of the other's presumed mental state (*"When you felt like your wife was judging you, how did that make you feel about yourself?"* ; *"What was that like for you, for everyone to be so impressed with you?"*).

We work with patients to explore and elaborate their feelings along these lines, gradually articulating some synthetic statement that "links" the other person's mental state to patients' own emotional experience. "It sounds like your wife's opinion of you can really impact your self-esteem. If she sees you in a negative light, it can make you feel worthless and ashamed." Or: "This experience at work seemed to mean a lot to you. When your co-workers were appreciating you, you ended up feeling much more confident, and even proud of yourself." These reflections function as "mini formulations" for patients with PN, enabling them to start forming representations of themselves as psychological beings whose identity and emotions exist in a dynamic relationship with other people's mental states. This lays the groundwork for more advanced *process-focused* interventions for patients' challenges with identity (see Chapters 9 & 10), where we help patients mentalize their tendency to base their self-esteem and identity on factors outside of themselves.

Empathic validation

Empathic validation stands as perhaps the most foundational intervention in MBT for narcissism—the single technique that we liberally employ at all stages of the trajectory of interventions, and to which we can always return when we feel lost or confused about what to say or do (Bateman & Fonagy, 2016 , pp. 238–245). As a therapeutic approach, "empathy" and "validation" are an important part of most therapies, although the meaning of such terms can vary widely depending on the modality in question. In MBT-N, we define empathic validation as the *marked* , *contingent* , and *supportive* reflection of patients' subjective state (Box 6.6 ; Drozek & Unruh, 2020).

Box 6.6 Characteristics of empathic validation in MBT for narcissism

Empathic validation involves therapists attempting to "put words on" their own understanding of patients' experiences, including patients' emotions, desires, self-states, and overall "impressions" of themselves and others in their lives.
This validation is *marked* —it maintains a distinction between the patient's mind and the therapist's mind.
Empathic validation is *contingent* —it refers to patients' conscious subjective experience in the present moment.
Such validation is *supportive* of patients' perspective, explicitly affirming that it is reasonable, understandable, and valid for patients to experience the situation in this particular way.

Such validation is *marked* in that it maintains a distinction between the patient's mind and the therapist's mind. We offer empathic statements that clearly refer to patients' mental states, rather than our own feelings and experience. This involves a persistent attempt to understand a situation from patients' perspective, without becoming excessively activated by (or merging with) their emotional states. So if a patient were passionately expressing her anger toward her boss, we would avoid saying, "How could he do that to you? That is completely unfair and wrong" (a contingent but non-marked response), instead offering something like, "It sounds like that was horribly upsetting to you—he never thought to consider things from your perspective" (a contingent and clearly marked reflection). This is particularly important for patients with narcissism, who often teleologically

equate agreement/sameness with interpersonal closeness, and disagreement/difference with interpersonal separation and even enmity. By clearly marking our empathic reflections, we maintain a focus on patients' own mental states, which helps them to become more aware of these states *as* internal events, rather than simply "the truth" about the situations under consideration.

Such validation is also *contingent* in that it refers primarily to patients' subjective experience in the present moment. Patients need to feel like we are *seeing* them as people, and that our understanding of them corresponds to what they are actually feeling. To that end, we try to remain as experience-near as possible in such efforts, attending to emotions, thoughts, and attitudes that are emerging most prominently in patients' conscious experience. For example, in the aforementioned example about the patient's boss, we would not initially highlight the more vulnerable dimensions of the patient's experience (e.g., hurt, insecurity, desires for attention), instead reflecting the "manifest" emotional content of her narrative: "You were absolutely outraged that he said that to you—it just did not seem fair." Such contingent reflections are essential in addressing the alexithymia often associated with PN, helping these patients to access and represent their current emotions—a necessary step toward expanding the breadth of their emotional experience.

Finally, such validation is explicitly *supportive* of patients' perspective. We do not simply describe or summarize patients' viewpoint; rather, we affirm that it is *reasonable, understandable, and valid* for them to experience the situation in this particular way. So, continuing with the example of the patient feeling angry with her boss, we might say something like, "No wonder you got so upset with him in that situation—you had been working so hard on that project, and it felt like he was completely dismissing you." We view this sort of supportive approach as crucial to the effective treatment of PN. In our experience, colder or more "neutral" technical approaches, in which therapists see themselves as merely describing or interpreting internal processes, are often too emotionally activating for these patients, resulting in increased rigidity, unnecessary power struggles, and treatment drop-outs. In contrast, as patients progressively come to feel like the therapist is accurately and supportively understanding them, they start to feel safe enough to reflect on subjective states in Self and Other in more flexible, authentic, and expansive ways. These observations are consistent with the mentalization-

based model of narcissism proposed earlier, in which narcissistic self-enhancement is conceptualized as a psychologically necessary effort to restore self-continuity in the context of attachment-related stress (Chapter 2).

Technical principles of empathic validation

There are a handful of technical principles that we try to follow when practicing empathic validation with patients with pathological narcissism (Box 6.7). Consistent with MBT's not-knowing stance, we offer our empathic reflections with humility and tentativeness, prefacing our statements with marked qualifications like "It sounds like you feel …" or "You seem to be feeling . …" From one perspective, every empathic reflection is an implied question, as if we are saying: "This is my best understanding of what you are feeling, but I really might be wrong. What do *you* think about my impression?" We are then quite curious about patients' response to our reflections—the extent to which patients resonate with what we are saying, versus elaborating or clarifying further in order to better express how they are experiencing the situation. We are always ready to "revise" our empathic reflections in response to patients' feedback: "I see, so you weren't simply feeling hurt by your boss, there was also an emotion of anger as well, and a desire to really 'tell him off'?" On this view, empathic validation is better understood as a process rather than a destination: our effort to give patients a snapshot of how we are seeing them at that particular moment in time, with the full recognition that every "snapshot" is an imperfect representation that will never do justice to the full complexity of their experience.

Box 6.7 Technical principles of empathic validation in MBT for narcissism

Offer empathic reflections with humility and tentativeness, prefacing statements with marked qualifications like “It sounds like you feel …” or “You seem to be feeling . …”
Deliver empathic reflections that “match” patients’ preceding narratives, at the level of content as well as complexity.
Liberally and frequently utilize empathic validation—do not allow several minutes to go by without offering some form of empathic reflection of patients’ experiences.
When possible, empathic validation tends to focus on patients’ *feeling states* .
If patients are unable to articulate their own emotions, empathically validate patients’ broad *experience* of the situation under discussion (e.g., beliefs, descriptions, or impressions).
“Mirroring the affective process”—when patients are unable to access the emotional states they are describing, therapists give themselves permission to *join* patients in these states.

This can involve explicitly affirming the validity of patients’ experiences (*“That is really unfortunate—I am really sorry that this happened to you”)* , or offering empathic reflections while inhabiting the affect in question (e.g., through non-verbal experiences like tone of voice or facial expressions).

Along similar lines, when attempting empathic validation in MBT-N, we try to deliver empathic reflections that “match” patients’ preceding narratives, at the level of content but also in the degree of complexity. From the perspective of content, we only reflect an experience that patients have explicitly articulated, or that is so overt that it seems to be “on the tip of their tongues.” This means that we empathically avoid “filling in” or assuming the emotional meaning of patients’ communications, as this would unhelpfully co-opt the mentalizing process for patients. Consider this example of one therapist’s non-contingent empathic reflection.

PATIENT: My fiancée blew up at me again the other day. She keeps saying that I am spending too much time on my work, and that I’m not really invested in the relationship. I am fed up with being treated this way by her. She wants me to earn extra

money for the wedding, but then she criticizes me for working more hours!

THERAPIST: You are clearly hurt by how she is treating you. It is understandable why you would be so upset by this. She doesn't seem to appreciate how hard you have been working lately.

While the therapist here is attempting to be supportive of the patient (*"It is understandable why you would be so upset by this"*), he appears to be making assumptions about the patient's experience in several important ways. First, he is assuming that the patient is feeling hurt by his fiancée's behavior. While that assumption is entirely reasonable, the patient has not yet expressed this feeling, and so we would not include this in our empathic reflections. Similarly, the therapist is assuming that the *reason* why the patient is upset is because his fiancée is not appreciating how hard he has been working. That might be true, but the patient has not yet articulated that perspective.

In contrast, a more "contingent" or "congruent" empathic reflection might be:

THERAPIST: It sounds like you are starting to get fed-up with these criticisms. It doesn't seem fair—she is criticizing you for doing the exact thing she asked you to do.

Here the therapist is reflecting back the patient's own words about his feeling states ("fed up"), while also articulating an impression that is clearly manifest in the patient's narrative—namely, that the patient feels like his fiancée is somehow unjustified in criticizing him, given the broader context of the situation. While the patient never explicitly describes his fiancée's behavior as "unfair," this term seems like another way of expressing the same idea that the patient is communicating.

We also attempt to mirror the level of complexity in patients' narratives. That is, we reflect whatever nuances of experience patients are explicitly communicating in the current moment, without "adding in" nuances that patients are not directly articulating. Consider this example of a clinician's non-congruent empathic reflection.

PATIENT: It is really difficult to be living in the house without my wife and kids. I'm feeling lonely without them, but mostly just sad when I think about all the things we used to do with each other there. Just the little stuff, really: helping them with their

homework, playing video games together, having dinner as a family. I just can't stop thinking about that stuff, playing it over and over in my mind.

THERAPIST: There's a lot of sadness here. Can you say more about that?

Here the patient is describing an emotionally painful experience at a relatively high level of complexity, involving multiple feeling states (e.g., loneliness, sadness), identification of context (e.g., living in the house alone), affect-imbued memories, and current cognitive processes (e.g., ruminations about the past). The therapist, in turn, attends only to the patient's feelings of "sadness," not mirroring the multiple sadness-related impressions the patient has already elaborated. This makes it seem like the therapist is not fully appreciating the nuanced emotional meaning of this experience for the patient.

In contrast, see here for an empathic reflection that more fully reflects the emotional complexity of the patient's dialogue.

THERAPIST: It sounds like you're feeling really sad and lonely without your family, and caught up in remembering the life you used to have together.

Here the therapist is mirroring the two specific feeling states the patient has already articulated (e.g., sadness and loneliness), along with one aspect of the patient's experience (e.g., ruminating about family-related memories) that seems emotionally salient, from the therapist's perspective. This reflection seems to match the content and complexity of the patient's experience more closely, which makes it more likely that the patient will feel understood by the therapist. It is important to note that every instance of empathic validation involves some technical choice, where we highlight some aspects of patients' experience at the expense of others. No statement of empathic validation is thus ever "correct" or "ideal," and there are often a range of reflections available to us that sufficiently cohere with patients' articulated experience. For example, in the above scenario, another therapist might have responded, "You can't stop thinking about your wife and kids, and all the things you used to do together." While this reflection focuses more on the patient's cognitive processes, it still seems roughly congruent with the broad "gestalt" of what the patient is attempting to communicate.

Another issue involves *when* we employ empathic validation in sessions. While no rule can be laid down about this, we rarely allow several minutes to go by without offering some empathic reflection of patients' experiences.

For example, if patients are talking for an extended period of time about some situation, we often interrupt them to share our understanding of what they are attempting to communicate. This approach continues to emphasize patients' experiences while guarding against unhelpful monologues, implicitly affirming MBT's principle of keeping "two minds in the room." Or if we find ourselves asking multiple clarifying and affect elaboration questions, we try to regularly intersperse our inquiries with empathic reflections of patients' responses. This makes the interaction feel like a caring, interested dialogue rather than a cold interrogation. As sessions proceed, when in doubt about what to say to patients, we can always confidently return to empathic validation as a secure technical base. Empathic validation is perhaps the "lowest risk" intervention in MBT-N. By attending to patients' own lived experiences of their lives in the present moment, empathic validation emphasizes contingency over markedness, increasing the chance that patients will feel "seen" and recognized by us in our communications.

By and large, empathic validation in MBT-N tends to focus on patients' *feeling states* . This is especially important in the treatment of narcissism, given patients' challenges with alexithymia, pretend mode, and overly cognitive and concrete processing styles. When presented with a plethora of content in patients' narratives (e.g., thoughts, emotions, descriptions of situations), we prioritize reflecting the emotional components described earlier—that is, patients' expressed feelings (e.g., emotions, desires, or self-states), along with any emotion-related impressions about Self, Other, or reality (see Table 6.4). In this way, affect elaboration and empathic validation go hand in hand: we utilize elaborative questions to elicit patients' reflection about feeling states, and then we employ empathic validation to "reflect back" and affirm these affect-focused reflections. As patients repeatedly internalize *our* impressions of their affects and desires, they progressively acquire what MBT calls "second-order representations" of their own feelings (Bateman & Fonagy, 2016 , p. 7). These new representations ultimately serve as the psychological infrastructure for a more cohesive, emotionally grounded sense of self.

Table 6.4 Affect-focused empathic validation: Examples from clinical practice

Type of feeling	Empathic reflection: feeling + impression
Affect	"You still feel extremely angry with your father *[feeling state]*. He doesn't seem to care about how much he is hurting you *[impression]* ." "It sounds like you're quite worried *[feeling state]* that you are going to embarrass yourself tomorrow *[impression]* ." "You're noticing that you're feeling more content and hopeful lately *[feeling state]* , like your life is finally starting to move in the right direction *[impression]* ."
Desire	"You really seem to want this new job *[feeling state]* . It feels like the perfect fit for you *[impression]* ." "You don't actually want your parents to come visit *[feeling state]* —they just bring drama everywhere they go *[impression]* ."
Self-state	"So you felt deeply ashamed *[feeling state]* when you had to withdraw from school, like you were letting everyone down *[impression]* ." "Whenever she compliments you or gives you positive feedback *[impression]* , you feel so much better about yourself *[feeling state]* ."

There are many cases where patients are unable to articulate their own emotions, or when they are primarily focused on non-emotional facets of a situation (e.g., observable events, visible factors, other people's actions, their own thoughts or beliefs). Here we still find it useful to employ empathic validation liberally, namely by working to reflect patients' broad *experience* of the situation under discussion, without including any explicit mention of feeling states. For example, if a patient is describing her estranged relationship with her mother but struggles to reflect on relevant affects, we might simply try to mirror the patient's externally focused viewpoint: "So it sounds like your mother has never been able to empathize with your feelings, since she is so caught up in getting HER needs met in the relationship." This approach helps patients feel like we are able to see things from their perspective—a necessary condition for any reflective process, which we can utilize to try to deepen patients' reflections on emotions and desires over time.

At other times, patients are able to "name" their emotions verbally, but they do not seem to *feel* the emotions they are describing. Here we utilize a technique that we refer to as "mirroring the affective process." Rather than simply mirroring patients' stated affects at the level of verbal content, we give ourselves permission to *join them* in these states, by explicitly affirming the validity of their experiences (*"That is really unfortunate—I am sorry that*

this happened to you") , and by offering our reflections while inhabiting the affect in question, which we express through our own non-verbal experiences (e.g., tone of voice, facial expressions). For example, as we empathically validate one patient's expressed feelings of anxiety about her upcoming divorce proceedings, we might sound slightly more concerned or empathic as we say the words, "You are so worried about what is going to happen tomorrow—that he is going to somehow take everything from you." Or when empathically validating a patient's feelings of anger about his work situation, we sound slightly frustrated or pressured as we say, "This has been going on for so long, it is making you extremely angry."

In these ways, we "dial down" the markedness in empathic validation, temporarily decreasing the distinction between our minds and patients' minds. While such interventions might be ill-advised with patients struggling with *underregulation* of emotions (e.g., many patients with borderline personality disorder, patients with PN experiencing rage or despair in the current moment), this approach can be especially useful when working with patients who are more disconnected from their feelings, or who draw an overly sharp distinction between themselves and others. By modeling a form of affective connectedness in the therapeutic dialogue, we invite patients to *experience and access* their emotions more fully, rather than simply describing them.

Chapter 6 contain excerpts from Drozek, R. P., & Unruh, B. T. (2020). Mentalization-based treatment for pathological narcissism. *Journal of Personality Disorders* , *34* (Supplement), 177–203.

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1 Whereas traditional cognitive behavioral therapy draws a sharp distinction between thoughts and emotions (Beck, 2021), we tend to be less picky about this in MBT-N. As long as we are helping patients articulate *both* internal feelings and relevant impressions, we can feel confident that patients are working toward building an increasingly complex emotional repertoire—the necessary condition for any progress in the treatment of narcissism.

7

Context-focused Interventions

Thus far we have reviewed techniques that focus on the "what" of patients' experiences: what happened, what they are feeling, and what they are wanting. We utilize empathic validation and affect elaboration to help patients reflect on emotions and desires in themselves and other people, and we employ clarification to arrive at a clearer and more comprehensive picture of patients' environments, relationships, behaviors, and interactions with others. Once all of these processes are "on the table," we proceed to employ *context-focused* interventions—that is, techniques geared toward stimulating patients' reflection about the relationship between their mental states and the broader context of their experiences.

By and large, context-focused strategies invite patients to reflect on the connection between two different aspects of experience:

some previously identified mental state (e.g., sadness, insecurity, desire for attention) in themselves or others; and
some other factor already discussed in the therapeutic dialogue: an event, an action, or another mental state (see Figure 7.1).

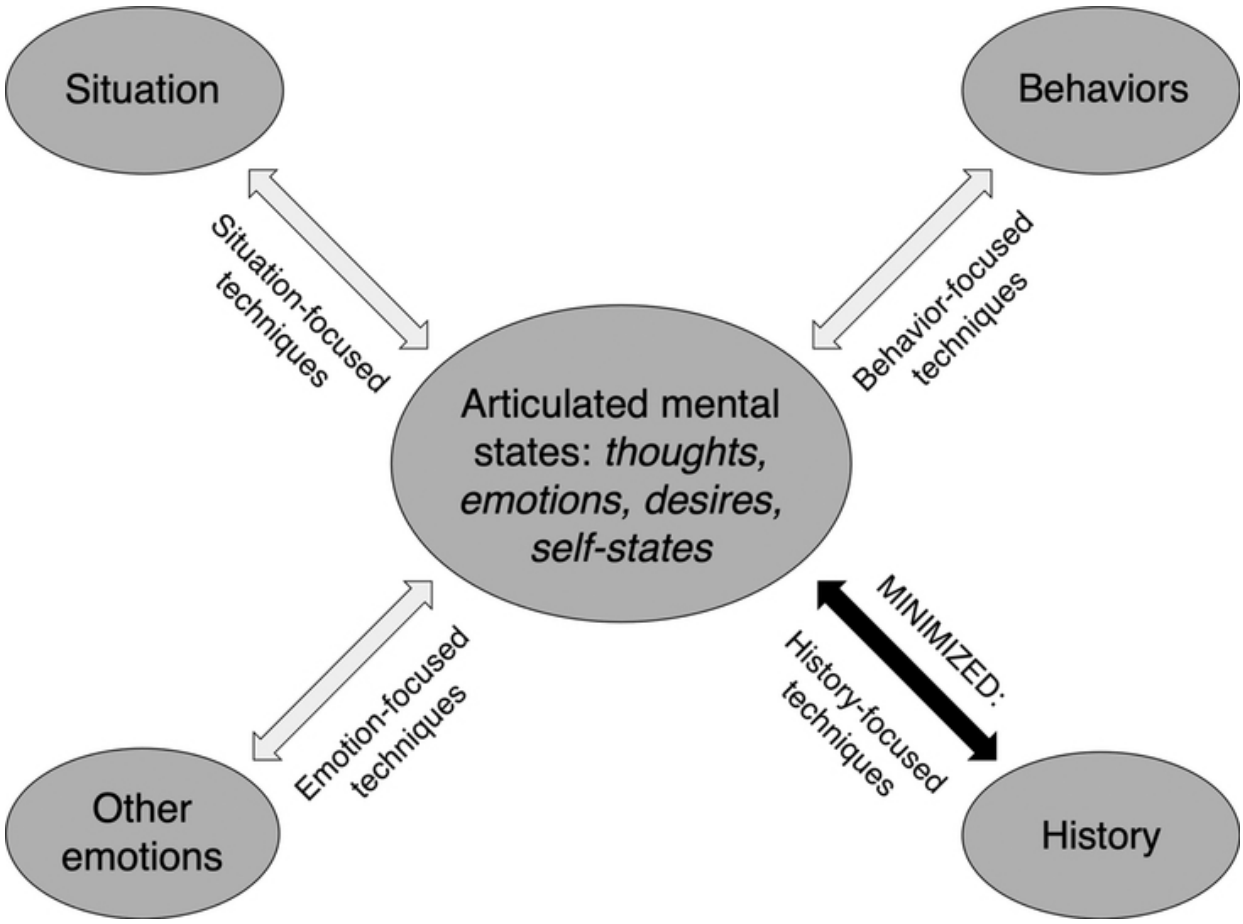

Figure 7.1 Context-focused interventions in MBT for narcissism. Once patients have articulated some mental state, therapists invite patients to "step back" and reflect on the potential relationship between that mental state and other aspects of their experience (e.g., events, actions, other mental states). History-focused techniques are minimized, given the risk of pretend mode and MBT-N's focus on patients' contemporary functionality.

As mentioned in Chapter 5 , we only ask patients to reflect on the possible connection between these two domains when *both elements have already been elicited and elaborated by patients themselves* in the therapeutic dialogue. Consistent with the not-knowing stance, this principle ensures that our own mentalizing is not "jumping ahead" of patients' mentalizing. If we are ever drawn toward introducing new "content" in inviting context-related reflections, we take that as an indication that we need to return to the content-based interventions to invite further descriptions of patients' lived experiences. Box 7.1 highlights the range of context-focused techniques in mentalization-based treatment for narcissism (MBT-N).

Box 7.1 Context-focused interventions in MBT for narcissism

Context-focused interventions focus on the relationship between patients' mental states and the broader context of their experiences. These interventions include:

Situation-focused techniques, which explore the relationship between events and mental states in Self and Other
Behavior-focused techniques , directed toward

The connection between behaviors and mental states in Self and Other
Patients' current experiences of agency, in the present moment of the session and in their lives outside of sessions
Patients' broader behavioral/interpersonal patterns, including their own contributions to relational dynamics
Inviting patients to imagine behaviors in future or hypothetical experiential contexts

Affect-focused techniques, geared toward examining the connection between two different feeling states
General **context-focused inquiries** , which invite patients to "step back" and consider their mental states surrounding the various processes (e.g., mental states, situations, behaviors) under discussion in session
Minimal use of **history-focused techniques** in MBT-N, given the prioritization of patients' contemporary lives and difficulties with functionality

In considering the relationship between multiple experiences, context-focused strategies always invite patients to "step back" from the immediacy of those experiences, and to occupy a vantage point where they can survey both elements at the same time, as well as their connection to each other. In this way, these strategies are often more complex and "cognitive" than the techniques we have considered so far in the book. When working contextually, we thus need to remain especially alert to the possibility of pretend mode processes, wherein patients respond to our queries in a more abstract or intellectual fashion, without a meaningful and authentic emotional engagement with the issues at play. Accordingly, as we broaden

and expand the scope of patients' reflections on mental states, we are actively trying to help them remain emotionally and experientially grounded in the original mental states under consideration.

The context of events

Patients with pathological narcissism (PN) can struggle extensively with identifying and understanding the situational precipitants to their own feeling states. Even when they are able to identify *what* they are feeling, they often do not recognize "why" they are feeling that way—that is, the factors in the environment (e.g., situations, relationships, interactions with others, broader life circumstances) that might be influencing their moods and emotions. [1] This can lead to a significant sense of confusion about emotional states. Feelings just seem to "happen" to these patients, which drastically limits their ability to regulate their emotions, or to conduct themselves in a manner that results in different emotional and interpersonal outcomes. As we help patients reflect on their emotional relationship to their environments, they begin to feel more understandable to themselves, more engaged and connected to the world, and better able to engage with others in a flexible and adaptive way.

If we have successfully conducted content-focused explorations with patients, they have discussed the details of some situation or topic that is meaningful to them (e.g., a scenario, relationship, or interaction outside of therapy; a problem behavior or functional challenge with which they are struggling), and they have identified some emotion, desire, or self-state in relation to the issue in question. At this point, therapists often reflexively assume that patients are already linking the "situation" and "feeling state," especially if the connection between these factors seems quite obvious to therapists themselves. However, this approach deprives patients of the opportunity of reflecting on the personal importance of these situations to them, and of gaining essential practice at considering their emotional relationship to their environments.

When attempting to stimulate patients' reflection about situational contexts, we summarize some emotionally salient situational factor; we recount patients' identified feeling state; and then we construct some context-focused inquiry inviting patients to consider the connection between these elements (Box 7.2). For example, we might say, "So when your boss

gave you that constructive feedback about the report *[situational factor]* , you immediately felt embarrassed and ashamed *[feeling state]* . What was it about the feedback that impacted you so strongly *[context-focused inquiry]* ?" Or we could share: "You felt so excited and relieved *[feeling state]* when your son finally allowed you to help him *[situational factor]* . Can you say more about what made that so meaningful to you *[context-focused inquiry]* ?"

Box 7.2 Situation-focused techniques in MBT for narcissism

Once patients have identified both a situation and feeling state (e.g., emotion, desire, self-state) in their narrative, therapists utilize the following interventional pathway:

Construct some context-focused inquiry about the possible connection between the situation and feeling state: *"So when your boss gave you that constructive feedback about the report, you immediately felt embarrassed and ashamed. What was it about the feedback that impacted you so strongly?"*

Invite further elaboration about additional internal processes (e.g., thoughts, emotions, desires, self-states) that make the situation meaningful to patients.

Synthesize these ideas into an empathic statement that summarizes patients' own ideas about the link between the situational factor and their feeling states: *"So when your boss gave you constructive feedback about your report, you felt quite certain he was looking down on you. You really want him to like you and respect you, so this made you feel embarrassed and ashamed."*

Employ an analogous interventional pathway when attempting to stimulate context-focused reflection about other people's mental states.

Start with developing a context-focused inquiry: *"So your advisor is up for tenure, and he has multiple papers under review, which makes him especially stressed and irritable. What's the connection here, between his irritability and all of these things he has going on in his life?"*

Utilize empathic validation and affect elaboration techniques to work toward an empathic statement that summarizes patients' ideas about the link between the situation and the other person's feeling states: *"So you feel like the tenure process has really impacted him—he is afraid of failure, and that makes him more aggressive and irritable with everyone else, including you."*

In the best-case scenario, patients reflect further on facets of the scenario that feel emotionally salient to them, while also sharing more about additional internal processes (e.g., thoughts, emotions, desires, self-states) that make these facets meaningful to them. Here we respond by inviting patients to further elaborate these reflections (*"So you really felt like your*

boss was looking down on you. What clued you in to that?" ; *"You've been feeling quite worried about your relationship with your son ever since the divorce. Could you say more about those worries?"*), ultimately working toward some form of empathic validation that summarizes patients' own ideas about the "link" between the situational factor and their feeling states. The format this takes is usually something like: "Situational Factor + Internal Process = Feeling State." For example, we might say:

> "So it sounds like, when your boss was giving you constructive feedback about your report, you felt quite certain that he was judging and looking down on you *[situational factor]* . You really want him to like you and respect you *[internal process]* , so for him to treat you that way, it really made you feel embarrassed and ashamed *[feeling state]* ."

Or we could summarize:

> "You've been feeling really guilty since the divorce, and quite worried that your son has been pulling away from you *[internal process]* . So when he finally let you buy him a new car *[situational factor]* , it made you feel excited and relieved, like he is finally letting you back into his life again *[feeling state]* ."

Through reflecting on these factors, patients gradually gain practice considering not simply situations but their *emotional relationship* to these situations. Over time, this helps patients develop a greater sense of agency in their lives, and an improved ability to make decisions that reflect a broader range of their emotions, wishes, and values.

We employ an analogous interventional pathway when attempting to stimulate context-focused reflection about other people's mental states. Consider the following interchange, where the patient is discussing her academic advisor's recent irritability with her.

PATIENT: He just has a lot on his plate right now. He's up for tenure, and he's got like five papers under review. So of course he's going to be an asshole to me!

THERAPIST: So when he is acting like an asshole, what do you think he's feeling *[content-focused inquiry to elicit reflection about the advisor's mental states]* ?

PATIENT: He's just stressed out and annoyed by everything. He's being aggressive and critical with all of his advisees.

THERAPIST: I see, so he's up for tenure, and he has multiple papers under review *[situational factors]* , which makes him especially stressed and irritable *[feeling state]* . What's the connection

here, between his irritability and all of these things he has going on in his life *[context-focused inquiry]* ?

PATIENT: Well, I am sure the tenure process is not easy for him. Everybody is evaluating him, so I am sure that makes him anxious, like he has to do everything perfectly or he's going to fail. For me, whenever I am feeling that sort of pressure, I end up taking it out on everybody around me. It's not right, but I bet that is why he is being so irritable and aggressive lately.

THERAPIST: So you feel like the tenure process has really impacted him *[situational factor]* —he is afraid of failure *[internal process linking the situation with feeling state]* , and that makes him more aggressive and irritable with everyone else *[feeling state]* , including you. Maybe we could think more about this together: the relationship between the fear and the aggression for him …

Here, the therapist invites reflection about the relationship between the academic advisor's feeling states (e.g., stress, irritability) and the situational context (e.g., paper submissions, tenure process), leading the patient to reflect more broadly about relevant internal processes possibly unfolding in the advisor (e.g., perfectionism, fear of failure). Through employing these techniques, we help patients consider other people's subjective relationship to the world around them—an important step toward increasing patients' emotional understanding and sense of connectedness with others.

The context of behavior

Patients with PN can also struggle significantly with reflecting on their own actions, behaviors, and patterns in relationships. They can overlook the emotional precipitants to their problem behaviors, leaving them without an essential mentalizing buffer that might prevent them from engaging in such behaviors. They often fail to appreciate the impact of their actions and interpersonal patterns on their moods and emotions, and on the feeling states of others. Patients with PN can thus end up feeling like perpetual victims in their own lives: they are often dissatisfied and upset with how people are treating them, but they "miss" the role they are playing in generating these interpersonal outcomes.

These observations lead us directly into the arena of *agency* in pathological narcissism. Agency involves a sense of ownership and responsibility over one's own behavior and its potential consequences, encompassing a complex array of mental processes that are both cognitive (e.g., planning, imagining, deliberating, anticipating consequences) and affective (e.g., desiring, valuing, empathizing) in nature. As Ronningstam (2016) has highlighted, deficits in self-agency can be seen as central to narcissistic disruptions, and effective treatment for PN involves helping patients develop "a more coherent interactive and reflective sense of agency" (p. 40; see also Weinberg & Ronningstam, 2020). These proposals are entirely consistent with Fonagy and colleagues' (2002) early formulations on the development of the *agentive self* , which is predicated on the capacity to construct second-order representations of mental states in Self and Other (Chapter 5). In our experience, as patients reflect more fully on the reciprocal relationship between mental states and behaviors, they begin to feel a greater sense of authorship and control over their actions, considering new interpersonal approaches that might lead to different feeling states in themselves and others.

Organized chronologically, behavior-focused techniques in MBT-N focus variously on past behaviors; patients' current experience of agency in the present moment; ongoing behavioral/interpersonal patterns; and alternative/hypothetical behavioral approaches in the future. We will consider these strategies in turn.

Context-mentalizing of past behaviors

The first set of techniques work to stimulate patients' mentalizing about their actions in past experiential contexts. In Chapter 6 , we reviewed affect elaboration techniques geared toward elaborating patients' feeling states before, during, and after taking certain actions in the past (p. 114). Once these mental states are all "on the table," we can proceed to consider the connection between relevant feelings and behaviors (see Table 7.1). We start by summarizing the identified feeling state as well as the action in question, and then we construct some context-focused inquiry inviting patients to consider the possible relationship between these two processes. "So you were feeling quite hurt and insulted by him *[feeling state]* , and then you started sending him all of those aggressive texts *[subsequent action]* . What

was the connection between these things for you *[context-focused inquiry]* ?"

Table 7.1 Behavior-focused interventions in MBT for narcissism: Past experiential contexts

	Context-focused inquiry	**Empathic summary**
Feeling state preceding behavior	"It sounds like the angrier you felt *[feeling state]* , you became more withdrawn and uncommunicative *[subsequent action]* . What led you to withdraw when you were feeling that way *[context-focused inquiry]* ?"	*Feeling State + Internal Process = Subsequent Action:* "In your anger *[feeling state]* , you needed to show her how much she had hurt you *[internal process]* , so you felt like you had to withdraw from her *[subsequent action]* ."
Feeling state concurrent with behavior	"As you were withdrawing from her *[behavior]* , you were hoping she would feel guilty about what she had done *[feeling state]* . What was the connection between these things for you *[context-focused inquiry]* ?"	*Behavior + Feeling State + Internal Process:* "You were afraid that, if you didn't do something *[behavior]* to show how angry you were *[feeling state]* , she would just keep treating you this way *[internal process]* ."
Feeling state following behavior	"You felt guilty and ashamed of yourself *[feeling state]* after you withdrew from her *[behavior]* . What was making that so difficult for you *[context-focused inquiry]* ?"	*Behavior + Internal Process = Feeling State:* "You love her and want to be a caring partner to her *[internal process]* , so it made you feel horrible about yourself *[feeling state]* to be treating her that way *[behavior]* ."

Here patients usually discuss some internal process that experientially "links" the action to the identified feeling state, such as some other emotion related to the action; a desire for some change to happen as a result of the action (e.g., in the environment, in another person, in themselves); some value or assumption *about* the action; or some self-state associated with the action (e.g., shame, pride, empowerment). When patients contextualize their behaviors in more concrete or externally oriented terms (*"He was lying about me, so I was just setting the record straight"*), we attempt to explore with patients the *psychological* processes related to the behavior in question (*"What made that important to you, to correct him in that way?"* ; *"If you had NOT corrected him at that moment, what would that have been like for you?"*). We work with patients to explore and elaborate relevant internal processes along these lines, eventually synthesizing these reflections into an empathic statement summarizing patients' ideas about the connection between the various processes at play (e.g. feeling states, behaviors, related internal processes). "So in addition to feeling hurt and insulted by him

[previously identified feeling] , when you sent those aggressive texts *[behavior]* , you had the desire to hurt him the way that he had hurt you *[internal process]* ."

Throughout these explorations, our hope is that patients engage in progressively more elaborated, emotionally nuanced, and psychologically oriented reflections about their own behaviors. We are not, however, attached to patients arriving at any particular explanation of "why they did what they did." Regardless of the content of their ideas, it is the *practice* of authentically reflecting on these matters that is most beneficial to patients. Over time, this experience leads to an enhanced ability to recognize the emotional antecedents to their actions, and to reflect on their behaviors in the moment rather than reflexively falling into longstanding behavioral pathways.

Context-mentalizing of patients' current experience of agency

Moving beyond patients' discreet actions in the past, we also utilize a range of strategies to stimulate patients' reflectiveness about their *current* experience of agency, in the present moment of the session or in their cotemporary lives more generally (Box 7.3). This can involve inviting patients to imagine the range of behavioral possibilities available to them (*"Can you imagine other ways you might have responded to her in that moment?"* ; *"What are the different ways you might proceed here?"*), or to reflect on their approach to the deliberative process itself (*"How do you go about figuring out what to do here?"*). We encourage patients to consider "what to do" from a more general perspective, for example by asking "Where do you go from here?" Or: "In light of all these reflections, what should you do about all of this?"

Box 7.3 Context-mentalizing about patients' current experience of agency

Invite patients to imagine the range of behavioral possibilities available to them.

"Can you imagine other ways you might have responded to her in that moment?"
"Where do you go from here?"
"How do you go about figuring out what to do here?"

Explore patients' experience of agency in relation to specific mental states.

Desires: *"What do want to do most in this situation?"*
Emotions: *"Of all the options, what feels like the best course of action to you?"*
Personal values: *"What do you feel like the right thing to do is?"*
Consequent mental states in Self: *"What approach do you think would make you feel the most stable, the most grounded in yourself?"*
Consequent mental states in other people: *"Do you have a sense of what you could do to help your wife feel better about all of this?"*

As patients identify specific actions to take, utilize content-focused interventions (e.g., empathic validation, affect elaboration) to explore their thoughts and feelings about potentially engaging in the actions in question.

Empathic validation: *"You need to move forward in your life, and applying to graduate school feels like the ideal way to make that happen."*
Clarification: *"What would that look like, if you were to try to be 'less perfectionistic' with these projects?"*
Affect elaboration: "*What would that feel like for you, to try to talk less in those meetings?"*

We can ask similar questions in relation to patients' specific internal states, including desires ("*How do you want to proceed here?*" ; "*What do want to do most in this situation?*"); emotions ("*Of all the options, what feels like the best course of action to you?*" ; "*What is your gut telling you to do?*"); and values and ethics ("*What do you feel like the right thing to do is?*" ; "*What action feels most consistent with your values—with who you are as a person?*"). We also invite patients to consider their actions in relation to their potential outcomes or consequences, most notably their own mental states ("*What approach do you think would make you feel the most*

stable, the most grounded in yourself?"), or the mental states of others (*"Do you have a sense of what you could do to help your wife feel better about all of this?"*). When patients are mentalizing *other people's* mental states in challenging relational dynamics, we sometimes invite patients to consider their own potential behaviors in light of these interpretations of others: "Given how worried your friends have been feeling about you lately, how do you plan to approach hanging out with them this weekend?"

As patients share about these topics, we utilize content-based techniques of clarification *("What would that look like, if you were to try to be 'less perfectionistic' with these projects?"* ; *"If you were being 'less aggressive' with your wife, what would you be doing instead?")* ; affect elaboration *("What would that feel like for you, to try to talk less in those meetings?"* ; *"What makes that so important to you, to try to repair things with your father?"* ; *"You say that your wife would feel more connected to you if were to work on empathizing with her more. Can you say more about what that would be like for her?"*); as well as empathic validation (*"You feel quite anxious about it, but you really want to start dating again"* ; *"You need to move forward in your life, and applying to graduate school feels like the ideal way to make that happen"* ; *"It sounds like you are feeling like this relationship is extremely problematic, and you hope to find a way to end things as soon as possible"*), to help patients further expound on the internal and behavioral processes under discussion.

Explicitly or implicitly, all of the above inquiries invite patients to reflect on the reciprocal relationship between some agentic mental state (e.g., thoughts, imagination, deliberation, plans, values, desires, emotions, self-states) and their own behaviors. We thus see these questions as mentalizing rather than strictly behavioral in nature. Rather than directing patients toward some specific behavioral content (e.g., "I should take such-and-such action, or employ this particular skill"), we are interested in the question: *Is the patient authentically connected to the mental processes in question, while also reflecting on these processes and behaviors in a genuinely curious and thoughtful way?* This experience serves as the bedrock for a burgeoning sense of agency. Over time, patients naturally begin to engage in the world in a manner that is more expressive of their own wishes and values, and the needs and desires of other people as well.

Context-mentalizing of broader behavioral and interpersonal patterns

Given the tendencies toward pretend mode and intellectualization among patients with PN, we tend to shy away from using more "general" or "abstract" language in MBT-N, instead privileging specificity, nuance, and affective groundedness in our interventions. One important exception to this concerns our focus on patients' *general behavioral and interpersonal patterns* , usually spanning past and contemporary experiential contexts. As discussed throughout this book, patients with PN can struggle extensively with "blaming" external factors (e.g., other people, life circumstances) for their challenges, leading them to respond reflexively when they are confronted with the element they see as unfair or unjust. In contrast, as patients begin to recognize their own more general patterns and tendencies in relationships (e.g., "I tend to do such-and-such thing in such-and-such situations"), they gain the increased ability to "hold onto their minds" when they encounter specific interpersonal/environmental triggers, enabling them to reflect more flexibly and adaptively on their own participation in these dynamics. See Box 7.4 for techniques geared toward helping patients mentalize these broader behavioral processes.

Box 7.4 Context-mentalizing of patients' broader behavioral and interpersonal patterns

Start by employing content-focused interventions (e.g., clarification, affect elaboration, empathic validation) to explore key elements involved in patients' behavioral processes:

Environmental and interpersonal precipitants to the behavior
Patient's mental states before taking the action
The behavior itself
Patient's mental states while taking the action
Patient's mental states after engaging in the behavior
Consequences of the action in the environment, including other people's mental states

After several specific examples of the behavior are identified, provide patients with direct feedback about the broader pattern.

"Lately I've been noticing something that occasionally unfolds between you and other people, which I wanted to see what you think about. When others give you constructive feedback *[precipitant]* , it often makes you feel quite insecure *[feeling state]* , and pretty quickly you can respond by criticizing them *[problem behavior]* . Over time, they can criticize you back and pull away from you, and then you end up feeling quite angry and victimized by them *[interpersonal and emotional consequences]* ."
Share these observations in a tentative and marked fashion, only including elements that patients have already communicated in the therapeutic dialogue.
Simply describe the elements involved in the pattern (e.g., precipitants, feeling states, actions, consequences), grouping them chronologically *without* supplying the psychological links between the elements themselves.

Explore patients' response to these observations, which can include asking questions, sharing their own examples of the pattern, and expressing disagreement.
Work with patients to reflect more expansively on the pattern itself, utilizing

Context-focused inquiries: *"So when you isolate from everyone, you end up feeling a dramatic decrease in your anxiety. Can you say more about this—how the isolation ends up improving the anxiety?"*
Exploring consequences of behavior in Self: *"How do you feel about yourself after you have isolated for so long?"*
Exploring consequences of behavior for other people: *"When you push your parents away like that, do you have a sense of how that impacts them?"*
Invite patients to reflect on the viability of the pattern: *"How do you feel like it has been working, to be managing your emotions like this?"*

When developing MBT formulations with patients, in the section on "Overly concrete and visible" challenges, we have already highlighted patients' behavioral difficulties and maladaptive interpersonal patterns that might serve as a focus for treatment. As the treatment unfolds and we get to know patients better, we begin to recognize additional behaviors or relational patterns that appear to negatively impact patients' overall functionality, stability, and sense of fulfilment in their lives and relationships. Patients are often unaware of these processes as general patterns in their experience, which drastically limits their ability to fully reflect on these processes in the moment of action itself.

To help patients mentalize these behavioral processes more fully, we start by using content-focused interventions to explore specific examples of the action in question. For example, we utilize clarification to examine the environmental and interpersonal precipitants to the problem behavior (*"What did she say to you that really set you off?"*); the details of that behavior (*"What did you actually say to her when you got so upset?"*); and the behavior's consequences (*"How did she respond to you when you spoke to her in that way?"*). We also employ affect elaboration strategies to stimulate patients' reflection about emotions and desires surrounding the behavior (*"What were you feeling right before you started criticizing her?"* ; *"How did you feel afterwards, when she walked away from you?"*), and about other people's relevant internal states (*"What do you think that was like for her, to have you yelling at her in that way?"*). See Table 7.2 for key elements involved in patients' behavioral processes.

Table 7.2 Key elements involved in patients' behavioral processes

Prior to behavior	During behavior	Following behavior
Environmental and interpersonal precipitants to the behavior Patient's mental states before taking the action	The behavior itself Patient's mental states while taking the action	Patient's mental states after engaging in the behavior Consequences of the action in the environment, including other people's mental states

Once we have conducted such explorations around several examples of the action/interpersonal strategy in question, we are prepared to give patients direct feedback about the broader pattern we are observing. This can take a range of different shapes, including simply "naming" the behavior itself (*"Lately I've been wondering more about your tendency to criticize other people—to tell them all the things you think they are doing wrong"*); citing the common precipitants plus the behavior (*"Sometimes it seems to me that, when other people give you constructive feedback about something, you can often respond by criticizing and attacking them"*); describing the feeling state that precedes the behavior (*"My sense is that, when you end up feeling insecure, you often shift the focus onto what other people are doing wrong in the situation"*); noting the behavior as well as its usual consequences (*"I've been struck by this lately—how you can start to criticize or evaluate other people, and then they respond by attacking you back, and often withdrawing from you"*); and finally synthesizing all of the aforementioned elements involved in the pattern itself: precipitants + feeling state = behavior + consequences.

> "Lately I've been noticing something that occasionally unfolds between you and other people, which I wanted to see what you think about. When others give you constructive feedback *[precipitant]* , it often makes you feel quite insecure *[feeling state]* , and pretty quickly you can respond by criticizing them *[problem behavior]* . Over time, they can criticize you back and pull away from you, and then you end up feeling quite angry and victimized by them *[interpersonal and emotional consequences]* ."

Once we share these observations with patients, we are prepared to offer examples of the pattern from patients' own experience, and to explore patients' response to our observations, which can include asking questions, sharing their own examples of the pattern, and expressing disagreement with what we are proposing.

Several principles guide our distillation of patients' behavioral processes in this way. First, we only explicitly include elements in our descriptions

(e.g., precipitants, feeling states, actions, consequences) that patients themselves have already directly communicated in the therapeutic dialogue. In order for these descriptions to be *usable* , patients need to feel like our depiction "maps onto" their own experiences in a real, personally meaningful way. Moreover, we always offer our descriptions in a tentative and marked manner, including verbal qualifications that indicate we are communicating our subjective impressions (*"It seems like …"* ; *"I have been noticing …"* ; *"It comes across to me …"*), rather than authoritative descriptions of an objective reality. Lastly, while we group these elements together chronologically (*"When you feel ashamed and embarrassed about your performance at school, I notice that you end up drinking a lot more"*), we never supply the *psychological* link between the elements in question. In our experience, when we simply "name" the behavioral pattern in question, patients gradually begin to notice the pattern as it unfolds in their lives. We are then able to utilize content- and context-focused interventions to help patients *themselves* reflect on psychological processes surrounding the relevant actions.

Once we have identified the behavioral pattern, we work with patients to begin reflecting more expansively on the pattern itself. We start by exploring with patients the emotional meaning of the issue to them, which usually involves synthesizing the aforementioned information about patients' mental states before, during, and after the behavior, and then inviting them to consider the role of the behavior in generating these internal shifts.

> "It sounds like you can often feel quite insecure about your appearance and weight *[mental state preceding the behavior]* . But then when you have these casual sexual encounters *[identified behavior]* , you feel much better about yourself *[mental state during/after the behavior]* , at least for a period of time. Can you say more about this—how the sex ends up making you feel so much better about yourself *[context-focused inquiry]* ?"

Especially when we feel concerned about the behavioral pattern (e.g., if it appears to negatively impact patients' functionality, psychological stability, or interpersonal relationships), we invite patients to consider the consequences or impact of the pattern—on patients themselves (*"When you criticize your wife in these moments, how do you end up feeling afterwards?"* ; *"How do you feel about yourself after you have isolated for so long?"*), and on other parties involved in the situation (*"What do you think it is like for your wife when you speak to her in that way?"* ; *"When you push your parents away like that, do you have a sense of how that*

impacts them?"). Perhaps even more directly, we explicitly inquire about the potential *negative* consequences of the behavioral pattern (*"Do you see this as a problem for you?"* ; *"Have you experienced any challenges related to your avoidance?"*), and to reflect on the broader viability of the pattern (*"What do you think about your defensiveness as an approach?"* ; *"How do you feel like it has been working, to be managing your emotions in this way?"*).

Context-mentalizing of future behavioral possibilities

If patients express an interest in addressing these matters, we encourage them to reflect on the process of change itself (Box 7.5). These techniques focus on *future or hypothetical* experiential contexts for patients' behaviors. We often start by asking patients to imaginatively enter into this process of change: "What do you think it would look like, if you were to try to work on your issues with dishonesty?" Utilizing strategies reviewed earlier focusing on patients' current experience of agency, we also explore *alternative* behavioral options in the areas in question. "If you were not defending yourself in these moments, what might you be doing instead?" "Are there other approaches that might make you feel better about yourself here?" "How do you think your wife would want you to respond when these issues come up?" In these discussions, we are always less interested in the content of these ideas than in encouraging patients' reflectiveness about the matters in question. Accordingly, as patients identify other potential behavioral approaches ("I guess I could try to listen to her more"; "I think that I need to be more open about my feelings"), we work to explore with patients their *process* of arriving at the ideas in question (*"What makes you feel like that is the right approach?"* ; *"What would be helpful about trying this instead?"*).

Box 7.5 Context-mentalizing of future behavioral possibilities

Invite patients to imaginatively enter into this process of behavior change: *"What do you think it would look like, if you were to try to work on your issues with dishonesty?"*
Explore alternative behavioral options in the areas in question: *"Are there other approaches that might make you feel better about yourself here?"*
When patients are interested in altering existing behavioral patterns, actively inquire about mental states surrounding the process of change.

"How motivated do you feel to work on this issue?"
"What might get in the way, if you were to really try to stop talking so much during meetings?"
"Do you have any ideas about how to go about changing this?"
"What would it feel like, to hold your tongue in situations like this?"
"How do you think your parents would feel if you were to really try to be present for their experience?"

When patients identify new behaviors they would like to take, ask similar questions to explore and elaborate patients' mental states related to these behaviors.

"How motivated do you feel to actually start dating again?"
"What would be the biggest internal barrier to working on this?"
"How would you go about trying to be more consistent with your job?"
"What do you think it would feel like for your boyfriend, if you were to be more accepting of him?"

When therapists have ideas about alternative behaviors patients might take, it can be helpful to try *marked advice-giving*.

Always start by exploring patients' *own* ideas about additional behavioral/ interpersonal options.
Identify the new behavior in a "marked" manner, explicitly emphasizing that the idea is coming from the therapist's mind, rather than from the patient's mind: *"Sometimes I wonder about you trying to empathize and validate your wife's experience, rather than simply telling her way to do."*
Construct some context-focused inquiry inviting patients to reflect on *their* mental states (e.g., thoughts, imaginations, emotions, desires, willingness, commitment) surrounding the idea of possibly engaging in the behavior: *"What do you think that would be like, to try something like this?"*

When patients are interested in changing or altering current behavioral patterns, we usually start by exploring issues of personal motivation (*"How motivated do you feel to work on this issue?"* ; *"If you were to look inward, how interested are you in decreasing these angry outbursts?"*). We explore potential barriers to change (*"What might get in the way, if you were to really try to stop talking so much during meetings?"* ; *"What do you think would be the most difficult thing about NOT seeking reassurance from him?"*). We invite patients to consider some of the internal and external "mechanics" of behavioral and interpersonal change (*"Do you have any ideas about how to go about changing this?"* ; *"How are you going to make this all happen?"*). And we examine the affective dimensions of behavioral change in Self and Other (*"What would it feel like, to hold your tongue in situations like this?"* ; *"How do you think your parents would feel if you were to really try to be present for their experience?"*).

When patients identify alternative behaviors they would like to take, we ask similar questions to explore and elaborate patients' mental states surrounding these behaviors. "How motivated do you feel to actually start dating again?" "What would be the biggest internal barrier to working on this?" "How would you go about trying to be more consistent with your job?" "What do you think it would feel like for your boyfriend, if you were to be more accepting of him?"

In working with patients with PN, we often notice that they are not taking certain actions that might lead to improved functioning in their lives, or a greater sense of well-being for themselves or other people. One patient consistently responds to his wife with defensiveness and criticism, but he rarely empathizes with her or validates her feelings and desires. Another patient struggles extensively with people-pleasing in the workplace: she works long hours and reflexively says "yes" to new responsibilities, but she does not ask her supervisor for accommodations (e.g., time off for vacations, modifications to her work schedule) that might improve her own quality of life. A college student remains quite self-centered in his interpersonal interactions, talking at length about himself and his accomplishments but rarely asking other people questions about *their* lives and experiences.

How do we engage with patients around such matters? By and large, MBT-N eschews extensive "advice-giving" with patients. When pursued too tenaciously, such an approach can undermine a mentalizing focus in treatment, placing more emphasis (teleologically) on specific concrete

behaviors than on stimulating reflection about relevant *mental states* surrounding these behaviors. Advice-giving is particularly fraught when working with patients with PN. By privileging therapists' minds over patients' minds, this approach risks alienating patients who are exquisitely sensitive to being patronized or controlled in interpersonal interactions.

In MBT-N, we thus practice what we call *marked advice-giving* . We first try to employ all of the aforementioned context-focused inquiries (e.g., asking open-ended questions about alternative behavioral pathways, exploring relevant feelings and reflections) in order to help patients consider their *own* ideas about additional behavioral/interpersonal options. However, if patients do not spontaneously identify the specific actions that strike us as potentially important, we grant ourselves some latitude to introduce new behavioral content into the therapeutic dialogue. This technique involves first identifying the action itself in a "marked" manner, explicitly or implicitly emphasizing that the idea is coming from our mind, rather than from the patient's mind. Without telling patients they "should" take a certain action, we emphasize our own *mental states* (e.g., thoughts, imaginations, emotions, desires) surrounding patients taking the action, or at least considering its potential relevance to their lives. Similarly, in a curious and non-authoritative manner, we then construct some context-focused inquiry inviting patients to reflect on *their* mental states (e.g., thoughts, imaginations, emotions, desires, willingness, commitment) surrounding the idea of possibly engaging in the behavior. Some examples of this technique include:

> "Sometimes I wonder about you trying to empathize and validate your wife's experience, rather than simply telling her way to do *[marked identification of new behavior]* . Do you think that would make a difference at all *[context-focused inquiry]* ?"
> "The more that you've struggled with drinking, I've been thinking a lot about you attending some mutual help groups, and really hoping you would give that a shot *[marked identification of new behavior]* . Would you ever be willing to try something like that *[context-focused inquiry]* ?"
> "You've shared that, when you feel anxious in those social situations, you feel a lot of pressure to talk about your positive qualities and achievements. Have you ever considered asking other people questions about themselves and their lives *[context-focused inquiry + implicit marking of new behavior]* ?"

Rather than offering any sort of "final statement" about patients' ideal behaviors, we offer these communications as a spur for further reflection about the relationship between patients' mental states and less-considered behavioral possibilities. If patients take issue with the proposed action ("I

don't think that would work at all"; "I could never see myself saying that to him"), we utilize affect elaboration techniques to help patients further articulate their concerns and misgivings (*"What clues you in that this would not work for you?"* ; *"So you think that your wife could actually get MORE upset if you tried to share your feelings with her. Upset in what way?"*).

When patients seem more amenable to our suggestions ("Yeah, I think that is a really good idea"; "OK, I'm willing to try that"), we do not rest easy. Instead, we respond with curiosity and interest about patients' receptiveness, inviting elaboration about their emotional relationship to the new behavior: "What resonates for you about this possibility?" "Something feels right about trying to be more open about your feelings?" "What makes you think it could be helpful to go this route?" In cases where patients appear authentically interested in engaging in the new behavior, we can utilize the affect elaboration strategies mentioned earlier to help patients reflect on mental states surrounding the alternative behavior: "What would it look like to start trying this?" "Can you imagine anything that could make it difficult to carry this out in your life?" "What might it feel like to interact with your kids in this way?" "How do you think your kids would feel, if you were to really treat them differently?"

Context-mentalizing of other people's behaviors and mental states

We employ many similar techniques in order to stimulate reflection about *other people's* behaviors and mental states (Box 7.6). As reviewed in Chapter 6 , we utilize clarification to help patients articulate some action taken by another person, either in the past or unfolding regularly in the present. Then we employ affect elaboration strategies to explore patients' ideas about other people's psychological processes (e.g., thoughts, emotions, desires) surrounding the actions in question. Once those elements are both present in patients' therapeutic narrative, we first summarize these elements, and next we construct some context-focused inquiry inviting reflection about the connection between them.

> "So you think your mother was feeling angry with you *[feeling state]* , and then she stopped responding to your texts *[behavior]* . How did the anger lead her to stop responding *[context-focused inquiry]* ?"
> "You mention that your boss is quite insecure *[feeling state]* , and that can lead him to be controlling of you and your work *[behavior]* . What is the connection between those things for him *[context-focused inquiry]* ?"

Patients usually proceed to discuss some internal process that experientially links the action to the identified feeling state, such as some other emotion, desire, or self-state in the other person. We use affect elaboration techniques to help patients expound on these ideas (*"You suspect your mother was wanting to hurt and punish you. Could you say more about that?"* ; *"It makes your boss feel better about himself when he is exerting control over other people. Better about himself in what way?"*), ultimately synthesizing patients' reflections into a broader empathic statement about the relationship between the elements under discussion (e.g. feeling states, behaviors, related internal processes).

> "So in her anger *[feeling state]* , your mother wanted to hurt you the same way that you had hurt her *[internal process]* , which led her to stop responding to your texts *[behavior]* ?"
> "You see your boss as quite insecure *[feeling state]* . When he's bossing you around *[behavior]* , it makes him feel much better about himself, like he has a sense of control over someone *[internal process]* ."

By reflecting on a broader range of psychological processes in others, and by considering the relationship between these processes and other people's actions, patients gradually begin to experience others' behaviors as more understandable, meaningful, and even potentially valid. This opens the door for greater sense of connection and empathic resonance with people in their lives, resulting in an improved ability to mentalize others' mental states in the moment of the challenging interaction.

Box 7.6 Context-mentalizing of other people's behaviors and mental states

Utilize clarification to help patients articulate some action taken by another person, and affect elaboration to explore patients' ideas about other people's mental states (e.g., thoughts, emotions, desires) surrounding the actions in question.
Once those elements are both present in the therapeutic dialogue, first summarize these factors, and then construct some context-focused inquiry inviting reflection about the connection between them.

"You think your mother was feeling angry with you *[feeling state]* , and then she stopped responding to your texts *[behavior]* . How did the anger lead her to stop responding *[context-focused inquiry]* ?"

Employ affect elaboration to help patients expound on their ideas about the internal processes (e.g., emotions, desires, self-states) linking the behavior and original feeling state, ultimately constructing an empathic statement synthesizing patients' ideas about the relationship between the elements under discussion.

"So in her anger *[feeling state]* , your mother wanted to hurt you the same way that you had hurt her *[internal process]* , which led her to stop responding to your texts *[behavior]* ?"

When patients are focusing extensively on other people's wrongs and deficiencies in a situation, work to stimulate reflection about patients' own behavioral contributions to the interpersonal challenge.

Utilize content-focused interventions to elaborate and empathically validate patients' experience of the situations in question: their actions; other people's actions; their mental states; and their ideas about others' mental states.
Direct patients' attention to their own behavioral/interpersonal participation: *"Do you think you have contributed to these challenges in any way?"*
Attempt context-mentalizing of patients' behaviors in relation to other people's mental states that patients have already identified: *"You noted that your wife has been quite angry with you recently. Could you have done anything that might be contributing to her feeling that way?"*

As mentioned previously, individuals with PN often end up feeling perpetually mistreated and victimized by other people. They can focus extensively on other people's wrongs, failings, and deficiencies, failing to reflect on the role that they have played in generating and aggravating the interpersonal scenarios that they find so aversive. In contrast, as patients begin to consider how *they* are often the context of other people's upsetting feelings and behaviors, they develop a greater sense of agency and autonomy in their relationships, considering new behavioral approaches that have the potential to generate different feeling states in themselves and in others.

We utilize a handful of techniques to stimulate patients' reflectiveness about these matters. As always in MBT-N, we start by utilizing content-focused interventions to elaborate and empathically validate patients' experience of the situations in question: their actions; other people's actions; their mental states; and their ideas about other people's mental states. By starting with these basic techniques, we ensure that patients will feel sufficiently supported and "seen" by us, prior to considering an area of experience that is inherently more challenging and anxiety provoking. Then we direct patients' attention to their own behavioral/interpersonal participation, usually by asking some general question about these dynamics. "What role do you play in these interactions?" "Do you think you have contributed to these challenges in any way?" "How do you see your part in all of this?" "What actions have you taken that might be impacting things here?" We also ask directly about how actions patients have not taken might be impacting their relationships: "Is there anything you haven't done that could be affecting your relationship with your son?"

If patients struggle with reflecting on these processes, we can summarize some mental state they have already identified in the other person (e.g., anger, anxiety, dislike, desire to avoid), and inquire about patients' potential role in provoking that specific mental state. "You noted that your wife has been quite angry with you recently. Could you have done anything that might be contributing to her feeling that way?" "You mentioned that your children have seemed much more withdrawn lately, like they don't want to be around you. What might they say about how that has happened?" Similarly, when patients have described both actions they have taken and potentially relevant mental states in the other person, we can recapitulate those elements and construct some context-focused inquiry inviting patients to consider the potential relationship between these factors. "You

acknowledged that you've been somewhat defensive and critical in your interactions with your boss recently, and he seems a lot more anxious in his interactions with you. Do you see these things as related in any way?"

When patients appear more reflective and emotionally engaged in their interactions with others, we ask analogous questions in order to validate and encourage this "positive mentalizing" of behavioral processes. "You feel like your wife has seemed more affectionate and loving toward you lately, ever since you started working on being less reactive with her. Do you think there could be a connection between these things?" As patients respond to these queries (e.g., identifying their own behavioral contributions, affirming or denying the potential connection between their actions and other people's feeling states), we employ a mix of empathic validation and affect elaboration to help them further reflect on their own behavioral engagement in their relationships. "You're recognizing now that you are quite a 'people-pleaser,' and that you can often hide your feelings if you suspect they might upset people. How has that played out in your relationships with your parents?" "I see, so you suspect that your dishonesty has really affected how emotionally safe your fiancé feels with you. Can you say more about how that has impacted her?"

When discussing these matters with patients, we are attentive to the extent to which patients seem to be taking full responsibility for initiating and maintaining maladaptive behavioral patterns with others, versus framing their behaviors as an ill-advised *response* to other people's problematic tendencies and qualities. The latter mindset reflects what we might call the "They started it" mentality that is highly common in PN, wherein patients are more likely to blame other people for their own challenging tendencies: "If you were not so problematic, I would not have to act the way that I do." In such cases, we utilize context-focused interventions to help patients explore the behavioral contribution they are identifying: reviewing the consequences and viability of the pattern (*"So you can be quite critical of your boss, but usually only after she has been dismissive and cold toward you. How do you end up feeling, after you have told her off in that way?"*); examining alternative approaches (*"If you were not criticizing her in those moments, what might you be doing instead?"*); and inquiring about patients' current experience of agency in the moment of discussion (*"In light of all of this, where would you like to go from here?"*). After exploring these matters with patients, if they continue to be focused primarily on their response to

other people's problematic tendencies, we start by empathically validating the reflective work they have done thus far, then explicitly inquiring about their role in potentially *initiating* some of the challenging processes under discussion.

> "I really appreciate what you are saying about your tendency to criticize your boss whenever she is dismissive or cold to you. It sounds like that can create a lot of anxiety in you, since you then end up worrying that she is going to fire you *[empathic validation of previous reflection]* . I am also curious about her being so dismissive and cold to you in the first place. Looking back at it, do you feel like you have ever done anything that might contribute to her feeling that way about you, and acting that way toward you *[direct inquiry about patient's role initiating an interpersonal process]* ?"

As we doggedly but compassionately direct patients' attention to their own participation in their interpersonal relationships, patients begin to reflect on that participation of their own accord, and to consider alternative ways of engaging with themselves and others.

Providing feedback about patients' challenges with behavior-focused mentalizing

We have considered a range of strategies geared toward encouraging patients' reflectiveness about behavioral processes. Even as we attempt such strategies, patients often struggle along these lines: continuing to engage in maladaptive behaviors; not considering their own roles in problematic interpersonal dynamics; and failing to take steps that might move them forward in their lives. In such cases, we have one additional technique at our disposal—namely, directly sharing our observations about patients' *absence* of reflection about these matters (Box 7.7). We tailor this feedback to the specific challenge in mentalizing patients seem to be experiencing in the moment, as discussed throughout this chapter. For example, when patients seem disconnected from their sense of agency in the present moment, we might remark, "You don't seem to be thinking very much about how to make your way through this situation." Or: "I'm hearing a lot about what your mother wants you to do, but you don't appear to be wondering what YOU want to do here."

Box 7.7 Providing feedback about patients' challenges with behavior-focused mentalizing

If patients continue to struggle with reflectiveness about behavioral processes, offer direct feedback about their *absence* of reflection in the area in question.
Provide feedback in a "marked" fashion, utilizing non-authoritative language that refers to one's own perspective: *"You don't seem to be . . ." "You don't appear to be . . ." "It comes across to me . . ."*
Highlight patients' challenges with agency in the present moment.

"You don't seem to be thinking very much about how to make your way through this situation."
"I'm hearing a lot about what your mother wants you to do, but you don't appear to be wondering what YOU want to do here."

Observe patients' difficulties mentalizing broader behavioral patterns.

"I can't quite tell, but you don't seem to be focusing on the *impact* of your argumentativeness, on other people but also on yourself."
"You are quite focused on your wife's behavior in this situation, but it doesn't sound like you're considering *your* part in these arguments—what you are doing that is potentially contributing to all of these conflicts."

Acknowledge patients' trouble reflecting upon the alteration of existing behavioral patterns.

"I know you say that you 'should' do something about your marijuana use, but it's not always clear to me how motivated you are to make a change here."
"You seem quite passive in relation to your anger issues. It's like you are just waiting for them to somehow get better, without trying to sort out HOW to make that happen."

When patients are less reflective about their broader behavioral patterns, we can offer feedback about whatever factor seems less prominent in their considerations (e.g., precipitants, their own behavioral contributions, patients' own mental states, other people's mental states). For example, in the case of patients who struggle to mentalize the various consequences of their behavior, we could share, "I can't quite tell, but you don't seem to be focusing on the *impact* of your argumentativeness, on other people but also on yourself." When patients are reflecting less on their own behavioral

participation in important dynamics in their lives, we might say something like: “You are quite focused on your wife’s behavior in this situation, but it doesn’t sound like you’re considering your part in these arguments—what you are doing that is potentially contributing to all of these conflicts.” Or we might state:

> “I know that you are quite angry that your friends have been distancing themselves from you, and that feels extremely unfair to you *[empathic validation of patient’s perspective]* . But I rarely hear you talk about anything *you* have done that might have made them upset with you in the first place *[feedback about absence of reflection]* .”

We also provide patients with feedback about their challenges reflecting on *altering* existing behavioral patterns. For example, for the patient who seems less thoughtful about the viability or efficacy of a particular behavior, we could say:

> “You seem to spend a lot of your time giving advice to your children, and telling them how they should be living their lives. I know you feel really strongly about these issues *[empathic validation of patient’s perspective*], but you don’t seem to be that curious about whether this approach is actually *working* for you in these relationships *[feedback about absence of reflection]* .”

We also share our observations about patients’ potential motivation to change a specific behavioral approach: “I know you say that you ‘should’ do something about your marijuana use, but it’s not always clear to me how motivated you are to make a change here.” Or: “You seem quite passive in relation to your anger issues. It’s like you are just waiting for them to somehow get better, without trying to sort out HOW to make that happen.” Along similar lines, we can share our impressions when patients seem less curious about cultivating alternative behaviors in a situation:

> “I appreciate how committed you are to being less critical of your wife. But you seem to be focusing mostly on what you shouldn’t be saying to her, while paying a lot less attention to how you really *want* to engage with her, in order to improve your relationship.”

In all of these communications, we attempt to frame our comments in a “marked” fashion, utilizing language that implies we are sharing our subjective viewpoints (“*You don’t seem to be …”* ; “*You don’t appear to be …”* ; “*It comes across to me …”*), rather than making any authoritative declarations. In many cases, patients are quite receptive to our feedback, taking the opportunity to further reflect on the area in question. Here we

utilize the techniques reviewed in this chapter to encourage further elaboration about the relationship between mental states and relevant behaviors. “So you think that your dishonesty might have played a role in your friends being so upset with you. Can you say more about how that has impacted them?” If patients disagree with our perspective, we tend to “roll with it,” utilizing empathic validation and elaborative questions to help them articulate their own views about these matters. “I see, so you feel like you HAVE thought a lot about how you have contributed to conflicts with your wife. What have you considered along these lines?” As patients further consider relevant factors here (e.g., their own behavioral contributions, their current motivation for change, our experience of them as *not* fully reflecting on their behavioral experiences), they are adopting a more curious, mentalized stance toward their own actions and mental states, which over time leads to greater behavioral and interpersonal flexibility.

The context of emotions

Thus far we have considered techniques for stimulating patients’ reflectiveness about the connection between mental states and “visible” things, namely the outside environment as well as behavioral processes. But mental states of course exist in relation to *internal* processes as well—that is, other subjective elements (e.g., thoughts, emotions, desires, self-states) that are continuously influencing (and being influenced by) the original mental state under consideration.

Patients with pathological narcissism can struggle extensively with reflecting on the relationship between different mental states. These patients often end up feeling like their moods and emotions are *caused* by the offensive factor in the environment, rarely considering how these feelings could be influenced by other affective processes unfolding inside of them. One patient feels angry at his wife for criticizing him, but he is less attentive to his feelings of hurt and inadequacy in that relationship, which could be impacting his difficulties with defensiveness and aggression. Another patient feels irritable and impatient throughout the day, attributing this to having to deal with her incompetent co-workers; she fails to consider her feelings of anxiety about an upcoming presentation, and the ways in which those worries might be exacerbating her irritability. As patients gain a greater ability to reflect on the connection between their various feeling states, they

are able to consider the range of psychological processes unfolding inside of them, especially in the moment of narcissistic disruptions. This lays the groundwork for a more cohesive, emotionally grounded sense of Self, while also enabling them to make choices reflective of a broader range of their subjective experiences.

In Chapter 6 , we reviewed affect elaboration techniques geared toward helping patients represent and reflect on internal processes. For our purposes here, the most important of these processes are affects (e.g., anger, sadness, anxiety), desires (e.g., to take certain actions, attain concrete things, or generate valued interpersonal outcomes), and self-states (e.g., shame, insecurity, pride). Once patients have acknowledged the presence of multiple feelings within a particular experiential context, we can then utilize context-focused interventions to invite reflection on the potential relationship between these feelings. By and large, patients tend to describe three different circumstances for their experiences of multiple emotions:

Consecutive emotions: Patients experience emotion #1 at one moment, and then they experience emotion #2 at a later moment;
Simultaneous emotions: Patients experience emotion #1 and emotion #2 at the same moment in time;
Nascent emotions: Patients experience emotion #1 at a specific moment in time; in hindsight, they recognize that emotion #2 was also probably present, but they had not yet recognized or identified it at the time.

We utilize different techniques for each of these circumstances, which we will review in turn.

Consecutive emotions

In many cases, when describing a chronological narrative about a particular experiential context, patients describe experiencing a specific emotion at an earlier part of the narrative, and then they note the presence of a different emotion at a later point in the narrative. One patient reports feeling initially confident during a social interaction; as the night wears on, she begins to feel increasingly self-conscious and insecure. Another patient has been discussing his sadness and hopelessness over the past several sessions; in today's appointment, he appears visibly upbeat, and he describes feeling "excited and optimistic."

In MBT-N, we try to maintain the not-knowing stance around consecutive emotions—that is, we avoid making assumptions about what is responsible for patients' affective shifts, and we refrain from telling patients our own theories about the causes and meaning of these alterations. Instead, we start by summarizing the two previously expressed emotional states (*"While initially you felt quite confident at the party, gradually you started to feel anxious and bad about yourself"* ; *"You have been quite despondent and desperate the past few weeks, but today you seem to be in a much better mood, even expressing your hope for the future"*), then constructing some context-focused inquiry inviting patients to reflect on the potential connection between these different emotional states. "What is your sense of how this change ended up happening for you?" "Do you have any ideas about what made things go differently for you?" "What do you make of this development?"

Box 7.8 Context-focused interventions for consecutive emotions

Summarize two previously expressed emotional states.

“You have been quite despondent and desperate the past few weeks, but today you seem to be in a much better mood, even expressing your hope for the future.”

Construct some context-focused inquiry inviting patients to reflect on the potential connection between these different emotional states.

“What is your sense of how this change ended up happening for you?”
“Do you have any ideas about what made things go differently for you?”
“What do you make of this development?”

Work to elaborate patients’ reflections about relevant internal processes, ultimately working toward an empathic statement that summarizes patients’ own ideas about the “link” between the two original emotional states.

This usually takes the format of something like: “Emotion #1 + Internal Process = Emotion #2.”
“So you had been feeling quite sad and hopeless about the state of your life *[emotion #1]* . But then you got the idea of applying to graduate school, feeling like you could actually be successful again and make a lot of money *[internal process]* . This has all made you feel much more excited about your life, and your future *[emotion #2]* .”

If patients respond by identifying some other psychological state (e.g., thoughts, emotions, desires, self-states) related to the shift in affective experience, we invite patients to further elaborate that state (*“I see, so you started thinking about applying to graduate school, to find a new career. Can you say more about?”*), gradually working toward some form of empathic validation that summarizes patients’ own ideas about the “link” between the two original emotional states. This usually takes the format of something like: “Emotion #1 + Internal Process = Emotion #2.”

> “So you had been feeling quite sad and hopeless about the state of your life *[emotion #1]* . But then you got the idea of applying to graduate school, feeling like you could actually be successful again and make a lot of money *[internal process]* . This has all made you feel much more excited about your life, and your future *[emotion #2]* .”

In contrast, if patients respond by sharing more about some external or situational factor (e.g., an interaction with another person, an event in the environment, some action they have taken), we utilize the context-focused strategies we have been discussing (e.g., situation-focused techniques, behavior-focused techniques) to explore with patients the relevant internal processes at play for them. For example, if the patient who attended the party shares that she started feeling insecure when she saw several of her friends talking together without her, we might construct some context-focused inquiry inviting reflection about the relationship between these factors, working to explore and elaborate relevant internal processes that might connect the two previously expressed feeling states. “So they were all talking together without including you *[situational factor]* . What about this really impacted you, and made you feel so self-conscious *[context-related inquiry]* ?”

Simultaneous emotions

In addition to identifying chronologically successive emotions, patients often articulate multiple emotional states unfolding at the same moment in time, either in past or present experiential contexts. One patient describes feeling hurt and rejected by his romantic partner, also expressing his desire to punish her for being insufficiently invested in the relationship. Another patient, when she learns that her colleague had a paper accepted by a prestigious academic journal, expresses intense feelings of jealousy, as well as shame about her own abilities and accomplishments.

The technique here parallels our approach to consecutive emotions. That is, we summarize the two emotional states in question, and then we construct some context-focused inquiry focused on the potential association between these feelings. “Do you think there is any connection between these emotions for you?” “How do these feelings relate to each other?” “What links *[emotion #1]* and *[emotion #2]* in your experience?” Usually patients respond here by discussing some other internal process (e.g., thoughts, emotions, desires, self-states) that somehow connects each emotion to each other. We then utilize affect elaboration techniques to further explore and elaborate such processes, ultimately delivering some empathic summary of patients’ own ideas about the link between the two original emotional states. See here for an illustration of these techniques, employed after the patient

mentioned earlier was discussing his distressing feelings about his romantic relationship.

THERAPIST: So you are feeling quite hurt by your girlfriend, but also wanting to punish her for not caring enough about you *[empathic summary of two emotional states]* . Is there a connection between these feelings for you—the hurt and the desire to punish *[context-focused inquiry]* ?

PATIENT: Yeah, absolutely. Who wants to feel hurt all the time?

THERAPIST: Say more about that. *[inviting further elaboration]*

PATIENT: I mean, it feels absolutely painful to keep wanting her, and to have her keep rejecting me. I think that I want to make her feel as bad as I feel, so I say things that I know are going to hurt her. It sounds messed up, but it actually gives me some feeling of relief—like if I can still make her feel pain, then maybe she still cares about me on some level. *[identifying additional internal process that links two previously discussed emotional states]*

THERAPIST: *[offering empathic summary statement of the internal "link" between the two emotions]* this sounds really important. you feel so much pain and hurt that she doesn't care about you *[emotion #1]* , and then by saying things that you know are going to hurt her *[emotion #2]* , you actually experience a sense of relief and comfort from that *[internal process]* . it sounds like her pain almost reassures you in a way that she still cares about you *[further reflection of newly identified internal process]* .

PATIENT: Yeah, exactly. It's like at that point I am so desperate I will take anything I can get, even if it's a bad thing.

THERAPIST: I wonder if we should look at this a little bit more—this idea that you need to hurt your girlfriend in order to know that she cares about you . …

Here the therapist builds upon the patient's previously successful reflection on mental content (e.g., hurt, desires to punish) to invite reflection about the broader context of these mental states, leading the patient to reflect more expansively on the relationship these mental states bear toward one another in his experience.

Nascent emotions

As we have discussed throughout this book, patients with PN can struggle extensively with alexithymia—failing to identify and access their emotions and desires, or experiencing a highly narrow range of these feeling states. Such challenges are exacerbated by processes of narcissistic self-enhancement, where patients are drawn primarily toward mental states that bolster their valued self-concepts (e.g., anger, superiority, judgment of others), while struggling to represent mental states that potentially undermine those self-concepts (e.g., sadness, insecurity, shame, desires for attention). Accordingly, when we utilize affect elaboration strategies to broaden the scope of patients' affective experience, patients end up articulating mental states unfolding at varying levels of awareness: *evident emotions* , or feelings that were more prominent or articulated in patients' experience, and what we might call *nascent emotions* —feelings that patients had not yet recognized or represented in themselves in the moment under discussion. For example, in an argument with his elderly parents, one patient was primarily aware of his feelings of anger and resentment toward them; in his next therapy appointment, he identified additional emotions of guilt and shame for being insufficiently attentive to them and their needs. When discussing recent interactions where her wife was criticizing her, a patient described feeling annoyed and judgmental of her partner; further exploration revealed emotions of hurt and sadness, as well as her strong desire for her wife to admire and appreciate her.

Once patients have articulated these different emotions in sessions, it is tempting for therapists to make assumptions about "why" some emotions are present and others are absent, or even to offer explanations or interpretations about this to patients directly (e.g., involving defense mechanisms, repression, unconscious dynamics). We avoid making any such proclamations in MBT-N, instead taking a series of steps to try to stimulate patients' *own* reflection on the relationship between their nascent and evident emotions.

We usually start by directly inquiring about patients' level of awareness of the nascent emotion, in the experiential context under consideration. "How much were you in touch with these feelings of hurt and sadness at the time?" "In your argument with your parents, were you actually *feeling* the guilt and shame, or is this something that you are recognizing more now?" "How attentive have you been to these emotions in yourself, as you've been

moving throughout your life?" If patients affirm some level of decreased attentiveness to these affects, we empathically summarize their reflections about their degrees of awareness of the nascent emotions, compared to other emotions involved in the situation. "So these emotions of hurt and sadness were not really on your radar until now." "Interesting … so you have been much more aware of your anger and resentment toward your parents, and far less in touch with your guilt and shame."

Box 7.9 Context-focused interventions for nascent emotions: Exploratory questions

Nascent emotions are feelings that patients had not yet recognized or represented in themselves in the moment under discussion; **evident emotions** are feelings that were more prominent or articulated in patients' experience.
Refrain from offering any explanations or interpretations about "why" some emotions are present and others are absent.
Directly inquire about patients' level of awareness of the nascent emotion.

"How much were you in touch with these feelings of hurt and sadness at the time?"

Construct some context-focused inquiry encouraging patients to consider their varying levels of attentiveness to these different feeling states.

"What do you make of this—that you were so cognizant of your anger, but only vaguely aware of these other feelings?"
"What is your sense of how you really 'missed' these other feelings in yourself?"

Starting with nascent emotions, explore patients' "feelings about their feelings."

Affect-focused inquiry: *"What does that feel like for you, when you are seeing yourself in such a negative light?"*
Desire-focused inquiry: *"Do you ever try to stay away from those feelings of grief and loss?"*
Cognition-focused inquiry: *"Do you have any judgments about these feelings of fear and anxiety?"*
General inquiry about mental states: *"If you had let yourself feel sadness in that moment, what would that have been like for you?"*
Inquiry about self-esteem: *"How does that make you feel about yourself, when you are wanting attention from your wife?"*

Explore patients' mental states surrounding evident emotions.

"Do you ever find yourself drawn to those feelings of superiority?"
"How much value do you ascribe to always feeling 'upbeat' and 'positive'?"
"When you are feeling so confident and certain in your perspective, how does that make you feel about yourself?"

Having reached this point with patients, we have a handful of techniques at our disposal. On the one hand, we can construct some context-focused inquiry encouraging patients to consider their varying levels of attentiveness to these different feeling states in themselves. “What do you make of this—that you were so cognizant of your anger, but only vaguely aware of these other feelings?” “What is your sense of how you really ‘missed’ these other feelings in yourself?” Similarly, we invite patients to compare their experience of nascent versus evident emotions: “What does that feel like for you, when you are filled with rage toward other people *[evident emotion]* , versus when you are overwhelmed by these feelings of shame *[nascent emotion]* ?” We work with patients to explore, elaborate, and empathically validate their reflections about these matters: “So the anger somehow feels more familiar and comfortable for you *[evident emotion]* , compared to the sadness *[nascent emotion]* . Could you say more about that?”

Along these lines, we find it especially helpful to “break down” patients’ experience of nascent versus evident emotions, examining their mental states surrounding each type of experience. Stated colloquially, we explore patients’ “feelings about their feelings.” We usually start by elaborating patients’ mental states surrounding nascent emotions, focusing variously on affects (*“What does that feel like for you, when you are seeing yourself in such a negative light?”*); desires (*“Do you ever try to stay away from those feelings of grief and loss?”*); cognitions (*“Do you have any judgments about these feelings of fear and anxiety?”*); and mental states in general (*“If you had let yourself feel sadness in that moment, what would that have been like for you?”* ; *“How do you relate to these feelings of shame in yourself?”*). Given the impact of self-enhancement processes on patients’ experiences of their emotions, we are especially curious about the relationship between patients’ nascent emotions and their sense of self-esteem and self-worth. “How does that make you feel about yourself, when you are wanting attention from your wife?” “When you are feeling vulnerable in that way, does that ever affect how you see yourself?”

Utilizing techniques of affect elaboration and empathic validation, we examine patients’ reflections about all of these processes (*“So you end up feeling ashamed whenever you crave attention from you wife. Can you say more about that?”*), ultimately working toward an empathic summary statement that relates the nascent emotion to some other internal process (e.g., thoughts, affects, desires, self-states) that patients have elucidated in

the therapeutic dialogue. “So it makes you feel ashamed and embarrassed *[newly identified internal process]* to be wanting attention from your wife in that way *[nascent emotion]* —like it is a sign of your weakness as a person *[further description of internal process]* .” Or: “It sounds like you are struggling with intense feelings of grief and loss *[nascent emotions]* , but you really don’t want to feel these feelings, so you do whatever you can to stay away from them *[newly identified internal process]* .”

Box 7.10 Context-focused interventions for nascent emotions: Empathic summary statements

Employing techniques of affect elaboration and empathic validation, work toward an empathic summary statement that relates the emotions in question to other internal processes (e.g., thoughts, affects, desires, self-states).

"It sounds like you are struggling with intense feelings of grief and loss *[nascent emotions]* , but you really don't want to feel these feelings, so you do whatever you can to stay away from them *[newly identified internal process]* ."
"When you judge other people *[evident emotion]* , you end up feeling quite powerful and strong, like you have access to 'the truth' about them and their deficiencies *[newly identified internal process]* ."

Utilizing patients' explicitly stated reflections thus far, construct and deliver a succinct formulation comparing patients' different internal stances toward nascent versus evident emotions.

"You appear to be drawn quite reflexively to this position of superiority and judgment of others *[summary of previous reflections about evident emotions]* , but you try to stay away from a lot of these 'softer' feelings in yourself, like loneliness or insecurity *[summary of previous reflections about nascent emotions]* ."
"It sounds like you can feel quite embarrassed and ashamed whenever you feel hurt by your boss, or when you crave recognition from your him *[summary of previous reflections about nascent emotions]* . It feels much easier to get angry at him and focus on his deficiencies—then he is the bad one, not you *[summary of previous reflections about evident emotions]* ."

Explore with patients their reactions and reflections about these impressions.

"What do you think about this?"
"Does this resonate with your experience in any way?"
"What is it about your sense of superiority over other people, that makes it feel so much better than the insecurity and fear?"

We employ analogous interventions when exploring patients' mental states surrounding their evident emotions, focusing variously on patients' affects (*"What emotions come up in you when you are judging other people*

in that way, and focusing on their defects?" ; *"Is there anything gratifying about always feeling annoyed with people?"*); desires (*"Do you ever find yourself drawn to those feelings of superiority?"*); cognitions (*"How much value do you ascribe to always feeling 'upbeat' and 'positive'?"*); self-states (*"When you are feeling so confident and certain in your perspective, how does that make you feel about yourself?"*); or mental states in general (*"What is that like for you, when are so enraged and wanting to punish your father in that way?"*). We work with patients to explore and elaborate their reflections about these matters (*"So there is something 'empowering' about judging other people. What does that feel like, to be empowered in that way?"*), ultimately synthesizing these ideas into an empathic summary statement that connects the evident emotion to some other internal process (e.g., thoughts, affects, desires, self-states) that patients are describing. "When you judge other people *[evident emotion]* , you end up feeling quite powerful and strong, like you have access to 'the truth' about them and their deficiencies *[newly identified internal process]* ."

Throughout all of these explorations, patients usually end up articulating something about their internal relationship to their nascent versus evident emotions: the ways in which they might be somehow drawn toward the emotions that are consistently more prominent in their experience, while more averse to experiencing those murkier emotions operating more "in the background." This is especially the case when patients experience their nascent emotions as potentially undermining their valued self-concepts, and when their evident emotions bolster or enhance these self-concepts (or at least do not disrupt them). We then construct and deliver some bite-sized, experience-near formulation statement comparing patients' different internal stances toward nascent versus evident emotions. Depending on the content of patients' reflections thus far, such statements can variously involve affects (*"You seem quite comfortable feeling anger and annoyance with your father; it feels much more painful to experience your own guilt and self-judgment in that relationship"*); desires (*"You appear to be drawn quite reflexively to this position of superiority and judgment of others, but you try to stay away from a lot of these 'softer' feelings in yourself, like loneliness or insecurity"*); and attentional processes (*"You are extremely focused on all the details of this situation, especially what you feel your wife is doing wrong. You seem to pay a lot less attention to how hurt you can feel by her, and what you might want from her"*). When patients have explicitly discussed issues of self-

worth and self-esteem in their experiences of nascent and evident emotions, we make sure to emphasize these reflections in our formulation statement as well.

> "It sounds like you can feel quite embarrassed and ashamed whenever you feel hurt by your boss, or when you crave recognition from your him *[summary of previous reflections about nascent emotions]* . It feels much easier to get angry at him and focus on his deficiencies—then he is the bad one, not you *[summary of previous reflections about evident emotions]* ."

After sharing these impressions, we explore with patients their reactions and reflections about them. "What do you think about this?" "Does this resonate with your experience in any way?" "Have you noticed any recent examples of this in your life?" "This reminds me a little bit of your feelings in your recent argument with your wife. Do you see any connection there?" Additionally, we can utilize affect elaboration strategies to further expand patients' reflections about the emotions in question (*"What is it about your sense of superiority over other people, that makes it feel so much better than the insecurity and fear?"* ; *"What do you think draws you so strongly to this sense of resentment, and keeps you away from your feelings of hurt?"*).

If patients see the relevance of these processes to their broader patterns of relating to their emotions, we utilize this as an opportunity to explore their interest in working on these matters in their lives and relationships more generally. "The next time this happens, I wonder what it would be like for you to try to pay attention to a broader spectrum of your feelings in the situation: the anger, but also any other emotions, desires, and feelings about yourself that might be coming up for you?" "Would you ever be interested in working on this in the treatment together? We could try to help you recognize and access a wider range of your emotions when you get upset, rather than just the ones you see as 'positive' and 'productive' in yourself."

In attending to these matters with patients, we are not attempting to generate any particular insights about the etiology of these challenges, or about causal or non-conscious determinants of "why" they experience their emotions in these ways. Rather, by simply helping patients to recognize and consider their different internal stances toward their nascent and evident emotions, we enable them to construct something of a "meta-framework" of these emotions that feels personally meaningful to them, which they can carry around with them outside of the therapy sessions. Patients become increasingly able to *notice* their own biases in their experiences of their

emotions, actively working to access a wider range of their feeling states in their everyday lives and interactions.

General context-focused inquiries

Thus far, we have reviewed therapeutic techniques focused on the relationship between patients' mental states and specific aspects of experience, namely situations, behaviors, and other emotions. We also employ more "general" context-focused techniques, which prompt patients to step back from the full gestalt and complexity of their experience, and to identify the facets of that experience that hold special importance to them. These general techniques implicitly encourage patients to take a more agentic stance in relation to their mental states—not simply naming and describing "what" they are feeling, or even "why" they are feeling that way, but determining the personal relevance of all of these things, within the broader context of their lives.

Box 7.11 General context-focused techniques in MBT for narcissism

General context-focused techniques prompt patients to step back from the broader gestalt and complexity of their experience, and to identify the facets of that experience that hold special importance to them.
When patients introduce an agenda item that contains multiple complex elements, consider asking:

“What part of this feels most important to you?”
“Where do you see the problem here?”
“What would you like to focus on in this situation?”

Following a detailed examination of some topic, invite further reflection about the meaning patients ascribe to the discussion.

“So where does this leave you?”
“What do you see as the take-away here?”
“Where do you go with these ideas?”
“What does this all mean to you?”

When patients engage more passively in the therapeutic dialogue, inquire further:

“What are the implications of this, to your life overall?”
“What is the moral of this story for you?”
“How do you want to proceed, in light of all these observations?”

After raising these queries, utilize empathic validation and exploratory strategies to explore and elaborate patients’ reflections.

“You’re really appreciating how much you can rely on other people’s admiration for a sense of self-esteem *[empathic reflection]* . Where else do you see that in your life *[elaborative inquiry]* ?”
“You are recognizing how defensive you can be in your relationship with your husband, and you really want to work on this *[empathic reflection]* . How would you go about trying to change this pattern *[context-related inquiry]* ?”

There are a handful of therapeutic circumstances where we find these general interventions especially helpful. First, when patients introduce agenda items that contain multiple complex elements (e.g., other people, chains of circumstance, emotions and desires), we often ask a general

question to help them pinpoint salient aspects of that experience for them. “What part of this feels most important to you?” “Where do you see the problem here?” “What would you like to focus on in this situation?” We also utilize such inquiries following a detailed examination of some topic, for example after we have employed content- and context-focused interventions to help patients elaborate and reflect on a wide range of mental states. Then we often ask questions like: “So where does this leave you?” “What do you see as the take-away here?” “Where do you go with these ideas?” “What does this all mean to you?”

In addition, patients sometimes engage quite passively in the therapeutic dialogue, concluding a mentalizing discussion without appearing to grapple with the bearing of these issues to their everyday lives, with an attitude that comes across as “OK, I get it. So what’s next?” Here we might ask, “What is the moral of this story for you?” “What are the implications of this, to your life overall?” “How do you want to proceed, in light of all these observations?”

After raising these queries, we utilize empathic validation and exploratory strategies to elaborate patients’ reflections along these lines. “You’re really appreciating how much you can rely on other people’s admiration for a sense of self-esteem *[empathic reflection]* . Where else do you see that in your life *[elaborative inquiry]* ?” Or: “You are recognizing how defensive you can be in your relationship with your husband, and you really want to work on this *[empathic reflection]* . How would you go about trying to change this pattern *[context-related inquiry]* ?” By encouraging patients to reckon with the significance of their content- and context-based reflections, we help them situate these ideas within a broader mental context, one that includes a representation of themselves as thinking, feeling, and behaving subjects. Over time, this leads to an enhanced sense of agency for patients, helping them to maintain a stance of personal authorship and influence over the psychological and behavioral dimensions of their experience.

The context of history

As we discussed in Chapter 4 , effective mentalizing can often involve reflecting about history—that is, considering the impact of past events and circumstances on mental states (e.g., thoughts, emotions, desires, self-states, personality traits) in ourselves and others. We reflect on our childhoods, and

the ways in which our relationships with caregivers in childhood have affected our current personalities and assumptions about other people. We think about our history in romantic relationships and friendships, and how our experiences there might affect how we feel and engage in important relationships now. As traditional psychoanalysis has compellingly illustrated, acquiring insight into such processes can play an important role in enhancing our self-understanding, while also deepening our sense of connectedness to ourselves and other people (Bateman et al., 2021 ; Drozek, 2019).

In spite of these potential benefits of history-focused mentalizing, we do not direct significant attention to such matters in MBT for narcissism. Perhaps most importantly, this is due to the extreme tendency toward pretend mode among patients with PN, whereby patients can engage in extensive cognitive activity without simultaneously accessing and experiencing their own emotions and desires. Patients might express multifarious *ideas* about the causal relationship between the past and the present, but they can remain largely disconnected from relevant affective processes, whether about the past event or (more commonly) crucial interpersonal circumstances in their everyday lives.

History-focused interventions can also detract from MBT-N's primary focus on patients' current functionality. As we reviewed in Chapter 4 , treatment is structured around patients' challenges in key experiential domains (e.g., emotional, identity-related, interpersonal, or functional in nature), which we explicitly link to contemporary difficulties with reflecting on mental states. In our experience, while the historical etiology of such challenges is relevant from the perspective of developmental process, "understanding" that etiology has minimal bearing on patients' ability to reflect on mental states *now* , in the manner that is usually necessary for robust functional improvement.

Box 7.12 History-focused interventions in MBT for narcissism

MBT-N does NOT direct significant attention to explicitly "linking" patients' historical experiences (e.g., in childhood, in the distant past) to their contemporary lives.

Such an approach can inadvertently encourage pretend mode processes, while also detracting focus from patients' current functionality.

Avoid asking questions or making statements that causally connect patients' contemporary challenges with their developmental histories.
Still permissible to focus on past experiences

During the assessment phase, when examining patients' history of functional challenges;
When exploring patients' problems with mentalizing throughout the lifespan;
When patients discuss relationships with people who bear important historical relevance in their lives: parents, past romantic partners, children from whom they have been estranged.

If patients appear more emotionally disconnected, or if they are directing significant attention to "explaining" the present in terms of the past, shift the sessional focus away from the past experience.

Empathically validate patients' expressed impressions about the past: "*So you never felt seen or cared for by your mother, and that has really impacted how safe and secure you are able to feel in your current relationships.*"
Reorient to the original agenda for the session, which always involves a mentalizing question surrounding some current or recent experiential context: "*This idea of you 'not feeling cared for' seems relevant to your recent argument with your wife, which I know you wanted to discuss today. Could we go back to that argument? I would like to hear more about what that was like for you, when she was yelling at you in that way.*"

Here MBT-N is entirely consistent with standard MBT (e.g., for borderline and antisocial personality disorders), which focuses on "current rather than past experience" (Bateman & Fonagy, 2016 , p. 185). Bateman and Fonagy (2016) warn:

> Reaching into the past can be more comfortable for both patient and clinician but is far less real, thus encouraging pseudomentalizing between patient and clinician about what the patient might or might not have felt as a child or what the motive of his/her parents might or might not have been all those years ago. (p. 218)

These forms of historical reflection have often been encouraged in patients' previous experiences in psychotherapy, such that many patients assume that "thinking about the past" is what therapy *is.*

How then do we manage discussions of the distant past in MBT-N? By and large, we refrain from asking questions or making statements that causally link patients' contemporary challenges with their developmental histories (*"Could your insecurities here have anything to do with how your father treated you when you were growing up?"* ; *"You're trying to win your wife's attention and recognition, in the same way that you did with your mother"*). That said, as reviewed in Chapter 3 , we still regularly inquire about patients' past experiences during the assessment phase, especially when examining their history of functional challenges and narcissistic disruptions. Similarly, when considering patients' historical difficulties with mentalizing discussed in Chapter 4 (e.g., certainty, concreteness, affective disconnection), we often explore their experiences in important relationships across the lifespan. In such discussions, we are not seeking causal or explanatory insights surrounding the past. Rather, we explore patients' past experiences as they bear relevance to their contemporary lives—that is, to clarify the shape that their challenges with mentalizing have traditionally taken, in order to structure a treatment that effectively targets patients' *current* vulnerabilities in reflecting on mental states in Self and Other.

Patients are often interested in discussing relationships with people who bear important historical relevance in their lives: previous romantic partners, children from whom they have been estranged, or parents with whom they continue to have emotionally complicated relationships. In the context of such discussions, patients will inevitably share memories about the distant past. We do not shy away from such topics. As long as patients appear to be emotionally engaged in their communications, we continue following the interventional pathway outlined in this book: first exploring and elaborating mental content, inviting reflection about the broader context surrounding the identified mental states, and then addressing relevant forms of non-mentalizing, all the while steering clear of "linking" current mental states to past experiences.

However, when we become concerned that patients are becoming disconnected from their current emotional experiences, or when patients are investing significant attention to "explaining" the present in terms of the past, we find it necessary to shift the sessional focus to a more relevant and emotionally grounded experiential terrain. Here we start by first empathically validating patients' expressed impressions in the moment: "So you never felt seen or cared for by your mother, and that has really impacted how safe and secure you are able to feel in your current relationships." We then gently reorient to whatever agenda item we had originally set for the session, which always involves some current or recent experiential context, as well as some mentalizing focus related to that context (pp. 95–100).

> "Well, I appreciate you raising this, especially since this idea of you 'not feeling cared for' is quite relevant to your recent argument with your wife, which I know that you wanted to discuss today *[reorienting to experiential context previously identified by patient]* . Could we go back to that argument for a bit? I would like to hear more about what that was like for you, when she was yelling at you in that way *[context-related mentalizing focus]* ."

In our experience, as long as we work to sufficiently "reflect back" and empathize with patients' historical reflections, patients are usually not too disrupted by these forms of redirection, and they are more than willing to engage around the original agenda item. We can thus comfortably resume encouraging patients' current reflectiveness about mental states—the primary aim of MBT.

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[1] These difficulties with contextual mentalizing are often related to processes of self-enhancement, whereby patients tend to focus on aspects of situations that enhance their sense of self-esteem, while ignoring and avoiding factors that make them feel bad about themselves. This leads to a highly narrow understanding of the aspects of reality that influence them: they arrive at explanations that support a sense of superiority, and they "miss" the impact of factors that might lead them to feel ashamed, embarrassed, humiliated, and hurt.

8

Process-focused Interventions: Pretend Mode

Introduction to process-focused interventions

We have been making our way through the basic trajectory of interventions in mentalization-based treatment for narcissism (MBT-N): first exploring and empathically validating the content of patients' mental states, and then working with patients to consider the relationship between these states and important factors surrounding them (e.g., events, behaviors, other emotions and desires). By this point in the session, patients have hopefully begun to express more elaborated, complex, and contextualized representations of subjective states in themselves and others. However, in most cases, we have invariably started to notice what MBT refers to as **non-mentalizing modes** in patients' experience (pp. 30–32, 65–69), or disruptions in the *process* of how patients relate to mental states in Self and Other. Patients might appear rigidly certain and authoritative about their own viewpoints, a psychological stance described as *psychic equivalence mode* : "If I think it, that makes it true." When in *teleological mode* , patients are excessively focused on visible, external aspects of reality, employing those factors as a basis for understanding subjective experience in themselves and others: "The outside determines the inside." With *pretend mode* , patients can be significantly dissociated from their own emotions and desires, while also struggling to be motivated by other people's mental states: "My head is disconnected from my heart."

At this stage in the trajectory of interventions, our next step is to identify the specific form of non-mentalizing that will serve as the central clinical focus for the next portion of the session (Box 8.1). In everyday practice, patients often display multiple non-mentalizing modes in the same clinical moment, manifested at varying levels of prominence, intensity, and severity. For example, one patient might simultaneously exhibit notable rigidity in

his devaluation of others (psychic equivalence), while also frequently discussing his own concrete successes (teleology) and engaging extensively in monologues and intellectualization (pretend). Accordingly, there is often no clear “right or wrong” about which mode warrants attention at any particular time.

Nevertheless, several principles guide our decision-making along these lines. By and large, pretend mode always takes the highest priority. If patients are detached from their own minds in the present moment, no authentic reflection about mental states is possible—from an experiential standpoint, there is nothing to reflect *about* . If pretend mode is not especially prominent at the time, we tend to select the non-mentalizing mode that (a) seems most relevant to their functional difficulties in the situation under discussion; (b) relates to patients’ explicitly identified treatment priorities, as well as their problems with mentalizing identified in the MBT formulation; or (c) connects to new challenges or themes that have been recently emerging in the therapy, which one or both parties are starting to see as meaningful in patients’ lives, functioning, and broader treatment goals.

Box 8.1 Process-focused interventions: Identifying the specific non-mentalizing mode

Non-mentalizing modes are disruptions in the *process* of how patients relate to mental states in Self and Other.

Such challenges variously involve certainty (psychic equivalence mode), concreteness (teleological mode), or disconnection (pretend mode).

After utilizing content- and context-focused interventions to address a particular agenda item, identify the specific non-mentalizing mode that will serve as the target of process-focused interventions.

Once we have identified the preferred non-mentalizing mode, we utilize specific strategies that are tailored to address the specific form of non-reflectiveness in question. We will review these techniques in detail over the next several chapters, starting with interventions for pretend mode.

Clinical manifestations of pretend mode in pathological narcissism

Pretend mode is marked by patients' disconnection from authentic subjective experience in themselves and other people (Box 8.2). As we have discussed throughout this book, this mode is a pervasive and subtly destructive feature of pathological narcissism (PN). When in pretend mode, patients come across as more emotionally removed and "in their heads," not actually *feeling* their emotions as they are discussing the matter at hand. Less interested in their own internal lives, they engage extensively in intellectualization, abstraction, and vague communications. This often shows itself in the use of seemingly sophisticated therapeutic jargon (e.g., "cognitive distortions," "defense mechanisms," "projection," "attachment strategies," "childhood trauma," "compartmentalization") drawn from the particular modalities to which they have been exposed, yet without a robust emotional engagement with the ideas in question.

Box 8.2 Clinical manifestations of pretend mode in pathological narcissism

Disconnection from emotions and desires in the present moment
Decreased interest in one's own internal experience
Often marked by intellectualization, abstraction, therapeutic jargon, vague communications, and meta-level explanations
Detachment from other people's minds: decreased empathy, minimal spontaneous curiosity about others' thoughts and feelings
Separation from the therapist: self-centeredness, dismissiveness, monologues
Disconnection from external reality: patients' everyday functioning does not improve; self-concept does not reflect their actual lives; minimizing facts about Self or Other that contradict patients' self-concepts

Rather than simply describing and expressing their feelings in an experience-near way, these patients can spend significant time providing meta-level explanations of their experiences: "I think the reason why I said

that is because he really triggered my abandonment issues . …" Or: "This goes back to her childhood—her father was an 'alpha' who always had to be in control, and now she is treating other people the way that her father treated her." Whenever the therapeutic dialogue starts to sound like an insightful conversation we might have about a patient with a colleague, our "pretend mode radar" should start to go off.

Patients in pretend mode can also appear detached from *other people's* emotions and desires. They exhibit minimal spontaneous curiosity about others' thoughts and feelings, failing to fully empathize and emotionally resonate with the person under discussion. In their interactions with us, patients often seem self-centered and dismissive, engaging in monologues with less apparent interest in what *we* are thinking or feeling in the therapeutic interaction.

Pretend mode is also marked by a disconnection from external reality. Patients talk about how helpful the therapy is, but their lives, challenges, and problem behaviors outside of therapy never seem to improve. They discuss their accomplishments and positive qualities, but the image they portray of themselves does not correspond to their actual lives, or the sort of person they seem to us to be. Similarly, they can ignore or minimize the facts about themselves or others that contradict their valued self-concepts, leading to two-dimensional depictions of reality that reflect how they *want* things to be, rather than how things are from a more objective vantage point.

In our experience, unaddressed pretend mode is often the single factor most responsible for lack of progress in the treatment of pathological narcissism. Treatments can go on for years, even decades, with therapist and patient both feeling good about themselves for how much insight they are generating. And yet until we help patients become more authentically connected to emotions in themselves and others, they continue to struggle with feelings of emptiness, disconnection, and isolation; they are never able to develop a more cohesive sense of self; they continue to alienate and hurt other people; and they remain trapped in the closed system of their own self-enhancement, a self-perpetuating loop of non-reality that is never punctured by outside minds.

We are reminded of one patient with vulnerable PN discussed in detail elsewhere (Drozek, 2019 , Chapter 7), who was treated on the couch for 16 years in four-times weekly, classically oriented psychoanalysis. Throughout

that treatment, the patient became increasingly non-functional, with nearly constant suicidal ideation and multiple inpatient admissions. He could eloquently speak about the developmental origins of his challenges, but he felt consistently dissatisfied and stagnant in his work and romantic relationships. After he finally terminated with his analyst, he was admitted to the MBT Clinic at McLean Hospital, where he was treated with once-weekly individual and group MBT, and where interventions for pretend mode were highly prioritized in his treatment. Within six months, the patient was no longer suicidal, reporting significant improvements in his anxiety and depression. He became much more engaged in his career, he finally started to date again, and he began to experience an unprecedented sense of vitality and fulfillment in his life. Eight years later at the time of this writing, these gains have continued and proliferated.

Process-focused interventions for pretend mode

We have a range of interventions to address pretend mode, many of which are tailored to the particular form of disconnection patients are exhibiting at the time (see Box 8.3). Perhaps the most important "intervention" for pretend mode is simply *noticing* it. It is extremely easy to get lost in patients' pretend mode narratives, mistaking them for authentic and meaningful discourse. This is most likely to happen when the content of patients' communication corresponds to our *own* narcissistic investments, for example when patients share insights that are consistent with our favorite theoretical framework, or when they are complimenting us and telling us how helpful the therapy has been for them. Rather than becoming concerned about the possibility of pretend mode, we get hypnotized by the content of patients' ideas and think, "Wow, they are really onto something here. They seem to be making a lot of progress . …" Bateman and Fonagy (2016) review common internal experiences that *therapists* are most likely to encounter when patients are in pretend mode (p. 210), which can include feelings of boredom, detachment, distractedness, and even physical tiredness and sleepiness. When patients are severely disconnected from themselves and us, our minds cannot remain fully engaged in the purported "interaction." It is as if we are sitting alone in a room!

Box 8.3 Process-focused interventions for pretend mode in MBT for narcissism

The main theme of interventions for pretend mode is that they disrupt patients' embeddedness in their own current narrative, directing their attention to something more reality-based or authentic in themselves or others.
Most important "intervention" for pretend mode: Notice it!
"Probe the extent"—ask patients some elaborative question about the narrative content under discussion, and then "listen" for the signs of authentic versus disconnected discourse.

"When you say that you are 'projecting' a lot, what are you getting at there?"
If patients cannot naturally elaborate on the meaning or context of their own ideas, take that as a sign of likely pretend mode and attempt further interventions.

In response to patients' abstractions and generalizations, move from "general to specific."

Empathically validate the broader formulation: "*No matter how careful you try to be with your language, your wife is extremely defensive and reactive with you.*"
Ask some clarifying question to elicit a more specific example: "*Can you give me a recent example of this?*"

Counterfactual interventions—questions or statements focusing on some state of affairs that is contrary to reality

Subtractive counterfactuals invite patients to imagine the removal of some element from the situation under discussion: "*What would it have looked like if you weren't so stressed out when you were interacting with your boss?*"
Additive counterfactuals ask patients to consider the inclusion of some new element into the situation: "*If your boss had come right up to you and told you what an amazing job you were doing, how would that have felt to you?*"

Affect elaboration of patients' emotions and desires in the present moment

"Can I interrupt you for one second? I want to invite you to pause and try to put words on what you are feeling right now."
"Do you have a sense of what you are wanting or desiring right now?"

"Naming what is absent"—give patients feedback about the form of disconnection in question.

In Self: *"You're sharing a lot about how 'sad' and 'depressed' you are today. But you're coming across to me as quite emotionally removed—as not really feeling much of anything at all."*
In Others: *"You're acknowledging that you might have hurt you mother's feelings by criticizing her in that way. But as you speak about this, you don't seem very* concerned *about your mom, or what she might be going through in these conflicts."*

"Challenge" the pretend mode more directly.

A surprising, irreverent, often provocative comment that has the effect of "waking patients up" to more authentically access their own emotional states, or to consider the mental states of the therapist
Difficult to prescribe, since the most effective challenges transgress implicit norms and patterns unique to the relationship in question

Once we suspect that patients are engaged in a pretend mode process, our first task is to "probe the extent" of this process (Bateman & Fonagy, 2016 , p. 210). This involves simply asking patients some elaborative question about the narrative content under discussion (*"When you say that you are 'projecting' a lot, what are you getting at there?"* ; *"What does that look like, when you get depressed in that way?"*), and then "listening" for the signs of authentic versus disconnected discourse. If patients cannot naturally elaborate on the meaning or context of their own ideas, or if they just restate their original notion in an abstract or circular way (*"You know, 'projection'—I put all of my feelings into the other person when I cannot deal with them in myself"* ; *"Basically just the normal depression … everything that goes along with major depressive disorder"*), we take that as a sign of likely pretend mode, and we proceed to utilize the interventions outlined in this section.

What can we do to actually address the pretend mode itself? Understood most broadly, the main theme of active interventions for pretend mode is that they attempt to disrupt patients' embeddedness in their own current narrative, directing their attention to something more reality-based or authentic in themselves or others. Whereas most other techniques in MBT-

N invite further reflection upon what patients are discussing, pretend mode interventions *divert* the discussion. They "flip the script" in some way—sometimes subtly, and sometimes (in the case of a "challenge") more overtly and dramatically. As one of the present authors (AB) likes to say, "When patients are in pretend mode and you ask more about what they are saying, what do you get? *More pretend mode* ." We thus have to "jerk the steering wheel" a bit in the treatment, waking patients up so that the car does not drive off the road. Once patients are authentically engaged with something more emotionally grounded and reality-based, we can utilize other steps in the trajectory of interventions (e.g., exploring the content of the experience; examining the broader context of mental states; tackling problems with certainty or concreteness) to stimulate further reflection about the more authentic experience that has emerged in the dialogue.

As noted earlier, patients with PN can exhibit significant tendencies toward abstraction and generalization. Especially in therapeutic contexts, rather than simply describing their experiences, they communicate their *ideas* about who they are as people, and about who other people are in the world as well. "I am the sort of person who. …" "My problem is that I tend to . …" "My boss really struggles with . …" "In our relationship, we have a long history of . …" The danger in these formulations is that they are ultimately one step removed from reality—from how patients actually experience and encounter their everyday lives, and thus from their emotions and desires in these experiential contexts. Accordingly, as long as patients are traversing in such generalities, it is nearly impossible to help them authentically access their own emotional states. To address these abstractions, we usually start by empathically validating the broader formulation (*"So your main problem is that you are too self-sacrificing—you always end up putting other people's needs in front of your own"* ; *"No matter how careful you try to be with your language, your wife is extremely defensive and reactive with you"*), then asking some clarifying question to help patients move "from general to specific" (Drozek & Unruh, 2020 , pp. 190–193). "Can you give me a recent example of this?" "What is one time that things got really bad in this way?" "Could you describe a situation where this came through most clearly?" Here we are hoping patients will identify a specific experiential context that can serve as a shared point of focus, around which we can try to generate more affectively grounded mentalizing.

If patients are able to identify a specific example of the broader issue, then we proceed to utilize content-focused interventions to help them explore and elaborate the "facts and the feelings" around the matter in question. In some cases, patients are unable to provide such an example, instead simply emphasizing the pervasiveness of the issue ("It's just happening all the time"; "This is really just who she is"), or continuing to express further intellectual formulations ("This really goes back to my childhood …"; "I think that our primary problem is co-dependency—both of us are using the other person to meet our emotional needs"). We take such responses as likely indications of continued pretend mode, and so we attempt some of the forthcoming interventions.

At times, patients discuss a specific topic or experiential context that in principle *could* be relevant and emotionally meaningful, but they use language in a way that sounds more stereotyped, "canned," or emotionally disconnected. For example, a patient describes a recent awkward interaction with her supervisor; the only emotion she can identify is the vaguely formulated idea of "stress," and she struggles to expound on her experience during the interaction itself. Another patient reports that he had observed his boyfriend texting with a former sexual partner; he started feeling strangely nauseous immediately following this, but he could not identify any internally grounded emotions or desires in the situation.

In such instances, we sometimes utilize what MBT calls *counterfactual* interventions—that is, questions or statements focusing on some state of affairs that is contrary to reality. Such techniques can gently disrupt pretend mode processes in patients, freeing them up to reflect on the topic in question in a manner that is more spontaneous and authentic. There are two types of counterfactual strategies: *subtractive* and *additive* techniques. Subtractive techniques invite patients to imagine the removal of some element from the situation under discussion, as utilized with the patient sharing about her awkward interaction with her supervisor.

After trying unsuccessfully to help the patient elaborate on her feelings of stress, the therapist attempted a subtractive counterfactual, ultimately asking, “What would it have looked like it you *weren’t* so stressed out when you were interacting with your boss?” The patient looked a bit taken aback by this question—a potential sign that more authentic reflection was underway. She responded, “Well, I would have felt confident, like I could stand up to him and actually speak my mind. I’m sick and tired of feeling so afraid of him. He just has too much control over me.” This response seemed much more authentic and spontaneous to the therapist, who proceeded to utilize content-based techniques of empathic validation and affect elaboration to explore the patient’s feelings of anxiety and insecurity surrounding her boss’ opinion of her, as well as her anger and annoyance at his more authoritarian manner of supervising her.

Additive techniques ask patients to consider the inclusion of some new element into the situation, as utilized with the patient discussing his boyfriend texting with a past partner.

The patient shared, “Something didn’t feel right, but I don’t know what it is. I would not have been upset by this. I really trust him, and I have complete confidence in our relationship.” The therapist empathically validated these feelings of trust and confidence, then offering an additive counterfactual to the patient. “I’m just curious—how would it feel if they were spending time together in person, rather than just texting?”

The patient was noticeably disturbed by this idea, expressing that this would be “completely unacceptable,” and that likely he would feel quite jealous and insecure: “I would worry they could develop feelings for each other again, or even that they were still attracted to each other.” The therapist nudged a bit further here, inquiring, “But I thought you said that you had ‘complete confidence’ in your relationship?” The patient ultimately recognized that he was likely experiencing analogous emotions surrounding the texting, enabling therapist and patient to begin exploring the patient’s feelings of jealousy and insecurity, and how he was working to manage these in the context of the relationship.

In the above examples, by (a) hypothesizing some state of affairs contrary to reality, and (b) elaborating patients’ reflections and feelings about these hypotheticals, the therapists help their patients to reflect more freely and naturally about the scenarios under discussion.

When patients seem more cognitively oriented and disconnected from their emotions, one technique that we find helpful is to inquire about patients’ affective states in the present moment (see Chapter 13). In general, we avoid asking questions about patients’ emotions in relation to the current narrative content (“*What are you feeling as you talk about these matters?”*), as patients usually then end up sharing more about the topic in question, thus keeping them stuck in the pretend mode. Instead, we press “pause” on the current discussion and inquire about patients’ feeling states in the immediacy of the moment. We focus variously on emotions (“*Can I interrupt you for one second? I want to invite you to pause and try to put*

words on what you are feeling right now."); desires (*"Do you have a sense of what you are wanting or desiring right now?"*); self-states (*"How are you feeling about yourself, right at this moment?"*); or even bodily sensations (*"Can you attend to what you are feeling in your body right now: any sensations, feelings, or physical states?"*).

If patients respond by trying to share more about the topic they were previously discussing (*"It's always triggering for me whenever I talk about my relationship with my parents. There was no space for me in that household …"*), we interrupt them and redirect the focus to their current experience: "I hear all this, but I really want to make sure that we do not lose what is happening for you right now. What *emotions* are you experiencing at this very moment?" Our hope here is that patients will turn inward and seek to consider their affective experience. Regardless of what they say about their feeling states, it is the *act of trying* to attend to their emotions that spurs a mentalizing process, thus disrupting the pretend mode. We then work with patients to elaborate their reflections on their current internal experience, being careful to steer the discussion away from any overly cognitive or externally focused narrative content. Once patients seem more attentive to and grounded in their current feeling states, we can reorient the session back toward the collaborative agenda for the session (pp. 100–106), which will always be more reality-based, contemporary, and grounded in the shared priorities for treatment.

Another useful technique for pretend mode is calling attention to the form of disconnection we are observing in patients. We refer to this as "naming what is absent." As patients begin to recognize and reflect on what might be missing in their experience, this opens up the door for them to begin to progressively *access* the mental state in question, in a more authentic and engaged fashion. For example, when patients appear detached from their emotions, we might say something like, "You're talking a lot about how 'sad' and 'depressed' you are today. But you're coming across to me as quite emotionally removed—as not really feeling much of anything at all." Along these lines, it can also be useful to highlight any discrepancies between the content of patients' verbal communications and their non-verbal displays (e.g., facial expression; eye contact; bodily posture and movements; tone, speed, or volume of voice). For instance, we could observe, "You're sharing about these extremely intense things your parents said to you—that they see you as 'selfish,' and they are tired of supporting

you. I'm not sure if you're aware that you've been smiling as you described this, and you even laughed a couple of times."

When patients seem less empathically connected to another person in their lives, we could observe, "You're acknowledging that you might have hurt your mother's feelings by criticizing her in that way. But as you speak about this, you don't seem very *concerned* about your mom, or what she might be going through in these conflicts." We attempt similar interventions if patients seem more dismissive of or uncaring about *our* experience in sessions (see Chapter 12). "I've been noticing that, when I ask you a question, you respond quite quickly and automatically. You don't really seem to be *thinking about* what I'm saying." Or: "You've been talking for a while now, without really looking up or making eye contact with me. It makes me wonder how interested you are in what *I* might be thinking or feeling about all of this." We do our best to share these observations in a manner that is warm rather than judgmental, curious rather than authoritative. We proceed to explore and elaborate patients' experience of these communications: ways in which the ideas resonate with them; how they feel receiving this feedback from us; or if patients do *not* identify with the feedback, their reflections about how we arrive at such different perspectives about their experience of connection versus disconnection.

"If all else fails": Challenging the pretend mode

If the aforementioned interventions fail to stimulate more authentic reflection in patients, we attempt what Bateman and Fonagy (2016) call a *challenge* of patients' non-mentalized experience (pp. 257–269). A challenge is a surprising, irreverent, often provocative comment that has the effect of "waking patients up" to more authentically access their own emotional states, or to consider the mental states of the therapist. As an intervention, challenge is somewhat difficult to prescribe, since the most effective challenges are conducted in a manner that is unique to the relationship in question. All therapeutic dyads have characteristic relational processes that are unfolding continuously, which are usually only implicit and unarticulated in customary interactions: therapist and patient say typical things to each other, speak in a certain tone of voice, hold a specific body posture, and so on. Challenges tend to transgress or violate these implicit

norms, in a manner that is surprising and mildly disruptive for the patient, without being cruel or traumatic.

Given the pervasiveness of pretend mode in pathological narcissism, we tend to utilize challenge quite liberally in MBT-N, perhaps more frequently than in MBT for borderline personality disorder. That said, as Bateman and Fonagy (2016) underscore, challenge remains a "higher-risk" intervention that we employ "when no other intervention has succeeded" (p. 256). In addition to hopefully stimulating mentalizing, such interventions can trigger more aversive emotions in patients with PN, such as confusion, impatience, frustration, or even insecurity or embarrassment. While clinicians might feel concerned about arousing such emotions, we suggest that these feelings are actually a good sign: once patients are feeling something, they are no longer in pretend mode, and the challenge has been successful! As patients authentically access their emotions, we are prepared to utilize the content-focused interventions reviewed earlier (e.g., empathic validation, affect elaboration of patients' emotional states), and then to take responsibility for our part in the disruption as appropriate (see Chapter 12). When effective, this approach is able to strike an ideal balance between shepherding patients "back to reality" while allowing them to still feel emotionally safe and supported in the process. Along similar lines, Bateman and Fonagy (2016) emphasize the importance of always delivering challenges with kindness, compassion, and nonjudgmentalness (p. 259). This enables us to maintain the therapeutic alliance with patients, minimizing any relational blowback from taking this more provocative stance with patients.

Of note, while challenge is especially useful to address pretend mode processes in patients, we can utilize challenge for any especially intractable form of non-mentalizing (e.g., process-related problems with certainty or concreteness, context-related difficulties with reflecting on one's own interpersonal role in relationships). There are five different types of challenge in MBT-N: the humorous challenge, the bizarre challenge, the counterintuitive challenge, the emotion-focused challenge, and the reality-based challenge (Box 8.4). We will consider these different interventions in turn.

Box 8.4 Types of challenge in MBT for narcissism

Humorous challenge—delivering a statement that is ironic, goofy, or somehow comical
Temporarily surprises patients, “lightening the mood” so that they feel free to engage more spontaneously and authentically in the current interaction
Bizarre challenge—making a statement that is strange, absurd, or illogical
Helps usher patients out of a more insular mind state, leading them to become curious about the therapist’s mental states in engaging in the communication
Counterintuitive challenge—making comments that surprise patients, or directly contradict their stated perspective
Abruptly “stops patients in their tracks,” enabling them to consider things in a more curious, engaged, or flexible way
Emotion-focused challenge—expressing or disclosing the therapist’s own feeling states (e.g., affects, desires, self-states) in the present moment
Catches patients off guard, drawing their attention to the therapist’s emotions and “ratcheting up” their anxiety and attentiveness in the current interaction
Reality-based challenge—invoking some aspect of reality that patients are ignoring, minimizing, or denying
“Pops the bubble” of non-reality for patients, inviting them to recon with facts or topics they would rather ignore

The *humorous challenge* involves delivering a statement that is ironic, goofy, or somehow comical, temporarily surprising patients and “lightening the mood” so that patients feel free to engage more spontaneously and authentically in the current interaction. Examples include lightly teasing the patient, for example by telling a patient who is working on her perfectionism, “I really hope that you do a horrible job on this assignment.” We can engage in self-deprecating humor, for instance when the notoriously neurotic therapist says, “This is going to surprise you, but I have been feeling a bit worried about this situation.” Or we could make reference to

some previously discussed topic in the therapy in a new or unexpected way, such as when a patient is ruminating about who will write her the strongest recommendation letter for graduate school, and the therapist suggests the patient ask her former boss, who had publicly criticized and ultimately fired her. The humorous challenge can also involve making an unexpectedly silly or ridiculous comment, as illustrated here.

> Following a relapse on alcohol, one patient described the experience simply as "sedating," refusing to elaborate on what he meant by this and referring the therapist to the dictionary if he needed any further information about "sedation." Exasperated, the therapist was able to gain his bearings and begin discussing his reasons for inviting further elaboration: "At the time, I think I felt like it would have been negligent of me to move forward without asking what the word meant to you. They could have called the Therapy Police on me, and I would have been taken away!" The patient smirked a bit at this and replied, "They have a Therapy Police?" *[an opening for mentalizing, in which the patient is finally considering the therapist's mental state]*
>
> The therapist responded with mock seriousness: "Yes, they do *[pause for effect]* . And they're waiting right outside the door!" This led both parties to start laughing, which broke the tension and allowed for a deeper discussion of the emotional and interpersonal processes surrounding the patient's initial unwillingness to elaborate on the word.

As seen in the above examples, the humorous challenge tends to playfully disturb the current tone or "vibe" of the therapeutic interaction, temporarily disorienting patients and enabling them to reapproach the discussion from a fresh, more reflective vantage point.

The bizarre challenge entails making a statement that is strange, absurd, or illogical. This strategy can help usher patients out of a more insular mind state, leading them to become curious about *our* mental states in engaging in the communication. Similar to other types of challenge (e.g., the counterintuitive or emotion-focused challenge), the bizarre challenge tends to work best when we simply "drop" the strange remark into the therapeutic dialogue, without explaining the meaning of the remark. This hopefully prompts patients to become curious about the meaning themselves—a sign that the challenge has been successful. For example, in response to one patient engaging in continuous monologues throughout the session, the therapist stated, as if to herself, "I am not really in the room right now . …" This confused the patient, who asked, "What are you talking about? Of course you're in the room!" The therapist responded, "Well, I am glad that you feel that way. It had seemed a bit like you were just talking to yourself for a while there . …"

Another patient brought her noisy, hyperactive dog into her appointment one day. The patient made no reference to the dog's constant barking and running around the office, instead just conducting herself by simply sharing about her life as usual. The therapist finally interrupted all of this by asking the patient, "What do you think your dog is thinking about how this session is going?" This led the patient to ultimately acknowledge these disruptions, apologizing to the therapist and reflecting on her tendency to ignore challenges in her life, even when they are clearly evident to other people.

The *counterintuitive challenge* involves making a comment that surprises patients, or that directly contradicts their stated perspective. The purpose of this is intervention is not to tussle with patients at the level of verbal content, or to convince them to see things in a different way. Rather, by expressing a viewpoint that is diametrically opposed to patients' own views, we abruptly "stop them in their tracks," which enables them to consider things in a more curious, engaged, or flexible way. For example, when patients are expressing their boredom about some topic in the session, we might say, "I was actually just starting to get interested. I feel like this is the most important thing we have discussed in weeks!" (see Bateman & Fonagy, 2016 , pp. 265–266). See below for other examples of counterintuitive challenges, drawn from everyday practice.

> One patient had been showing many signs of inconsistent motivation in treatment: missing appointments, arriving to sessions late, and continuing to engage in many of the behaviors (e.g., infidelity, argumentativeness, gambling) he had identified as problems to address in the therapy. When discussing his goals for treatment, the patient said in passing, "Well, obviously I want to work on myself . …" The therapist interrupted and said, "Wait—it is OBVIOUS that you want to work on yourself? It actually doesn't come across that way at all" *[a disclosure that directly counters the patient's stated perspective]* . The patient was initially taken aback by this feedback, eventually acknowledging that his behaviors often do not indicate a clear motivation for change. This led to a more authentic discussion about the patient's significant ambivalence about altering some of his longstanding patterns, and his willingness to use therapy to do so.
>
> Another patient was sharing about a recent argument with her overbearing, self-centered mother, toward whom she held strong anger and resentment. She spoke extensively about her mother's deficiencies, with a tone suggesting that everyone would see this the same way: "She is always focused on other people and what *they* are doing wrong. She never recognizes her own role in things." The therapist reflected back to her, "I guess in this way, you two might finally have something in common with each other" *[a surprising comment that contradicts the patient's view on how different she is from her mother]* . While initially feeling defensive, the patient was able to reckon with the therapist's perspective about her imbalanced, potentially unhelpful manner of approaching these topics. She ultimately started to reflect on her *own* manner of relating to her mother in these conflicts, which often included tendencies toward defensiveness, superiority, and judgmentalism.

In these examples, by making surprising comments that significantly depart from patients' own perspectives, the therapists are able to disrupt patients' embeddedness in rote narratives, opening the door for more curious reflection about emotionally salient processes in the treatment.

The *emotion-focused challenge* involves either explicitly disclosing our own emotional experience in the present moment, or expressing our emotions through some non-verbal means (e.g., tone or volume of voice, body language). Since these forms of expression tend to be less common in therapeutic work, they usually catch patients off guard, drawing their attention to our internal states and "ratcheting up" their anxiety and attentiveness in the current interaction. In this way, the emotion-focused challenge disrupts the pretend mode process, or in the case of psychic equivalence or teleological experience, enables patients to reconsider the topic at hand from a different vantage point, namely as cognizant participants in the therapeutic relationship itself. Implicit emotion-focused challenges might entail becoming quite serious and concerned when a patient seems overly glib or nonchalant; speaking passionately about something that feels important to us in the therapy; or communicating in a more casual, laid-back manner if the patient appears obsessive, anxious, and ruminative (see Bateman & Fonagy, 2016 , p. 266).

More explicit challenges involve simply "putting words on" our feeling states, whether that be some affect (*"You are driving me crazy!"*); desire (*"As you talk about this situation, I'm noticing myself wanting to argue with you—to tell you all the reasons why you're wrong"*); or self-state (*"I think that I'm starting to feel a bit insecure about how this treatment is going"*).

> Twenty minutes into an appointment with a patient who regularly ignored concerning aspects of his life situation (pretend mode), the therapist shared, "I'm feeling a strange sense of dread right now," without elaborating on the context of the emotion. The patient understandably expressed curiosity about the cause of the feeling—a sign that he was starting to move out of the pretend mode and consider the therapist's mind. The therapist was ultimately able to express his concern that they were ignoring important areas of the patient's life (e.g., poor performance at work, regular arguments with his wife) where the patient was actively struggling. The patient responded, "Well, of course I don't want to talk about those topics. They just make me feel bad about myself!" *[a more authentic, emotionally engaged communication]* . Therapist and patient thus began to explore the patient's longstanding pattern of avoiding topics and situations that led him to feel ashamed, as well as the impact of this pattern on his manner of engaging in treatment.

When attempting emotion-focused challenges, we often end up sharing emotions and desires that connect to broader relational processes in the treatment (e.g., our discouragement surrounding a patient's disconnectedness, our frustration about a patient's dismissiveness toward us). Accordingly, once patients begin to reflect more authentically on relevant mental states in the present moment, we are prepared to utilize techniques involved in "mentalizing the relationship," to further explore clinically meaningful relational patterns in the therapeutic dyad (Chapters 11 & 12).

Finally, the *reality-based challenge* involves invoking some aspect of reality that patients are ignoring, minimizing, or denying. As we have discussed throughout this book, pathological narcissism is marked by the tendency to amplify factors that augment the person's sense of self-esteem, while simultaneously avoiding those factors that diminish self-esteem. This contributes to pretend mode processes in psychotherapy, as patients remain perpetually disconnected from aspects of themselves, other people, and their circumstances that feel more threatening to them. Reality-based challenges impel patients to reckon with these experiences, "popping the bubble" of self-enhancement and helping patients to access the emotions and desires attendant in that process.

Such challenges can variously involve referencing facts about patients themselves (*"You talk a lot about your 'music career,' but I'm aware that it's been several years since you've actually worked on your music"* ; *"I completely understand that your wife can be quite critical of you. You seem to focus a lot less on your own anger issues, including your history of violence with her"*); facts about other people in patients' lives (*"I know that you are extremely certain that you and your ex will get back together. Do you ever think about the fact that she's actively dating other people?"* ; *"You always describe your father as a 'successful businessman.' I never know what to make of that, given his difficulties with bankruptcy and embezzlement"*); or facts about patients' circumstances (*"I hear that you want to talk about dating today. But I can't stop thinking about the fact that you're about to be evicted from your apartment, and you still haven't found a place to live"* ; *"I rarely hear you mention that you are on a performance improvement plan at work"*). After attempting these challenges, we explore with patients their reflections about the aspect of reality in question: their emotions and desires surrounding the topic; their reflections about what

might lead them to downplay this facet of experience; and their emotional experience of contending with the issue in the present moment and interaction.

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9

Process-focused Interventions: Psychic Equivalence Mode

Introduction: Clinical manifestations of psychic equivalence in pathological narcissism

As discussed previously (Chapters 2 & 4), psychic equivalence mode encompasses a range of psychological experiences in which patients exhibit excessive certainty and rigidity regarding their own perspectives and viewpoints: “If I think it, that makes it true” (Box 9.1). In traditional cognitive models of psychopathology, the problem with maladaptive cognitions is that they are distorted, irrational, or inaccurate—that is, the content of the belief contradicts or fails to reflect the content of a consensually validated reality (Beck, 2021). In mentalization-based treatment for narcissism (MBT-N), we are less concerned with the accuracy or validity of patients’ beliefs. After all, this would imply that we have access to some truth about what patients “should” believe! Especially for patients with pathological narcissism (PN), the problem stems less from “what” they believe than “how” they believe it: tightly, rigidly, confidently, and adamantly. The thought does not *feel* like a thought—it feels like a fact. It thus becomes almost impossible for patients to spontaneously generate other perspectives, other ways of seeing things. Under these conditions, patients lack any “reflective buffer” from their own mental state, such that the state can exert inordinate influence over their feelings, behaviors, and interactions with others. In this way, psychic equivalence overlaps with the concept of “cognitive fusion” in acceptance and commitment therapy (ACT), understood as “the pouring together of verbal/cognitive processes and direct experience such that the individual cannot discriminate between the two” (Hayes et al., 2012 , p. 244).

Psychic equivalence comes across most strongly in patients' verbal tone when they are speaking about the matter at hand. Much of what they say sounds more "matter-of-fact," as if they are informing us of some obvious conclusion that has already been drawn: *This is the only way to see this situation.* This type of thinking encompasses diverse domains of experience, but we will consider forms of psychic equivalence most common within PN. Under the heading of "grandiosity," patients can rigidly endorse positive views about their own traits and characteristics (e.g., involving intelligence, attractiveness, interpersonal aptitudes, strength, psychological characteristics), as well their past and present life circumstances (e.g., professional success, social status, wealth, fame, power). While occasionally patients frame themselves as being globally "better" or "superior" to other people, usually patients exhibit what we call *dimensional* superiority—that is, the tendency to experience themselves as superlative in specific domains of life and experience (e.g., intelligence, success, power), and inferior or neutral in other domains. Patients can also inflexibly see themselves as fundamentally different or separate from other people, leading to significant feelings of alienation and loneliness in their relationships. This sense of separateness can arise only in particular relational contexts (e.g., work, family life, treatment settings, mutual help groups), or it can cut across patients' lives more broadly.

Box 9.1 Clinical manifestations of psychic equivalence in pathological narcissism

Excessive certainty and rigidity regarding one's own perspective
Verbal tone comes across as more matter of fact: "This is the only way to see this situation"
Grandiosity and superiority: rigid endorsement of positive views about one's own traits, characteristics, life circumstances
"Dimensional" superiority: the tendency to experience oneself as superlative in specific domains of life and experience (e.g., intelligence, success, power), and inferior or neutral in other domains
Inflexibly seeing oneself as fundamentally different or separate from other people
Confidence about the categorical presence or absence of certain mental states (e.g., emotions, motives, needs) in Self and Other
Rigid endorsement of certain internal conditions for one's own sense of self-esteem, especially other people's admiration and the presence/absence of specific mental states in oneself
Inflexible ascription of negative value to oneself, either categorically or under certain conditions
Extreme confidence about other people's mental states, actions, attributes, or personalities more broadly
Idealization and devaluation of other people or groups
Rigid expectations and predictions about the future, for oneself or others

Especially relevant for clinical work, patients often feel quite certain about their own feeling states. They feel convinced that certain emotions are *not* present in their experience (e.g., anger, insecurity, sadness), especially when those emotions undermine their valued self-concepts, which are usually held in psychic equivalence as well. Similarly, patients can express certainty about the categorical presence of other "positive" feeling states in themselves (e.g., desire to help others, happiness or contentment, confidence), even when their behaviors or non-verbal cues appear to suggest a more complex internal tapestry.

Perhaps most importantly in PN, patients rigidly endorse specific conditions for their own sense of self-esteem, self-worth, and personal value (Drozek, 2019). As we will discuss in Chapter 10 , patients can base their self-esteem on visible or concrete factors *(teleological mode)* , including appearance, vocational success, wealth, or possessions. From the

perspective of psychic equivalence mode, patients also base their sense of self-worth on *internal* processes in themselves and others, most notably other people's admiration, approval, and positive opinions of them. *I can only feel good about myself if you are admiring me, needing me, or seeing me in a positive light.* This self-state leads understandably to the need for "excessive admiration" that is endemic to PN, as emphasized in the diagnostic criteria for narcissistic personality disorder (NPD) in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* . In addition, patients frequently base their self-esteem on the presence of certain mental states in themselves, for example euthymic mood, "positive" attitude or thinking, "confidence," or seemingly altruistic motives. *I can only feel good about myself if I maintain a positive attitude.* Or: *I am only valuable if I feel confident and upbeat.*

These conditions for self-esteem are often associated with inflexible standards, expectations, and beliefs about the conditions in question. For example, patients presume that other people *should* see them in a positive light, that they *should* be confident, or that they *should* maintain a positive attitude at all times. Such judgments lead to powerful desires for the factor in question, along with feelings of intense anxiety if they worry the condition might not be met.

The underbelly of such processes is that patients also rigidly ascribe *negative* value to themselves under certain internal conditions as well. They might devalue themselves when other people view them in an unfavorable light; when they encounter mental states in themselves they see as harmful or deleterious (e.g., anxiety, sadness, desires for attention); and when they are unable to feel confident or strong in their relationships. *I am bad, insufficient if you are judging me, or looking down on me* . In addition: *I am weak whenever I need or want something from you.* Once again, these processes often connect to other inflexible judgments or expectations about self surrounding the condition in question. For example, patients feel like it is *not right* when other people judge them negatively; they believe that they should *avoid* feeling the emotions they see as problematic; and they believe that they should *not* struggle with feelings of insecurity or inadequacy. Accordingly, patients also end up experiencing a range of painful emotions when they violate these standards: depression, anxiety, shame, worthlessness, self-hatred, embarrassment, humiliation, and self-disgust.

All of these forms of rigidity can significantly impact patients' expectations and predictions about their future experiences. For example, if a patient overestimates his own social aptitudes, he will anticipate future success in upcoming interactions, leading to cockiness, overconfidence, and self-centeredness in the interaction itself. Or if a patient rigidly bases her sense of self-esteem on her vocational success, she could experience every new assignment as a potential "test of her value," resulting in perpetual feelings of pressure, anxiety, and insecurity about her ability to perform at the desired level.

Patients can also endorse highly rigid perspectives about other people as well, for example by feeling extremely certain about other people's mental states, actions, attributes, or personalities more broadly. On the "positive" end of the spectrum, we see this in patients' tendency to idealize specific other people—to experience them in an unequivocally positive light. Here patients are less likely to attend to the aspects of others (e.g., personal failings, more complex emotional states, specific behaviors or interpersonal tendencies) that might betray a greater subjective complexity, or a more diverse array of feelings (e.g., anger, concern, dissatisfaction, lack of interest) toward patients themselves. In these circumstances, patients frequently base their sense of well-being and self-esteem on the status of these relationships. *My life is only meaningful if we are together. If you leave me, I have no reason to be alive.* These psychic equivalent mind states can lead to powerful affective experiences for these patients (e.g., obsessiveness, jealousy, desire to control), in addition to intense emotional responses (e.g., panic, desperation, suicidal impulses) if the relationship is ever placed at risk.

Conversely, patients often rigidly devalue other people, endorsing perspectives that emphasize the defects, failings, and insufficiencies of specific individuals, groups, and institutions. Other people thus often come across quite "two-dimensionally" in patients' narratives, with patients failing to consider mental states of these parties that could imply greater vulnerability, thoughtfulness, or care. Such viewpoints significantly structure patients' expectations and predictions about other people's *future* behaviors and experiences, thus impacting patients' manner of experiencing and relating to others in their contemporary relationships. For example, if a patient confidently believes that his wife is always trying to humiliate him,

he will anticipate similar behaviors in future interactions, leading him to be more vigilant, defensive, and aggressive in his interactions with her.

In many cases, patients' specific judgments imply broader standards and expectations about other people, which patients also endorse with confidence and certainty. *You should act, feel, be, and see things in this particular way. If you depart from that, then you are bad, wrong, and problematic.* These forms of rigidity leave patients vulnerable to a range of "anger-related" emotions in their relationships, including frustration, impatience, irritability, and rage when other people violate the standard in question.

Process-focused interventions for psychic equivalence mode

As Bateman and Fonagy (2016) observe, when encountering psychic equivalent thinking in everyday clinical practice, we often experience a desire to reason or "argue" with patients, in the hopes of helping them arrive at a more adaptive perspective (p. 210). Such an approach is rarely successful, leading over time to feelings of anger, helplessness, inadequacy, and emotional withdrawal from patients (Tanzilli et al., 2017). Accordingly, the aim of interventions for psychic equivalence mode is not to "correct" patients' beliefs by bringing them into alignment with some pre-determined vision of reality, but rather to enhance patients' mentalization by *broadening* their perspectives on an event (Bateman & Fonagy, 2017 , p. 2900). As always in MBT, we seek "addition, not subtraction." Without trying to change patients' minds, we follow an interventional pathway geared toward (1) helping patients to recognize the psychic equivalent experience *as a mental state* , and then (2) considering other ways to view the issue in question (see Box 9.2). In our experience, when repeated over time, this approach helps patients progressively achieve a stance of greater flexibility, curiosity, and "reflective distance" from the original mental process.

The first step involves empathically validating patients' current state of mind in psychic equivalence. For example, we might say, "So it really feels like the other patients in group have nothing to offer you. You have been through so much more than they have, so they simply do not have the ability to see things from your perspective." On the most basic level, this

approach communicates what we see as the experiential “target” for the forthcoming interventions, marking out our intended area of focus. Patients then have the opportunity to give us feedback if we have misunderstood them, or if they would frame their experience in a different way. We revise our empathic summary accordingly, until patients confirm (implicitly or explicitly) that our statement roughly coheres with their experience. This also allows patients to feel “seen” by us at the outset of the process, decreasing emotional arousal so that they are potentially more receptive to reflecting on the psychic equivalent area.

Box 9.2 Process-focused interventions for psychic equivalence in MBT for narcissism

The aim of interventions for psychic equivalence mode is to enhance patients' mentalizing by *broadening* their perspectives on an event.
Start by empathically validating patients' current state of mind in psychic equivalence.

"So it really feels like the other patients in group have nothing to offer you. You have been through so much more than they have, so they simply do not have the ability to see things from your perspective."

Explore with patients their process of arriving at the perspective in question.

"What lets you know they really cannot understand you?"

Consider with patients the consequences of their certainty, in themselves as well as other people.

Internal experience: *"How does that impact you—to be attending group with people who feel so different from you?"*
Behaviors and interpersonal approaches: *"Do you think this affects how you engage with the other group members?"*
Experiences in other people: *"What do you think it is like for the other members, when you are so focused on how different you are from them?"*

Gently inquire about areas of potential nuance.

"You referenced this other group member named Holly, saying that she was 'a little less clueless' than the other members. What makes her easier for you to take?"

Empathically summarize patients' more variegated viewpoint.

"Unlike the other members, Holly has had some experience in therapy, so it feels easier to relate to her. You also find her reasonably articulate, so you actually don't mind listening to her."

Cautiously share own perspective on the matter in question, in a marked and tentative fashion.

"While I understand why you find the group so pointless, I still can't shake the feeling that there might be something you could get from it, even with all of these faults."

Examine patients' reactions to this additional perspective, and to the discussion more generally.

"What do you think about this idea?"
"Where does this conversation leave you?"

We proceed to explore with patients their process of arriving at the perspective in question. "What lets you know they really cannot understand you?" "What clues you in that you have been through so much more than they have?" "Walk me through how you get there—that the other group members have no ability to help you." Bracketing any interest in altering patients' beliefs, we ask such questions with curiosity and openness, with the sincere desire to learn what *supports* patients' sense of conviction about the topic in question. As patients share about these topics, we provide some empathic statement summarizing their reflections:

> "So it sounds like a lot of this has to do with age. Most of the members are much younger than you, so they just have not experienced that much in their lives. But also you have actually *tried* to share about yourself in the group, and it never goes very well. No one seems to give you much feedback, and you just end up feeling worse afterwards."

We then examine with patients the *consequences* of these forms of certainty in their experience, in themselves as well as other people. We variously inquire about patients' internal experience (*"How does that impact you—to be attending group with people who feel so different from you?"* ; *"When you are seeing things in this way, what is that like for you?"* ; *"This really must affect how it feels for you to attend group …"*); their behaviors and interpersonal approaches (*"Does this affect how you engage with the other group members?"* ; *"When you are feeling so different from other people, what do you do?"*); and the experiences of other people (*"Do you suspect that anyone can notice how separate you feel?"* ; *"What do you think it is like for the other members, when you are so focused on how different you are from them?"*). Depending on the belief state in question, here patients usually elaborate on some of the "challenges" related to the belief: disruptions in mood, emotions, or sense of self; maladaptive interpersonal approaches; problems in relationships; or negative impact on others. Again, as patients discuss these matters, we empathically "reflect back" our understanding of their views:

> "So when you feel like the other patients have nothing to offer you, you end up feeling quite lonely in the group, like there is a huge gulf separating you from the other members *[empathic summary of patient's previously expressed emotional experience]* . It sounds like you respond to this by not talking and withdrawing from people, which over time makes you feel even more resentful at them *[empathic summary of relevant behaviors and emotions]* ."

The above interventions—exploration of support for the psychic equivalence, as well as its consequences—might seem somewhat trivial, since they do not directly "take issue" with patients' beliefs about the issue under discussion. However, we see these techniques as an essential step in addressing patients' challenges with certainty and rigidity. As patients consider what leads them to feel so certain about something, and to examine the various implications of this confidence, they implicitly start to relate to their experience as a mental state, rather than a veridical reflection of "reality." Until that happens, patients are often unable to think more flexibly about the topic at hand. It is much easier to call a *belief* into question than it is to call a *fact* into question.

Throughout these discussions, patients often give voice to a more nuanced perspective, describing some aspect of their experience that departs from the more rigid, categorical viewpoint they have been espousing. We privately "hold onto" such moments, returning to them later to gently invite further elaboration. "You mentioned earlier that you *had* tried sharing in group once, back when you first started. What led you to give it a shot back then?" "You referenced this other group member named Holly, saying that she was 'a little less clueless' than the other members. What makes her easier for you to take?" "You suggested before that some of your frustration in group could be affected by your anxiety about the divorce. What were you getting at there?" Here we work with patients to "open up" their more nuanced position, helping them to grow and expand it more fully. Rather than directly confront the certainty head-on, we walk up alongside it with patients, developing the other viewpoint as a parallel but non-competing line of thought.

Once patients have expounded upon these matters, we empathically summarize the more variegated viewpoint. "Unlike the other members, Holly has had some experience in therapy, so it feels easier to relate to her. You also find her reasonably articulate, so you actually don't mind listening to her." "When you first started in the group, you had hoped to find some people with whom you could connect and relate. You felt quite lonely and isolated in your life, and you really wanted to change that." We can also

summarize *both* the psychic equivalence and the nuanced perspective in tandem with each other:

> "So it feels clear to you that the other group members cannot relate to you, and that is not ever going to change *[psychic equivalent viewpoint]* . At the same time, you have been under a lot of stress due to the divorce, and you've wondered at times whether group might *feel* a bit different if you weren't so anxious and irritable about all of these conflicts with your wife *[more nuanced perspective]* ."

As seen here, we usually start with the psychic equivalent idea and end with the subtler one, in the hopes that patients will invest further attention in the more flexible, curious forms of reflection.

After patients have elaborated a broader range of their own feelings and viewpoints, we are free to share our own perspective on the matter in question, albeit in a marked and tentative manner that does not assert any special authority about "the truth" of the situation. Here we are not attempting to alter the content of patients' beliefs in any way; rather, we are simply continuing this process of expanding the diversity of perspectives under consideration—this time not only within the patient's mind but across the therapeutic relationship itself, encompassing *both* the patient's mind and our mind. For example, we might say, "While I really understand why you find the group so pointless, I still can't shake the feeling that there might be something you could get from it, even with all of these faults." Or:

> "The more that we talk about this issue, I'm gathering that it feels to you like there is something inherent in the group that stops you from getting anything out of it. While that could totally be the case, I am also hearing that you have sort of given up on the group: withdrawing from the other members, not sharing about yourself, and spending most of your time focusing on how useless it us. I don't know for sure, but this makes me more curious if your manner of *participating* in the group could be somehow impacting how it feels to be there."

Finally, we explore patients' reactions to this additional perspective, and to the discussion more generally. "What do you think about this idea?" "Where does this discussion leave you?" "What do you make of all this?" In this way, we progressively work to help patients arrive at a more mentalized stance toward their own thought processes. Even when patients disagree with our perspective, if they are able to consider it and compare/contrast it to their own, then they are temporarily assuming a more reflective stance toward their own rigidly held beliefs.

“If all else fails”: What to do when process-focused interventions for psychic equivalence are ineffective

There are times where, even after we have carefully employed the above interventions, patients continue to exhibit significant inflexibility in their thinking around the issue under discussion. Here we have a handful of strategies at our disposal, as summarized in Box 9.3 . First, we can temporarily shift the focus to a distinct but related area where patients are more readily able to mentalize, often a topic that is less emotionally charged for patients (*“Has this ever come up for you before, where you have found it challenging to identify with other people in a group setting?”* ; *“Are there any areas of your life right now where you do feel more connected to other people, where you feel like they can really understand you?”*). Once patients are reflecting more flexibly in this new area, we can return to the original psychic equivalent arena, trying again with the process-focused interventions outlined above (*“So getting back to the situation in the current group … where does this all leave you at this point?”* ; *“Did you learn anything from that other situation, which you could use to find a path forward in the current group?”*). With their mentalizing now “back online,” patients are often able to approach the original topic with greater flexibility and receptivity.

Box 9.3 Techniques for when process-focused interventions for psychic equivalence are ineffective

Temporarily shift focus to a distinct but related topic where patients are more able to reflect on mental states, and then return to the psychic equivalent area once mentalizing has resumed.

“Has this ever come up for you before, where you have found it challenging to identify with other people in a group setting?”

Provide patients with direct feedback about their lack of reflectiveness about the topic in question.

“As we talk about this issue, you’re coming across to me as extremely certain, as if you ‘know the truth’ about this issue.”
“When I asked you that question back there, you didn’t really seem to think before you answered it—you just sort of responded automatically.”

Invoke the parts of patients’ MBT formulations that reference their challenges with rigidity and certainty.

“In your formulation, we observed that you can sometimes become quite certain about the idea that you are bad and insufficient—‘You are a failure, and you will always be a failure.’ Could any of that be relevant right now?”

If the above techniques successfully stimulate some mentalizing, encourage patients to actively evaluate the content of the viewpoint in question.

“Are there any other perspectives you could have on the matter, which might have some validity as well?”
“We’ve already considered what supports your position. Could you also consider what might undermine it?”

We also sometimes give patients direct feedback about their *lack* of reflectiveness on the topic in question. We see this as a “higher risk” intervention for psychic equivalence, approaching something of a challenge (pp. 189–194). Unlike the process-focused interventions we have reviewed, this approach is decidedly non-contingent, since we are implying that patients’ perspectives are *perspectives* , while at the time, they are experiencing them as brute facts. We are also highlighting something that patients are *not* doing (i.e., reflecting on mental states), which can naturally

make them feel like we are criticizing them, or looking down on them. We thus tend to use this strategy only as a last resort, when all of the aforementioned interventions have proven ineffective.

From the perspective of technique, we simply attempt to "put words on" our impressions of patients' current challenges with rigidity, in the present moment. "As we talk about this issue, you're coming across to me as extremely certain, as if you 'know the truth' about this issue." "When I asked you that question back there, you didn't really seem to think before you answered it—you just sort of responded automatically." "I'm not sure how it feels to you, but you're striking me as a bit defensive right now, as if you are 'making a case' for why you are right and your wife is wrong." Along similar lines, we sometimes remind patients of our earlier discussions about the aims of MBT-N:

> "I'm not sure if you remember, but previously we had discussed how, in mentalization-based treatment, you would be working to become more reflective and curious about your own thoughts and feelings, and the thoughts and feelings of others. Right now you seem to be investing a lot of energy in *arguing* for your perspective, rather than really considering the possibility that there could be other ways to see this situation."

Once we provide this feedback, we invite patients to reflect on their experience of engaging with the feedback itself. "Does this resonate with you at all?" "What is your sense of this: your overall level of certainty that you are right and your wife is wrong?" "What comes up for you as I say these things?" In exploring these matters with patients, we are not hoping that they "accept" or "recognize" their rigidity and certainty. Rather, as they reflect on their *process* of relating to their own thoughts (i.e., with rigidity versus curiosity), this enables them to increasingly shift to a standpoint of greater flexibility and openness surrounding their original perspectives.

Another technique for addressing intractable psychic equivalence involves invoking the parts of patients' MBT formulations that speak to these matters. When developing patients' formulations, we highlight patients' challenges with psychic equivalence in the "Rigid and overly certain" section (pp. 71–72); in the "Implications for the current treatment" section, we forecast any potential difficulties with rigidity that are likely to arise in the therapeutic relationship itself (p. 73). So when patients are struggling with rigidity and certainty around some issue in the treatment, we can sometimes invoke these parts of the formulation, inquiring about the possible significance of these processes in the current interaction. For

example, we might say, “In your formulation, we observed that you can sometimes become quite certain about the idea that you are bad and insufficient—‘You are a failure, and you will always be a failure.’ Could any of that be relevant right now?” We could note:

> “When we were developing your formulation together, we discussed how you can sometimes become quite certain about what other people are feeling, especially around the idea that people in authority are looking down on you and ‘not respecting’ you. I have to admit that the more that we talk about this situation with your boss, you are coming across as pretty certain about what he is feeling. What do you think about that?”

We explore with patients their reflections about the issue in question, essentially inviting them to reappraise it in light of their difficulty in mentalizing referenced in the formulation. Since patients have already seen the relevance of the problem with rigidity and certainty in their lives more broadly, they are often more able to consider the issue of *how* they are relating to the experience under discussion. They gain a degree of “reflective distance” from the experience, opening up the door for greater flexibility and curiosity about their own perspective.

If the above techniques are successful in generating some degree of reflection about the psychic equivalent mind state, we can also encourage patients to actively evaluate the content of the viewpoint in question. This approach is important as the treatment progresses, especially when we are working on specific forms of psychic equivalence that are more foundational in patients’ experience (e.g., shame, self-loathing, and self-criticism; tendencies toward superiority and judgmentalism; convictions about others’ mental states). For example, we might ask patients, “Are there any other perspectives you could have on the matter, which might have some validity as well?” Additionally: “We’ve already considered what supports your position. Could you also consider what might undermine it?” When patients are viewing another person’s viewpoint more dismissively, we sometimes “plant our feet” and encourage them to assess what might *support* the viewpoint in question: “I realize that you completely disagree with your husband here, that you are even offended by his opinion. But if you were to bracket that just for a moment, try to think about it: is there even a grain of truth to what he is saying here?” In cases where we have offered some idea for patients to consider, we could inquire, “Could you really try to reflect on what I am proposing here: what resonates with you, and what feels like it does not fit?”

Here we are hoping that patients assume a more agentic stance in relation to psychological constructions in themselves and others: to take a step back from these perspectives, examine them, and devote some effort to assessing their strengths and weaknesses. This constitutes a posture of greater flexibility and curiosity, tempering patients' sense of certainty, as well as the psychological and behavioral challenges associated with that certainty.

Clinical illustration: Process-focused interventions for psychic equivalence

To illustrate these ideas, we will consider a clinical example of a patient named Brenda, a 35-year-old graphic designer diagnosed with NPD, vulnerable subtype, covert expression (Pincus, 2023). Brenda has a long history of interpersonal conflicts and anger issues in the workplace. This has led her to be fired from several jobs, with accompanying difficulties with depression, suicidality, and binge drinking. Brenda recently applied for a promotion to the role of creative director at the advertising agency where she works, but the position was given to one of her peers, whom Brenda sees as poorly suited to the role. She is now enraged, feeling like the position was unfairly awarded to her colleague. She is considering raising these concerns to her boss and filing a formal complaint through Human Resources.

Thus far in the session, the therapist has utilized content-focused interventions to help Brenda articulate a range of emotions surrounding this situation, including feelings of anger and resentment; a desire for recognition and admiration from her colleagues; and a sense of insecurity and fear about what her supervisor thinks of her. Employing context-focused interventions, the therapist has encouraged Brenda to reflect on the broader context of these feelings. Brenda has been able to link her emotions to the high-pressure, competitive environment at her agency (*environmental context*), and also to her strong impulse to complain about this situation to others, in order to attain some justice for the maltreatment (*behavioral context*). At this point in the session, the therapist has privately identified psychic equivalence as the most pressing non-mentalizing mode requiring therapeutic attention, specifically Brenda's certain belief that she was unfairly robbed of this position. The therapist is concerned that Brenda's

certainty about this perspective might lead her to relate more aggressively to her colleagues, placing her at risk for the functional challenges (e.g., interpersonal conflict, getting fired, depression and suicidality) with which she has historically struggled.

THERAPIST: So it seems like the thing that is upsetting you most right now is the fact that they didn't choose you for this position as creative director. It really feels unfair and unjust. *[empathic validation of psychic equivalent mind state]*

PATIENT: Exactly. It is just another example of this toxic culture at this agency. I am so fed up with it.

THERAPIST: I hear you. Could you help me understand more: what makes you feel like they really made the wrong decision in hiring your colleague? *[inviting elaboration of the process of arriving at the perspective]*

PATIENT: Where do I start? I have been at this agency for FIVE YEARS, working my ass off for very little pay. My work is legit, and I have shown that on project after project. And I actually have creative vision: I come up with ideas, and I am able to realize them, on a very consistent basis. Melissa *[the peer who was hired]* has no substance, no real sense of imagination or innovation. I think that management just likes her because she is nice, and she is going to do what she is told. But that is not what the job is. The job title it is "creative director," not "boring follower."

THERAPIST: I see, so you really feel much more qualified for the job than Melissa: you've paid your dues, and you actually have a sense of imagination and creativity. You suspect that management is more drawn to Melissa because she is agreeable, rather than because she is actually talented? *[empathic summary of patient's support for the psychic equivalence]*

PATIENT: Yeah, exactly. I mean, Melissa is fine, I have no problem with her as a person. But she is not a creative director.

THERAPIST: So help me understand: when you are focusing on the unfairness here, how does that impact you? *[exploration of the consequences of psychic equivalence]*

PATIENT: I just feel furious all of the time. I'm doing my work, but I can't really focus on anything, because I am so angry that they are doing this to me.

THERAPIST: Is this where the idea of complaining to your supervisor comes in? *[inquiring specifically about the behavioral consequences of psychic equivalence]*

PATIENT: I mean, I can't just lie down and let them treat me this way. I am actually qualified for this job, and they are denying me. It isn't right.

THERAPIST: So the more that you think about this, the more furious you get. And it sounds like you feel like you basically *have* to complain about this, given the unfairness of this decision. *[empathic summary of the consequences of psychic equivalence]*

PATIENT: It does feel that way. That sounds a little extreme, but that is how I feel.

THERAPIST: Now earlier you mentioned that Melissa is "fine," and that you have "no problem with her as a person." What were you getting at there? *[inviting elaboration of a more nuanced perspective]*

PATIENT: Well, she actually is a pretty nice person. When I was having those conflicts with my boss a couple of years ago, she was really supportive of me: asking if I was OK, even covering some of my work for me. Everybody likes her, so I am sure that is part of the reason why they hired her. But obviously they shouldn't just be hiring the nicest person; they should be hiring the most *qualified* person.

THERAPIST: I really appreciate everything you are articulating here. You feel like Melissa *does* have some strengths, namely her kindness and supportiveness— this probably played some role in the management team choosing her *[empathic validation of more nuanced perspective]* . At the same time, that doesn't change your recognition that, at the level of creativity and innovation, you are better suited for this job *[empathic validation of psychic equivalence]* .

PATIENT: Exactly. That is why I am so upset about this.

THERAPIST: Definitely—this has been extremely difficult. Would it be OK if I shared some of my reactions to all this?

PATIENT: Yeah, of course.

THERAPIST: I know you have been so focused on how unfair this decision is, and all of the things that make you the ideal candidate. I completely hear that, and it does sound like you would have brought a tremendous number of strengths to this role. But it seems to me that you are thinking a lot less about management's possible reasons for *not* choosing you—any potential challenges you might have experienced in this role. This feels important to me, especially given how much you have struggled with your relationships at work. *[cautious sharing of independent perspective]* I'm curious what you think about that *[inviting reflection about additional perspective]* ?

PATIENT: *[softening in her tone]* I mean, I'm not saying that I would have been perfect at the job.

THERAPIST: Can you say more?

PATIENT: Obviously I've got some strong opinions, and I don't have much of a filter. I know the creative director is supposed to be in charge of the whole team. I think that I could do it, but I don't know how it would go if people didn't agree with me, or didn't want to do things my way. That would be tough for me. I have a lot of ideas, but as you know, it can get a little messy when I get push-back from people.

THERAPIST: So where do you feel like this all leaves you? *[inviting reflection about the discussion more broadly]*

PATIENT: I don't really know. I'm still really upset about this, and I am seriously considering making a complaint. I *am* the most qualified candidate—there's no way around that. But I can't really deny this issue of my interpersonal challenges at work. Strangely, I wasn't really thinking about that until just now. I guess that is the one thing that Melissa has on me! It's my Achilles heel.

In this example, the therapist utilizes process-focused interventions for psychic equivalence—exploring the certainty and its sequalae, considering more balanced aspects of the patient's narrative, and cautiously sharing

one’s own perspective—to help the patient adopt a more flexible, curious stance toward her own belief state. Of note, by the end of the session, the content of the patient’s original judgment (i.e., that she was unfairly denied the promotion) had not shifted in any significant way. However, rather than being singularly focused on that content, the patient had broadened her outlook to include an additional area of focus as well—namely, the impact that her interpersonal vulnerabilities might have had on her ability to be an effective leader. This shift illustrates an essential part of the clinical management of psychic equivalent mind states in MBT-N. We are not trying to get patients to “change their beliefs,” but rather to relate to those beliefs less rigidly, such that other views can be entertained and considered. Patients thus begin to experience their beliefs *as mental states* , rather than veridical facts. Under these conditions, they are less controlled and dominated by their initial impressions, enabling them to be receptive to a broader range of experiences in their lives and relationships.

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10

Process-focused Interventions: Teleological Mode

Introduction: Clinical manifestations of teleological mode in pathological narcissism

Teleological mode involves relying excessively on concrete, visible factors to structure our experience of mental states in ourselves and other people. In everyday clinical practice, very few patients articulate this form of non-mentalizing explicitly, for example by saying, "I am assuming he does not respect me because he did not accept my friend request," or "I tend to base my self-esteem on my attractiveness and professional achievement." Rather, the distinguishing feature of teleological mode is patients' tendency to extensively *focus on and discuss* external factors in themselves and other people: physical appearance; material possessions; behaviors, behavioral patterns, and interpersonal approaches; visible events or circumstances; academic, professional, or social status; and relationships or affiliations with certain people, organizations, or groups. In Chapter 6 , we reviewed mentalization-based treatment for narcissism's content-focused interventions, which help patients to elaborate the "what" of their experience. Arrived at this point in the trajectory of interventions, patients will have articulated two broad spheres of their lived reality: (a) the concrete, visible aspects of the situation under discussion, and (b) internal processes (e.g., emotions, desires, self-states) associated with these concrete factors.

How then do we assess for the operation of teleological mode in patients' experience? As we have seen, psychic equivalence mode involves patients' rigid attachment to the content of a belief state. In contrast, teleological mode involves rigid, certain assumptions about the necessary *relationship* between specific external factors and internal processes. Accordingly, we begin to suspect some form of teleological thinking when patients

frequently and consistently “link” particular external and internal processes in their experience, or if they appear quite certain about the necessity of such connections. See Table 10.1 for examples of the elements involved in teleological mode in therapeutic work.

Table 10.1 Key elements involved in teleological experience

External factor	Internal process	Clinical manifestation
Patients' behavior or behavioral pattern	Mental state in patients before, during, or after the action	Strong desire to take an action in order to generate/alleviate a particular feeling state; strong desire to avoid taking an action, in order to generate/alleviate some feeling state. Gives rise to behavioral compulsions, impulsivity, and maladaptive interpersonal approaches.
Event or situation: interpersonal interactions; circumstances unfolding in different life spheres (e.g., work, family, friendships, community, finances, possessions); happenings in broader society and culture	Some affect, desire, or self-state in patients in relation to the event/situation	Patients feel like they can only generate some positive feeling if the event occurs/does not occur; patients assume they can only avoid some painful feeling if the event occurs/does not occur. Leads to powerful impulses to seek out (or to avoid) the event or situation in question.
Visible aspect of self: attractiveness; appearance; possessions; behaviors, behavioral patterns, and interpersonal approaches; academic, professional, or social status; relationships with certain people, organizations, or groups	Some affect, desire, or self-state in patients	Strong desire to actualize some valued aspect of self; positive feelings when this aspect materializes, painful feelings when it fails to materialize
Visible aspect of self: attractiveness; appearance; possessions; behaviors, behavioral patterns, and interpersonal approaches; academic, professional, or social status; relationships with certain people, organizations, or groups	Patients' sense of self-esteem and self-worth	Pride, self-confidence, emotional stability when some valued aspect of self materializes; shame, self-attack, worthlessness when it fails to materialize
Actions of another person, organization, or group	Some presumed belief, affect, desire, or self-state in the other party	Sense of certainty that the action in question implies the presence of a particular mental state; other feelings (e.g., emotions, desires, self-states) associated with such certainty
Visible aspect of other people: attractiveness; appearance; possessions; behaviors, behavioral patterns, and interpersonal approaches; academic, professional, or social status; affiliation with certain people, organizations, or groups	Affects or desires *about* the other person	Valuing of others dependent on these external qualities; "conditional" care and interest in others; use of other people for own ends

Teleological experience perhaps shows itself most overtly in behavioral domains, for example when patients feel compelled to take particular actions (e.g., attention-seeking, perfectionism, sex, suicide, substance use, "performing well" in social and vocational contexts) in order to generate certain feelings (e.g., happiness, excitement, self-confidence, contentment), or to avoid painful feelings (e.g., sadness, anxiety, shame, anger). Patients can also engage in avoidant behaviors (e.g., social isolation, missing work, interpersonal withdrawal, leaving relationships or treatment), similarly in order to generate pleasurable emotions (e.g., relief, empowerment), or to minimize more challenging internal states (e.g., distress, humiliation, powerlessness). Here patients often feel like the *only way* they can feel better is by taking the action in question, which gives rise to a quality of compulsivity, impulsiveness, and involuntariness surrounding the behavior.

Patients also maintain a teleological relationship to events or situations in their environment: people treating them in a certain way; circumstances unfolding in different life spheres (e.g., work, family, friendships, community, finances, possessions); and happenings in broader society and culture. Patients can ascribe a profound positive value to certain visible factors, as illustrated by various internal processes: intense desires for the event to take place; positive feelings (e.g., joy, pride, satisfaction, increased self-esteem) when the situation occurs, or when imagining its occurrence; believing that "I can only feel good if" the thing happens, and "I am *unable* to feel good" if the thing does not happen; and internal "pressure" surrounding the circumstance, including rumination, planning, and need to take actions to generate the preferred outcome.

In addition, patients can endow strong negative value to particular events, as indicated by painful feelings (e.g., fear, sadness, distress, anger, shame) surrounding the imagination or occurrence of the event; the belief that they cannot experience positive feelings if the situation unfolds; and fervent desires surrounding the circumstance, including yearnings for the event to not transpire, impulses to take actions to prevent its occurrence, and need to avoid the circumstance if it does take place. These teleological processes are especially relevant in patients' interpersonal relationships, where patients can be powerfully drawn to certain forms of relatedness (e.g., receiving positive feedback, compliments, admiration, or sexual attention from other people), and averse to other forms of interaction (e.g., other people criticizing, ignoring, disregarding, or outshining them).

In addition, patients display teleological experience regarding specific visible aspects of themselves: their attractiveness, appearance, and material possessions; their ability to engage in certain behaviors (e.g., completing tasks, being “productive,” effectively performing at work or school), or to relate to other people in particular ways (e.g., coming across as intelligent, charming, charismatic, competent, or powerful); possessing status, power, or positive reputation in particular contexts (e.g., academic, professional, social); and maintaining relationships with highly valued people, organizations, or groups. Patients with pathological narcissism (PN) often ascribe unconditional value to these extrinsic qualities, such that their sense of self-esteem relies on their ability to realize and actualize them in their lives (Abeyta et al., 2017).

This “teleological sense of self” can structure patients’ subjective experience in foundational ways, giving rise to compelling desires to manifest these characteristics; the tendency to fantasize about ways they exemplify the traits, and to ignore and minimize perceived failures in these domains; positive mood and emotions (e.g., joy, happiness, excitement, contentment) when they feel like they possess the quality in question; painful mental states (e.g., sadness, depression, anxiety, despair, distress) if they fail to express that quality; and positive self-states (e.g., pride, confidence, security) when they embody such factors, as well as “negative” self-experiences (e.g., shame, worthlessness, self-disgust) if they struggle in these areas. These teleological processes are also associated with patients’ tendencies toward dishonesty and misrepresentation, where they can overemphasize their positive attributes, while hiding, deemphasizing, or lying about the parts of themselves (e.g., physical imperfections; problematic actions or traits; affiliations or relationships seen as embarrassing or undesirable) that make them feel ashamed or inferior.

Patients can also interpret other people’s behavior in a teleological manner, assuming that certain actions imply the presence of particular mental states (e.g., beliefs, emotions, motives) in the other party. Patients might feel quite certain that another person has more critical or aggressive feelings or personality traits (e.g., anger, arrogance, desire to humiliate, “disrespect” for them), seeing actions that the person has taken, or not taken, as a direct indication of those experiences. Here patients can often be less attentive to actions and interpersonal tendencies that express a more

complex array of subjective states (e.g., care, insecurity, altruistic motives) in the other person.

Similarly, patients can regard past or present actions of another person as clearly revealing more "positive" feelings or personality traits (e.g., care, love, respect, trustworthiness), disregarding behaviors that might reflect a broader range of internal processes (e.g., feelings of dislike, irritation, pity, lack of interest, malicious or self-serving motives) toward patients. These teleological interpretations structure patients' broader experiences of the other person, influencing their emotional responses in that relationship, as well as their manner of engaging with the individual. For instance, if a patient experiences her boss' constructive feedback as an obvious sign that he is looking down at her, she could then feel more insecure and self-conscious about herself as an employee, leading to difficulties with irritability and avoidance in her interactions with him.

In teleological experience, other people's visible qualities can also significantly impact patients' feelings *about and toward* the person in question. For example, patients are often more emotionally drawn to people who display the visible qualities that they value (e.g., attractiveness; wealth; behavioral aptitudes; status or power in valued contexts; offering positive feedback and attention), while feeling more indifferent, averse, and superior to people who exhibit those qualities that they judge or criticize (e.g., unattractiveness; poverty; perceived incompetence or inefficiency; affiliation with devalued groups; lack of status in valued contexts; criticism and disapproval). This can lead to more "conditional" or instrumental forms of connectedness with others, where patients feel interested in and responsive to the other person when the person meets the condition in question, and more disinterested and uncaring if the individual fails to meet that condition.

In these ways, teleological mode frequently involves more superficial and constrained forms of relatedness with others, which are not immediately apparent to the people with whom patients are engaged. As long as the other person facilitates patients' sense of self-esteem, patients *seem* authentically and empathically engaged with the person. However, as the relationship unfolds and the other person naturally displays qualities (e.g., anger, self-focus, indifference or neutrality, prioritization of other things) that do not strictly facilitate patients' self-esteem, patients struggle to remain emotionally engaged with the individual. This can precipitate the

difficulties with estrangement, impatience, boredom, avoidance, and aggression that are so pervasive in PN.

Process-focused interventions for teleological mode

Taken together, all of the aforementioned forms of concreteness lead patients to feel like the problem and the solution to their lives reside perpetually outside of them. *The cause of my suffering is this outside thing. The only way for me to feel better is for that thing to be altered, in the specific way I have determined that it should be.* Patients' moods and emotions thus get continuously "tugged around" by external processes, leading to perpetual feelings of pressure, anxiety, agitation, and powerlessness. Accordingly, when working with patients in teleological mode, clinicians can reflexively collude with this external formulation of the problem. This gives rise to certain common patterns in clinicians: the desire to give advice or "problem solve" external situations; impulses to take action to alleviate patients' distress (e.g., complying with patients' demands in sessions, advocating for patients outside of sessions), or to satisfy patients' desires for admiration or recognition (e.g., not interrupting monologues, avoiding more challenging interventions); inclinations to teach patients concrete skills or behavioral strategies; and sometimes the temptation to blame other people or circumstances for patients' difficulties (*"His wife really is too critical of him. She really needs to start therapy, if he is going to get any better … "*). While such approaches are understandable and occasionally helpful, they do not directly address patients' teleological *tendency* to structure their experience in terms of external factors. Rather than residing "out there" in the world, such tendencies are internal processes rooted in patients' own psychology. Thus, in principle, they are amenable to therapeutic intervention.

Similar to strategies for psychic equivalence mode, the aim of techniques for teleological mode is *not* to correct or change patients' teleological beliefs. Instead, the interventional pathway works toward (1) helping patients to explicate the ways in which they are "linking" some outside factor with some internal process, and then (2) stimulating greater curiosity about the presumably categorical nature of the connection in question (see Box 10.1). Over time, this approach helps patients to cultivate a posture of

greater flexibility and curiosity about the teleological experience, such that they are eventually able to consider the issue in a manner that is not strictly dictated by the external factor.

Box 10.1 Process-focused interventions for teleological mode in MBT for narcissism

The aim of interventions for teleological mode is to stimulate patients' reflectiveness about the assumed necessary relationship between some external factor and another internal process.
Start by empathically validating patients' teleological mind state.

"So at this point, you feel like you absolutely need to get your old job back."

Explore with patients their process of arriving at the perspective in question.

"This sounds so important. Can you tell me more about what makes this the perfect job for you?"

Examine with patients the consequences of the teleological view, in themselves as well as other people.

Internal experience: *"How does this make you feel about yourself—to be deprived of this job that was once so meaningful to you?"*
Behaviors and interpersonal approaches: *"When you are so focused on needing to get your job back, what do you end up doing?"*
Experiences in other people: *"What has this been like for your family, for you to be so depressed about losing this job?"*

Explicate and empathically validate patients' assumptions about the connection between the external and the internal.

"So for you, your old job *[external factor]* was literally the source of your self-worth *[internal process]* . Without it, you have nothing, and you are nothing."

Gently inquire about the necessary relationship between the external and internal factors.

"So if you were to get your job back, would it make you feel good about yourself permanently, once and for all?"

Empathically validate patients' more flexible perspective about the teleological association.

"It sounds like you have struggled for a long time with insecurities about your work: worries about what other people think about you, and also concerns about your intelligence and overall competence at your job. So even if you got your old job back, it would probably not erase all of those problems."

Cautiously share own perspective about the teleological connection, in a marked and tentative fashion.

"I am hearing that, for you, that job is the only way for you to have a sense of self-worth. While you may be right about that, personally, there's something that just doesn't feel right about the idea that your only value comes from your professional achievements."

Examine patients' reactions to this additional perspective, and to the discussion more generally.

"What comes up for you, as you consider this possibility?"
"Thinking about the things we've discussed today, where do you go with all of this?"

Process-focused interventions for teleological mode parallel the techniques we have already reviewed for psychic equivalence mode. We start by empathically validating patients' teleological mind state, working to remain as "close" as possible to their experience in the present moment—however concrete, inflexible, or non-elaborated that experience might be. For example, we might say, "So at this point, you feel like you absolutely need to get your old job back." When patients are more engaged in teleological interpretations of other people's experience, we empathically summarize the content of their externally focused perspective: "When your wife was criticizing you at that moment, it felt clear that she is trying to humiliate you, and to assert her power over you." This approach shines a spotlight onto the area of non-mentalizing that will serve as our intended area of inquiry, so that patients have clarity at the outset about our focus for exploration. We revise our empathic statements based on patients' feedback: "I see, so you are really feeling like. …" Or: "That is really helpful. Your sense of this is that. …" This ensures that patients feel like we

are addressing an experience that is personally meaningful to them, thus increasing the utility of our subsequent interventions.

We then explore with patients their process of arriving at the teleological perspective, inviting them to elaborate the internal and situational factors that, from their point of view, *support* the viewpoint in question. “This sounds so important. Can you tell me more about what makes this the perfect job for you?” Or: “What clues you into the fact that your wife actually wanted to humiliate you?” Here patients usually share more about the external factors (e.g., actions or qualities of other people, events or circumstances in the world, their own visible characteristics) that validate their concrete formulations. In this way, patients begin to articulate a more complex and multifaceted concrete perspective, often inadvertently betraying areas of actual or potential nuance within the teleological system. These are the proverbial “cracks in the wall,” to which we can return later in the process. As patients share more about these experiences, we empathically validate their reflections.

> “So your wife was quite incessant about itemizing your faults, listing so many ways that she saw you as failing: your social isolation, your unemployment, missing all of those medical appointments. And even though you asked her to stop, she just kept talking about it, which clearly shows that she was trying to make you feel bad about yourself.”

Next we examine with patients the consequences of the teleological perspective, in themselves as well as other people. We invite patients to reflect on their internal experience (*“How does this make you feel about yourself—to be deprived of this job that was once so meaningful to you?”* ; *“What was that like for you, to feel like your wife was intentionally trying to humiliate you?”*); their behaviors and interpersonal approaches (*“When you are so focused on needing to get your job back, what do you end up doing?”* ; *“How did you respond to your wife in that moment?”*); and the experiences of other people (*“What has this been like for your family, for you to be so depressed about losing this job?”* ; *“How do you think your wife felt, when you were insulting her personality like that?”*). Patients commonly respond by describing some of the functional challenges related to the teleological experience (e.g., instability in mood, identity, relationships, or behaviors)—difficulties that often further exemplify patients’ tendency to base their experience on the external factor in

question. We respond by offering some empathic summary of patients' reflections about these matters.

> "So when your wife was criticizing you in that way, you felt humiliated and ashamed *[empathic summary of patient's previously expressed emotional experience]* , and you responded by trying to insult and disparage her in return *[empathic summary of patient's previously expressed interpersonal behaviors]* . It sounds like you might have really hurt her feelings, which just drove her further away from you *[summary of patient's ideas about impact on the other person]* ."

As patients recognize the deleterious impact of teleological thinking on other areas of their lives that matter to them (e.g., emotions/behaviors in self, impact on others), this thinking becomes more "problematized" in their experience, enabling them to feel more motivated to work on these areas in treatment.

Thus far in the interventional process, our techniques have largely collapsed the distinction between external factors and internal processes, in this way remaining highly contingent to patients' teleological mind state. However, now that patients have detailed a more elaborated vision of the teleology, we can articulate what we have learned about patients' assumptions about the *connection* between the external and the internal. Along these lines, we explicate and empathically validate patients' perceptions about these matters: "So for you, your old job *[external factor]* was literally the source of your self-worth *[internal process]* . Without it, you have nothing, and you are nothing." Or: "When your wife was enumerating your difficulties *[external factor]* , that showed that she genuinely wanted to embarrass you *[internal process]* , and so you felt like you had to retaliate by being cruel in response." While these techniques might seem rudimentary, they often prove essential in ultimately addressing the teleological mind state. Patients are usually unaware that they are blurring the distinction between "the inside and the outside." Without some explicit recognition of the specific external and internal processes that they are linking together in the teleological experience, they are unable to generate any curiosity about the connection in question.

Once patients' teleological associations are "on the table," we gently inquire about the necessary relationship between the external and internal factors. Throughout the conversation, if patients have made any comments indicating a more nuanced perspective on this relationship, we now reference these statements and invite further reflection about them (*"Earlier*

you mentioned that 'it wouldn't be perfect' if you got your old job back. What were you getting at there?" ; *"A couple of minutes ago, you said in passing, 'I know my wife is worried about me.' What might she be worried about?"*). In addition, we can ask patients to imagine the possibility of different internal processes in relation to the same external factor, for example by saying, "So if you were to get your job back, would it make you feel good about yourself permanently, once and for all?" Or: "Can you consider anything else that your wife might have been feeling, as she was discussing all of your recent challenges?" In cases where patients are focused on some more valued internal state in themselves or others, we urge patients to envision how such a state might adhere even in the absence of the external factor: "Let's imagine, worst case scenario, that you are never able to get your old job back. Can you conceive of any situation where you would be able to actually feel good about yourself again?"

When patients struggle to reflect on the teleological association in question, we can also invite patients to imagine what *other people* might think about this association. For example, we might ask, "What do you think your kids would think about this idea—that your only value as a person comes from what job you have?" Or we could inquire: "If your wife were here, what do you think *she* would say about why she was listing all of your challenges in that way?" By putting themselves in the other person's shoes, patients are often able to at least *consider* another viewpoint on the teleological linkage, even if they continue to feel most certain about their original perspective on the matter.

If patients give voice to more nuanced ideas about the teleological experience, we encourage them to expand further on these considerations. "Interesting. You suspect you would still end up struggling with insecurity, even if you got your old job back. What might you struggle with there?" "So you believe that your wife has been more worried about you lately. What do you think has been so concerning to her?" In this way, we hope to reinforce and validate patients' efforts at increased flexibility and curiosity, ultimately offering an empathic summary of patients' reflections.

> "It sounds like you have struggled for a long time with insecurities about your work: worries about what other people think about you, and also concerns about your intelligence and overall competence at your job. So even if you got your old job back, it would probably not erase all of those problems."

In cases where patients continue to have a strong emotional investment in the original teleological viewpoint, we make sure to incorporate some version of that viewpoint in our empathic summary. This can help patients feel less threatened by the new perspective, as if we are reassuring them: *You don't have to give up the old view in order to entertain a new one.*

> "So after considering everything, it still feels quite clear that your wife was trying to make you feel bad about yourself *[empathic validation of the teleological viewpoint]* . At the same time, you know that your wife loves you, and she has actually been feeling quite worried about you lately, so she might have been trying to motivate you to start taking care of yourself *[empathic validation of more flexible viewpoint]* ."

Once patients have reflected further on the teleological experience, we can share our own perspective about the topic under discussion. As noted with process-focused interventions for psychic equivalence mode, we offer such disclosures with tentativeness and humility, without claiming any authority or objectivity about the "right" way to see things. Our aim here is never to *change* patients' minds, but rather to grant them the opportunity to recon with another person's viewpoint on the teleological linkage.

Such disclosures can take numerous shapes, including expressing our doubt about the necessary presence of the assumed internal process: "I know that you feel extremely certain that your wife was trying to make you feel bad about yourself. But when I hear the story, it feels a lot less obvious to me." Moreover, we can raise the possibility of other possible internal processes at play in the situation: "I completely agree that you would feel so much better if they were to rehire you. But for me, the job doesn't seem like such a cure-all, in the same way it does for you. I just keep thinking about how unhappy you were when you used to work there. …" "As I'm sitting here, my mind just starts to go through all of the other things your wife might have been feeling at that moment, especially given how much you have been struggling lately." And in cases where patients are assuming that certain mental states are wholly dependent on the presence of some external factor, we can contemplate their relevance even in the absence of that factor: "I am hearing that, for you, that job is the only way for you to have a sense of self-worth. While you may be right about that, personally, there's something that just doesn't feel right about the idea that your only value comes from your professional achievements."

Finally, we explore patients' reactions to this additional perspective, and to the conversation overall. "What do you make of this idea?" "What comes

up for you, as you consider this possibility?" "What are you taking away from this discussion?" "Thinking about the things we've discussed today, where do you go with all of this?" Here we are hoping for patients to truly interrogate our independent position: considering our reasons for seeing things this way; reflecting on the ways in which it resonates with their experience, as well as the ways it does not fit for them; examining the potential implications of the outlook for their lives more generally; comparing and contrasting it with the original viewpoint under discussion; and ultimately reexamining their initial view in light of the dialogue thus far.

By following the trajectory in this way, we hope to simply expand the range of perspectives patients are considering about the teleological experience. Even when patients continue to endorse the original teleological linkage, by engaging in the steps in this process (e.g., articulating their view; examining the support for and consequences of the outlook; considering more nuanced aspects of their thinking; and reckoning with our distinctive point of view), patients are implicitly relating to that linkage as a psychological construction, rather than a definitive reflection of the outside world. When repeated over time, patients progressively exhibit a greater sense of flexibility, curiosity, and internal freedom surrounding the external circumstance.

"If all else fails": What to do when process-focused interventions for teleological mode are ineffective

Of course the above interventions are not always successful. Even when we thoughtfully employ them, patients can continue to display significant rigidity surrounding the teleological experience: powerful desires for certain events to occur; overwhelming urges to engage in particular behaviors; significant confidence that they "need" to actualize particular visible qualities (e.g., related to attractiveness, appearance, possessions, money, social or professional status); or a sense of certainty about the connection between other people's external qualities and internal experiences. In such cases, we have a handful of techniques at our disposal to help stimulate patients' mentalizing surrounding the teleological experience (Box 10.2).

Box 10.2 Techniques for when process-focused interventions for teleology are ineffective

Provide patients with direct feedback about their lack of reflectiveness about the teleological factor.

"You have been very focused on finding the perfect medication to get rid of your depression. But you don't appear to be considering the things happening in *you*, and in your life, that might be really contributing to these feelings, which might need to be addressed."

Invoke the parts of patients' MBT formulations that reference patients' challenges with externally focused thinking.

"In your formulation, we discussed how you can become quite self-conscious and insecure whenever your husband gets really caught up with his work projects, and is spending less time with you. Do you think that any of that could be relevant to how you have been feeling lately?"

Explore issues related to patients' motivation and commitment to work on problems with teleology in the treatment.

Examine negative consequences of the teleology: *"These difficulties with defensiveness and reactivity … have they caused any trouble for you in your life?"*
Inquire about patients' level of motivation: *"Would you ever want to work on this in treatment: trying to develop a sense of self-worth that is not so dependent on performance and achievement?"*
Encourage reflection on the process of change itself: *"How would you go about working on this issue?"*
Invite patients to consider the positive consequences of addressing the teleology: *"What would that be like for you, if your mood were less controlled by how things are going at work?"*

First, we can give patients direct feedback about their challenges with reflectiveness about the issue under discussion. For example, we might share with patients:

> "We've talked a lot here about how you can base your sense of self-esteem on your salary at your job. You seem to be cognitively aware of this tendency in yourself, but I rarely hear you actually *question* this association—that the only way you can feel good about yourself is if you make a certain amount of money."

Or we could say: "You have been very focused on finding the perfect medication to get rid of your depression. But you don't appear to be considering the things happening in *you*, and in your life, that might be really contributing to these feelings, which might need to be addressed." These interventions shift patients' focus away from the external factor in question, and onto their *assumptions* about the relevant teleological association. When patients are more cognizant of their confidence or certainty about those associations, they are often more able to reflect on these connections in a more flexible manner. We explore with patients their experience of receiving this feedback from us, at the level of process: "Where does your mind go, as I share this impression?" "What do you think of this idea?" "What is *your* sense of this—that you just sort of assume that your wife is trying to humiliate you?"

Another method for addressing intransigent teleological mode is to reference the section of patients' MBT formulations that speak to these challenges, outlined in the "Overly concrete and visible" section (pp. 71–73). For example, we might offer:

> "When we were working on your formulation together, you noted how, if someone insults you, you can feel like you HAVE to retaliate against them, in order to preserve your sense of self-respect. I have to admit, I keep thinking about that section as this situation has been escalating with your boss . …"

Or we could share, "In your formulation, we discussed how you can become quite self-conscious and insecure whenever your husband gets really caught up with his work projects, and is spending less time with you. Do you think that any of that could be relevant to how you have been feeling lately?" Here we explore with patients their thoughts and reflections about the possible role that these teleological difficulties might be playing in their contemporary experience. Since patients have already recognized the personal significance of these difficulties, they are often able to think more flexibly about the current concrete association (e.g., ways in which it might not always adhere, other emotionally salient aspects of the situation) when considering it "alongside" their broader challenges with externally focused thinking.

In many cases, patients who struggle extensively with teleological mode do not feel especially motivated to work on these problems in treatment. Since they experience the problem and solution to their suffering as residing perpetually outside of them (i.e., in the external factor), they often feel more invested in changing their external circumstances than in altering their *psychological relationship* to these circumstances. We thus sometimes need to "take a step back" when working with patients on these matters, examining issues related to their motivation and commitment to addressing these issues in the therapy. Here we explore with patients the negative consequences of the teleological thinking. "How has this impacted you, to base so much of your self-esteem on your appearance and attractiveness?" "These tendencies toward defensiveness and reactivity … have they caused any difficulties for you in your life?" We inquire about patients' level of motivation to address the teleology. "Would you ever want to work on this in treatment: trying to develop a sense of self-worth that is not so dependent on performance and achievement?" "So it sounds like this has caused some real trouble in your relationship: judging your girlfriend's feelings for you based on how much attention she shows you. How interested would you be in starting to look at this in our sessions?"

In addition, we invite patients to reflect on the process of change itself. "How would you go about working on this issue?" "What would have to happen for you to really make progress on this?" "As you think about changing this in yourself, do you have any ideas of what might get in the way?" And we inquire about the potential positive consequences of targeting the teleology. "What would that be like for you, if your mood were less controlled by how things are going at work?" "Imagine you could improve your argumentativeness and defensiveness. How might that impact your relationship with your husband?" As patients reflect on these matters, they often begin to feel more personally invested in addressing their challenges with teleological mode, increasing their receptivity to the process-focused interventions reviewed earlier in the chapter.

Clinical applications: Process-focused interventions for teleological self-esteem

As discussed previously, patients with pathological narcissism can struggle with a largely teleological sense of self-esteem, in which they base their self-worth on visible or extrinsic factors: attractiveness; appearance; possessions; effective behavioral performance; vocational or social standing; and relationships with valued people, organizations, or groups. Accordingly, when patients face disruptions in those domains, they can experience many of the symptoms of emotional dysregulation (e.g., depression, anxiety, anger, shame, hopelessness, suicidality) that lead them to seek out psychiatric treatment in the first place. In our experience, in order to address patients' longstanding functional challenges, we often need to stimulate patients' reflection on their assumptions about the *necessary relationship* between these extrinsic factors and their sense of themselves as valuable. As patients are able to become more curious about these assumptions, they begin to experience greater flexibility surrounding the external elements in question: feeling decreased distress and shame in the absence of such elements, and also feeling like these elements are less essential in order for them to experience a sense of personal value. In contrast, if such teleological assumptions are never addressed in treatment, patients often remain vulnerable to their characteristic challenges with emotional and identity-related instability, as well as the behavioral concomitants of these challenges.

Box 10.3 Process-focused interventions for teleological self-esteem

In pathological narcissism, teleological self-esteem is the tendency to base one's self-worth on visible or extrinsic factors:

Attractiveness; appearance; possessions; effective behavioral performance; vocational or social standing; and relationships with valued people, organizations, or groups.

As patients become more curious and reflective about their teleological expectations for themselves, they experience greater flexibility, resilience, and coherence in their sense of self.
Rather than approach these matters from an abstract perspective, therapeutic interventions focus on specific instances of patients applying external standards to themselves, or of patients failing to meet those standards.
Techniques follow the trajectory of process-focused interventions for teleological mode, focused specifically on patients' teleological sense of self-esteem:

Empathically validate the concrete standard or disruption;
Explore the process and consequences of patients seeing themselves in this way;
Articulate the "link" between the visible factor and patients' sense of self;
Invite patients to reflect on the necessary relationship between these elements;
Share own perspective about patients' tendency to base their self-worth on the visible factor in question;
Explore patients' thoughts and feelings about own perspective, and about the discussion more broadly.

At the level of technique, rather than approaching these matters from a more abstract or general perspective, we focus on specific, discreet instances of patients applying certain standards to themselves ("I have to look attractive, thin, and 'put together' in order to feel good about myself"; "I really need to do a good job on that test tomorrow"), or times when patients feel like they are failing to meet these standards ("I just feel so disgusted with my body today"; "I am so angry at myself that I got a 'B' on that test"). We tend to follow the same trajectory of interventions outlined earlier in "Process-focused interventions for teleological mode" (pp. 214–

220), in this case focused primarily on some aspect of patients' teleological sense of self-esteem (Box 10.3): empathic validation of the teleological standard or disruption; exploration of the process and consequences of patients seeing themselves in this way; articulating the "link" between the external factor and patients' sense of self; helping patients to reflect on the necessary relationship between these elements; sharing our own perspective about patients' tendency to base their self-worth on the external factor in question; and exploring patients' thoughts and feelings about our perspective, and the discussion more broadly.

To illustrate this process, let us consider a clinical example of a patient named Joseph, a 20 year-old college student diagnosed with narcissistic personality disorder, with both grandiose and vulnerable traits. High-achieving academically, Joseph sees himself as intellectually superior to most people, leading to challenges with arrogance, argumentativeness, and dismissiveness in many of his relationships (e.g., with professors, other students, family members). At the same time, Joseph feels deeply inferior and ashamed in the domains of appearance and romantic relationships. He is moderately obese, and he has never dated or had sex. He thus concludes that he is deeply unattractive, leading him to feel ashamed, humiliated, and worthless as a person.

In this session, Joseph shared about a party he attended over the weekend, where he spent time with a female friend, on whom he has a crush. He had been planning on asking her out on a date, but he felt insecure about his attractiveness and was unable to do so: "I just felt so disgusting. Why would she ever want to go out with me when she is so out of my league?" The therapist utilized content-focused interventions to explore Joseph's current emotional response to the party, with Joseph articulating emotions of shame, humiliation, and insecurity about his appearance, as well as his self-described "lack of charisma" in his interactions with women. He expressed strong feelings of longing for greater closeness with his friend, as well as a sense of regret for "not just being a man and asking her out like I had planned to." Examining the broader context of these feelings, the therapist and Joseph considered how Joseph felt drawn to criticize and attack himself for his insufficiencies, and that this approach felt far more comfortable for him than experiencing his feelings of longing and regret surrounding his relationship with his friend *[emotional context of evident versus nascent emotions]* .

In light of these explorations, the therapist privately identified teleology as the non-mentalizing mode that was most responsible for Joseph's current distress, specifically his tendency to base his self-worth on visible issues of appearance, social aptitudes, and success in romantic relationships. This teleological sense of self-esteem seems directly related to many of Joseph's recent functional challenges: his difficulties with inhibition and avoidance in dating interactions, as well as symptoms of depression and self-loathing in response to perceived failures in this domain.

THERAPIST: It really sounds like this experience at the party has left you feeling horrible about yourself—just deeply ashamed and humiliated. *[empathic validation of teleological mind state]*

PATIENT: Exactly. It is really excruciating.

THERAPIST: It sounds excruciating. I am wondering if we could look at this a little further: what about this whole situation is making you feel so bad about yourself? *[exploring the process of arriving at the teleological view]*

PATIENT: I mean, it's a lot of things. Hanging out with Jenny at the party, it just became clear to me that she is totally out of my league. She is actually hot, and I am a fat, ugly piece of shit. Also I just had no idea about how to interact with her. Like she was talking about all of this interesting stuff she is doing—going to concerts, planning a trip to Costa Rica, trying to adopt a dog—and all I had to talk about was video games and "getting an A" in my organic chemistry class. Like who the hell do I think I am even approaching this woman? It is pathetic.

THERAPIST: So you were doing a lot of comparing yourself to Jenny, and it left you feeling quite defective: unattractive, uninteresting, overweight, and socially inferior as well. *[empathic validation of support for the teleological view]*

PATIENT: Yeah, I finally realized that we are operating on completely different levels: she is up in the penthouse, and I am locked down in the basement.

THERAPIST: I see. How does this impact you, to be seeing yourself in this way? *[inquiring about the consequences of the teleological view]*

PATIENT: I mean, I just walk around hating myself all the time. Like, what is the point of any of this? If I cannot even get things off the ground with Jenny, who is basically the sweetest girl in the world and actually LIKES spending time with me, there is no chance that I am going to be able to do this with anyone else. I just need to double down on my schoolwork and get used to the fact that I am going to be alone. It is sad, but it is true.

THERAPIST: Your situation ends up feeling sort of hopeless to you—you are so problematic that you will never be able to have a relationship, with Jenny or with anyone. *[empathic validation of the presumed consequences of teleology]*

PATIENT: Yeah—that pretty much sums it up.

THERAPIST: The more that we talk about this, it is really starting to sound like so much of your self-worth seems to depend on these outside factors: namely your appearance and whether or not you have a romantic relationship. Without those things, it seems like you just end up seeing yourself in such a negative light. *[summary and empathic validation of the connection between external factors and patient's self-esteem]*

PATIENT: I mean, absolutely. Like, what else is there? If I'm fat, ugly, and alone, then what is the point of anything?

THERAPIST: I hear that—these external factors actually DO determine your experience of yourself, even the reason for your existence. But I want to look at this a little further, if possible. Let's imagine that, by some grand miracle, you and Jenny were to end up together. Do you think that would fully resolve your problems with self-esteem? *[gently inquiring about the necessary connection between the external factor and the patient's self-esteem]*

PATIENT: I mean, of course not.

THERAPIST: OK, say more.

PATIENT: I hate myself, and I've always hated myself. If I were to be with Jenny, or even some other woman who is even moderately attractive, it would definitely make me feel a bit better about myself—like, "I can't be so horrible if somebody like that is willing to date me." But in the end, I

am still me, and there's only so much you can do about that. *[starting to laugh]* Shit, being with Jenny might even make me feel worse, since I would be so worried that everybody would be looking at us and thinking, "What the hell is *she* doing with somebody like him?"

THERAPIST: That is a really interesting idea. So while you are pretty certain that being in a relationship would help you feel better about yourself, you are also aware that it wouldn't fully solve the problem. *[empathic validation of the more flexible perspective about the teleological association]*

PATIENT: Yeah, deep down I know that. But in the moment, I think that Jenny becomes like something of a "magic bullet" to me—the one thing that is going to make everything better.

THERAPIST: I am really glad that you are putting words on this. I was thinking about something similar: namely, that you can get so focused on these outside things—good grades, a different body, attention from women—in order to have a sense of self-esteem. But I am really curious: what would it be like if you were to take the focus off of those "magic bullets," and to work more on developing a sense of self that is not strictly dependent on those things? *[cautiously sharing own perspective about the teleological connection under discussion]*

PATIENT: I mean, that sounds great in theory, but how the hell am I supposed to do something like that?

THERAPIST: That is a very good question. What are you wondering here? *[inquiring about patient's reaction to the new perspective]*

PATIENT: I would love to feel good about myself regardless of those external things. But it's almost like I can't even conceptualize what you're saying. I've been this way my whole life. It's like the air that I breath.

THERAPIST: It's difficult to even imagine what change would even look like here.

PATIENT: Yeah.

THERAPIST: So where does this all leave you? *[inviting reflection on the discussion more generally]*

PATIENT: I think that I am feeling a little better than I did when we started talking today, which I guess is a good thing. It helped to remember that Jenny is not necessarily the solution to everything. That made me feel less horrible about how everything went this weekend. In terms of the other stuff, like I said, I don't really know how I would care less about all of those outside things. But I would be up for talking about it more and trying to figure that out. It definitely would make my life easier, and help me feel more stable when things don't go my way.

The above transcript offers one illustration of process-focused interventions to address teleological self-esteem. Of note, Joseph displays multiple forms of non-mentalizing throughout the session (e.g., convictions about his unattractiveness and inferiority; certainty that Jenny was "out of his league"; hopelessness about future romantic prospects), any of which could have been targeted utilizing the process-focused interventions we have been considering in the last two chapters. In this case, the therapist decides to prioritize Joseph's rigid assumptions about the necessary *relationship* between visible factors and his sense of self-worth, as exemplified by the ideas "I am bad because of these external conditions" and "The only way that I can feel good about myself is if I have this outside thing."

The therapist spends considerable time exploring and empathically validating the teleological mind state itself, a process that ultimately enables the therapist to articulate the teleological association in an experience-near way: "So much of your self-worth seems to depend on these outside factors: namely your appearance and whether or not you have a romantic relationship." Joseph resonates with this formulation, which paves the way for the therapist to gently inquire about the teleological association, namely by inviting Joseph to reflect on the status of his self-esteem in a hypothetical scenario in which he finally is able to date Jenny. Given Joseph's exquisite attunement to his self-hatred, it becomes almost cognitively impossible for him to continue affirming the teleological association in this scenario. Even the amazing Jenny would be unable to "cure" his longstanding difficulties with shame and self-loathing! Here the "cracks in the wall" of the teleology begin to appear, and the therapist takes this opportunity to express his own interest in prioritizing Joseph's

teleological self-esteem in treatment, prompting a collaborative discussion about what this might look like.

Joseph shows several signs of potentially improved mentalizing throughout the course of the session. Although he begins by confidently endorsing his inherent defectiveness, Joseph ultimately expresses an interest in working on his challenges with self-esteem in therapy. This interest implies (a) that these challenges in self are *psychological* processes, rather than simply visible deficiencies (e.g., obesity, unattractiveness); and (b) that it might be possible to change and evolve these aspects of his psychology. Joseph struggles to conceptualize a sense of himself that is *not* teleological, but he also exhibits some level of curiosity about how to envision and develop this type of identity.

While these improvements can of course be understood in a range of different ways, we suggest that they might be related to Joseph's increased reflectiveness about the teleological association under discussion. By considering the idea that being in a relationship will not fully resolve his challenges with self-loathing, Joseph is starting to question the presumed link between these external factors and his experience of self-worth. And if it turns of that these external conditions are not the "magic bullet" for his difficulties, Joseph will be less likely to hate and attack himself for not fulfilling these conditions.

Consistent with MBT's not-knowing stance, the therapist never attempts to directly alter Joseph's viewpoints during this interchange, whether about his own deficiencies or about the teleological connection in question. Rather, when working to stimulate mentalizing about the teleology, the therapist simply invites reflection about the aforementioned hypothetical scenario, and he cautiously shares his own perspective about the possibility of developing a less externally oriented self-esteem. This enables Joseph *himself* to arrive at a more flexible perspective on these matters, thus opening the door for increased reflectiveness and curiosity about how he relates to his own sense of worth and value. This is the heart of treating teleological self-esteem in MBT for narcissism.

Chapter 10 contain excerpts from Drozek, R. P., & Unruh, B. T. (2020). Mentalization-based treatment for pathological narcissism. *Journal of Personality Disorders* , *34* (Supplement), 177–203.

11

Mentalizing the Therapeutic Relationship: Auxiliary Relational Techniques

Introduction to mentalizing the relationship in MBT for narcissism

Throughout this book, we have suggested that pathological narcissism (PN) can be understood in terms of attachment-related inhibition of mentalization, resulting in the reflexive need to engage in self-enhancement processes in order to maintain stability and self-coherence. Patients pursue admiration from others, but they rarely reflect on *their desires* for admiration. They retaliate when injured by others, but they feel less curious about *the impulse* to retaliate, or the feelings and needs of other people involved in the situation. On this view, the therapeutic relationship can play an invaluable role in the treatment of PN. By offering innumerable opportunities for recognition as well as rejection, this relationship serves as a powerful, intimate context for activating patients' attachment needs.

By working with patients to mentalize the therapeutic relationship, we help them gain essential practice reflecting on mental states in an emotionally charged relational circumstance: accessing and representing a broader range of emotions surrounding the current relationship; remaining cognitively *and* emotionally attuned to subjective processes within us; and "holding onto their minds" under conditions where they tend to get stuck in unhelpful forms of non-reflectiveness (e.g., rigidity, concreteness, emotional disconnection, empathic deficits, overlooking their own interpersonal contributions in relationships). As patients begin to reflect in these ways, they experience a greater sense of self-continuity in the dyad, becoming less reliant on the self-enhancement strategies responsible for so many of their interpersonal challenges (Miller et al., 2007). Over time,

such developments generalize beyond the therapy. Patients are able to *understand* and *feel understood by* others, and to experience increased "epistemic trust" in their relationships, and in the broader relational world (Fonagy & Allison, 2014 ; Fonagy et al., 2015).

In Chapter 5 , we considered the key experiential contexts for mentalizing in psychotherapy practice: events outside of sessions, patients' engagement in the therapeutic activity, and the therapeutic relationship itself (pp. 95–100). Thus far, we have focused primarily on techniques for stimulating mentalizing around these first two experiential contexts: the "then and there" and the "here and now." Having now reviewed the full trajectory of interventions (i.e., mentalizing content, then context, and finally process), we can turn our attention to techniques for mentalizing this final experiential context: the here and now *with us* .

Here our technical repertoire is dramatically and fundamentally expanded. When examining patients' challenges in relationships in their everyday lives, we naturally focus on patients' *impressions* of themselves and others, working to stimulate reflectiveness always based on such impressions. Accordingly, our image of the other person in the situation is always second-hand, and several steps removed from the other party's lived experience. In contrast, when focusing on the therapeutic experiential context, we *are* the other person in the relationship. We do not simply have a "front row seat" to patients' relational patterns—we are right up there on the stage with them! We thus have access to *our* experience of patients in this interpersonal process, as well as our own psychological processes while we are engaging with them. The focus of mentalizing is now able to include *our* mental content (e.g., our impressions, emotions, desires); *our* context for these experiences (e.g., how patients interact with us, how we interact with them); and the process of how *we* relate to mental states in ourselves and patients (e.g., flexibly versus rigidly, psychologically versus concretely, authentically versus disconnectedly). With these additional vantage points at our disposal, we are optimally situated to help patients begin "to think about the relationship they are in at the current moment" (Bateman & Fonagy, 2016 , p. 275).

In this chapter, we will consider several foundational techniques for stimulating patients' reflection about the clinical interaction: relational tracers, interpersonal affect focus, and affective self-disclosure. In different ways, each of these techniques focus on specific circumstances that arise in

interpersonally focused work with patients. They might be seen as essential yet "auxiliary" relational strategies, as distinguished from our primary mentalizing the relationship interventions (Chapter 12), which we utilize for comprehensively exploring interpersonal processes and addressing challenges in mentalizing within the dyad. We will start by reviewing technical strategies that we do *not* tend to employ when working relationally in mentalization-based treatment for narcissism (MBT-N).

The "don'ts" of mentalizing the relationship in MBT for narcissism

Despite the importance of mentalizing the relationship in MBT-N, there are several clinical approaches that we tend to eschew when focusing on the therapeutic context (Box 11.1). First and foremost, in contrast with more traditional psychoanalytic conceptions of narcissism (Diamond et al., 2022 ; Kernberg, 1975 ; Kohut, 1977), we do not assume that disruptions or impasses stem primarily from patients' pathology or unconscious processes. Consistent with contemporary relational and intersubjective conceptions of psychoanalysis (Aron, 2013 ; Cooper, 2010 ; Drozek, 2019 ; Kuchuck, 2021), MBT presumes that the therapeutic situation is constituted by the bidirectional interaction of *two* subjectivities, both of which are continuously influencing and being influenced by the other, in ways that are often only implicit and difficult to fully ascertain by either party—a state of affairs MBT refers to as "two minds in the room." As Bateman and Fonagy (2016) observe, *our* psychology and behavior are perhaps just as responsible for challenges in the therapy as patients' psychology and behavior: "It is equally possible that the clinician has acted according to his/her own patters" (p. 279). Accordingly, MBT dispenses with terminology that situates therapeutic disruptions as originating primarily in patients: "distortions," "projection," "acting out," "splitting," "projective identification," and so on.

Furthermore, we avoid delivering any authoritative declarations about the content, meaning, and etiology of patients' psychological processes in the therapeutic interaction. As we have highlighted throughout this book, MBT's not-knowing stance affirms that mental states are inherently opaque, such that we can never fully know, with any degree of objectivity, what

another person is feeling or wanting. When applied to the clinical situation, this means that we have access only to our *impressions* of patients' experiences with us, not to what they are "actually" feeling and wanting, or to the deeper meaning of such processes.

Box 11.1 Dos and don'ts of mentalizing the relationship in MBT-N

DON’T

Assume that disruptions or impasses stem primarily from patients’ pathology or unconscious processes

Utilize terminology that situates therapeutic disruptions as originating primarily in patients: “distortions,” “projection,” “acting out,” “splitting,” “projective identification,” etc.

Categorize patients’ perceptions of the therapist as “inaccurate,” “irrational,” or “distorted”

Attribute our own feelings in the therapy to patients’ psychological dynamics

Causally link patients’ current experiences in the therapy to their past experiences in relationships

Employ theoretical constructs that blur the distinction between past and present (e.g., transference, countertransference, enactment, internalized object relationships)

Focus primarily or mostly on the therapeutic relationship across the treatment as a whole

Interpret patients’ comments as being “about” the therapeutic relationship when they are discussing their experiences outside of sessions

Mentalize the relationship when patients are emotionally dysregulated or upset

DO

Recognize that our own psychology and behavior are perhaps just as responsible for challenges in the therapy as patients' psychology and behavior
Consider that we can never possess objective knowledge about what we are "really" feeling in the therapeutic dynamic, and what is responsible for that
Examine our own emotions and desires as they might arise in relationship with patients
Explore patients' affective experience in the current moment and interaction
Prioritize patients' everyday lives and functionality, focusing on the therapeutic relationship when it is clinically relevant (e.g., situations of impasse or conflict; when relational patterns emerge that undermine the therapeutic process, or that parallel patients' interpersonal challenges outside of treatment)
Work to decrease patients' arousal levels when they are emotionally dysregulated, returning to mentalize the relationship when they are calmer and less distressed

The not-knowing stance applies equally to our own experiences in the therapeutic relationship. We have access only to our *perceptions* of our mental states, with no ability to step outside of ourselves and attain some objective vantage point on what we are "really" feeling, and what is responsible for that. For this reason, we would never categorize patients' perceptions of us as "inaccurate," "irrational," or "distorted"—designations that all imply a level of impartiality that is fundamentally beyond our reach.

Along similar lines, we do not tend to attribute our own feelings in the therapy to patients' psychological dynamics, whether conscious or unconscious. While such feelings are of course *about* and *related to* patients, they are also ultimately reflections of our own idiosyncratic personalities and psychologies, and so they often say more about *us* than they do patients. As Aron (1991) points out in his seminal psychoanalytic paper "The patient's experience of the analyst's subjectivity,"

> Referring to the analyst's total responsiveness with the term *countertransference* is a serious mistake because it perpetuates defining the analyst's experience in terms of the subjectivity of the patient. Thinking of the analyst's experience as "counter" or responsive to the patient's transference encourages the belief that the analyst's experience is reactive rather than subjective, emanating from the center of the analyst's psychic self. (p. 33)

Given MBT's appreciation of the separateness of minds, we avoid talking specifically about "countertransference" per se, instead focusing simply on therapists' own emotions and desires as they might arise in relationship with patients.

Moreover, as discussed in Chapter 7 , we do not tend to explicitly and causally link patients' current experiences in the therapy to their past experiences in relationships, either in childhood or throughout the lifespan. For example, we would not say, "You are experiencing me as a critical and controlling presence, in much the same way that you experienced your mother." Nor would we contextualize current interactions in terms of broader generalizations drawn from patients' histories: "You feel like the abandoned child who is seeking validation and care, while I seem like the self-centered parent who is neglecting you." MBT thus steers clear of offering what psychoanalysis refers to as "transference interpretations" or "genetic interpretations," also avoiding theoretical constructs that blur the distinction between past and present (e.g., transference, countertransference, enactment, internalized object relationships).

We forgo such history-focused interventions for a variety of reasons. Perhaps most importantly, patients can experience this approach as highly invalidating, as if we are saying, "The reason why you are experiencing me this way is because of some pathological factor in *you* , not because of anything problematic that I am actually doing." Furthermore, by attributing patients' current perceptions to their past experiences, we risk undermining rather than reinforcing what might be current adaptive mentalizing on patients' parts. As Bateman and Fonagy (2016) note, "Most experiences of the patient about the clinician are based on reality, even if on a partial connection to it or an exaggerated component" (p. 279). Additionally, historical interventions detract from what is perhaps most immediate and clinically relevant about mentalizing the therapeutic relationship. When starting to examine therapeutic interactions, patients often do not yet have a clear sense of what they are thinking and feeling, or what we are thinking and feeling. History-focused interventions tend to jump ahead of patients' mentalizing, emphasizing the "why" over the "what" of patients' mental

states. Such techniques risk encouraging pretend mode in patients, whereas they have a cognitive understanding of "the reason" why they are feeling something without actually *accessing and experiencing* their emotions and desires in the current interaction.

Across the treatment as a whole, we do not focus *primarily* on the therapeutic relationship in our work with patients. Admittedly, working "in the relationship" can be intense, exciting, and emotionally compelling, for patients and therapists alike. For therapists in particular, relational work is often *narcissistically* gratifying, especially when mentalizing patients' feelings that signify our value or importance in their lives (e.g., idealization, desires for attention or care, feelings of hurt or insecurity). However, we never want the therapeutic relationship to become "an end in itself," such that focusing on the treatment usurps an emphasis on patients' actual functioning and fulfillment in the world. As reviewed earlier, MBT-N is structured around shared treatment priorities, which reflect key spheres of experience (e.g., emotions, identity, relationships, functionality) in patients' lives. We can think of mentalizing the relationship techniques as akin to the secondary character in a movie—absolutely essential to moving the action forward, but always there to *support* the protagonist in the film. If these techniques receive too much screen time, we start to get concerned they might be "stealing the show" from the main character: patients' everyday lives and experiences! While there might be periods in the treatment when relational work is prioritized (e.g., situations of impasse or conflict with patients; when exploring patients' interpersonal patterns that are undermining therapeutic process), we explicitly "mark" these as the exception rather than the rule (*"This feels really important to me, so I think that we should spend some more time looking at this, if you are willing"*), and we return to a focus on the shared treatment priorities as soon as we can.

Relatedly, when patients are discussing their feelings and experiences about situations outside of sessions, we refrain from interpreting their comments as being "about" the therapeutic relationship. For example, we would not say, "You are expressing anger at your husband for not understanding you. Perhaps you feel like *I* am not understanding you in this relationship, and you are angry at me as well." Such interventions are overly "knowing," in that they problematically assert our own ideas about what patients are *really* feeling and wanting, rather than helping patients

elaborate their own mental states about the scenario. Such comments are also potentially inaccurate! In actuality, patients might simply be discussing a topic that is meaningful to them, and it might not be directly related to us in any way. This can be confusing and disorienting to patients, leading them to doubt the personal relevance of their communications to us: “I thought that I knew what was important to me about this situation, but maybe I was completely wrong.” Given the challenges with intellectualization and pretend mode associated with PN, we find it most effective to help patients become grounded in what *they* find emotionally meaningful about an experience (i.e., via content-focused interventions), prior to encouraging them to step outside the experience and considering its connection to other situations (i.e., via context-focused interventions).

Finally, we forgo mentalizing the therapeutic relationship when patients are more emotionally dysregulated or upset. We have suggested that patients’ ability to reflect on mental states is indirectly correlated to the extent of their emotional arousal (pp. 15, 87–88). Focusing on the therapeutic relationship can be especially stimulating for patients, given their sensitivity to power differentials in relationships, as well as their (often unmentalized) desires for approval and recognition from the therapist. In our experience, when patients are upset or agitated about some topic, they are often unable to productively and flexibly reflect on their experiences in the therapy, instead often falling into unhelpful states of defensiveness, agitation, paranoia, dismissiveness, inflexibility, or confusion. Accordingly, as proposed in Chapter 5 , we prioritize addressing patients’ emotional distress in these scenarios, usually by employing techniques like empathic validation, elaboration of cognitions (rather than affects), and assuming responsibility for our own role in the emotional disruption. Once patients have “cooled down” in the current moment, we are free to utilize the various techniques reviewed in the present two chapters (Chapters 11 & 12).

Relational tracers

As noted throughout this book, patients with PN can become consumed with the minutiae of interpersonal interactions, often focusing extensively on the behaviors and qualities of other people that they see as problematic

and unjust. In these moments, it can be challenging for patients to reflect on their own contributions to their challenges in relationships—the internal and behavioral tendencies they *carry into* their interactions, which impact how these interactions unfold, and how others experience them. This all places them at significant risk for reflexive action in their relationships, leading to difficulties with defensiveness, argumentativeness, interpersonal reactivity, and avoidance.

Relational tracers , also called "transference tracers" elsewhere in the MBT literature (Bateman & Fonagy, 2016 , pp. 269–272), are interventions geared toward helping patients reflect on their broader patterns and tendencies in relationships (Box 11.2). These techniques focus on highlighting parallels in behavioral/interpersonal patterns across the three main experiential contexts reviewed in this book: patients' lives outside of sessions, patients' manner of engaging in the therapeutic activity, and within the therapeutic relationship itself (pp. 95–100). Rather than imply any sort of causal linkages between these contexts (e.g., "Such-and-such past experiences are leading you to behave in such-and-such a way here"), we focus on *thematic* linkages across contexts: "Such-and-such thing happened over there, and such-and-such thing also might happen over here." These interventions work to stimulate patients' reflectiveness about the shape such parallels might take *(content-mentalizing)* , and about things that they and we might do to address any challenges that might arise under these circumstances *(context-mentalizing)* .

Box 11.2 Relational tracers in MBT for narcissism

Relational tracers are interventions that highlight parallels in behavioral/interpersonal patterns across experiential contexts.

Can variously focus on patients' lives outside of sessions, patients' manner of engaging in the therapeutic activity, and the therapeutic relationship itself

Aim is to stimulate patients' reflectiveness about the shape such parallels might take, and about effective approaches to address potential challenges. *Inbound* relational tracers link interpersonal patterns from patients' lives outside of sessions to their experiences within sessions.

First summarize the pattern in question, and then inquire about the potential relevance of the pattern to some other experiential context within the treatment.
Manner of engaging in sessions: *"It sounds like sometimes you try to stay away from certain emotions and desires in yourself, especially if they make you feel embarrassed or ashamed. Do you think that ever happens here, in the therapy?"*
The therapeutic relationship: *"So you can be quite argumentative sometimes—telling other people why* they *are wrong, and focusing less on the potential validity of their perspectives. Can you imagine that ever occurring between us?"*
Utilize context-focused interventions to stimulate patients' reflection about how to optimally address these challenges: *"What might be important for us to hold in mind, if this were to come up here?"*

Outbound relational tracers link patients' interpersonal/psychological tendencies within sessions to their patterns and experiences outside of the therapy.

First summarize the tendency in question, and then make some statement (e.g., asking a question, sharing an observation) geared toward stimulating patients' reflection about relevant experiences in their everyday lives.
Manner of engaging in sessions: *"In our meetings, we have noticed that, as soon as you access any desires for things from other people, you start to criticize and insult yourself for having these feelings. Is this something that happens in your life outside of here as well?"*
The therapeutic relationship: *"You're acknowledging that you can sometimes put me up on a pedestal, assuming that I have some special knowledge about how to fix your life. Have you ever seen this play out in any of your other relationships, outside of the therapy?"*

After encouraging patients' reflection on these matters, therapists can share their own conjectures.

Offered with tentativeness and curiosity: *"It comes across to me … ." "I wonder if . …" "I have noticed … ."*
Inbound tracers: *"You're noting that you can sometimes be quite avoidant in your relationship with your husband. If he ever feels like you should be doing something differently, you feel humiliated and ashamed, and you want to withdraw from him. I could imagine that potentially arising in our relationship as well … ."*
Outbound tracers: *"We are seeing how you can often become quite externally focused in our sessions: sharing a lot about what other people are doing wrong, and finding it more challenging to consider your feelings in those relationships. This makes me think about your relationship with your ex-wife … ."*
Explore patients' reactions to these proposals: *"What do you think of this idea?" "What comes up when I suggest this?" "Where do you go with all of this?"*

By considering these matters outside the heat of the moment, patients are more able to "reflect rather than reflex" in the context of relational instability, inside and outside of sessions: recognizing that the instability might be somehow related to their *psychological* processes, rather than veridical facts about the situation (e.g., another person's problematic or positive qualities, patients' own superiority or deficiencies); reflecting on

relevant mental states in themselves and the other party; and considering how they can optimally respond to these disturbances, in the moment that they are unfolding. As clinicians, relational tracers also enable us to be cognizant of the "interpersonal potholes" in the treatment, helping us to minimize unnecessary disruptions, and to engage with patients in a manner consistent with their unique needs and sensitivities.

MBT divides relational tracers into two broad categories: inbound tracers and outbound tracers (Bateman & Fonagy, 2016 , pp. 269–271). *Inbound* relational tracers link interpersonal patterns from patients' lives outside of sessions to their experiences within sessions. In this book, we have considered a range of strategies for identifying and articulating patients' patterns in relationships: exploring relational triggers, self-enhancement processes, and narcissistic disruptions during the evaluation phase (pp. 41–47); summarizing the trajectory of functional challenges when giving the diagnosis of pathological narcissism (pp. 47–51); outlining these tendencies in writing when delivering the MBT formulation (pp. 69–79); and reviewing broader behavioral and interpersonal approaches while implementing context-focused interventions (pp. 151–155). We tend to utilize relational tracers immediately following such interventions.

The interventional pathway involves first summarizing the pattern in question, and then inquiring about the potential relevance of the pattern to some other experiential context within the treatment. For example, we invite patients to reflect on the connection between the pattern and their manner of engaging in the session itself: "It sounds like sometimes you try to stay away from certain emotions and desires in yourself, especially if they make you feel embarrassed or ashamed. Do you think that ever happens here, in the therapy?" We can also ask directly about the significance of the pattern in the therapeutic relationship: "So you can be quite argumentative sometimes—telling other people why *they* are wrong, and focusing less on the potential validity of their perspectives. Can you imagine that ever occurring between us?" Of note, we can variously ask patients to consider such processes in the past (*"Has that ever cropped up here?"*), present (*"Could something like this be unfolding right now?"*), and future (*"What would it look like, if that were ever to arise in the treatment?"*).

In addition, we sometimes share our own ideas about the potential bearing of patients' relational tendencies to the treatment situation. We have

already attempted a preliminary version of this in the "Implications for the current treatment" section of the MBT formulation, where we cautiously forecast how patients' problems with mentalizing might manifest themselves in the therapeutic relationship. Along similar lines, we offer relational tracers with tentativeness and curiosity, explicitly framing them as reflecting our personal perspective (*"It comes across to me …"* ; *"I wonder if …"* ; *"I have noticed …"*), rather than authoritative declarations about patients. When focusing on patients' engagement in the therapeutic activity, we might say:

> "I really appreciate you noticing this about yourself: how you can sometimes get stuck 'in your head' about things, and find it more challenging to actually feel your feelings. I think that I've observed that a bit in our sessions together, especially when you talk about your relationship with your girlfriend. You share a lot about your ideas and insights about your relationship, but I hear so little about how you *feel* with her, and what you actually *want* when you are with her."

Or when considering the relevance of patients' relational patterns to the therapeutic relationship, we could aver:

> "You're noting that you can sometimes be quite avoidant in your relationship with your husband: if he ever feels like you should be doing something differently, you feel humiliated and ashamed, and you want to withdraw from him. I could imagine that potentially arising in our relationship as well. If I ever give you feedback about some area where you are struggling, I wonder if it might feel like I am criticizing you, and you could be tempted to withdraw from me in our work together."

Just as when we invite patients to reflect on their own relational tendencies, when offering our hypotheses about these matters, we can variously focus on the past (*"I have seen that in our relationship sometimes …"*), the present (*"This might be happening right now …"*), or the future (*"I could envision that happening here as well …"*), the latter of which takes the shape of a cautious "prediction" about how these processes might unfold in the treatment situation.

We explore patients' reactions to our proposals (*"What do you think of this idea?"* ; *"What comes up when I suggest this?"* ; *"Where do you go with all of this?"*), encouraging them to elaborate on potential areas of agreement and disagreement, and to share any further reflections. As always when conveying our perspective in MBT-N, our aim is not to convince patients to agree with the content of our views. Rather, we simply hope that patients *reckon* with our views about them, considering them

alongside their own experiences and thus moving toward a broader outlook on themselves as participants in this particular relationship.

If patients agree that some specific relational dynamic could potentially unfold in the therapy, we utilize context-focused interventions to stimulate their reflection about how to optimally address these challenges. We ask patients to identify objective markers of the pattern: “What will clue me in that you are struggling in this way?” Or: “How could we tell if this dynamic were starting to unfold here?” Through examining these matters with us, patients are able to maintain a greater level of awareness of their interpersonal processes in the dyad, enabling them to “catch” these processes as they unfold, and to approach them with greater curiosity and flexibility. These considerations also help *us* to recognize the shape these patterns might take, so that we can anticipate and call attention to them before they significantly interfere with the treatment.

Furthermore, we encourage patients to imagine steps they might take to address these difficulties: “Do you have any ideas about what you could do in these moments?” “If I were to offend you in this way, how could you let me know what was happening for you?” “What might be important for you to hold in mind, if this were to come up here?” “How could you approach an impasse like this in our relationship?” With these sorts of questions, we are not attempting to promote problem-solving, or to prescribe any particular behavioral interventions. Rather, consistent with the context-focused interventions reviewed in Chapter 7 , we hope to stimulate a reflective process around patients’ own sense of agency in their relationships, especially concerning their ability to manage complex interpersonal interactions. Such inquiries function as an imaginal “test drive” for challenging relational scenarios, increasing the chance that patients pause and reflect in the heat of the moment, when disruptions arise. We are also able to invoke these reflections later when mentalizing the relationship, if patients ever become entrenched in typical non-mentalizing responses.

> “I’m not sure if you remember, but when we were working on your formulation together, you had predicted that something like this might happen in the therapy: you would feel so mistreated by me that you might want to disengage, and leave the treatment entirely. At the time, you had thought that it might be useful to stick it out for a while, to understand how you could be trying ‘to get away from something’ by quitting the therapy. What would you think about trying out this approach right now?”

In addition, we invite patients to consider our optimal participation in such dynamics. “What would be most helpful for ME to do, if you were starting to feel insecure like that?” “Is there anything I should really avoid doing, that could make things worse?” We work with patients to elaborate their presumptions along these lines (*“How would that be helpful for you—if I were to prioritize validating your perspective, prior to sharing my own ideas?”*), explicitly expressing our willingness to attempt any approaches that we agree could bolster patients’ reflectiveness.

> “So you feel like, if you were ever to be more dismissive of my perspective, it might be useful for me to call your attention to that, since it is likely that you would not be fully aware that is happening in the moment. I would totally be willing to try that, although I would want to think more with you about how to do this in a way that does not feel critical to you.”

We can also share our own ideas about relational approaches we might employ, exploring patients’ reactions to these.

> “This is all making me think that, if I see you getting worked up and ‘arguing’ with what I am saying, it will be important for me to not just jump into the fray with you. I am wondering if it might be helpful for me to slow things down a bit, so that we can look into what was happening in our interaction that could be bringing up some feelings for you. What do you think that would be like for you, if I were to try that?”

Along similar lines, if patients agree with that a particular relational pattern could appear in the treatment, we often write a shared “mentalizing prescription” for that pattern—namely, recommending that *both* parties actively work to notice its potential emergence: “I was thinking that maybe this is something we need to remain aware of” (Bateman & Fonagy, 2016 , p. 271). Or: “What would you think about really trying to look out for this here? It could be beneficial for us both, so that these problems do not ‘sneak up on us’.” In these ways, we work to assume joint responsibility for monitoring, exploring, and navigating interpersonal processes in the dyad. This helps to create a culture of mutuality and collaboration around the therapeutic interaction: we are both continuously influencing and being influenced by the other person, and so both of us are responsible for managing the challenges that arise in this relationship.

Outbound relational tracers link patients’ interpersonal/psychological tendencies within sessions to their patterns and experiences outside of the therapy. Here the interventional trajectory involves first summarizing the tendency in question, and then making some statement (e.g., asking a

question, sharing an observation) geared toward stimulating patients' reflection about relevant experiences in their everyday lives. For example, when attempting outbound interventions focusing on patients' engagement in the therapeutic activity, we could state:

> "In our meetings, we have noticed that, as soon as you access any desires for things from other people, you criticize and insult yourself for having these feelings. 'I shouldn't need attention or care from anyone else.' 'I'm pathetic for wanting them to like me.' *[summary of previously identified pattern in sessions]* Is this something that happens in your life outside of here as well *[inquiry about parallel experiences in everyday life]* ?"

In addition, after examining a particular relational pattern unfolding in the therapeutic interaction (e.g., when utilizing techniques for mentalizing the relationship), we might observe:

> "You're acknowledging that you can sometimes put me up on a pedestal, assuming that I have some special knowledge about how to fix your life. You always seek my opinion about your work situation, rather than asking yourself what is important to *you* in your career: your hopes, aspirations, and values. *[summary of previously identified relational pattern in the treatment]* Have you ever seen this play out in any of your other relationships, outside of the therapy *[inquiry about parallel experiences in everyday life]* ?"

Similar to inbound relational tracers, we can inquire about patients' parallel life experiences in the past (*"Did you ever observe interactions like this in your marriage?"*), present (*"Does anything similar unfold for you at work?"*), and future (*"Could you imagine these dynamics happening in your new relationship, as things get more serious with your girlfriend?"*).

If patients confirm the potential relevance of the pattern to their lives outside of sessions, we utilize content-focused interventions (e.g., clarification, affect elaboration) to help them examine the core elements of the pattern (*"You really judge yourself for wanting recognition for your academic achievements. What comes up for you around this?"* ; *"So you have seen this pattern in your relationship with your boss as well. Could you share a recent example of this?"*). We also employ context-focused interventions to explore and articulate patients' broader behavioral and interpersonal tendencies along these lines: inquiring about precipitants, feeling states, behaviors, and consequences involved in patients' interpersonal processes; providing feedback about general relational patterns; and helping patients to reflect more expansively on the pattern itself (pp. 151–155).

Finally, we share our own observations about the potential bearing of patients' in-session experiences to their lives outside of sessions. We start by summarizing some pattern that we have already discussed and examined with patients; we cautiously share our own observations about situations and relationships in patients' lives where analogous patterns might have occurred; and finally, we explore patients' reflections and reactions to our proposals. For example, when offering feedback about patients' engagement in the therapeutic activity, we could note:

> "We are seeing how you can often become quite externally focused in our sessions: sharing a lot about what other people are doing wrong, and finding it more challenging to consider your feelings in those relationships, and how you are engaging in them *[summary of previously identified pattern in sessions]* . This makes me think about your relationship with your ex-wife, where you were extremely focused on her problematic behavior and qualities, and less attentive to how you were communicating with her *[tentative observation about parallel experiences in everyday life]* . Do you see any similarities between these things *[invitation for patient's reflections/reactions]* ?"

Or when delivering an outbound relational tracer about the therapeutic relationship, we might say:

> "We've begun to notice how you can feel a bit sensitive to criticism in our relationship—feeling like I am always judging you, and often 'holding back' information about yourself if you think that I might look down on you or criticize you for something *[summary of previously identified relational pattern in sessions]* . This reminds me of your relationship with your boss, where you have felt so worried that he might see you in a negative light, such that you don't give him updates about your projects if you think he might be disappointed with how much you have accomplished *[tentative observation about parallel relational patterns outside of therapy]* . What do you think about this *[invitation for patient's reflections/reactions]* ?"

As with all relational tracers, we can focus these conjectures on past situations ("I seem to recall something similar unfolding between you and your best friend …"), current circumstances ("This sounds similar to what happens in your relationship with your siblings …"), and future experiential contexts ("I wonder if this could ever come up at your new job …"). Over the course of treatment, these outbound interventions help patients to "generalize" the relational work in therapy to their everyday lives. As patients practice mentalizing in emotionally charged scenarios in sessions, and as they recognize the connections between these scenarios and their patterns outside of treatment, they develop an expanded ability to reflect on

mental states in challenging interpersonal interactions, and in the relationships that matter most to them.

Interpersonal affect focus

As other authors have noted, so much of the interactional process in psychotherapy unfolds only implicitly, outside of the conscious awareness of both therapist and patient (Boston Change Process Study Group, 2010 ; Schore, 2011). Through a range of verbal and non-verbal processes, each person is continuously influencing the other, while simultaneously registering and thus being influenced by the verbal and non-verbal contributions of the other party. As the Boston Change Process Study Group (2002) explains: "Although the therapeutic medium is linguistic, the interactions we observe here and the patterns that emerge are largely implicit, in that *much of what transpires does not enter reflective consciousness* " (p. 1053). The content of the dialogue is thus only the tip of the relational iceberg in treatment, with significant interpersonal dynamics operating without the deliberate attention of either party.

These observations have significant implications for mentalizing the therapeutic relationship. As reviewed in Chapter 5 , mentalizing can only occur in relation to some specific context of experience, which is clear and understandable enough to serve as the focus of joint attention. To the degree that therapist and patient are reflexively reacting to some relational event of which they are only vaguely aware, it will be nearly impossible for them to fully mentalize Self and Other surrounding the issue in question. Bateman and Fonagy (2016) describe these implicit dynamics as follows:

> The affect focus refers to the "atmosphere" or "shared affect" between patient and clinician which is present in a session. It is the "elephant in the room," that is, something that is apparent in the interpersonal/relational domain but is unexpressed. It is an aspect of implicit mentalizing that is influencing the interaction but is hidden and unstated. (p. 255)

These observations are especially relevant in the treatment of pathological narcissism. Patients with PN can often struggle to understand what they and others are feeling, and how these feelings are related to the nuances of interactions in relationships. By helping patients to recognize these implicit dynamics, we enable them to deepen their experience of emotions in

themselves and others, and to gain practice reflecting on the connection between these feelings and the current relational context.

In MBT-N, these implicit processes can be defined as some event or series of events in the therapeutic relationship (a) that both parties have observed, if not explicitly acknowledged at the time, and (b) to which both parties are currently having some sort of emotional reaction. In these respects, the processes in question are in principle "shared," but that does not imply that both people are having an *identical* emotional reaction to the situation. Three different types of interpersonal scenarios deserve mention along these lines. First, the patient might mention some meaningful event in their lives outside of sessions (e.g., interpersonal conflicts, engagement in some problem behavior, difficulties with suicidality), and therapist and patient both have an unspoken affective response to this. For example, a patient with alcohol use disorder, who had been pursuing sobriety for the past year, mentioned in passing that he "had a beer with some friends" on Saturday night. The session proceeded without further discussion of this, but the therapist felt internally quite anxious, given the severity of the patient's drinking in the past. In turn, the patient was worried that the therapist would be disappointed in him for the relapse.

Secondly, some discreet event might unfold during the session (e.g., one or both parties speak, act, or express themselves in a manner that seems interpersonally significant), to which therapist and patient both have unexpressed subjective responses. For example, when discussing his interpersonal challenges at work, one patient became upset with his therapist's efforts to explore his feelings about the situation, leading him to raise his voice and swear at the therapist. The conversation moved on, but the therapist felt hurt and intimidated by the patient, and the patient felt guilty about responding so aggressively, a pattern that occurred regularly in his conflicts with co-workers. In another instance, when a patient was sharing about a painful interaction with one of her children, the therapist became visibly tearful, which had never happened in the therapy before. While neither party acknowledged this, the therapist felt embarrassed about the emotional display, and worried that the patient would see this as unprofessional. In turn, the patient felt quite moved and validated by the therapist's emotionality, but also worried that something was occurring in the therapist's personal life that might have triggered this.

Finally, therapist and patient mutually participate in some tacit, bidirectional interpersonal exchange, and both parties experience affective responses in these interactions. While such exchanges can be isolated incidents, they often unfold recurrently across time. For example, one patient regularly struggles with argumentativeness and superiority in his relationship with his wife. Within sessions, whenever the therapist offers a divergent viewpoint about the topic under discussion, the patient responds defensively and dismissively, itemizing all of the reasons why the therapist's perspective is incorrect. In these moments, the therapist often feels insulted, and insecure that she has nothing of value to offer to the patient; and the patient feels angry and ashamed, assuming that the therapist is criticizing him when offering her independent perspective. Another patient provides regular updates about her academic successes, and the therapist responds by praising and complimenting the achievement in question. The "emotional subtext" of these interactions, which is never explicitly named, is the patient's desire for approval from the therapist, as well as the therapist's wish to maintain a sense of equilibrium in the relationship, which he worries would be disrupted if he is insufficiently validating of the patient.

In response to these scenarios, we utilize a stepwise technique that MBT designates as the *interpersonal affect focus* , or more colloquially "the elephant in the room" technique (Box 11.3). Taken as a whole, these interventions work to explicate implicit processes in the therapeutic dynamic, first at the level of facts and then at the level of feelings. The initial step involves defining the implicit experiential context (pp. 95–100). We simply describe the objective, shared aspects of the therapeutic interaction that until now have remained unarticulated. At this stage, we refrain from hypothesizing about patients' emotions in the dynamic, and we do not yet disclose any of our own affects or desires. The aim is simply to communicate our impression about a potentially meaningful aspect of the interpersonal process, and thus to develop a shared point of focus with the patient, prior to delving into anyone's subjective responses. In order to examine the elephant in the room, we first need to acknowledge the elephant!

Box 11.3 Interpersonal affect focus in MBT for narcissism

The interpersonal affect focus technique works to explicate implicit processes in the therapeutic dynamic, first at the level of facts and then at the level of feelings.
Utilized in three different interpersonal scenarios:

The patient mentions some meaningful event in their lives outside of sessions, and therapist and patient both have an unspoken affective response to this.
Some discreet event unfolds during the session (e.g., one or both parties speak, act, or express themselves in a manner that seems interpersonally significant), to which therapist and patient both have unexpressed subjective responses.
Therapist and patient mutually participate in some tacit, bidirectional interpersonal exchange, and both parties experience affective responses in these interactions.

The first step involves describing the objective, shared aspects of the therapeutic interaction that until now have remained unarticulated.

“I was hoping to return to something that happened earlier in the session. When we were discussing your conflict with your colleague, you raised your voice a bit and started criticizing me.”

Utilize affect elaboration techniques to help patients reflect on their emotions surrounding the specific relational event.

“What emotions did you experience, after you ended up raising your voice at me?”

Therapists express their own feeling states in relation to the newly identified relational event.

“On my end, I felt a bit hurt that you spoke to me in that way. I felt like I was really trying to help you, but you didn’t seem to be recognizing that.”
Invite patients to share their reactions to these disclosures: *“What comes up for you when I say this?”*

Encourage patients to reflect on the process of mutual sharing more broadly, and the meaning that this holds for them personally.

“What parts of this feel most important to you?”
“What are your take-aways here?”
“Where does this all leave you?”

In scenarios where patients have mentioned a meaningful event in their lives outside of session, we summarize patients’ description of the event. “A couple of minutes ago, I heard you mention that you ‘had a beer with some friends’ on Saturday night.” When some discreet event has unfolded in the session itself, we attempt to detail the concrete aspects of the event. “I was hoping to return to something that happened earlier in the session. When we were discussing your conflict with your colleague, you raised your voice a bit and said that I was being ‘a fucking asshole’.” Or: “I’m not sure if you noticed this, but back when you were sharing about your relationship with your daughter, I ended up becoming quite emotional.”

When attempting to highlight an interpersonal exchange that has unfolded in session, we describe our behaviors and patients’ behaviors in the interaction. Even if the dynamic tends to unfold regularly, we focus on a single, most recent example of the pattern. As always in MBT-N, we try to steer clear of abstractions with patients, instead remaining grounded in the immediacy of the affective moment, and the nuances of the specific interpersonal interaction. “If it’s OK, I wanted to get back to something that happened when we were discussing your recent argument with your wife. I shared my perspective about what she might have been feeling in the argument, and you proceeded to list all of the reasons why you thought I was wrong about this.” “I don’t know if you remember this, but back when you told me about all of your recent academic successes (e.g., earning straight A’s, getting the new internship, receiving all of that positive feedback from your professor), I ended up responding by complimenting you, and talking about how impressed I was with everything you are accomplishing.”

In most cases, if we have been careful to articulate only the objective aspects of the previous interaction (i.e., withholding any mention of internal processes), most patients will readily agree with our portrayal of the circumstance in question. When patients take issue with our manner of describing the interchange, we work with them to collaboratively revise the depiction, to ensure that both parties feel like they are looking at the same

picture of reality. “I see, so you were not trying to tell me I was wrong. You were just sharing your own opinion that your wife is not really hurt by your comments, and you were reviewing all of the things she has said supporting that view.”

We then utilize affect elaboration techniques to help patients reflect on their emotions surrounding the specific relational event. These techniques can variously focus on patients’ emotions before, during, or after that event. Continuing with the examples reviewed in this section, we might say:

“Leading up to our session today, how were you feeling about telling me you had been drinking with your friends?”
“When I started to tear up, what was that like for you?”
“What emotions did you experience, after you raised your voice at me?”
“What was coming up for you, as I was empathizing with your wife’s perspective back there?”
“What were you hoping for, while you were telling me about all of these recent successes?”

If patients are able to acknowledge any emotions or desires related to these interactions, we empathically validate these feelings and invite them to expound on them further: “You were a bit worried about what I might think about you for relapsing. What were you worried I might think?” “Oh, that is so important: you felt quite angry at me, like I was taking your wife’s side over yours. Can you say more about that anger?”

Consistent with the affect elaboration techniques reviewed in Chapter 6 , we also ask questions about additional internal processes (e.g., other affects, desires, or self-states) potentially relevant to the situation under discussion, in the hopes that patients might progressively reflect on a broader array of feeling states in the current relationship. “So you were worried that I would judge you and look down on you for relapsing. Did *you* happen to have any concerns about starting to drink again?” “In addition to anger, did any other feelings come up for you, when you felt like I was aligning myself with your wife, instead of you?”

If patients deny any emotions surrounding the issue in question, we do not tend to push the matter. We refrain from insisting that such feelings “must” be present, or from attempting to convince patients that a particular interaction is affectively meaningful for them. Such approaches assume a

level of authority about mental states that we eschew in MBT-N, emphasizing *our* mentalizing rather than attempting to stimulate patients' own reflections about mental states, independently of the particular content we are espousing.

Whether or not patients articulate their emotional experience here, we proceed to express our own feeling states in relation to the newly identified relational event. As relevant, we can identify our emotions before, during, or after the event in question.

"To be honest, I feel pretty concerned about you starting to drink again. Things escalated so quickly the last time that you tried this. I am afraid that you could really harm yourself."
"On my end, I felt a bit hurt that you spoke to me in that way. I felt like I was trying to help you, but you didn't seem to be recognizing that."
"I was quite moved when you were sharing about your relationship with your daughter. You two have been through so much together, and you have worked extremely hard to improve your relationship. Afterwards, I felt self-conscious, worried that it could come across as unprofessional for me to be crying in session."
"When you responded to me in that way, I felt somewhat insulted, and maybe even a little insecure. It didn't seem to me like you were even *considering* what I was saying, which made me wonder how I was going to be able to help you."
"I really appreciate that you share so openly about your academic achievements, since I know how important they are to you. At the same time, I am realizing that I feel some pressure in these interactions. I worry that, if I am not explicitly validating enough of your successes, you might feel rejected by me, and it could disrupt our relationship."

By sharing our internal experiences in these ways, we invite patients to consider *our* response to the "elephant in the room," without assuming or implying that patients themselves are primarily responsible for these responses. This sharing allows patients to adopt a more mentalized stance in the therapeutic dynamic, since they can then reckon with our independent mind states about the formerly implicit relational process. Along these lines, we invite patients to share their reactions to our disclosures ("*What comes up for you when I say this?*" ; "*Where does your mind go as I share*

these feelings"), exploring and elaborating their reflections along these lines. "So you feel surprised that you hurt my feelings, and also guilty for snapping at me in that way. What about this makes you feel so guilty?"

Finally, we conclude the process of interpersonal affect focus by encouraging patients to reflect more broadly on the process of mutual sharing, and the meaning that this holds for them personally. "What parts of this feel most important to you?" "What are your take-aways here?" "Where does this all leave you?" In many cases, these discussions reveal more meaty, significant emotions and interpersonal patterns, which bear relevance to the treatment more broadly and to patients' lives as a whole. Now that such processes are explicitly "in the room" between us and patients, we can proceed to utilize the more complex techniques for mentalizing the therapeutic relationship, reviewed in Chapter 12 .

As Bateman and Fonagy (2016) write, "The affect focus indicates that the unspoken can be spoken, that it is safe to share emotional aspects of relationships and check out personal understanding of an element of the relationship" (p. 256). By shining a spotlight onto implicit dynamics, we help to increase the depth and complexity of our dialogue with patients, allowing for a greater degree of reflectiveness and connectedness in the therapeutic relationship.

Affective self-disclosure

As we discussed in Chapter 2 , patients with PN often experience challenges with what might be called "self-focus" or "self-centeredness" in interpersonal relationships: diminished empathic capacities (Leunissen et al., 2017); difficulties recognizing emotions in others (Fossati et al., 2017); cognitive empathy with impaired emotional empathy (Jonason & Krause, 2013); and a reduced ability to assume others' perspectives, which can lead to decreased altruism and generosity in relationships (Böckler et al., 2017). As Baskin-Sommers and colleagues suggest (2014), rather than categorically lacking empathy for other people, patients with PN are likely to experience context-dependent disruptions in empathic capacities, especially influenced by fluctuations in their sense of self-esteem:

> Narcissistic people may be able to appropriately empathize when feeling in control, that is when their self-esteem is enhanced and when displaying empathy is in their best self-interest. On the other hand, opportunities for self-enhancement or situations that may expose compromised emotion tolerance can result in self-serving empathic disengagement. (p. 327)

These deficits contribute to many of the harmful interpersonal approaches associated with PN (e.g., arrogance, aggression, argumentativeness, dismissiveness, entitlement, competitiveness), wherein the needs and rights of *other people* are less prominent in patients' psychological landscape. Such problems are often not readily apparent at the start of relationships, when patients are usually actively working to maintain others' positive opinions of them. This gives rise to the *appearance* of mutuality in relationships. However, as relationships develop and people are naturally less validating of patients, the fault lines for patients' empathic vulnerabilities are progressively revealed: the ways in which patients can struggle to fully value and care about other people for their own sake, regardless of whether they are satisfying patients' own needs for self-esteem. Over time, people gradually withdraw from patients, leading to emotional distance, alienation, and the destruction of relationships—all common precipitants to patients seeking treatment in the first place.

The above challenges underscore the essential importance of self-disclosure of therapists' feeling states in MBT-N. For ease of reference, we refer to this technique as *affective* self-disclosure, referring specifically to our efforts to identify and explicitly communicate our own emotions, desires, and self-states that arise during the therapeutic encounter. We distinguish this technique from *autobiographical* self-disclosure, or the communication of objective facts about ourselves (e.g., involving personal history, demographic information, living situation, family constellation) to patients. As a treatment approach, MBT-N does not tend to involve extensive autobiographical disclosures, although this varies depending on the preferences, personality, and individual style of the particular clinician.

In our experience, affective self-disclosure helps to cultivate a culture of reciprocity and mutual sharing in the treatment, where both parties work to express their feelings and desires, and over time to empathically resonate with what is shared. Patients thus gain experience recognizing and resonating with our feeling states, while also considering their own agency in influencing those states. As the therapy unfolds, these processes enable

patients to transition from more self-centered forms of relatedness, and to develop greater capacities for mutuality, reciprocity, and empathic concern. Choi-Kain and colleagues (2022) refer to these evolutions as the trajectory "from me-mode to we-mode" in the treatment of narcissism:

> After entering "me-mode," where the patient perceives their own intersubjectivity, the patient can entertain the personal perspectives of others, in we-mode, to enrich their appreciation of reality and other people. … Epistemic trust and learning from others becomes possible. (p. 42)

In our experience, no specific clinical circumstances are required to utilize affective self-disclosure in MBT-N. On the most basic level, such disclosures are a natural extension of MBT's supposition of "two minds in the room": two full human beings experiencing a wide range of thoughts and feelings in the therapeutic interaction, with both people registering and "taking in" the other person, while simultaneously reflecting upon and communicating their own mental states arising throughout the process. Whenever we express our own emotions or desires in the treatment, we are affirming ourselves as "another mind" with distinct feelings, experiences, and perspectives.

At the same time, there are a handful of scenarios where we find affective self-disclosure especially helpful. As discussed in Chapter 8 , when patients are struggling with disconnection from authentic emotional states in themselves and others, we often utilize an emotion-focused challenge: explicitly disclosing our own affects in the present moment, or expressing our emotions through some non-verbal means (e.g., tone or volume of voice, body language). In particular, if patients appear to be disconnected from a specific feeling that we happen to be actively experiencing at the moment (e.g., sadness, fear, frustration toward someone in their lives), we often disclose our emotions to patients, in order to "deepen the affect" in the room and model a more engaged emotional experience. Affective self-disclosure can also be useful when patients seem to be circling around a narrower range of affects in the therapeutic dialogue (e.g., anger, anxiety, shame), and we are experiencing notably discrepant feeling states. Such disclosures can serve as something of a counterintuitive "mini challenge" to patients, helping them to consider a greater complexity of feelings about the same event, and thus to reapproach their own original experience from a different vantage point.

In addition, we can utilize affective self-disclosure as a contingent expression of care, support, and empathy toward patients, for example when we express joy and excitement about patients' successes, or sadness in response to patients' losses or setbacks. We also often communicate our feelings when patients describe experiences outside of sessions to which we are having some sort of emotional reaction. For instance, we might share our concern about patients' binge eating, or our happiness about their improved flexibility and functionality at work. Moreover, we can employ these techniques to reinforce positive mentalizing, such as when we express affirming emotions (e.g., excitement, relief, happiness, admiration, gratitude) in response to patients' enhanced reflectiveness around mental states in themselves and others: increased ability to identify and contextualize emotions and desires; greater flexibility and psychological mindedness; improved ability to experientially access their own emotions; and expanded empathy and compassion toward other people.

Affective self-disclosure plays a unique role when we recognize emotions in ourselves that directly involve the therapeutic dynamic. We might choose to disclosure our feelings when they are potentially interfering with the therapeutic process itself, for example when we feel frustrated with patients' manner of relating to the frame of the treatment (e.g., arriving late, not paying their bills, not following the crisis plan), or concern about patients' engagement in the therapeutic activity (e.g., avoiding certain topics, dismissing particular emotions, failing to consider their own contributions in relationships). In addition, we often experience emotions in relation to specific interpersonal approaches that patients employ in sessions. For example, we might feel frustrated with patients' argumentativeness, worried about patients' apathy, or insecure about patients' devaluation of us. By sharing these feelings, we help patients to reflect further on their own behavioral/interpersonal approaches arising in the treatment, as well as the potential impact those approaches have on how we feel when we are with them, and how we experience them as individuals. As Bateman and Fonagy (2016) suggest:

> The patient needs to be able to accurately monitor feeling states in other people and recognize his/her part in creating those states. To encourage this process, the clinician openly communicates what is in his/her mind when it is relevant to the patient–clinician interaction. (p. 282)

On this view, affective disclosures can spur patients to consider their interpersonal approaches more broadly, as well as their own role in influencing the mental states of other people.

At the level of technique, we can disclose our emotions concerning any of the three experiential contexts for mentalizing reviewed in this book: patients' lives outside of sessions, patients' engagement in the therapeutic activity, and the therapeutic relationship itself (pp. 95–100). Several core principles guide our approach, outlined in Box 11.4 . By and large, we always attempt to explore patients' feelings about some topic *prior* to sharing our own emotions and desires. This is consistent with the emphasis on contingency over markedness in MBT-N, where we prioritize elaborating and affirming patients' subjective states, before introducing more discrepant viewpoints. In this way, we ensure that we are approaching these discussions with our "eyes wide open," possessing some understanding of patients' emotional relationship to the topic in question. In most cases, our emotional experience of a situation is significantly influenced by hearing patients share in detail about *their* emotional experience of that situation. For example, our affective response would be quite different if a patient feels guilty and ashamed after an aggressive outburst at work, versus if the patient expresses mostly anger, contempt, and entitlement surrounding the conflict. Furthermore, we require information about patients' affective states in order to consider how to frame and deliver our self-disclosures most effectively. For instance, if we are aware that a patient is feeling more insecure or self-conscious about some topic, we will likely want to temper or postpone the affective self-disclosure itself, or to offer some preparatory comments to "cushion the blow" of the intervention ("*I am not sure how you are going to feel about this . . .*").

Box 11.4 Affective self-disclosure in MBT for narcissism

Affective self-disclosure refers to therapists' efforts to identify and explicitly communicate their emotions, desires, and self-states that arise during the therapeutic encounter.

Therapists disclose feeling states in relation to the three experiential contexts: patients' lives outside of sessions, patients' engagement in the therapeutic activity, and the therapeutic relationship itself.

Therapists explore patients' feelings about some topic prior to sharing their own emotions and desires.

Therapists identify and privately "put words on" their feelings about the issue in question.

Consider the question: "To what extent would it be helpful for me to explicitly share my feelings, given patients' mentalizing capacities at this specific moment in the session?"

If relevant, cautiously forecast patients' potential response: *"I think that I've identified some emotions in myself about this situation, but I'm aware this could be challenging for you to hear."*

Articulate the emotional experience in relation to the experiential context in question.

Outside of sessions: *"I'm realizing that I've been feeling a bit concerned about your wife, and the impact that these arguments could be having on her."*

Engagement in the therapeutic activity: *"As soon as you started to reflect on your own desires, I felt much more engaged with you, and connected to you."*

The therapeutic relationship: *"When you dismiss my perspective, I can sometimes end up feeling insecure, like I have nothing of value to offer you."*

Explore and examine patients' reactions to the self-disclosure.

If requested, elaborate further on the expressed affects: *"In my experience, my anxiety arises most strongly when you … ."*

Explore patients' emotions and reflections surrounding the self-disclosure: *"What come up for you as I share these feelings?"*

Encourage patients' reflection about their own role in the scenario in question: *"Have you noticed any actions you have taken, or any way of engaging with me, that could impact this aspect of our dynamic?"*

Once we have sufficiently appreciated patients' emotional experience, we seek to identify and privately "put words on" our own feelings about the issue in question, falling under the heading of affects (e.g., sadness, frustration, anxiety, guilt); desires (e.g., desire to argue with the patient, urge to take some action to keep the patient safe, wish to reassure or appease the patient); or self-states (e.g., insecurity, pride, shame). This of course entails essential content-focused mentalizing of ourselves—we cannot disclose our internal states unless we first have some sense of what those states are (pp. 55–56). Bateman and Fonagy (2016) explain, "The clinician must identify the feeling itself or, at least, be able to talk about it coherently while working it out" (p. 283).

Next we ask ourselves the question: to what extent would it be helpful for us to explicitly share our feelings, given patients' mentalizing capacities at this specific moment in the session? While it is impossible to answer such a question with any degree of certainty, several considerations hold sway in our reflections. In general, we feel free to engage in affective self-disclosure if we suspect that patients would be able to productively consider our feelings—to use them as an opportunity to further reflect on mental states in themselves, us, or other people beyond the treatment situation. Accordingly, we rarely engage in self-disclosure when patients are upset or affectively dysregulated, either in relation to us, the topic of the session, or events in their lives outside of the session. Instead, we utilize MBT's techniques for decreasing patients' arousal in such moments (e.g., empathic validation, cognitively oriented techniques, assuming responsibility for our role in the disruption; pp. 87–88), postponing self-disclosure until patients are less emotionally activated. Similarly, if we expect that sharing a particular feeling could be too destabilizing for patients (e.g., causing excessive anxiety, anger, or shame), we consider "quarantining" the feeling in question, waiting to disclose until patients are more able to engage in flexible, collaborative reflection around the topic area (Bateman & Fonagy, 2016 , p. 282).

Conversely, it sometimes feels clinically pressing and even imperative to engage in the self-disclosure, for example when we are especially worried about patients' safety or functionality; when we are struggling with emotions that threaten to undermine the treatment (e.g., anger, significant anxiety, desires to placate patients); or when a highly unreflective relational dynamic appears to be dominating the therapeutic relationship (e.g.,

involving paranoia, aggression, extreme idealization, or eroticized elements). In such cases, it is sometimes necessary to engage in self-disclosure in order to safeguard the viability of the therapy, even if we risk disturbing or dysregulating patients in the process.

If we decide to communicate our internal experience to patients, and we expect that the disclosure could generate challenging emotions in patients, we cautiously forecast patients' potential response (Bateman & Fonagy, 2016 , pp. 282–283). We offer these predictions in a non-authoritative manner that clearly "marks" them as an expression of our own personal wonderings and concerns, rather than as confident declarations about patients' reactions. For example, we might say, "I think that I've identified some emotions in myself about this situation, but I'm aware this could be upsetting for you to hear." Or: "I realize that how I am feeling about this is probably quite different from how you've been feeling." Additionally: "I have been a bit worried about sharing my feelings about this, since I'm not sure how this will land with you."

Regardless of their specific content, these conjectures serve as an invitation for intersubjective reflection about mental states surrounding the affective self-disclosure. With them, we are essentially communicating to patients: *I have been thinking about your mind, and I am having some feelings about where your mind will go with what I am about to say.* At an emotional level, patients usually move to the "edge of their seats" in the interaction: *What is in the therapist's mind right now? What is in the therapist's mind about ME? And what is MY reaction going to be, once I hear?* This constitutes an enhanced process of mentalizing for patients, often enabling them to "take in" and reflect on our feelings, in a manner that often is not possible when we simply deliver distressing content into the therapeutic dialogue without warning. Once we offer our predictions, we give patients a chance to respond, sharing any reactions or reflections about their expected response to engaging with our affective experience.

With all of this preparatory work completed, how then do we go about communicating the affective states themselves? Our approach differs depending on the particular experiential context under discussion. When engaging in affective self-disclosure around patients' experiences outside of sessions, we can communicate our feelings about past events: "When you were describing that period when you were bullied in school, I found myself feeling quite sad." "I never said this at the time, but I was so worried

that you were going to get fired from your job." We share our emotions surrounding current events in patients' lives: "I am so happy for you—it really seems like things are starting to come together in your life." "I'm realizing that I've been feeling a bit concerned about your wife, and the impact that these arguments could be having on her." We also disclose our feelings about future circumstances outside of the treatment: "There's been so much build-up to this court hearing … I think that I'm feeling pretty anxious about how it is going to go." "I'm realizing that I would feel a lot less concerned about you if you had more support in your life: friends, a romantic partner . …"

Analogously, when sharing our emotions about patients' engagement in the therapeutic activity, we can focus on the past: "As soon as you started to reflect on your own desires, I felt much more engaged with you, and connected to you." "At the start of our work together, I used to get so frustrated when you would only talk about OTHER people's flaws and deficiencies, and very little about yourself." We disclose our subjective states about patient's present engagement in the treatment: "Whenever you criticize and make fun of yourself in sessions, I get this sinking feeling in my stomach." "Ever since you have started trying to access your emotions here, I have been feeling extremely hopeful about our work together." "When you focus so extensively on your wife's defects, I experience a strong desire to argue with you, to tell you all the reasons why you are wrong." Additionally, we express our internal processes surrounding patients' future participation in the therapeutic task: "Given how depressed you've been lately, I worry that it could be overwhelming for us to discuss your trauma today." "I think that, if you were to share about actual examples of your interactions with other people, I would feel relieved, like I am finally getting a picture of what your life is like on a daily basis."

Patients can respond to these disclosures in a variety of ways. In some cases, they ask further questions about the expressed affects themselves, and what is leading us to feel that way. We are free to respond by explaining more about the meaning and context of our emotions, as well as any "impressions" we might have in relation to them (e.g., about patients, other people, ourselves, or the therapeutic process; pp. 110–112). We explicitly frame these communications as expressions of our own personal viewpoints, without affirming that we have an objective vantage point on the issue in question. For example, after we have expressed our concern

about the impact of recent arguments on the patient's wife, we might elaborate:

> "I am aware that the relationship has always been quite rocky, with frequent argument and lots of tension. But recently, it has seemed to me that you have started to become quite aggressive toward her, even mean sometimes, in a way that feels somewhat different than before."

Or when we share about the "sinking feeling" when the patient criticizes herself, we could explain further, "Usually I feel like you are expressing something quite important and reasonable in these moments, and I find it kind of sad that you are judging yourself so negatively, and talking to yourself in such a cruel way." We then invite patients to share their reactions and reflections to these ideas. "What do you think of this?" "Where does your mind go as I give voice to these things?" "What comes up for you around this?"

At other times, patients proceed to share more about the specific experiential context referenced in our self-disclosure: providing further information about the situation; reflecting about mental states in themselves or other people; or considering the broader context of such feelings (e.g., how the situation impacts them, their own behaviors, other relevant emotions). For instance, the patient with marital conflict reflects on his wife's potential emotional response to these arguments, or the self-critical patient considers what she might be feeling when she is so drawn to devalue herself. Here the affective disclosure serves as a jumping off point for patients, an additional perspective that prompts them to reflect further on relevant mental states in themselves or others. We respond by inviting patients to elaborate further on their ideas. "You think your wife is starting to feel depressed … Depressed in what way?" "So you get kind of embarrassed when you identify your more vulnerable emotions here, and then it makes you feel better to start criticizing yourself. How does the self-criticism help with the embarrassment?"

On the other hand, patients sometimes respond by sharing their reactions to the expressed feeling itself, which usually involves shifting their focus to a more immediate experiential context. For example, the married patient might express his feelings of guilt for not considering his wife's feelings enough—a move from a peripheral experiential context to the "here and now" of the session. Or the aforementioned self-critical patient could share

that she feels comforted and connected to us in light of our disclosure—a shift from focusing on the therapeutic activity to the therapeutic relationship itself. We respond by inviting patients to elaborate further on these feelings: "What is it like to feel guilty in this way?" Or: "You mentioned feeling more 'connected' to me … What was it about my comment that made you feel that way?" If these explorations reveal substantive emotions related to more pressing or consequential processes in the therapeutic dynamic, we are prepared to transition to techniques for mentalizing the relationship in MBT-N, reviewed in Chapter 12 .

This brings us to the final experiential context for affective disclosure: the therapeutic relationship itself. Here we can focus on past experiences: "When we first started working together, I used to feel like I had to 'walk on eggshells' with you—that if I said the wrong thing, you would leave the treatment and never come back." "When you were criticizing yourself back there, I noticed a wish to reassure you, and to comfort you." We can share our feelings in the present: "I am feeling a bit frustrated with you right now." "When you dismiss my perspective, I can sometimes end up feeling insecure, like I have nothing of value to offer you." In addition, we can imagine our future or hypothetical experiences in the dyad: "If you were to start trying to 'take in' what I am saying before arguing with me, I suspect I would feel safer with you, and more connected to you." "In principle, I would like to be more challenging of you here, to 'push back' when you are being more antagonistic and close-minded. But I worry that your feelings could get hurt—you might withdraw and refuse to engage with me." In making these disclosures, we make sure to simply *describe* our feelings and their related impressions (e.g., of ourselves, of patients, of our interactions or dynamic with patients), without implying that patients are primarily "causing" us to experience things in the way that we are. Bateman and Fonagy (2016) explain:

> Counter-relationship experience expressed verbally by the clinician is an important aspect of therapy, but when it is being expressed it must be marked as an aspect of the clinician's state of mind. It should not be attributed to the patient, even though it may be a reaction to the patient. (p. 193)

We explore with patients their responses to these disclosures, in an open-ended way that does not initially direct patients to any particular aspect of the relationship (e.g., our experience, their experience, the interactions

between us). “What comes up for you as I express these feelings?” “Do you have any reflections about this?” “Where does your mind go with all of this?” Patients can respond to these questions in a range of different ways: asking us further questions about the affective disclosure (a potential sign of mentalizing our experience); discussing their emotions in the current moment of the session (e.g., in themselves, toward us); or reflecting further on the interactional process in question. We feel free to answer patients’ queries about our experience with additional marked reflections of our own (“*I suspect my anger might be related to …*” ; “*My sense of you in these moments is that you …*”), and to utilize content-focused techniques (e.g., empathic validation, affect elaboration) to help patients expand upon their own reactions, affects, and observations. “So you don’t really see yourself as arguing with me. It feels more like you are simply ‘explaining’ your perspective . …” “You feel ‘disturbed’ by the idea that I sometimes worry about upsetting you here. What feels so disturbing about that?”

In these explorations, we are especially interested in patients reflecting on their potential role in relevant interpersonal processes in the therapeutic dynamic: through taking certain actions; utilizing specific relational approaches; interpreting interactions in a particular way; or even by experiencing and maintaining certain subjective states in the relationship (e.g., affects, desires, attitudes). So if patients are able to spontaneously identify any such processes, we are prepared to shine a spotlight onto them and invite further elaboration of relevant emotions and interpersonal tendencies. “When I share my perspective here, you often worry that I am saying you are doing something wrong, and you end up getting quite ‘defensive.’ What is the emotion in there for you?” “So at the start of treatment, you would often become quite angry and impatient with me, and you were ready to quit the therapy at the drop of a hat. Do any examples come to mind?”

If patients do not spontaneously reflect on their contributions to the situation in question, we utilize context-focused interventions of patients’ relational patterns to help them consider these processes in the therapeutic relationship itself (pp. 151–155, 162–165). We offer our queries without specifying patients’ role in the situation, thus maintaining a not-knowing stance surrounding the etiology and meaning of our own emotional experience: “Is it mine, is it my representation of your mind state, or is it a combination of both?” (Bateman & Fonagy, 2016 , p. 192). For example,

we might ask, “Do you have a sense of anything in our relationship that might be contributing to me feeling this way?” “Have you noticed any actions you have taken, or any way of engaging with me, that could impact this aspect of our dynamic?” “I have shared a bit about my feelings around this issue, and how they come up for me here. Do you see yourself as having any part in all of this?”

We work with patients to unpack and examine their reflections along these lines, ultimately delivering a context-focused empathic summary that connects our expressed emotions to any relevant relational approaches that patients have identified throughout the discussion. This serves as a mini version of the summary statements about patients’ relational patterns reviewed in Chapter 7 , where we explore and recap the connection between patients’ behaviors and their interpersonal consequences (pp. 151–155). While we explicitly acknowledge the potential impact that patients are having on us, we make sure to frame patients’ actions as one of many contributing factors to our feelings. We do not want to abscond responsibility for our emotions, nor do we ever “blame” patients for processes that ultimately reside in us. For instance, we might say:

> “You do feel like you can be quite willful and stubborn in these discussions, with more of a desire to ‘prove me wrong’ than to take in and consider my perspective *[summary of patient’s previously expressed ideas about their relational contribution]* . I really appreciate you noticing that about yourself. This resonates with my experience of these moments, and also partially explains my feelings of insecurity in these interactions. I *do* feel wrong, in a way. *[balanced description of the potential impact of patient’s relational approach]* ”

Or in another example, we could summarize:

> “So on some level, you were hoping that, if you criticized and devalued yourself, I was going to respond by feeling sorry for you, and by telling you that you are not bad in the ways you were describing *[summary of patient’s previously expressed ideas about their relational contribution]* . This makes sense, and also sounds consistent with the feelings I described earlier: I really wanted to reassure you and comfort you back there *[balanced description of the potential impact of patient’s relational approach]* .”

At this phase of the interventional pathway, we are squarely in the terrain of considering patients’ interpersonal approaches in the dyad, as well as the potential impact those approaches have on us. In this way, our affective self-disclosures can reveal clinically significant relational patterns that warrant further examination, and so we are prepared to transition to techniques for mentalizing the therapeutic relationship itself (Chapter 12).

In many cases, patients react to our affective self-disclosures more dismissively: telling us that we *shouldn't* feel the way that we are feeling; attempting "talk us out of" our emotions; or even criticizing us for the experiences in question. This is a highly common interpersonal approach that patients employ in their relationships outside of treatment, especially when they are faced with other people's emotions that they experience as more threatening or aversive. This can have a corrosive impact on intimacy and connectedness. People end up feeling like there is no space for their emotions in their interactions with patients, resulting in challenges with withdrawal, estrangement, and animosity in close relationships.

We respond by empathically validating patients' perspectives here. "You feel like I should not worry about your alcohol use—you have it completely under control." "You don't think it's fair for me to be frustrated with you for missing these appointments, since you have had a valid reason every time." "This is just part of your communication style to argue with me, so I shouldn't feel hurt or concerned when you engage with me in this way." We then tend to "stop and stand" and simply affirm the original emotional experience expressed in the affective self-disclosure (Bateman & Fonagy, 2016, p. 193). "And yet I am still feeling *[previously expressed emotion]* , despite the fact that you are explaining all of these things." "I hear that you believe that I shouldn't feel this way, but nevertheless I do." We can also explore with patients their experiences of and reactions to these discrepant affective states: "What is it like to be engaging with me, when I am experiencing these emotions you see as invalid or irrational?" "So you feel quite strongly that I have nothing to be worried about. In spite of this, I continue to feel worried. So where does this leave us?"

If patients continue to argue with us rather than considering our subjectivity, we shift attention to the interactional process itself: explicitly naming that process (*"I have shared my concerns here, and you are spending a lot of time telling me that my feelings are invalid"*), and utilizing the more comprehensive techniques for mentalizing the therapeutic relationship. In the next chapter, we will review these interventions in detail.

12

Mentalizing the Therapeutic Relationship: The Interventional Pathway

In Chapter 11 , we reviewed techniques for addressing particular circumstances arising in the therapeutic relationship: examining parallels between relational processes inside and outside of the treatment *(relational tracers)* ; explicitly naming implicit processes in the dyad *(interpersonal affect focus)* ; and communicating our own emotions and desires arising in our interactions with patients *(affective self-disclosure)* . All of these strategies stop short of what we might call "full" mentalizing the relationship, which always involves a more mutual, detailed examination of the bidirectional processes unfolding in the therapeutic dynamic.

Common indicators for relational mentalizing include an interpersonal disruption, conflict, or tension with patients; a sense of "stuckness" in the therapy; persistently experiencing some subjective state that is likely relevant to patients' patterns outside of therapy (e.g., feelings of frustration and anger, desire to argue with or "punish" patients, a sense of boredom or disconnection); patients explicitly referring to us, the therapeutic relationship, or the treatment itself; the appearance of some relational approach described in the formulation (e.g., tendencies toward idealization, attention-seeking, superiority, argumentativeness, defensiveness, devaluation of others); recognizing an interpersonal dynamic not previously identified, which seems relevant to patients' challenges outside of the therapy; or the observation of a pattern that threatens to undermine patients' progress in the treatment (e.g., extreme dismissiveness, frequent missed appointments, potential dishonesty or misrepresentation).

The trajectory of mentalizing the relationship in mentalization-based treatment for narcissism (MBT-N) synthesizes many of the principles reviewed throughout this book so far: first exploring the content of patients' mental states surrounding the relational issue; then taking responsibility for

our role as the context of these mental states; and finally working to stimulate patients' reflection about forms of non-mentalizing related to the interpersonal scenario in question (see Figure 12.1). In this way, we "frontload" an exploration and validation of patients' experience of the situation. We reserve our perspective for later in the trajectory when delivering domain-specific interventions, which always involve some version of therapists sharing their experience of the matter under discussion.

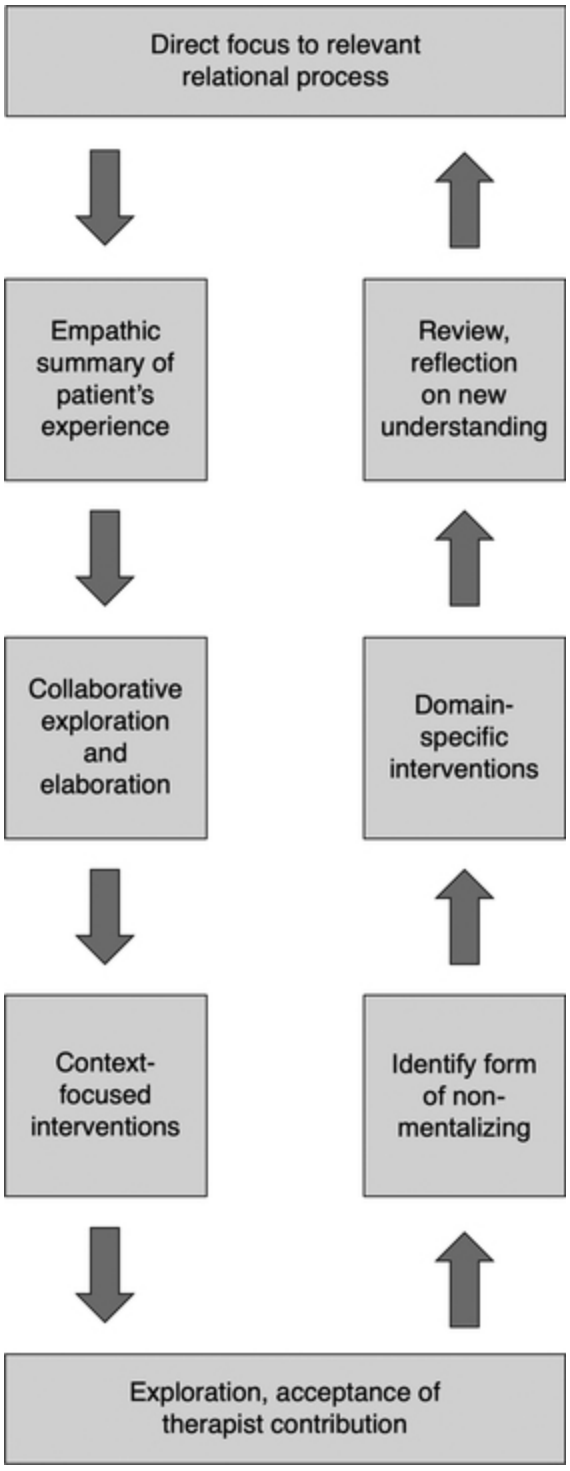

Figure 12.1 Steps for mentalizing the therapeutic relationship in MBT for narcissism. The therapist directs attention to the relevant (past or present) relational scenario, then exploring, contextualizing, and empathically validating the patient's experience of the issue in question. The therapist accepts responsibility for their role in the process, also employing MBT-N interventions to address remaining non-mentalized forms of thinking. The therapist invites further reflection on the new understanding that emerges, repeating these steps as needed for additional relational processes/events.

Direct focus to relevant relational process

The first step in the trajectory involves actively directing the sessional focus toward the relational issue we want to explore further (Box 12.1). In most cases, this will be some observable facet of the therapeutic relationship, either in the present moment or at some point in the past (e.g., earlier in the session, during some previous appointment where there was conflict or tension). We variously highlight some comment patients have made (*"You mentioned that you have been feeling angry with me since our last appointment. Is that something that we could talk about a bit more?"*); some non-verbal display from patients (e.g., facial expressions, eye contact, vocal tone, bodily posture or movements) that might be related to the current interchange (*"I'm noticing that you've been raising your voice, and moving forward to the edge of your seat, the longer that we talk about this"*); patients' manner of engaging with us (*"It strikes me that you've become a lot quieter the last several minutes: not really talking much, and only providing brief responses to my questions"*); a comment we have made that we suspect has impacted patients (*"Earlier in the session, I let you know that I would be raising my rates next month. I am wondering if we could go back to that moment?"*); or some interaction with patients that feels clinically meaningful (*"When I expressed my concerns about your binging and purging, you said that I 'could never understand' what you are going through, and you don't want to talk about this with me"*).

Box 12.1 Mentalizing the relationship: Directing focus to the relevant relational process

The first step in mentalizing the relationship involves actively directing the sessional focus toward the relational issue the therapist wants to explore further.
This is usually some observable facet of the therapeutic relationship, either in the present moment or at some point in the past. Can include

Some comment patients have made: *"You mentioned that you have been feeling angry with me since our last appointment. Is that something that we could talk about a bit more?"*
Some non-verbal display from patients: *"I'm noticing that you've been raising your voice, and moving forward to the edge of your seat, the longer that we talk about this."*
Patients' manner of engaging with the therapist: *"It strikes me that you've become a lot quieter the last several minutes: not really talking much, and only providing brief responses to my questions."*
Some comment by the therapist that might have impacted patients: *"Earlier in the session, I let you know that I would be raising my rates next month. I am wondering if we could go back to that moment?"*
Some interaction that feels clinically meaningful: *"When I expressed my concerns about your binging and purging, you said that I 'could never understand' what you are going through, and you don't want to talk about this with me."*

In identifying the relational focus, do NOT

Make proclamations about patients' mental states involving the processes in question: *"You are extremely angry with me right now."*
Offer any generalized observations about patients' behaviors or relational tendencies in sessions: *"In our discussions, you tend to … ."*
Link observations to patients' broader interpersonal patterns outside of the treatment: *"This reminds me of something that happens for you in romantic relationships … ."*

In keeping with MBT's not-knowing stance, we make no proclamations about patients' mental states involving the processes in question (*"You are extremely angry with me right now"* ; *"You are hoping that I will comfort you and reassure you, in the same way that your wife does"*), instead simply shining a spotlight onto a shared aspect of the clinical plane. In this

way, we work to define the joint attentional focus for the ensuing discussion, which will serve as the experiential context for mentalizing as we progress through the trajectory.

At this stage of the process, we avoid offering any generalized observations about patients' behaviors or relational tendencies in sessions (*"In our discussions, you tend to …"* ; *"When I give you feedback about something, you often respond by …"* ; *"I have observed this with you before …"*). Such comments are likely to pull for patients' abstract *ideas* about these processes (*pretend mode*), rather than encouraging patients to reflect on mental states in Self and Other in the immediacy of the specific, recent interaction. Similarly, we do not yet link our observations to patients' broader interpersonal patterns outside of the treatment (*"This reminds me of something that happens for you in romantic relationships …"*). Such an approach unfairly "stacks the deck" in the discussion, presuming in advance that the issue in question is primarily related to *patients'* relational challenges rather than our own. This can lead patients to feel unnecessarily defensive and on edge, shutting down the possibility of flexible reflection at this early stage of the process.

Collaborative exploration and elaboration

Next we explore patients' emotional experience of the issue under discussion. We can inquire about patients' general subjective responses (*"When I said that to you, what was that like for you?"* ; *"What is coming up for you right now?"* ; *"What was happening inside you, as we were on such different pages from each other?"*); emotional processes (*"What emotions are you experiencing right now?"* ; *"What were you feeling, when you said that to me?"*); and desires (*"When you first told me about that situation, how were you hoping I would respond?"* ; *"As we discuss this, do you have a sense of what you are wanting from me?"*). Utilizing empathic validation as well as affect elaboration strategies (pp. 110–131), we encourage patients to expand further on their reflections about relevant internal experiences. "So you felt quite angry when I said that to you. Can you say more about the anger?" "You're noticing a strong desire for me to be more validating and supportive of you. What would that look like, if I were to engage with you in that way?"

Box 12.2 Mentalizing the relationship: Collaborative exploration and elaboration

When examining patients' experience of the relational scenario, explore and elaborate patients'

General subjective responses: *"When I said that to you, what was that like for you?"*
Emotional processes: *"What were you feeling, when you said that to me?"*
Desires: *"As we discuss this, do you have a sense of what you are wanting from me?"*

If patients focus primarily on anger-related emotions in the dyad, actively work to help them expand their feeling states to include softer and more vulnerable emotions as well.

Temporarily "bracket the anger" and inquire about other potential affects: *"In addition to the anger, do you notice any other emotions coming up toward me right now?"*
Elaborate emotions related to some previously mentioned "softer" impression: *"You mentioned previously that you don't feel like you are 'doing a good job' in the therapy. What emotions does that bring up, when you are seeing yourself in that way?"*
Explicitly inquire about patients' sense of self-esteem: *"When it feels like I am criticizing you like that, how does that make you feel about yourself?"*
Tentatively "fill in feelings": *"If I were in your shoes, I might even feel a bit hurt about all of this … ."*

Therapists invite patients to reflect on therapists' own emotions and desires in the scenario under discussion, variously focusing on

General subjective experiences: *"Do you have a sense of where I am at regarding all of this?"*
Emotions: *"As I was giving you that feedback, what could I have been feeling?"*
Desires: *"If you had to guess, what was I was hoping for in that discussion?"*
Therapists' views and opinions of patients: *"How do you think I was seeing you, when you made that disclosure to me?"*

When patients share their assumptions about therapists' mental states, therapists utilize these impressions to further encourage elaboration of

patients' own affects.

"You suspect that I actually get quite impatient and frustrated with you in these discussions. How does that make YOU feel, when I am coming across in that way?"

In many cases, patients start out by recognizing only anger-related emotions in their experience (e.g., anger, frustration, resentment, feeling "disrespected"), struggling to identify and access their softer and more vulnerable feeling states surrounding the relational issue (e.g., hurt, insecurity, shame, desires for admiration). Even if they briefly recognize these softer feelings, they often find it difficult to *remain* in these feelings, reflexively moving away from them and focusing on our perceived failings, or on concrete aspects of the situation. These processes have important implications for patients' sense of stability and closeness in their relationships. Whereas anger-related emotions are more likely to lead to hostility and interpersonal conflict with other people, the more vulnerable emotions are naturally more prosocial, indicating patients' desires for affiliation and closeness with others. When we explore a wider range of patients' feelings in the therapeutic relationship, patients gain the extremely rare experience of expressing their feelings *to and about* the person with whom they are engaged, in the present moment of feeling: "I think that I am feeling worried about what you think about me. I want you to respect me, and I was feeling like you were really looking down back there." As patients practice this in the therapeutic relationship, they gradually begin to consider a wider range of their emotional processes in their relationships outside of therapy, leading to decreased aggression and increased connectedness with other people.

Accordingly, when patients focus primarily on anger-related emotions in the dyad, we actively work to expand their feeling states to include softer and more vulnerable emotions as well. As discussed in Chapter 6 (pp. 121–126), such techniques include temporarily "bracketing the anger" and inquiring about other potential affects (*"In addition to the anger, do you notice any other emotions coming up toward me right now?"*); elaborating emotions related to some previously mentioned "softer" impression (*"You mentioned previously that you don't feel like you are 'doing a good job' in the therapy. What emotions does that bring up, when you are seeing*

yourself in that way?"); explicitly inquiring about the relevance of patients' sense of self, identity, and self-esteem (*"When it feels like I am criticizing you like that, how does that make you feel about yourself?"*); and tentatively "filling in feelings" (*"If I were in your shoes, I might even feel a bit hurt about all of this . . ."*).

We also utilize MBT-N's techniques for exploring other people's mental states (pp. 131–135), in this case inviting patients to reflect on *our* emotions and desires in the scenario under discussion. This can take a range of different shapes, including encouraging patients to consider our general subjective experiences (*"What do you imagine that was like for me, when you were speaking to me in that way?"* ; *"Do you have a sense of where I am at regarding all of this?"*); our emotions (*"As I was giving you that feedback, what could I have been feeling?"* ; *"What emotions are you picking up in me, as we try to sort this out together?"*); our desires (*"If you had to guess, what was I was hoping for in that discussion?"* ; *"Do you have a hunch about how I am wanting you to approach these interactions?"*); and our views and opinions of them (*"How do you think I was seeing you, when you made that disclosure to me?"* ; *"As things have become more challenging here, what have you gathered about how I have been feeling toward you?"*). When examining our past interactions with patients, we also can find it useful to examine patients' *previous* assumptions about our mental states in these scenarios: "When I was late to the appointment, what did you suspect what was happening inside of me that day?" "At the time, did you have a sense of what I was feeling, that might have led me to say that to you?"

These sorts of explorations can play an invaluable role in stimulating patients' reflections about interpersonal processes in the therapeutic relationship. To a greater or lesser degree, patients are continuously drawing conclusions about our mental states in the clinical interaction—conclusions that then impact how they feel and engage with us in the therapy. These discussions enable us to understand patients' experience in a broader way, while also providing us with crucial information about *ourselves* , and how patients experience us. We take patients' reflections seriously, recognizing that we can actually learn new things about our own mental processes through patients' observations of us. *To what extent can I identify with this patient's perceptions of me? Are they onto something here? In what ways do the patient's observations NOT accord with my conscious experience? If*

there is a discrepancy between the patient's ideas and my own understanding of my mental states, what do I make of that fact? Could I be missing something in myself? At this stage in the trajectory, we do not yet speak to the content of patients' ideas (e.g., giving feedback about their correspondence or discrepancy with our own self-experience), instead simply working with patients to elaborate and empathically validate their observations: "So you felt like I was judging you after that disclosure, maybe even feeling disgusted with you. Can you say more about what my judgments would be?" Or: "You suspect that I am feeling anxious about your suicidal thinking, and that is making me want to protect you, and keep you safe. Where have you seen this in me—this desire to keep you safe?"

While patients can struggle to recognize their own emotions in the therapeutic interaction, they are often much more able to consider our emotions in the interchange. We see this especially with patients with vulnerable narcissism, who tend to be highly focused on other people's mental states, especially others' thoughts and feelings about *them* . We can thus utilize patients' ideas about us to jump-start the exploratory process surrounding their own affective experience. Here we employ the technique of *impression-specific affect elaboration* reviewed in Chapter 6 (pp. 115–123), wherein we invoke patients' impression of us and inquire about their feelings in relation to that specific impression. Along these lines, we invite patients to reflect on their general subjective experience (*"So you feel like I genuinely care about you, and want what is best for you—not just as a patient but as a person. What is that like for you to be working with me, in light of that?"*); emotions (*"You suspect that I actually get quite impatient and frustrated with you in these discussions. How does that make YOU feel, when I am coming across in that way?"*); desires (*"You get the sense that I am looking down on you, even feeling disappointed in you. I am curious … do you know how you* want *me to see you, or to feel about you?"*); and self-states (*"When it seems like I am feeling disgusted by you, how does that make you feel about yourself?"*). As always with affect elaboration, we work with patients to expound upon their emotions surrounding their perceptions of us. "Tell me more about the insecurity . …" Or: "So you end up feeling quite connected to me, when you experience me in that way. What are the emotions involved in that sense of 'connection'?"

Context-focused interventions

Throughout this phase of mentalizing the relationship, if we are dogged and targeted in our inquiries, patients end up sharing a range of reflections about mental states surrounding the relational issue under discussion: their emotions, desires, and self-states, as well as their impressions of our internal experiences. With these mental states now "on the table" in the dyad, we utilize context-focused interventions to help stimulate patients' reflectiveness around the connection between these mental states and other relevant factors involved in the scenario (Box 12.3).

Box 12.3 Mentalizing the relationship: Context-focused interventions

After elaborating patients' various mental states surrounding the therapeutic interaction, therapists utilize context-focused interventions to examine the connection between these mental states and other relevant factors involved in the scenario.
Summarize (a) some mental state patients have already identified in the therapeutic dialogue (e.g., in themselves, in us), and (b) some other contextual factor in the dyad (e.g., an event, behavior, or another psychological process).

Situations: "*You suspect that I am looking down on you for your financial decisions* [situational factor], *and that makes you anxious about talking about these issues here* [feeling state]."
Behaviors: "*You want to 'feel good about yourself' in our interactions* [feeling state], *and so you talk a lot about your successes, achievements, and talents* [behavior]."
Other emotions: "*So initially you felt guilty when I gave you that feedback* [feeling state #1], *but then you quickly became angry with me for being 'overly critical'* [feeling state #2]."
Therapists' internal experiences: "*You believe that I have been feeling quite hurt by you* [therapist's feeling state] *ever since you said that the therapy was a 'waste of time'* [situational factor]."

Construct some context-focused inquiry inviting patients to consider the potential connection between these two elements.

"What is it about me looking down on you that makes you so anxious?"
"Can you say more about this—how telling me these things helps you feel good about yourself?"
"What do you make of this progression from the guilt to the anger?"
"How might that comment be making me feel so hurt?"

Explore with patients their context-related reflections, helping them to consider other internal processes (e.g., thoughts, emotions, desires, self-states) that connect the contextual factors to the mental states in question.

"You want me to see you in a positive light *[internal process]* , so you end up feeling quite anxious *[original feeling state]* whenever we discuss your finances *[situational factor]* —an area where you already feel so insecure. Could you share more about how you are hoping I will see you?"
"You think that I really want to do a good job here *[internal process]* , so it might have hurt my feelings *[original feeling state]* for you to insult the therapy *[situational factor]* . What clues you in that I am so invested in doing a good job?"

Consistent with the context-focused interventions reviewed in Chapter 7 , this step involves first summarizing (a) some mental state patients have already identified in the therapeutic dialogue (e.g., in themselves, in us), and (b) some other contextual factor in the dyad (e.g., an event, behavior, or another psychological process). We then construct a context-focused inquiry inviting patients to consider the potential connection between these two elements.

For example, we could focus on the connection between patients' feelings and situational factors in the dyad (e.g., our comments, behaviors, or emotional experiences).

> "You suspect that I am looking down on you for your financial decisions *[situational factor]* , and that makes you anxious about talking about these issues here *[feeling state]* . What is it about me looking down on you that makes you so anxious *[context-focused inquiry]* ?"

We can also examine the association between patients' mental states and behaviors in the clinical process:

> "You want to 'feel good about yourself' in our interactions *[feeling state]* , and so you talk a lot about your successes, achievements, and talents *[behavior]* . Can you say more about this —how telling me these things helps you feel good about yourself *[context-focused inquiry]* ?"

When patients have identified multiple emotions at play for them in the relational scenario, we inquire about the possible connection between these feelings:

> "So initially you felt hurt when I gave you feedback about your intellectualization *[feeling state #1]* , but then you quickly became angry with me for being 'overly critical' *[feeling state #2]* . What do you make of this progression from the hurt to the anger *[context-focused inquiry]* ?"

We explore with patients their reflections about the connection between their feeling states in the therapeutic relationship and these various contextual factors, helping them to consider other internal processes (e.g., thoughts, emotions, desires, self-states) that connect their feelings to these factors. For instance, in the case of the patient who is anxious that the therapist is "looking down" on him about his financial decisions, the patient might share about his desire for the therapist to view him in a positive light, thus further contextualizing the anxiety. Or for the patient who shares about her achievements in order to experience improved self-esteem in sessions, the patient could discuss her feelings of shame upon coming to therapy appointments. In her view, needing to attend therapy is a sign of her abnormality and deficiency, and itemizing her achievements helps to alleviate those feelings. And in the example of the patient who progressed from hurt to anger when he felt like the therapist was being "overly critical," the patient might share about relevant self-states in the interaction: "When I felt hurt by you, I felt weak and small, and stupid for allowing myself to care what you think of me. But then when I got angry with you, I felt powerful and in control. I didn't care about you anymore … I didn't care about anyone." In all of these examples, the patients are elaborating on additional internal experiences that inform their emotional relationship to the contextual factor in question (e.g., aspects of the situation, their behaviors, other mental states), as well as to the original emotional experience in the dyad.

In cases where patients are especially focused on *our* internal experiences surrounding the relational issue, we can invite them to reflect on the potential connection between these experiences and relevant contextual factors in the scenario, including events (*"You believe that I have been feeling quite hurt by you ever since you said that the therapy was a 'waste of time.' How might that comment be making me feel so hurt?"*); behaviors (*"You imagine that I am angry with you for relapsing, and so I am 'interrogating' you by asking you all of these questions. Can you say more about this: how the anger leads to the interrogation?"*); and other emotions (*"You suspect that I am worried about your progress in the therapy, but I also seem a bit impatient with you. Do you see these as connected at all: my worry and my impatience?"*). We work to help patients elaborate potential internal processes unfolding within us (e.g., thoughts, emotions, desires, self-states) that might further contextualize the processes under discussion:

“You think that I really want to do a good job here *[internal process]* , so it might have hurt my feelings for you to insult the therapy *[original feeling state]* . What clues you in that I am so invested in doing a good job?”

Empathic summary of patients’ experience

Having now placed the mental states under discussion in a broader context, we utilize empathic validation to summarize and supportively validate patients’ experience of the relational issue. There is no single formula for these empathic summaries, as the content of these reflections varies considerably based on the particular patient, dyad, and situation in question. Consistent with the principles of empathic validation in MBT-N (pp. 135–141), we attempt to capture the “spirit” of patients’ experience, while making sure to reflect the content and complexity of patients’ reflections thus far about the matters at play: patients’ affects, desires, and self-states surrounding the interpersonal scenario; their ideas about *our* mental states; and contextual reflections about events, behaviors, and other psychological processes in the therapeutic interaction. See Box 12.4 for examples of empathic summaries from mentalizing the relationship.

Box 12.4 Mentalizing the relationship: Examples of empathic summaries

"So not only were you frustrated with me, but you felt hurt by me *[patient's expressed emotions]* , like I wasn't really focusing on how hard you have been working in the treatment, and in your life overall *[patient's expressed experience of therapist]* ."
"You get the sense that I am judging you for these arguments with your boss *[patient's expressed experience of therapist]* . You worry about what I think of you *[patient's expressed emotion]* , and you end up withholding information about these conflicts when they arise *[patient's behavior]* , so that I continue to see you in a positive light *[patient's expressed desires]* ."
"Going into that session, you were already feeling embarrassed and ashamed about these matters *[patient's expressed self-states]* . This made you feel more defensive and on edge in our discussion *[patient's expressed emotions]* , also leading you to become quite argumentative when I tried to share my perspective about the situation *[patient's behavior]* ."
"You see me as wanting to feel powerful in the therapy *[patient's expressed experience of therapist]* , which causes me to be more rigid and controlling in our interactions *[therapist's behavior]* . In light of this, you can feel angry and resentful toward me *[patient's expressed emotions]* , and you need to resist me *[patient's behavior]* in order to maintain your self-respect *[patient's expressed desire]* ."
"You are starting to rely on me more, which makes you feel 'weak and pathetic' *[patient's expressed self-states]* . But then when you are more critical of me *[patient's behavior]* , you feel much better about yourself—like you are more independent and autonomous, and not depending on me at all *[additional expressed self-states]* ."

After offering these empathic summaries, we give patients the opportunity to share reactions and reflections about them, revising our impressions based on patients' feedback. "I see, so intellectually you actually do not believe that I am judging you about your work situation. But at an emotional level, it *feels* like I am looking down on you, which makes it more challenging to share openly with me."

Exploration and acceptance of therapist contribution

Having explored and mirrored patients' experience of the interpersonal scenario, we explicitly assume responsibility for our part in the situation in question. This approach is important for several reasons. On the most basic level, this technique is consistent with MBT's "not-knowing" stance. If we accept the inherent opaqueness of mental states, it is just as possible that we have unwittingly contributed to an impasse as it is that the patient has "distorted" something. Furthermore, this stance demonstrates a form of self-reflection about our own agency in the therapeutic relationship, in this way modeling the reflectiveness we are encouraging patients take toward relationships more generally (pp. 147–165). This helps to establish a culture in the treatment where both parties are curious about their idiosyncratic manner of engaging in the clinical interaction.

Finally, we see this approach as essential in helping patients to consider their own role in the relational scenario under discussion. In keeping with patients' tendency to blame others for their difficulties (Campbell et al., 2000), patients often struggle to accept how they might have contributed to an interpersonal disruption in therapy. If they have played a part, that means *they* are bad or wrong—a psychologically impossible state, given patients' need for self-enhancement. By conceptualizing impasses in terms of patients' pathological unconscious processes (e.g., projections, splitting, acting out), more "neutral" therapeutic modalities (e.g., Transference-Focused Psychotherapy, classical psychoanalysis) can inadvertently make patients feel blamed or judged in the therapeutic interaction, leading to defensiveness, aggression, and unnecessary power struggles. In contrast, consistent with more intersubjective models of psychotherapy (Benjamin, 2004 ; Drozek, 2018 , 2019), MBT implores us to "go first" in assuming responsibility for the problem in question. We are essentially communicating to patients: "You are not alone in holding all of the badness in this relationship. I have played a part, and perhaps you have a played a part, too." This helps patients feel emotionally safer in the dynamic, enabling them to consider their own role in the interaction without disrupting their need for self-continuity and self-stability.

Box 12.5 Mentalizing the relationship: Exploration and acceptance of therapist contribution

Explicitly affirm patients' accurate perceptions.

"I think that you are right about this . …"
"Now that you mention it . …"
"I really think you are onto something here . …"
"I agree with you on this front . …"

Specify the nature of the therapist's involvement in the scenario.

Thoughts or beliefs: *"I* was *judging you a bit for these arguments at work."*
Emotions: *"I recognize that I have been feeling a bit impatient with you lately, and more on edge in our discussions."*
Desires: *"I have been noticing that in myself lately: the desire to convince you that I am right and you are wrong."*
Personality traits or interpersonal tendencies: *"I know that I can be stubborn sometimes, and I suspect that was playing into our interaction that day."*
Behaviors: *"I have been quite dogged about bringing up your anger issues, even though you have not been very interested in this."*
"Failures" in mentalizing: *"You needed me to be more supportive and validating of you in that discussion, and I really missed that."*

Utilize additional strategies, as relevant to the situation in question.

Further contextualize and validate patients' emotional experience: *"In light of this, it is really understandable that you would feel hurt by me."*
Directly apologize for the issue in question: *"I am sorry that I treated you that way."*
Identify approaches to prevent future difficulties: *"Now that I understand how challenging these discussions are for you, I want to try to 'check in' with you before going down these roads—to see how you are feeling and how you would like to proceed."*

Explore patients' reactions and responses to therapists' assumption of responsibility.

“You’re surprised that I am apologizing for this. What surprises you about that?”
“You don’t feel like I’m really addressing my rigidity around the appointment scheduling. That’s a good point. Perhaps we can think this through together right now?”

From the perspective of technique, we work to explicitly and authentically identify the particular ways in which we have contributed to the relational scenario. If we agree with patients’ impressions of us in the situation in question, we start by explicitly affirming that. “I think that you are right about this . …” “Now that you mention it . …” “I really think you are onto something here . …” “I agree with you on this front . …” We then specify the nature of our involvement in the scenario, whether by acknowledging our thoughts or beliefs (*“I* was *judging you a bit for these arguments at work”* ; *“I think that I have been assuming that you are not trying as hard here as you could be”*); our emotions (*“Looking back at that moment, I suspect I was feeling a bit worried about your dishonesty at work—that it was really going to get you into trouble”* ; *“I recognize that I have been feeling a bit impatient with you lately, and more on edge in our discussions”*); our desires (*“I have been noticing that in myself lately: the desire to convince you that I am right and you are wrong”* ; *“I was feeling a bit protective of you at the time—wanting to say something that could alleviate all of that pain you were in”*); our personality traits or interpersonal tendencies (*“I know that I can be stubborn sometimes, and I suspect that was playing into our interaction that day”* ; *“I see that I have been quite passive around this issue, in a way that has not been helpful for you”*); or behaviors (*“I was so focused on encouraging you to mentalize your wife, and I spent very little time exploring* your *feelings about the issue”* ; *“I have been quite dogged about bringing up your anger issues, even though you have not been very interested in this”*). We can also take responsibility by recognizing our “failures in mentalizing” in the interaction in question. “The more that we talk about this, I am realizing that even *mentioning* your previous therapist was highly upsetting to you. I was not being attentive enough to how that would impact you.” Or: “You needed me to be more supportive and validating of you in that discussion, and I really missed that.”

At times, “assuming responsibility” involves simply identifying our role in one of the aforementioned ways. At other times, we take additional steps along these lines, for example by employing these reflections to further contextualize and validate patients’ emotional experience of the situation. “In light of this, it is really understandable that you would feel hurt by me.” “No wonder you have been finding it challenging to trust me, given that I acted that way.” When we feel like we have approached patients in a problematic manner, we often directly apologize for the issue in question. “I am sorry that I treated you that way.” “That wasn’t fair of me, and I genuinely regret that.”

Similarly, we can identify approaches that we plan to employ in the future, to prevent further difficulties. “Moving forward, I will try to keep this on my radar . …” “Now that I understand how challenging these discussions are for you, I want to try to ‘check in’ with you before going down these roads—to see how you are feeling and how you would like to proceed.” “I am going to try to work on this issue: refraining from giving advice before you have sorted out your own opinion about the problem. If I slip up and fall into this again, could you please let me know?”

After making these comments, we welcome patients’ responses to our assumption of responsibility, exploring any thoughts and emotions that arise for them in the conversation. “You’re surprised that I am apologizing for this. What surprises you about that?” “You don’t feel like I’m really addressing my rigidity around the appointment scheduling. That’s a good point. Perhaps we can think this through together right now?” In all of these ways, we reflect MBT’s core tenet that minds can be changed by other minds: we can take active steps to repair disruptions, and to become progressively more responsive to the evolving image of the patient that emerges in the therapeutic process.

Identify form of non-mentalizing

By this point in the trajectory, we will likely have observed some form of non-mentalizing that appears relevant to patients’ experience of the relational scenario under discussion. At the level of content, patients might feel confused about what they are feeling surrounding the situation, or they could be making some narrow assumptions about the nature of our feelings.

From the perspective of context, patients may not be appreciating the aspects of the interaction that are really affecting them (the “why”), or they could struggle to reflect on the connection between their different emotions surrounding their relationship with us (e.g., anger, insecurity, desires for validation). They also might fail to recognize their own role in the interaction, for example by not considering how they might be impacting *us* and our manner of engaging with them.

In the domain of process, patients can endorse rigid, overly certain views of themselves and us in the dyad (*psychic equivalence*). They might be excessively focused on visible, concrete aspects of either party (e.g., actions, appearance, success, or status), relying on these things to understand relevant psychological experiences (*teleological mode*). They could be disconnected from their emotions or desires in the interactional process, lacking curiosity about these feelings (*pretend mode with Self*). Or they might be engaging in self-focused narratives about the topic under discussion, while appearing more dismissive or uncaring about our experiences (*pretend mode with Other*). See Table 12.1 for an outline of patients’ various challenges with mentalizing in the therapeutic relationship, organized in the domains of content, context, and process.

Table 12.1 Patients' domain-specific problems in mentalizing surrounding the therapeutic relationship

	Patient-focused	**Therapist-focused**
Content-related problems	• Confusion about patients' specific mental states (e.g., thoughts, beliefs, emotions, needs, desires, sense of self, attitudes) concerning Self, the therapist, or the therapeutic relationship • Drawing inaccurate conclusions about their mental states in the clinical interaction • Tendency to "miss" or ignore specific mental states in themselves involving these interactions • Difficulty identifying and "putting words on" mental states in themselves that arise in the treatment relationship • "Biases" toward recognizing certain mental states in themselves regarding the dyad, while neglecting others	• Difficulty "reading" or understanding mental states in the therapist • Drawing inaccurate conclusions about the therapist's mental states • Tendency to "miss" or ignore specific mental states in the therapist • Challenges identifying and "putting words on" mental states in the therapist • "Biases" toward recognizing particular mental states in the therapist, while neglecting others
Context-related problems	• Feeling unsure about "why" they are feeling a certain way surrounding the therapy • Difficulty identifying events in the therapeutic relationship (e.g., actions or comments of therapist, interactional processes with therapist) that might be influencing their mental states • Problems recognizing other psychological processes (e.g., specific thoughts or emotions about the therapist or the clinical interaction) that might be influencing their mental states • Challenges understanding the connection between their mental states and their behaviors in the dyad—for example, how their feelings affect how they behave in the therapy, or how their manner of engaging in the relationship affects their moods/emotions/desires • Tendency to "miss"/fail to recognize their broader relational patterns unfolding in the clinical interaction	• Difficulty identifying situational/environmental factors (e.g., the treatment frame, role responsibilities, other professional obligations, life or world events) that might be influencing the therapist's mental states • Problems considering other psychological factors (e.g., specific thoughts or emotions) that could be impacting the therapist's mental states • Challenges understanding the connection between the therapist's mental states and behaviors—for example, how the therapist's feelings affect their behaviors, or how the therapist's behaviors impact "how they feel" • Trouble recognizing how **they** are often the context of the therapist's mental states—the effect that their feelings/behaviors/interpersonal patterns have on how the therapist feels, and how the therapist engages with them

	Patient-focused	Therapist-focused
Process-related problems	*Rigid and overly certain (psychic equivalence mode):* • Rigid thinking or beliefs about themselves in the therapeutic relationship: positive or negative evaluations of themselves in the dyad; rigid depictions of their own characteristics, emotions, qualities, or actions in the clinical interaction; rigid standards or expectations for themselves surrounding these interactions; predictions about their future behavior or experiences in the treatment relationship • Powerful emotions directed toward themselves in the clinical interaction • Intense desires and urges surrounding the therapy • Rigidly held experiences of self/identity arising in the dyad	*Rigid and overly certain (psychic equivalence):* • Rigid thinking or beliefs about the therapist: positive or negative evaluations of therapist; rigid depictions of therapist's characteristics, emotions, qualities, or actions; rigid standards or expectations of therapist; predictions about therapist's future behavior or experiences • Powerful emotions directed toward the therapist • Intense desires and urges aimed at the therapist's mental states—need for the therapist to think, feel, or want certain things • Tendency to base their own mental states (e.g., emotions, desires, interest, self-states) on their perceptions of the therapist's mental states
	Concrete and external (teleological mode): • Significant focus on visible aspects of self in the relationship with therapist: actions; physical appearance; perceived competence in the therapeutic task; status or success in the world outside of treatment (e.g., regarding finances, possessions, or achievement) • Tendency to base their mental states (e.g., emotions, self-esteem) on these visible factors • Need to engage in specific behaviors (e.g., attention-seeking, argumentation, dishonesty/misrepresentation, dismissiveness) in the clinical interaction when emotionally or interpersonally triggered	*Concrete and external (teleological mode):* • Significant focus on visible aspects of the therapist: actions; physical appearance; office space, fees, and appointment schedules; credentials and organizational affiliations; tangible success or status • Tendency to interpret the therapist's mental states (e.g., thoughts, emotions, desires) largely utilizing these visible factors • Propensity to base their own feelings toward the therapist (e.g., emotions, desires, interest, valuations) largely on these visible factors

	Patient-focused	Therapist-focused
	Disconnected and dissociated (pretend mode): • Lack of interest or curiosity in their own mental states (e.g., thoughts, emotions, desires) surrounding the therapeutic relationship • Apparent detachment from their mental states about the relationship • Overreliance on cognition, abstractions, jargon, or intellectualization when speaking about themselves in the dyad • Disconnection from/ minimization of certain objective facts about themselves in the treatment: their behaviors, communications, or presentation • Difficulties elaborating on the intended meaning of their comments about the clinical interaction	*Disconnected and dissociated (pretend mode):* • Lack of interest or curiosity in the therapist's mental states (e.g., thoughts, emotions, desires) • Difficulties resonating with, caring about, and being motivated by therapist's mental states • Overreliance on cognition, abstractions, intellectualization, and jargon about the therapist • Detached communications in the therapeutic interaction: monologues, self-centeredness, and self-focused attention • Disconnection from/ minimization of certain objective facts about the therapist: specific characteristics, behaviors, interactions, professional and life circumstances

In most cases, patients evince multiple forms of non-reflectiveness related to the relational scenario. How then do we decide which problem in mentalization to address when mentalizing the relationship? Several considerations guide our decisions along these lines. By and large, we tend to prioritize forms of non-mentalizing that (a) seem most responsible for the interpersonal disruption in the therapy; (b) have the potential to place the treatment or therapeutic alliance at risk; (c) appear most prominent or pressing in the current moment; or (d) overlap with patients' core interpersonal challenges outside of the treatment. At other times, we choose to focus on forms of non-mentalizing that have not received significant attention in the therapy—challenges with reflectiveness that until now have not been "on our radar," which strike us as potentially relevant to the relational issue under discussion.

Domain-specific interventions

Having identified the form of non-mentalizing that warrants further attention, we now implement domain-specific interventions to address these challenges.

Potential content-focused interventions

When patients are struggling to reflect on the content of mental states in the therapeutic relationship, we utilize content-focused interventions to stimulate mentalizing in this domain (Box 12.6). For example, if patients fail to consider a broad range of their own mental states, we begin by explicitly highlighting the problem area (*"You are really in touch with your anger toward me, but it seems more challenging for you to identify any other feelings that could be at play for you here"*). We then utilize general affect elaboration inquiries (*"When you are feeling so angry toward me, do you have a sense of what you might be wanting from me?"* ; pp. 112–114); affect elaboration of vulnerable emotional states (*"You mentioned that you feel like I don't really respect you. When you get that sense of me, how does that make you feel about yourself?"* ; pp. 121–126); and the "fallback" affect elaboration strategies (pp. 126–131), reserved for when traditional exploratory work is ineffective (*"If I were in your shoes, I might feel a bit hurt by all of this . . ."*).

Box 12.6 Mentalizing the relationship: Addressing problems in content-mentalizing

Implement content-focused interventions when patients struggle to reflect on the content of their mental states in the therapeutic relationship.

Explicitly highlight the problem area: *"You are really in touch with your anger toward me, but it seems more challenging for you to identify any other feelings that could be at play for you here."*
Utilize general affect elaboration inquiries: *"When you are feeling so angry toward me, do you have a sense of what you might be wanting from me?"*
Explore vulnerable emotional states: *"You mentioned that you feel like I don't really respect you. When you get that sense of me, how does that make you feel about yourself?"*
Employ "fallback" affect elaboration strategies: *"If I were in your shoes, I might feel a bit hurt by all of this … ."*

Utilize content-focused techniques when patients draw narrow, biased, or inaccurate conclusions about therapists' mental states.

Offer feedback about the two-dimensional nature of patients' experience: *"You felt like I was really judging you and looking down on you in that discussion. It is difficult for you to imagine me having any other feelings back there, given that we were on such different pages from each other."*
Encourage patients to consider additional internal processes in the therapist: *"Apart from judging you, can you imagine any other emotions I could have been experiencing?"*
Invite patients to reflect on some facet of the interaction potentially associated with more nuanced psychological states: *"When you told me that I was incompetent, and that I was not really helping you … Do you have a sense of what I might have been feeling in that moment?"*
Invoke sections of patients' MBT formulations: *"In your MBT formulation, we observed how sometimes you can see relationships through a 'judgment lens,' and you can miss other emotions people might be experiencing. Could that ever be relevant to this difficulty in our relationship?"*
After exploring these matters with patients, engage in affective self-disclosure surrounding the relational scenario: *"I suppose that I* was *judging you a bit in that discussion. But for most of the conversation, I was feeling mostly worried that you were so upset with me, and also a bit insecure that I was doing a bad job managing things here."*

When patients are drawing narrow, biased, or inaccurate conclusions about our mental states, we use content-focused interventions to further stimulate patients' reflection about our experiences in the therapeutic relationship. We start by providing patients with feedback about the two-dimensional nature of their experience of us.

> "You felt like I was really judging you and looking down on you in that discussion, even though I was trying to act 'professional.' It is difficult to imagine me having any other feelings back there, given that we were on such different pages from each other."

We can then apply the various techniques for affect elaboration of other people's mental states (pp. 131–135). For instance, we encourage patients to consider additional internal processes in us: "Apart from judging you, can you imagine any other emotions I could have been experiencing?" We "hold up" some facet of the interaction potentially associated with more nuanced psychological states in us, offering an affect-related inquiry about that facet. "When you told me that I was incompetent, and that I was not really helping you … Do you have a sense of what I might have been feeling in that moment?" And when relevant, we invoke an aspect of patients' formulations that speak to the form of non-mentalizing in question: "In your MBT formulation, we observed how sometimes you can see relationships through a 'judgment lens,' and you can miss other emotions people might be experiencing. Could that ever be relevant to this difficulty in our relationship?"

After exploring these matters with patients, we can engage in affective self-disclosure surrounding the relational scenario (pp. 247–258). This involves validating any of patients' specific assumptions that resonate with our self-experience, and then sketching out a broader picture of our subjectivity, including relevant details that might depart from patients' initial perceptions of us.

> "I suppose that I was judging you a bit in that discussion—assuming perhaps that you were being a bit stubborn, and that you weren't really trying to reflect on what was happening between us *[validating patient's original impression of the therapist]* . But for most of the conversation, I feel like I was more focused on what *I* was doing wrong than on anything about you. I felt worried and anxious that you were so upset with me, and also a bit insecure that I was doing a bad job managing things here. From my perspective, you have some very serious things going on in your life right now, and I really want to be helping you with them *[therapist sharing a broader picture of subjective experience]* ."

We then explore and examine patients' reactions to the self-disclosure (*"Where do you go with all of this?"* ; *"What goes through your mind, as I articulate these feelings?"*), especially encouraging patients to reflect on similarities and differences between our respective perspectives around these matters: "What stands out to you about our different impressions here?" "What do you make of these differences?" "As I share about this, does it affect your original view on what I was experiencing?"

Potential context-focused interventions

When patients fail to reflect on the broader context of their mental states, we tailor our interventions to the particular problem in context-mentalizing we are observing, as reviewed in Box 12.7 . This usually involves explicitly observing the form of non-mentalizing in question, and then utilizing the context-focused techniques best suited to address these (Chapter 7). For example, when working with patients who find it challenging to consider the context of events in the therapeutic relationship, we first provide the patient with feedback about this: "You have been feeling more anxious and uncomfortable sharing with me recently, but you are quite confused about what might be triggering this." We proceed to utilize situation-focused techniques (*"You had mentioned previously that you were quite upset with me for raising my rates. Could there ever be a connection between these things: me raising my rates and you feeling less comfortable here?"*) to help patients explore the relationship between their internal processes and events in the therapy (pp. 144–147).

Box 12.7 Mentalizing the relationship: Addressing problems in context-mentalizing

To address patients' difficulties reflecting on the context of events

Provide feedback about the difficulty: *"You have been feeling more anxious and uncomfortable sharing with me recently, but you are quite confused about what might be triggering this."*
Utilize situation-focused techniques: *"You had mentioned previously that you were quite upset with me for raising my rates. Could there ever be a connection between these things: me raising my rates and you feeling less comfortable here?"*

To address patients' difficulties reflecting on the context of behavior

Provide feedback about the difficulty: *"You have been extremely focused on all of the things that I am doing here that you find problematic and objectionable. You seem to be thinking a lot less on how you might be contributing to our difficulties—in terms of your emotions but also how you engage with me."*
Explore patients' broader behavioral patterns in the therapy: *"What have you noticed about your manner of discussing your challenges here?"*
Utilize the "last resort" behavior-focused techniques: *"It strikes me that you have an apathetic tone as you speak about these tendencies. It is not really clear to me how interested you are in working on this pattern . . . ."*
Employ context-focused techniques for examining future behavioral possibilities: *"What do you think it would look like, if you were to start to share more openly about your challenges here?"*

To address patients' difficulties reflecting on the context of emotions

Provide feedback about the difficulty, and then utilize context-focused techniques to help patients consider the different types of emotions under discussion.
Consecutive emotions: *"You don't seem very curious about how you became so numb and detached, after feeling such intense guilt about how you spoke to me. What is your sense of how this change ended up happening for you?"*
Simultaneous emotions: *"You recognize that you've been wanting to end the treatment, but also you've been feeling quite hurt by me. You don't seem to be considering if those feelings could be connected in some way …."*
Nascent emotions: *"Looking back on our discussion, you suspect you were feeling extremely worried about what I thought of you. But in the moment, you seemed much more focused on feelings of frustration and criticism toward me. What do you make of this fact—that you were so in touch with your anger, but you had very little sense that you were worried that I was disappointed in you?"*

To address patients' difficulties reflecting on the context of therapists' mental states

Provide feedback about the difficulty: *"You've noted that you can often be quite argumentative with me, and also that I sometimes seem anxious and on edge in our interactions. You don't appear to be considering if my anxiety could ever be related to how you engage with me."*
Offer context-focused inquiries: *"How might the arguing impact my anxiety with you?"*
Engage in affective self-disclosure surrounding the contextual factors in question: *"I think that I want to connect with you, and I see the arguing as interfering with that. I worry that it is bad for our relationship, and bad for you."*

Explore patients' reactions to these collaborative reflections: *"Where does your mind go as I share these feelings?"*

If patients are having difficulties considering the connection between their emotions and behaviors in the dyad, we share our impressions about this:

> "You have been extremely focused on all of the things that I am doing here that you find problematic and objectionable. You seem to be thinking a lot less on how you might be contributing to our difficulties—in terms of your emotions but also how you engage with me."

We then utilize behavior-focused techniques to help patients with these challenges, including exploring patients' broader behavioral patterns in the therapy (pp. 151–155). "What have you noticed about your manner of discussing your challenges here?" "So when you hold back all of this information about how you are struggling, do you think that impacts how you end up feeling about the therapy?" We utilize the "last resort" techniques for when patients are struggling with behavior-focused mentalizing (pp. 162–165). "It strikes me that you have an apathetic tone as you speak about these tendencies. It is not really clear to me how interested you are in working on this pattern . …" And once patients have begun to reflect on their own behavioral processes in the therapy, we employ the context-focused techniques for examining future behavioral possibilities for patients (pp. 155–158). "What do you think it would look like, if you were to start to share more openly about your challenges here?" "Do you have any ideas about how to go about changing this pattern?"

When patients experience problems reflecting on the connection between two of their emotions about the therapy, we articulate our observations of this: "Looking back on our discussion, you suspect you were feeling quite worried about what I thought of you. But in the moment, you seemed much more focused on feelings of frustration and criticism toward me." As discussed in Chapter 7 (pp. 165–174), we then employ specific context-focused techniques to help patients consider the different types of emotions under discussion (e.g., consecutive emotions, simultaneous emotions, nascent emotions). In the above example, we would likely utilize the range of techniques for stimulating reflection about the nascent emotion of anxiety: inquiring about patients' level of awareness of the nascent emotion (*"Were you aware that you were feeling this anxiety at the time?"*); encouraging patients to consider their varying levels of attentiveness to these different feeling states (*"What do you make of this fact—that you were so in touch with your anger, but you had very little sense that you were worried that I was disappointed in you?"*); and exploring patients' mental states surrounding the emotions in question (*"When you are worried about what I think of you, how does that make you feel about yourself?"* ; *"When*

you are feeling more angry with me, and focusing on my deficiencies, what is that like for you?"). Synthesizing patients' various reflections about these matters, we work toward delivering an empathic statement that summarizes patients' affective stance toward the different emotions in question.

> "When you are worried about what I think about you, you feel 'weak and pathetic,' so you really try to stay away from those emotions in yourself. You are much more comfortable getting angry at me and thinking about my defects. This makes you feel strong and autonomous, like you do not need me in any way."

In cases where patients are not considering the broader context of *our* mental states arising in the therapeutic interaction, we convey our impressions of the particular problem in mentalizing we are observing. Consider some examples below:

Context of events: "You've noted that you can often be quite argumentative with me *[event in the therapeutic interaction]* , and also that I sometimes seem anxious and on edge in our interactions *[therapist's emotional state]* . You don't appear to be considering if my anxiety could ever be *related* to how you engage with me."
Context of behavior: "You get the sense that I genuinely care about you, and want to help you *[therapist's emotional state]* . At the same time, you really take issue with me interrupting you and steering the conversation here, rather than simply following your lead *[therapist's behavior]* . It doesn't seem to occur to you that these things might be related in some way."
Context of emotions: "You're aware that I can feel quite worried about your safety *[therapist's emotions]* , and also that I come across as a bit frustrated by all of your missed appointments *[therapist's additional emotional states]* . From what I can tell, you're not really wondering if there is a connection between these feelings for me."

After providing this feedback to patients, we utilize context-focused interventions to encourage patients' reflection about these matters, including offering context-focused inquiries: "How might the arguing impact my anxiety with you?" "Do you have any ideas: could my interruptions ever be related to my desire to help you?" "What would the connection be between my frustration and my concerns about your safety?"

We can also engage in affective self-disclosure surrounding the contextual factors in question. “I think that I want to connect with you, and I see the arguing as interfering with that. I worry that it is bad for our relationship, and bad for you.” “Personally, I feel compelled to jump in when you seem more disconnected from your emotions. I do hope to assist in those moments—to say something to help you get more grounded in yourself.” “I feel like I am quite ‘in the dark’ about what is happening with you when you miss these appointments. So I end up feeling worried about you, but also maybe a bit frustrated at YOU for making me worry.” Finally, we explore patients’ reactions to these collaborative reflections: “Where does your mind go as I share these feelings?” “What stands out to you about all of this?” “What do you observe about our different views on this situation?”

Potential process-focused interventions

If patients exhibit process-related difficulties in their experience of the therapeutic relationship, we target our interventions to address the non-mentalizing mode in question. For example, we utilize process-focused interventions for psychic equivalence mode when patients struggle with rigidity and certainty in their thinking (Box 12.8). We start by empathically validating the psychic equivalent viewpoint (*“So your sense is that you do not care what I think about you in any way. This is strictly a ‘professional’ relationship, so you have no real emotions or desires here”*); we explore patients’ process of arriving at the rigid perspective (*“What clues you into the fact that you don’t care what I think?”*); we examine the consequences of the rigidity and certainty (*“What is this like for you—to engage in therapy without having any feelings about our relationship?”*); we examine any areas of potential nuance in patients’ views (*“I am remembering one time when you felt ‘insulted’ that I asked if you had any history of infidelity. What was coming up for you in that moment?”*); and we summarize the more variegated outlook that has emerged.

> “In general, you feel like you don’t really care about what I think about you. You have been through so much in your life, and you have had to learn to be secure in yourself—to not need anything from anyone *[psychic equivalent view]* . At the same time, you know that you cannot totally ‘shut off’ your feelings, and you can occasionally feel hurt and insulted by things that I say. So you suspect that on some level you ‘must’ want me to see you in a positive light, although you don’t really like to admit that *[more nuanced perspective]* .”

We then proceed to share our own perspective on the topic under discussion. Since this topic is always some scenario that directly involves us, this often entails directly expressing our feelings and impressions of ourselves, patients, or the therapeutic dynamic in general.

> "I hear that you really value NOT relying on other people, which is completely understandable given your history. I realize that my experience is very different from yours, but I end up having a positive response to you sharing your feelings here, including your desire for me to think well of you. In these moments, you come across as much more vulnerable, authentic, and relatable to me. I feel more connected to you, and more at ease in our interactions together."

We conclude by exploring with patients their reactions to these disclosures: "What do you think of this idea?" "What comes up for you, as I share this perspective?" "What do you make of our different experiences of this issue?"

Box 12.8 Mentalizing the relationship: Addressing problems with rigidity and certainty

Empathically validate the psychic equivalent viewpoint: *"So your sense is that you do not care what I think about you in any way. This is strictly a 'professional' relationship, so you have no real emotions or desires here."*
Explore patients' process of arriving at the rigid perspective: *"What clues you into the fact that you don't care what I think?"*
Examine the consequences of the rigidity and certainty: *"What is this like for you—to engage in therapy without having any feelings about our relationship?"*
Examine areas of potential nuance: *"I am remembering one time when you felt 'insulted' that I asked if you had any history of infidelity. What was coming up for you in that moment?"*
Summarize the more variegated outlook: *"While you don't like to admit it, you occasionally feel hurt and insulted by things that I say. So you suspect that, on some level, you 'must' want me to see you in a positive light."*
Share own perspective on the topic: *"I realize that my experience is very different from yours, but I end up having a very positive response to you sharing your feelings here. I feel more connected to you, and more at ease in our interactions together."*
Explore with patients their reactions to these disclosures: *"What comes up for you, as I share this perspective?"*

When patients display more concrete or externally focused thinking, we employ process-focused interventions for teleological mode (Box 12.9). We first empathically validate the teleological perspective (*"It was highly offensive to you when I declined to answer those personal questions"*); we explore patients' process of drawing the concrete conclusion (*"Can you say more: what was so upsetting to you when I didn't answer those questions?"*); and we examine the impact of the concreteness and externalization (*"How did that make you feel about yourself—to reach out in that way, and for me to be so unresponsive?"*). Synthesizing patients' reflections, we explicate patients' assumptions about the connection between the external and the internal:

> "So when I refused to answer those questions *[external factor]* , this showed you that I was looking down on you, and I didn't truly respect you *[internal process]* . If I truly respected you, I would have just answered the questions, the way that I would in any 'normal' relationship."

We then gently inquire about the necessary relationship between the external and internal factors (*"Can you imagine any other possible things I might have been feeling, when I declined to answer those questions?"*), also encouraging patients to elaborate any more nuanced perspectives they have articulated in the discussion thus far (*"You mentioned previously that you sometimes avoid sharing personal information at work. What is going into that for you?"*).

If patients are able to arrive at a more flexible viewpoint about the teleological association, we empathically summarize this view.

> "When you decide not to share personal information at your job, you usually are just trying to remain focused on all of the work you have to do: 'Keep work at work and home at home.' So while you still think I was being disrespectful by not answering your questions, it is possible that this was my way of keeping good boundaries here."

We also convey our own perspective about patients' teleological assumptions, drawing on our experiences as co-participants in the therapy:

> "Personally, I don't usually mind sharing a bit about myself in the therapy, if relevant things come up. In this case, I was remembering what you had told me about your history in treatment, where you develop more personal, 'friendship' dynamics with your therapists, rather than working to be truly vulnerable with them. So when you started asking me those questions, I wanted to understand more about what was *driving* these questions for you, rather than just falling into the dynamics you have found unhelpful in the past."

We then invite patients to reflect on their responses to this additional perspective. "What do you feel, when I share this experience?" "Where does your mind go with all of this?" "As we discuss these matters, does it affect your original view in any way?"

Box 12.9 Mentalizing the relationship: Addressing problems with concrete or externally focused thinking

Empathically validate the teleological perspective: *"It was highly offensive to you when I declined to answer those personal questions."*
Explore patients' process of drawing the concrete conclusion: *"Can you say more: what was so upsetting to you when I didn't answer those questions?"*
Examine the impact of the externalization: *"How did that make you feel about yourself—to reach out in that way, and for me to be so unresponsive?"*
Explicate patients' assumptions about the connection between the external and the internal: *"So when I refused to answer those questions* [external factor], *this showed you that I was looking down on you, and I didn't truly respect you* [internal process]."
Inquire about the necessary relationship between the external and internal factors: *"Can you imagine any other possible things I might have been feeling, when I declined to answer those questions?"*
Encourage patients to elaborate on any areas of greater nuance: *"You mentioned previously that you sometimes avoid sharing personal information at work. What is going into that for you?"*
Empathically summarize the more flexible viewpoint about the teleological association: *"While you still think I was being disrespectful by not answering your questions, it is possible that this was my way of keeping good boundaries here."*
Share own perspective on the teleological assumptions: *"When you started asking me those questions, I wanted to understand more about what was* driving *these questions for you, rather than just falling into the dynamics you have found unhelpful in the past."*
Invite patients to reflect on their responses to this additional perspective: *"Where does your mind go with all of this?"*

Finally, when mentalizing the relationship, if patients appear to be more disconnected from authentic emotions in themselves or us, we utilize process-focused interventions for pretend mode to help deepen patients' affective engagement in the interaction (Chapter 8 ; see Box 12.10). If patients are speaking in more abstract or general terms ("I tend to be quite sensitive to criticism here"; "You are a highly professional person, so I really value your opinion"), we ask some clarifying question to help

patients move “from general to specific” (*“Could you share about a recent time when you felt like I was criticizing you?”* ; *“What is one area where my opinion really matters to you?”*), then employing content-focused interventions to explore the specific example provided (pp. 185–186).

Box 12.10 Mentalizing the relationship: Addressing problems with disconnection and dissociation

Ask clarifying questions to help patients move “from general to specific”: *“Could you share about a recent time when you felt like I was criticizing you?”*
Attempt counterfactual interventions to help jar patients into more spontaneous reflection.

Subtractive counterfactuals: *“What would it look like if you were not upset at all here?”*
Additive counterfactuals: *“So if you had to complete a performance review of my work as your therapist, could you imagine even a single constructive thing you might say in it?”*

Explore patients’ emotional experience in the present moment: *“I would like to press ‘pause’ for a minute, if we can. Could you try to put words on what you are feeling right now?”*
“Name what is absent” in patients’ level of connectedness to subjective experience.

In Self: *“You’re noting that you feel angry with me for making that comment. And yet you seem quite deadpan, even emotionally distant.”*
In the therapist: *“You don’t appear very interested in my thoughts about the matter, even coming across as a bit impatient with me when I try to speak here.”*

“Challenge” the disconnection in the therapeutic relationship.

Five types of challenge: humorous, bizarre, counterintuitive, reality-based, and emotion-focused
“I am a bit taken aback by you describing yourself as ‘deferential’ here. I think of all of the times you boss me around, and tell me that I do not know what I am talking about. How do you square these things?”

When patients use language that sounds more canned or emotionally superficial, we attempt counterfactual interventions to help jar patients into more spontaneous reflection about the issue in question (pp. 186–187). For example, if a patient vaguely states that she is feeling "upset" in the interaction with the therapist but she cannot elaborate further, we might offer a "subtractive" counterfactual: "What would it look like if you were not upset at all here?" In another case, a patient speaks in more idealizing terms about the therapist, implausibly denying any feelings of dissatisfaction about the therapy. Here the therapist could try an "additive" counterfactual: "So if you had to complete a performance review of my work as your therapist, could you imagine even a single constructive thing you might say in it?"

When patients appear more disconnected from their emotions, we often inquire about their emotional experience in the current interaction (pp. 187–188). "I would like to press 'pause' for a minute, if we can. Could you try to put words on what you are feeling right now?" "What do you think you are wanting or hoping for, at this very moment?" Utilizing the "naming what is absent" technique (pp. 188–189), we also provide patients with direct feedback about the ways in which they appear to be affectively disconnected in the therapeutic dynamic. "You're noting that you feel angry with me for making that comment. I believe you, but I also wanted to observe that you're not coming across as especially angry as you talk about this. You seem quite deadpan, even emotionally distant."

We attempt an analogous technique in situations where patients appear less connected to *our* emotions and desires (see Drozek, 2022). "You've been spending a lot of time articulating your own views and ideas. You seem a lot less interested in my thoughts about the matter, even coming across as a bit impatient with me when I try to speak here." Or: "You've been communicating a lot of your criticisms of me here, even insulting my personality and my office space. I can't tell if you're considering my feelings as you say all of these things, or how concerned you are about how I am taking all of this."

If these sorts of interventions are ineffective in stimulating patients' reflectiveness about their experience in the clinical interaction, we also can attempt a more overt "challenge" of the pretend mode. In Chapter 8 , we reviewed the various types of challenges in MBT-N, which all have the

effect of helping patients to more authentically access their own emotional states, or to consider the mental states of the therapist (pp. 189–194). When utilizing these interventions to mentalize the relationship, we tailor the content of the challenge to the specific relational processes unfolding in the dyad.

The humorous challenge makes reference to some aspect of the therapeutic dynamic in an ironic or comical way. For example, one patient regularly struggled with argumentativeness and dismissiveness with the therapist, a pattern that had been identified and explored in the patient's MBT formulation. Prior to sharing her perspective about some topic, the therapist jokingly warned the patient: "Now whatever you do, DON'T try to take in and understand what I'm about to say."

The bizarre challenge involves some statement or question about the clinical interaction that is strange, absurd, or illogical. For instance, when working through a therapeutic impasse with an emotionally removed software engineer, the therapist asked, "If you were to write a computer program to help us resolve this, what would it say?"

The counterintuitive challenge entails making a comment about the therapy that surprises patients, or directly contradicts their stated perspective about the interpersonal dynamic with the therapist. For instance, in response to one patient discussing his conviction that the therapist strongly disliked him, the therapist shared: "I've got some bad news for you about this *[pause for effect]* . I actually feel quite fond of you, and I've been feeling worried that *you* strongly dislike me. What are we going to do about this?"

The reality-based challenge highlights some aspect of the therapeutic relationship that patients are ignoring, minimizing, or denying. Another patient, who regularly displayed haughty and entitled behaviors in sessions, mentioned how "humble and deferential" he is in his relationship with the therapist. Here the therapist expressed: "I am a bit taken aback by you describing yourself as 'deferential' here. I am thinking of all of the times you boss me around, and tell me that I do not know what I am talking about. How do you square these things?"

The emotion-focused challenge involves either explicitly disclosing our own emotional experience in the dyad, or expressing our emotions through some non-verbal means (e.g., tone or volume of voice, body language). For example, if a patient seems bored and apathetic when discussing an

interpersonal disruption in the therapy, we might adopt a more earnest and serious attitude about the situation. More explicitly, as described in a recently published paper about the psychoanalytic application of MBT-N (Drozek, 2022), one of the present authors employed a “high-risk” emotion-focused challenge when treating a psychiatrist patient who was engaging in ongoing and extensive boundary violations against the therapist: “I am so, so angry with you right now. … I am having the strong desire to stand up and throw you out of my office, to say ‘fuck you’ and never have to deal with this again” (p. 17). These provocative comments prompted a deeper examination of previously unexplored interpersonal processes in the therapy, ultimately resulting in a shift in the patient’s emotional experience of the therapist, and a discontinuation of the boundary crossings.

When effective, the aforementioned process-focused interventions for pretend mode help patients authentically access their own emotions in the therapeutic relationship, or to consider and resonate with the mental states of the therapist. Once patients are more connected in this way, we can return to an earlier stage in the interventional pathway—namely, collaborative exploration of patients’ subjective experience of the newly identified relational process.

Review, reflection on new understanding

The final step of mentalizing the relationship involves collaboratively considering the meaning and implications of the discussion so far (Box 12.11). This allows for the consolidation of any new learning gained from these explorations, while encouraging patients to take an agentic stance toward their reflections about their experiences and participation in the therapeutic process. Here we usually start by offering general context-focused inquiries, in an open-ended way. “So where does this all leave you?” “What do you see as the take-away here?” “Where do you go with these ideas?” “What does this all mean to you?”

Box 12.11 Mentalizing the relationship: Review, reflection on new understanding

The final step of mentalizing the relationship involves collaboratively considering the meaning and implications of the discussion so far.
Start by offering general, open-ended context-focused inquiries.

“So where does this all leave you?”
“What do you see as the take-away here?”
“Where do you go with these ideas?”
“What does this all mean to you?”

Utilize contextual interventions to help patients reflect upon alternative behavioral possibilities: *“What would it look like, for you to try to share more openly with me when you are struggling?”*
Invite patients to consider the process of addressing problems in mentalizing in the dyad.

“Can you imagine what it might look like to question some of these assumptions about me, rather than simply running with them?”
“The next time this happens here, what will you keep in mind?”
“What would that feel like for you, if you were to try to experience a wider range of your feelings here, as we are interacting together?”

Offer outbound relational tracers surrounding the interpersonal process under discussion.

“Today we’ve considered how you can sometimes feel quite sensitive to being controlled by me in sessions. Have you seen this play out in any of your other relationships, outside of the therapy?”
“This reminds me a bit of what can come up in your relationship with your best friend . …”

Summarize any new or salient reflections.

“I was really struck by you disclosing that you can often compare yourself to me in our sessions, and end up feeling inferior that you have not achieved enough in your life.”

Underscore important problems in mentalizing discussed.

“I am learning how you can often be quite perfectionistic here, putting a tremendous amount of pressure on yourself to express yourself articulately, and with poise.”

Share openly about any planned changes in therapeutic approach, in light of the proceeding explorations.

"Moving forward, I am really going to work on what we've talked about today: making sure to explore and validate your perspective before offering my own."

Attempt "marked advice giving."

"Would you ever be willing to share when you are feeling angry with me, rather than just keeping it inside and letting it fester?"

If topics remain that warrant further attention—

Explicitly "tag" these items for future examination: "*You mentioned in passing today that sometimes you feel insecure about what I think about your parenting. Could we plan to talk about this further next week?"*
Feed these topics back into the interventional pathway for mentalizing the relationship: *"I wanted to follow-up with you about your comment earlier that you can sometimes feel 'ashamed' about being in therapy … ."*

When we have been considering maladaptive behaviors patients employ in the therapy (e.g., argumentativeness, dismissiveness, avoidance, inconsistent engagement in treatment), we utilize contextual interventions to help patients reflect upon alternative behavioral possibilities in the dyad (pp. 155–158). "What would it look like, for you to try to share more openly with me when you are struggling?" "What would that feel like for you, if you were to communicate with me in that way?" "As you start to work on this, what could get in the way?"

When we have been focusing more on patients' problems in mentalizing not directly related to their behaviors (e.g., challenges reflecting on mental content in themselves and the therapist; trouble considering the connection between mental states and events, or mental states and other psychological processes; difficulties with certainty, teleological interpretations, emotional disconnection, or empathic deficits), we invite patients to consider the process of attempting to address these matters in the treatment. We encourage patients to imaginatively enter into this process (*"How might you try to work on these matters here?"* ; *"Can you imagine what it would look like to question some of these assumptions about me, rather than simply*

running with them?"); we explore issues of personal motivation (*"How motivated do you feel to try to approach things differently next time?"*); we ask patients to consider the "mechanics" of these changes (*"The next time this happens here, what will you keep in mind?"* ; *"How could you catch these processes, before they started to unfold?"* ; *"How might you try to attend to these feelings in yourself, as we move forward together?"*); and we examine the affective dimensions of working on these issues (*"What would that feel like for you, if you were to try to experience a wider range of your feelings here, as we are interacting together?"*).

We can also offer outbound relational tracers surrounding the interpersonal process under discussion in the trajectory (pp. 240–242). This involves summarizing the process in question (*"Today we've considered how you can sometimes feel quite sensitive to being controlled by me in sessions, such that you can experience humiliation whenever I share an observation about you"*), and then making some statement (e.g., asking a question, sharing an observation) geared toward stimulating patients' reflection about relevant experiences in their everyday lives. "Is this something that happens in your life outside of here as well?" "Have you seen this play out in any of your other relationships, outside of the therapy?" "Did you ever notice things like this unfolding in your marriage?" "Could you imagine this coming up, the longer that you stay at your job?"

We can also share our own perspective about the processes under discussion in the interventional pathway. This might involve summarizing new or salient reflections that emerged through the exploratory process: "I was really struck by you disclosing that you can often compare yourself to me in our sessions, and end up feeling inferior that you have not achieved enough in your life. I had not been aware that was coming up for you here." We also underscore any important problems in mentalizing discussed. "For me, one take-away from our discussion is that, when you feel disrespected by me, you can very quickly focus on my failings, and often 'skip over' your own emotional response to the interaction." "I am learning how you can often be quite perfectionistic here, putting a tremendous amount of pressure on yourself to express yourself articulately, and with poise."

If we plan to make any changes to our approach with patients, we openly express these intentions. "Moving forward, I am really going to work on what we've talked about today: making sure to explore and validate your

perspective before offering my own." "I want to keep this in mind in our future sessions—that sometimes when you seem more emotionally disengaged, you can actually be quite upset. I am going to try to inquire more about what you are going through, rather than just ploughing forward with whatever is on the agenda."

We can also engage in "marked advice-giving" with patients (pp. 157–158), tentatively articulating our ideas about how patients might work on their challenges moving forward. "I wonder what it would look like if you were to try to 'catch' these moments (where you can become quite certain that I am judging you), and to really try to *consider* your perceptions. Is this truly the only way to interpret my motives?" "Would you ever be willing to share when you are feeling angry with me, rather than just keeping it inside and letting it fester?"

In addition, we can offer an outbound relational tracer about the matters under discussion: first by summarizing the relational pattern under discussion (*"We've really looked at how you can feel quite hurt by me when I do not explicitly compliment your participation here"*); then by sharing our own observations about analogous circumstances in patients' lives outside of sessions (*"This reminds me a bit of what can come up in your relationship with your best friend …"* ; *"While the situations are quite different, this makes me think of your recent interaction with your boss …"*); and finally by exploring patients' reflections and reactions to our proposals (*"Do you see any parallels here?"* ; *"What do you think about this?"* ; *"Where does your mind go when I note these similarities?"*).

Having pursued the full interventional pathway for mentalizing the relationship, we often notice remaining topics that warrant further attention and exploration. In the terms of the domain-based conception of mentalizing outlined in this book, these could be unexplored areas of mental content (e.g., patients' feelings toward us, patients' assumptions about our psychological states); context (e.g., patients' ideas about the broader context of their feelings, or our feelings); or process (e.g., areas of certainty, concreteness, emotional disconnection, or empathic deficits surrounding the therapeutic dynamic). Here we can explicitly "tag" these items for future examination: "You mentioned in passing today that sometimes you feel insecure about what I think about your parenting. Could we plan to talk about this further next week?" Alternatively, as time allows, we feed these topics back into the interventional pathway: first directing

explicit attention to the additional relational process (*"I wanted to follow-up with you about your comment earlier that you can sometimes feel 'ashamed' about being in therapy"*), then exploring and elaborating the experience (*"Could you say more about this 'feeling ashamed'?"*), and so on.

Clinical illustration: The interventional pathway for mentalizing the relationship

To illustrate these ideas, we will return to the case of Brenda, discussed in Chapter 9 (pp. 206–209). As reviewed previously, Brenda is a 35-year-old graphic designer diagnosed with vulnerable narcissistic personality disorder, presenting to treatment to address anger issues and interpersonal conflicts in the workplace. Brenda is especially sensitive to constructive feedback from supervisors, a pattern that has been identified in her MBT formulation and examined in detail in the therapy. When Brenda feels like she is being criticized by an authority figure, she quickly falls into a stance of hostility and anger, finding it more challenging to recognize a broader range of her feelings in the interaction. She can feel quite certain about her judgments of the other person, and she struggles to see things from the other's perspective. This has led to a history of defensiveness, argumentativeness, and dismissiveness in her work relationships.

Throughout the treatment so far, Brenda has made considerable progress in her ability to "hold her tongue" when she is feeling angry at other people, and she is increasingly able to consider a wider array of her emotions unfolding in these moments (e.g., hurt, insecurity, desires for recognition). However, she continues to *feel* like she is being disparaged by people in authority, resulting in difficulties with insecurity and emotional isolation at work, and in her life more generally. As Brenda describes it, "I've stopped 'fighting back,' but I still feel like I am constantly under attack."

In the current session, Brenda has shared about a recent e-mail exchange with her supervisor, where he asked her to make some revisions to a creative brief she submitted. She felt incensed by the request. "The brief was fine, and none of those edits were necessary. This is just another example of him criticizing me, and micromanaging me because he needs to be in control." Brenda ultimately made the requested revisions, but she

never replied to her supervisor's e-mail confirming this: "I'll do my job, but I'm not going to grovel and demean myself by responding to him." Later in the week, the supervisor followed-up again about his e-mail, expressing his concern about Brenda's non-responsiveness and asking her to communicate more directly in the future.

In light of this feedback, the therapist started by utilizing content-focused interventions to explore Brenda's emotional experience surrounding her behavior of ignoring her supervisor's e-mail (p. 114). Brenda expressed feeling angry and resentful about feeling "micromanaged and controlled" by her supervisor. This gave rise to a desire to punish her boss, as well as a sense of power and satisfaction from ignoring him. Utilizing the technique of affect elaboration of other people's mental states (pp. 131–135), the therapist inquired, "What do you think your boss was feeling, as you continued to not respond to him?" Brenda stated that she had "no idea" what her boss was feeling, and the therapist encouraged her to really try to consider this. Brenda responded with a raised voice, "You're not listening to me! I don't know, and I don't care. He is a controlling asshole. He doesn't care about my feelings, so why should I care about his?"

At this moment, the therapist recognizes several indicators for mentalizing the therapeutic relationship (p. 259): an emotional disruption in the process of the session; Brenda explicitly referring to the therapeutic relationship ("You're not listening to me!"); and the appearance of a relational pattern identified in Brenda's formulation: anger and defensiveness in an interaction with an authority figure, in this case the therapist himself. The therapist commences at the start of the interventional pathway.

THERAPIST: Brenda, I'm wondering if we could press "pause" for a moment. You raised your voice a bit and noted that I'm not listening to you. Is something coming up for you right now? *[directing focus to relevant relational process, without "filling in" the patient's feelings]*

PATIENT: Yeah, you're obviously not listening to me. I am here to talk about me, not my boss. This is MY therapy, not his.

THERAPIST: I see, so it feels like I am just putting too much focus on your boss, and not enough focus on you. *[empathic validation of patient's experience]*

PATIENT: Exactly. I mean, come on.

THERAPIST: I wonder if we could look into this a bit further: what was the moment when you found yourself first starting to feel upset with me? *[initial clarification/exploratory inquiry]*

PATIENT: To be honest, almost like right from the get-go. You were so interested in me ignoring my boss, and then you were asking about HIS feelings. This whole thing has felt like the third degree.

THERAPIST: "The third degree"? *[inviting elaboration about an affectively charged impression]*

PATIENT: Well, clearly you are pissed off at me for not e-mailing my boss back. And you try to be all professional about it, but deep down I can tell you are judging me.

THERAPIST: So it really comes across like I am judging you, even interrogating you here *[empathic validation of patient's assumptions about therapist's mental states]* . Judging you in what way? *[affect elaboration of patient's Other-focused assumptions]*

PATIENT: I feel like you just want me to toe the line with my boss, to do whatever he tells me to do. And if he gives me any trouble, you want me to just "eat it" and not complain about it. But here I go again: ignoring my boss and getting into trouble—the exact opposite of what you think I should be doing.

THERAPIST: Your sense is that I really want you to be complying with all of your boss' expectations. And so when you defy those expectations, you suspect I judge you for that. *[empathic validation of a more elaborated picture of therapist's mental states]*

PATIENT: Definitely.

THERAPIST: So when it felt like I was judging you, Brenda, how did that make *you* feel? *[impression-specific affect-elaboration]*

PATIENT: Well, pissed off, obviously.

THERAPIST: "Pissed off" how? *[inviting elaboration on vague feeling state]*

PATIENT: It just made me angry. Like I am working so hard here to improve my attitude at work, but you're just noticing all of the things I'm doing wrong. It just doesn't seem fair. I had

thought you would be *complimenting* me on how I handled that situation!

THERAPIST: I see, so there's some anger there—I'm prioritizing your challenges at work, and not sufficiently appreciating your successes. *[empathic validation of patient's anger]*

PATIENT: I mean, I don't need a pat on the back every time I come in here, but at least not all of this criticism and interrogation.

THERAPIST: Of course. It also sounds like you were expecting me to be more positive and validating of how you interacted with your boss? *[inviting elaboration of an impression possibly associated with more vulnerable emotions]*

PATIENT: Well, I would think so. In the past, I would have just told him to "fuck off," and then I would get written up again. This time I actually made the revisions he requested, and I didn't say a single thing that was critical to him. But you didn't recognize any of that. You're just thinking about how I didn't send him a stupid e-mail.

THERAPIST: This is so important, Brenda. So you came to session today actually expecting that I was going to feel *positively* about how you handled this, but instead it just felt like I was judging you. What emotions did that bring up in you? *[impression-specific affect elaboration]*

PATIENT: I guess I felt a bit hurt. I don't want to be a baby about this, but I do respect your opinion, especially when it comes to professional matters. If I'm doing a good job at something, it would be nice to get a little bit of recognition for that here.

THERAPIST: So on some level you *do* want some recognition from me. When it felt like I was seeing you in a more negative light, that was actually quite hurtful to you. *[empathic validation of more elaborated emotional experience]*

PATIENT: Yeah, I think that's right. It's weird, but I don't think I knew that I was hurt by you until we started talking about this right now. I just jumped right to the anger, like, "This guy is being an asshole!"

THERAPIST: That is interesting. What do you make of this fact: that you were so in touch with your anger toward me, and not really

attentive to the hurt feelings? *[context-focused inquiry about nascent versus evident emotions]*

PATIENT: I mean, the anger is way more comfortable for me. I feel powerful, like: "You're wrong, I'm right, and that's the end of the story." With the hurt, I feel pathetic, like, "I'm a little baby, pay attention to me!" It's embarrassing, and definitely not how I want to come across to people.

THERAPIST: I am really grateful that you are putting words on these things, Brenda. It sounds like there were just so many feelings at play for you in our discussion about that e-mail exchange with your boss. Approaching that discussion, you were expecting and hoping that I would feel impressed with how you handled that situation. Instead I came across as much more judgmental of you, which made you feel angry but also quite hurt. At the time, you were much more in touch with your anger toward me. The anger makes you feel more powerful, but the hurt feels more embarrassing, almost like you're being infantile in a way. *[empathic summary of patient's experience]*

PATIENT: Yeah, that pretty much sums it up. That is something I have really been trying to work on—feeling *all* of my feelings, not just the anger. But it just snuck up on me this time, especially this idea that I wanted validation and recognition from you. I really was not even aware that all of this was happening for me.

This section of the session exemplifies the first four steps of the interventional pathway for mentalizing the therapeutic relationship: directing attention to the relevant relational process; collaboratively exploring the patient's experience of that process; attempting to place that experience within a broader context; and empathically summarizing the patient's experience. Without supplying the content of Brenda's feelings, the therapist employs an active, inquisitive, and targeted stance to help Brenda elaborate her emotional experience of the therapeutic interaction. The therapist invites Brenda to expound upon affectively charged impressions (*"The third degree?"*); he explores her assumptions about *his* mental states (*"Judging you in what way?"*); he invokes these assumptions to examine Brenda's own internal processes (*"So when it felt like I was*

judging you, Brenda, how did that make you *feel?"*); and he works to expand Brenda's reflections to encompass more vulnerable affects (*"It also sounds like you were expecting me to be more positive and validating of how you interacted with your boss?"*). Finally, once Brenda articulates a broader array of mental states surrounding the relational scenario, the therapist utilizes context-focused interventions to encourage her to consider the connection between these different feelings (*"What do you make of this fact—that you were so in touch with your anger toward me, and not really attentive to the hurt feelings?"*).

Brenda begins the interchange by focusing largely on the therapist's deficiencies, while directing minimal attention to her own emotions and desires in the situation. As the session unfolds, Brenda exhibits potential progress in all three domains of mentalizing. At the level of content, she identifies specific mental states in herself and the therapist: her ideas that the therapist was feeling angry and judgmental; her own feelings of anger and hurt; and her desires for recognition and validation. At the level of context, Brenda considers the broader psychological circumstances for these internal processes: her relative levels of awareness of angry versus more vulnerable feelings; her attraction to anger as an emotional state; and her aversion to experiencing hurt and desires for recognition from the therapist. And already at the level of process, Brenda exhibits greater curiosity about her own mental states ("I really was not even aware that all of this was happening for me"), as well as some level of increased flexibility surrounding her initial devaluations of the therapist ("I just jumped right to the anger …").

Thus far in the session, the therapist has focused only on *Brenda's* experience of the interpersonal scenario—an essential first step in relational mentalizing. Brenda appears to feel roughly "seen" by the therapist, and as noted above, she seems to be genuinely thinking about her mental states in the interaction. Under these conditions, the therapist is well-situated to commence the second half of the interventional pathway, which gradually introduces clinicians' own feelings and experiences into the therapeutic dialogue.

THERAPIST: Would it be OK if we switched gears for a moment so that I can speak to some of the concerns you have raised? *[explicitly marking the shift in sessional focus]*

PATIENT: Sure, that's fine.

THERAPIST: First of all, I think you are completely right that I was prioritizing this issue of you not responding to your boss' e-mail. I did not really try to explore your emotional response to receiving that constructive feedback from him, instead just jumping to the part of the interaction that felt most pressing to me. But thinking about it now, I should have asked what felt most important to *you* in the situation, so that we could collaboratively set a focus for the discussion, the way that we normally do. I am sorry about that. *[acceptance of therapist's behavioral contribution to the relational disruption]*

PATIENT: I mean, that's fine, it's no big deal.

THERAPIST: I also appreciate you recognizing that you were hoping for some positive validation from me today—for me to explicitly acknowledge your strengths in managing this situation with your boss. I have to admit: I really missed that you were needing this from me, so I did not do a good job of providing you with that validation. It was not on my radar. *[identifying a "failure" in mentalizing on the therapist's part]* Given that you were needing that from me, as well as my focus on the e-mail situation, I think that it's completely understandable that you would feel angry at me, and hurt by me *[further contextualization and validation of patients' emotional experience]* .

PATIENT: Uh, OK.

THERAPIST: What comes up for you as I say these things? *[inquiring about patient's reactions to therapist's assumption of responsibility]*

PATIENT: I mean, I definitely did not expect you to apologize. But it makes me feel better to hear this—like I am not crazy, and not just making this stuff up. I already feel calmer, less on edge.

THERAPIST: What's the calmness? *[inviting further elaboration about feeling state]*

PATIENT: Like I don't have to keep my defenses up, or go to battle with you. *[starting to laugh]* If you're taking some

responsibility, then I don't have to fight you to get you to admit that you're wrong!

THERAPIST: OK, so you end up feeling calmer as I take responsibility. It validates your experience, and you don't feel like you have to argue with me as much. *[empathic validation of patient's reflections]*

PATIENT: Exactly.

THERAPIST: Now I wanted to follow up on another part of our interaction: this idea that I was angry at you and judging you as we were discussing these things. *[identifying and empathically validating a problem in mentalizing related to the interpersonal disruption]*

PATIENT: Yeah, definitely.

THERAPIST: What clues you in to the idea that I was judging you? *[exploring patient's process of drawing the rigid/concrete conclusion]*

PATIENT: I mean, your tone, for one. You were all serious and severe, not laid back and nice, the way that you usually are. But also just this obsessive focus on my boss. Usually you would be asking me questions about how it felt for me to get that negative feedback about that creative brief, but you skipped right over that and started asking about the e-mail. Putting it all together, it seems pretty clear that you were probably upset with me for how I handled the whole situation.

THERAPIST: Well this completely makes sense, Brenda. My tone there was more serious, and I was genuinely more focused on your feelings around the e-mail, rather than all of the other aspects of the situation. This all made you feel like I was upset with you, and probably even judging you, for not e-mailing your boss back. *[explicating patient's teleological assumption about the connection between external and internal factors]*

PATIENT: Definitely.

THERAPIST: Now you mention that I was "probably" upset with you for ignoring your boss. What were you getting at there? *[encouraging patient to elaborate on an area of greater nuance]*

PATIENT: I mean, I don't know. I guess you could have been feeling a bunch of different things there. Maybe you were upset by something in your personal life, and it had nothing to do with me! Maybe you got into an argument with your wife this morning, or you got stuck in traffic on the way to work.

THERAPIST: OK . …

PATIENT: I say all that, but I don't really believe it, in the end. That doesn't explain why you were so fixated on the e-mail, and on what my boss was feeling.

THERAPIST: That is a good point. Do you have any thoughts about that part specifically: given my emphasis on the e-mail, can you imagine any additional emotions I might have been experiencing, other than just anger and judgment toward you? *[inquiring about the necessary relationship between external and internal processes]*

PATIENT: *[pausing to consider]* I guess you could have been stressed out.

THERAPIST: Stressed out in what way? *[inviting further elaboration on more nuanced perspective]*

PATIENT: Well, you and I have worked a lot on my conflicts with my boss. I know that you want me to be less aggressive with him, and you definitely do not want me getting into trouble the way that I used to. So when you hear that my boss is pissed at me again, maybe it stresses you out, and you get exasperated with me. Like, "I've worked so hard getting Brenda in line, and now here she is screwing things up again."

THERAPIST: I really like what you're articulating here, Brenda. You recognize I might have been feeling stress around the situation: really wanting you to NOT get in trouble at work, and maybe exasperated that these conflicts are happening again. *[empathic validation of patient's more nuanced perspective]*

PATIENT: Yeah, now that we talk about it, I think that is probably true. You can get really stressed out about this stuff.

THERAPIST: I think you are right about that, Brenda. In light of all this, I am wondering if I should say a bit about how it seemed to

me like I was feeling in that interaction? *[explicitly "marking" a shift to sharing therapist's own perspective]*

PATIENT: Of course, I would love to hear that.

THERAPIST: I know that you were initially feeling like I was angry at you, and judging you for not responding to your boss' e-mail. I suppose that could have been happening for me on some level, but I was more in touch with feeling quite worried about you. While part of that worry was about you "getting in trouble," as you say, I was feeling most concerned about your *attitude* as you were sharing about this situation. From my perspective, you were focusing so much on your boss' faults, and all of the things that he was doing wrong. But you seemed to be reflecting far less on *your* role in these difficulties. For better or for worse, I think that is why I prioritized this issue of you ignoring your boss. I was worried that, if I didn't do something to help you consider your *own* behavior with your boss, the situation could potentially escalate and get worse. *[sharing own perspective about the teleological association—in this case an affective self-disclosure of therapist's mental states]*

PATIENT: That is so interesting.

THERAPIST: Where is your mind going? *[exploring patient's response to therapist sharing his own perspective]*

PATIENT: I definitely wasn't thinking about you feeling worried about me. Even when I was talking earlier about you being stressed out, I still felt like you were mad at me, and blaming me for making bad decisions. But I guess this does explain why you were being so serious, and asking me to think about my boss' feelings: you were wanting me to "wake up" and look at myself! I appreciate that, I guess. That is not always easy for me.

THERAPIST: What do you feel, as you think about things in this way? *[impression-specific affect elaboration]*

PATIENT: A bit better, actually. I would much rather you be worried about me than pissed off that me. All in all, I feel a lot less agitated, and more comfortable with you again.

THERAPIST: So when you experience me as feeling worried about you rather than just angry at you, you end up feeling less upset, and more comfortable in our relationship. *[empathic validation of patient's response to therapist's affective self-disclosure]*

PATIENT: Yeah, I think so.

THERAPIST: So where does this all leave you, at this point? *[inviting reflection on new understanding]*

PATIENT: I mean, it's pretty crazy how similar this whole thing is to what goes on at work.

THERAPIST: OK, in what way? *[inviting patient to elaborate/develop an outbound relational tracer]*

PATIENT: I mean, I wanted validation from you, and when you didn't give it to me, I immediately became convinced that you were judging me. But then rather than feel hurt by you, I just got pissed off and started acting like an asshole. That is the exact same thing that happens with my boss.

THERAPIST: I appreciate you noticing these parallels. They are quite striking.

PATIENT: *[laughing]* unfortunately with you, you're sitting right in front of me, so I don't get to ignore your e-mails!

THERAPIST: *[laughing as well]* We'll have to think about some ways that you can ignore me too—when I really deserve it.

PATIENT: OK, it's a deal.

THERAPIST: So do you have a sense of what it might look like for you to work on these challenges here? *[inviting patient to consider the process of addressing problems in mentalizing]*

PATIENT: Well, I need to continue what I have already been trying to do: when I am upset with you, trying to feel *all* of my emotions, rather than just the anger and frustration. Like I said earlier, I had no idea that I was feeling hurt by you, so I really need to stay on top of that. But I also need to pay attention to this suspicion that you are judging me and criticizing me. It is weird, sometimes I do not feel that way at all. And then out of the blue, you look at me the wrong way, and I am off to the races. It's actually pretty humbling.

At the time, I don't even realize that it is happening, but I feel so convinced that I am RIGHT about what I am seeing.

THERAPIST: I was thinking something similar, Brenda. One thing that stood out to me today was how you *arrived* at the idea that I was judging you—namely by seeing these observable factors (my tone of voice, my focus on the e-mail) as some form of "proof" about how I feel about you *[underscoring a problem in mentalizing—teleological thinking—that emerged in the discussion]* . This reminds me a bit of what happens with your boss: when he gives you some form of constructive feedback, you take that to mean he is looking down on you, and seeing you in a negative light *[offering an outbound relational tracer]* .

PATIENT: Yeah, I see that.

THERAPIST: What do you think about us trying to "catch" these moments here? The times when you quickly draw confident conclusions about how I am feeling toward you, based on something I do or say. If you can notice these tendencies in the heat of the moment, that might give you more of an opportunity to *reflect* on these conclusions in a new way, rather than simply running with them *[offering "marked advice" about how to address the problem in mentalizing]* .

PATIENT: I think that I could do that. Or at least start *trying* to do it. I could use this like a "practice space" to work on the issues that really mess with my relationships at work. If I can consider other things that you might be feeling, that might make it easier to imagine additional things my boss could be feeling, when he does something that really pisses me off.

This portion of the session encompasses the final four stages of the interventional pathway for mentalizing the relationship: exploration and acceptance of the therapist's contribution to the disruption; identification of some problem in mentalizing relevant to the patient's experience of the disruption; utilization of domain-specific interventions to address the mentalizing difficulty; and collaborative reflection on the new understanding. As mentioned previously, whereas the earlier steps in the pathway focus primarily on the patient's experience of the relational

scenario, these interventions involve a progressive introduction of the therapist's own perspective into a therapeutic discourse.

The therapist starts by sharing his own ideas about his interpersonal "role" in the conflict, including acknowledging behaviors that contributed to the conflict (*"I did not really try to explore your emotional response to receiving that constructive feedback …"* ; *"I did not do a good job of providing you with that validation"*); recognizing his own problems in mentalizing impacting the situation (*"I really missed that you were needing this from me …"*); identifying alternative behaviors that he could have employed (*"I should have asked what felt most important to you in the situation …"*), which might have ameliorated Brenda's experience of the interaction; and explicitly apologizing to the patient (*"I am sorry about that"*). Of note, these communications all introduce new content into the discussion, and that content clearly derives from the therapist's own mind, rather than simply reflecting Brenda's mind. However, by itemizing his *own* potential failings, the therapist is only relaying ideas that explicitly validate Brenda's original experience of the relational problem, in this way "titrating the otherness" presented to Brenda.

As the session progresses, the therapist gradually but persistently attempts less contingent interventions: inviting Brenda to reflect on an aspect of her *own* experience that departs from her initial assumptions (*"Now you mention that I was 'probably' upset with you for ignoring your boss. What were you getting at there?"*); encouraging her to consider alternatives to the assumed teleological association (*"Given my emphasis on the e-mail, can you imagine any additional emotions I might have been experiencing, other than just anger and judgment toward you?"*); sharing his own understanding of his feelings in the interchange (*"I felt worried that, if I didn't do something to help you consider your* own *behavior with your boss, the situation could potentially escalate and get worse"*); underscoring the problem in mentalizing as a topic for future attention (*"One thing that stood out to me today was how you arrived at the idea that I was judging you …"*); delivering an outbound relational tracer (*"This reminds me a bit of what happens with your boss …"*); and engaging in "marked advice-giving" around how to address these challenges moving forward (*"What do you think about us trying to 'catch' these moments here?"*).

By emphasizing the therapist's own experiences in the therapeutic relationship, all of these interventions prompt Brenda to expand her original outlook on the interaction. However, the therapist intersperses these more "challenging" interventions with a range of techniques that validate and prioritize Brenda's experience as well. He maintains an inquisitive, curious stance focused on the nuances and contours of Brenda's perspective (*"What clues you into the idea that I was judging you?"*), liberally employing empathic validation to affirm her reflections (*"So when you experience me as feeling worried about you rather than just angry at you, you end up feeling less upset, and more comfortable in our relationship"*). The therapist also explicitly and frequently praises Brenda's efforts at reflection (*"Well this completely makes sense, Brenda"* ; *"That is a good point"* ; *"I really like what you're articulating here, Brenda"* ; *"I think you are right about that"* ; *"I appreciate you noticing these parallels"*). He affirms Brenda's autonomy by eliciting her consent prior to sharing his own views (*"Would it be OK if we switched gears for a moment so that I can speak to some of the concerns you have raised?"* ; *"I am wondering if I should say a bit about how it seemed to me like I was feeling in that interaction?"*), also exploring Brenda's thoughts and feelings about those disclosures (*"What comes up for you as I say these things?"* ; *"Where is your mind going?"*). In these ways, the therapist works to help Brenda to feel emotionally safe and supported in the interaction—in our view, the necessary condition for enabling Brenda to reflect more broadly on the interpersonal disruption.

Brenda exhibits notable improvements in mentalizing throughout the course of the session. At the start of the discussion, Brenda appears quite convinced that the therapist is feeling angry and judgmental toward her, an experience that parallels Brenda's difficulties with paranoid thinking in relationships with supervisors and other authority figures. The therapist privately identifies this form of non-mentalizing as teleological thinking, utilizing process-focused techniques for teleological mode to address Brenda's excessive concreteness in the current scenario. In response to these interventions, Brenda is able to consider her potential "reasons" for teleologically interpreting the therapist as being angry with her (e.g., the therapist's serious tone, his emphasis on the e-mail situation)—a sign that she is starting to see the teleology as a *psychological* process, rather than simply a veridical fact.

Brenda also demonstrates increased flexibility surrounding her conviction that these external factors entail that the therapist is feeling angry with her. She states that "probably" the therapist was upset with her, rather than categorically so. At a cognitively level, Brenda reflects on factors in the therapist's personal life (e.g., marital issues, traffic) that might have led him to be more serious. Brenda also considers mental states other than anger that the therapist might have been experiencing in the interaction, including stress, exasperation, and a desire for Brenda to avoid interpersonal conflict at work. All of these reflections suggest a potential weakening of Brenda's certainty surrounding the teleological association in question.

When the therapist shares his experience of his own emotions surrounding their earlier interaction, Brenda appears to genuinely consider the potential relevance of these feelings ("I definitely wasn't thinking about you feeling worried about me"), spontaneously employing these ideas as an alternative explanation for the therapist's behavior earlier in the session ("I guess this does explain why you were being so serious, and asking me to think about my boss' feelings …"). This demonstrates Brenda's ability to "take in" the therapist's perspective about his own mind, while reexamining her teleological assumptions about the meaning of the therapist's behavior.

Brenda also displays progress in context-mentalizing throughout the interchange. In response to the therapist taking responsibility for his part in their conflict, Brenda begins to consider her own tendencies toward argumentativeness and antagonism ("If you're taking some responsibility, then I don't have to fight you to get you to admit that you're wrong!"). Similarly, when the therapist invites Brenda to reflect more generally on the discussion (*"So where does this all leave you, at this point?"*), Brenda is able to consider her own contribution to the interpersonal disruption ("I wanted validation from you, and when you didn't give it to me, I immediately became convinced that you were judging me"); to observe parallels with her challenges at work ("That is the exact same thing that happens with my boss"); and to identify steps she might take to address these difficulties in the future ("I also need to pay attention to this suspicion that you are judging me and criticizing me").

Of note, Brenda starts to acknowledge her behavioral role in the relationship only *after* she recognizes her teleological processing of the situation. Prior to that moment, she is focused only on the *therapist's*

deficiencies, and so at an experiential level, she has no substantive part in their conflict. If the therapist is simply judging her, then *he* is the problem, and so she needs to react accordingly: with defensiveness, criticism, argumentation, and so on. However, as Brenda considers a broader range of mental states at play in their dynamic (e.g., additional emotions in herself, a wider array of feelings in the therapist), she begins to reflect upon her tendency to engage with the therapist in a more suspicious and defensive manner. This opens up the pathway for Brenda to assume an increased sense of agency in the interaction, and in her relationships more generally. Through working together to explore each party's experience of the interpersonal process, patient and therapist move toward a position of greater understanding, trust, and responsibility in the therapeutic relationship.

Chapter 12 contain excerpts from Drozek, R. P., & Unruh, B. T. (2020). Mentalization-based treatment for pathological narcissism. *Journal of Personality Disorders* , *34* (Supplement), 177–203.

PART 4

CLINICAL APPLICATIONS

Part 4 explores the clinical applications of mentalization-based treatment for narcissism (MBT-N). The chapters review the most common clinical challenges that are likely to arise in the treatment of patients with pathological narcissism (PN), providing practical recommendations about managing these problems in everyday clinical practice. Each co-author shares an extended example of his work with a patient with PN, thus illustrating MBT-N with three-dimensional human beings over the course of longitudinal psychotherapy.

13

Moving Forward in the Treatment

Once mentalization-based treatment for narcissism (MBT-N) is initiated, two additional techniques prove essential during the early phase of treatment and beyond: *contrary moves* to rebalance across mentalizing polarities; and *mentalizing functional analysis* to address patients' maladaptive behaviors. In this chapter, we outline how to utilize these techniques to address some of the core clinical challenges in pathological narcissism (PN), including suicidality. Additionally, we review common therapeutic developments and challenges appearing during the middle and later phases of treatment, as MBT-N progresses toward termination.

Contrary moves and mentalizing polarities

As outlined in standard MBT, contrary moves are interventions aiming to "rebalance" mentalizing when it becomes fixed at one end of the standard mentalizing polarities (Bateman & Fonagy, 2016 , pp. 197–200). We will review mentalizing polarities and how they are assessed clinically, before discussing special modifications and emphases for PN.

Classic polarities of mentalizing

In an attempt to take into account the multifaceted nature of mentalizing, and to help clinicians and patients target problem areas in treatment, a number of polarities of mentalizing have been described (see Figure 13.1). The "poles" are paired along what were initially called dimensions thought to reflect different social-cognitive processes: automatic/controlled, self/other, internal/external, and cognitive/affective. These are not dimensions in the normal sense of the word, containing distinct mental faculties operating to the exclusion of one another, akin to a seesaw. Rather,

paired poles work together to create a balanced and flexible mentalizing process across each polarity that is responsive to context, goals, and intentions. Whereas adaptive mentalizing flexibly recruits and navigates between both poles as is called for by the situation at any given time, in ineffective mentalizing, poles become over- or under-used, out of balance, and unresponsive to context. Rigid fixation at any of the poles impedes context-responsive mentalizing, contributing to disordered interpersonal interactions and incongruence within the self. With each polarity, sometimes it is more helpful to be closer to one end or the other, not just always in the middle; what is most helpful will depend on the situational context.

During the assessment phase of MBT-N, we create a picture within a wider mentalizing formulation of how, and in what circumstances, patients mentally flip and fixate along each polarity. By explicitly sharing our understanding of how these polarities become imbalanced, we help patients become more cognizant of the functioning of their mind, and how it can interfere with flexible engagement in interpersonal relationships. We clarify the ineffective use of the poles, as well as when, where, and how patients fail to integrate them.

Inevitably, assessment of PN focuses heavily on the self/other polarity as described earlier in the I-, me-, we-modes which dynamically govern basic social functioning (Chapter 1). But recognizing where most of our patients' processing falls along the cognitive/affective polarity, for example, helps to refine treatment. Over-recruitment of cognitive rational processing in relationships causes considerable problems in PN. Patients might seem to be listening carefully to other people, but in actuality they may be distant, detached, over-protective, and uninvolved. But this is really I-mode masquerading as we-mode. It is an illusion created through pretend mode, and we can easily be tricked into thinking therapy is taking place when there is no meaningful interaction. There is no integration of affective processing with cognitive appraisal.

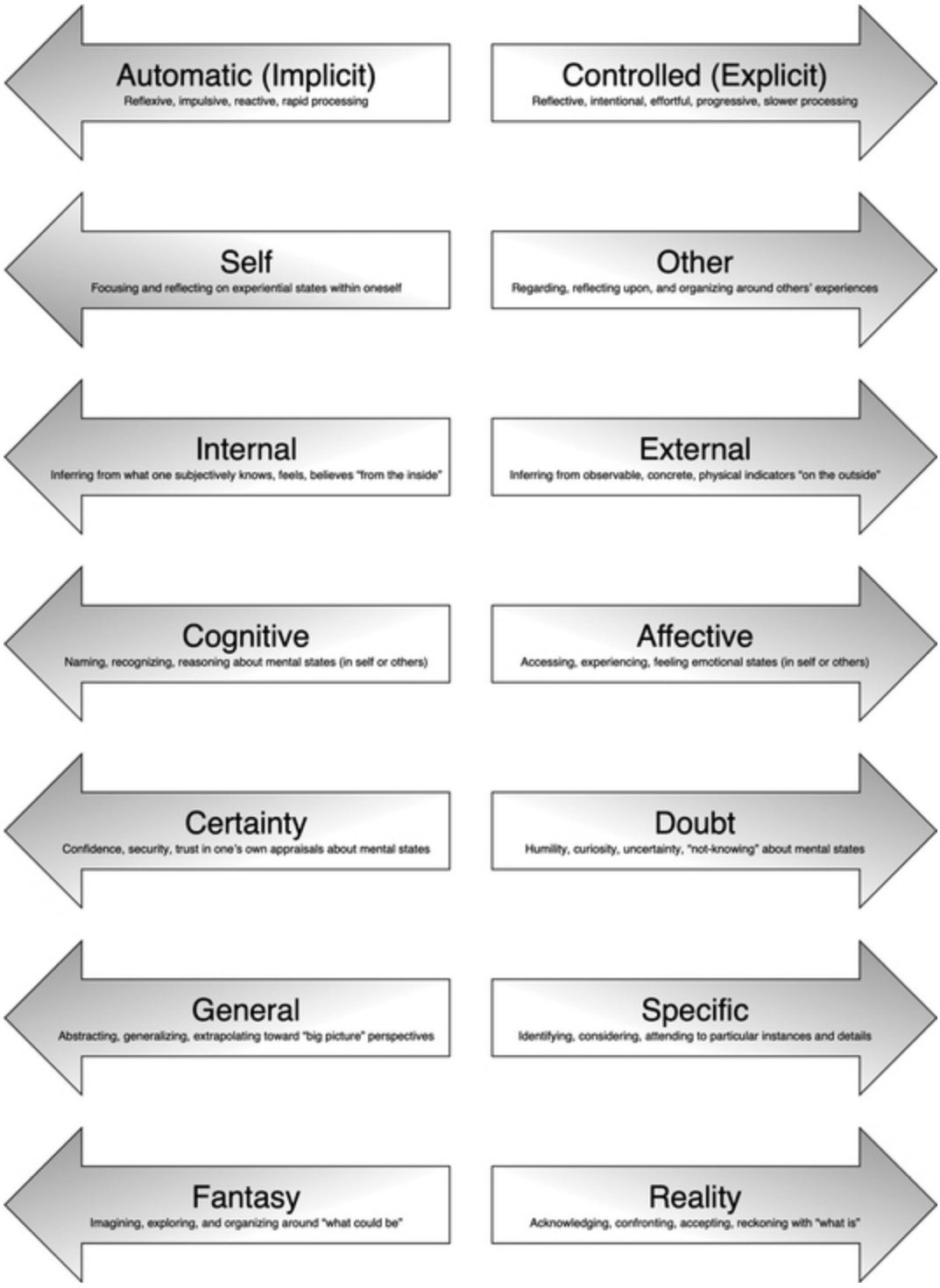

Figure 13.1 Classic and additional polarities of mentalizing assessed in MBT for narcissism.

This imbalance may be accompanied by further imbalances along the automatic/controlled polarity, for example when patients rarely utilize the automatic mentalizing that is necessary for fast and reflexive interaction

between people, as a first step toward we-mode. Relying on automatic assumptions about mental states is an effective way of making rapid progress toward a shared understanding, as it is not necessary to begin from the starting line when reliable shortcuts can be taken. This allows for the serve-and-return of reciprocal understanding to continue smoothly. Only when an obstacle appears, such as a misunderstanding, is it necessary to temporarily divert to controlled mentalizing. Inversely, when patients underuse automatic mentalizing and overuse controlled mentalizing, this can result in laborious and off-putting interpersonal processes.

Additional polarities assessed in MBT for narcissism

In addition to assessing the four polarities listed above, which are well-characterized neurobiologically and clinically elsewhere (Bateman et al., 2022 ; Lieberman, 2007), we have found it helpful to consider three additional polarities firmly rooted in clinical process: certainty/doubt, general/specific, and fantasy/reality (see Figure 13.1). Certainty and doubt are always imbalanced in psychic equivalence, insofar as doubt is inactive, and certainty is dominant. Inversely, excessive doubt can be as disabling to mental function and decision-making as unquestioned certainty. Patients with PN often convey excessively generalized descriptions of personal experience (“One feels that it was uncomfortable, and something was going on”), describing a situation as if they have zero bearings in it, and no way to make sense of it. Patients can also focus excessively on specific details of scenarios, while struggling to extrapolate to meaningful wider views of a situation. In tracking how patients with PN manage mentalizing along the certainty/doubt and general/specific polarities, we often need to shift the balance toward more detail and nuance, or toward what can be known in the current moment with some confidence. Otherwise, the conversation can become vapid and empty within an entrenched pretend mode. A third additional polarity of fantasy/reality is of utmost clinical concern in MBT-N. Muller and Midgley (2020) have linked this polarity with developmental stages of healthy and abnormal pretend mode functioning. Some patients live in a mind that is not tethered to painful realities within themselves or others, overusing fantasy in managing themselves with no realistic check or calibration. We see this especially when patients’ mental states organize

tightly within me-mode around problematically unrealistic narratives of self (see Chapter 1).

Contrary moves: General aims and techniques

MBT posits that patients' mentalizing polarities are significantly influenced by a range of factors: here-and-now emotional experience, predominant attachment strategies, and current relational contexts, including the people with whom they are interacting, what they are doing, their interpersonal aims and agendas, and so on. Since flexibility across all polarities is essential for effective mentalizing, one of our central tasks is to monitor how patients engage each pole of mentalizing, and then to employ *contrary move* interventions to help restore flexibility and balance in mentalizing (Box 13.1). The chief aim of a contrary move is to stimulate reflection at mentalizing poles that are currently "offline" or underprioritized. Toggling whichever pole is being left out often helpfully rebalances mentalizing synchronously across all polarities. We find this especially useful when discussing key content or contexts identified in the formulation as causing difficulties with "holding the balance" across specific polarities.

Box 13.1 Contrary moves in MBT for narcissism

Purpose:

To promote flexible, balanced, context-responsive mentalizing across polarities when mentalizing has become fixed at any specific pole
To advance the scope of what can be considered in therapeutic dialogue when the process seems “stuck”

DO:

Monitor patients’ mentalizing process according to the polarities, attempting contrary moves in recurrent areas of imbalance identified in the formulation
Defer contrary moves during acutely heightened distress, instead prioritizing empathic validation of current experience
When deciding a contrary move is indicated, be persistent. Do not be deterred by unreflective rebuffs
Insert one’s own perspectives only by clearly marking it as one’s own, leaving room for patients to express distinct views, and directing joint attention to discrepancies
Assess whether the contrary move has truly improved mentalizing by “checking out” what has happened to the original perspective, and how it is now held in relation to the new pole
Judiciously praise patients’ effort to “try on” a new perspective (flexible mentalizing), and to hold multiple perspectives simultaneously in mind (balanced mentalizing)

DON’T:

Introduce contrary moves to patients when they are in psychic equivalence
Feign not-knowing when one feels convinced. Instead, express awareness of confidence regarding one’s own position, as well as curiosity/interest about how both parties see things so differently
Aim primarily to persuade patients to adopt a particular conclusion

Contrary moves are thus a basic, broadly applicable MBT intervention for helping patients recover and maintain balanced mentalizing whenever it is challenged across all stages of treatment. We readily apply contrary moves whenever patients seem to be overusing or underusing any pole of a mentalizing polarity. Yet we have found that clinicians new to MBT can

become confused about how to integrate contrary moves with other aspects of the model. Four points of guidance can be offered which are especially relevant in MBT-N.

First, when working with acutely distressed patients who are caught up in externalizing or other-focused blaming, therapists often mistakenly attempt a contrary move shift too prematurely. In contrast, we take care to manage patients' heightened emotional arousal through content-focused techniques of empathic validation and elaboration of patients' own current experiences (Chapter 6), especially if they seem poorly mentalized. For example, if a patient erupts into loudly expressing anger toward her husband for years of perceived injustices, we would not immediately ask her to consider the husband's potential motivations; she is likely not currently adequately mentalizing around her own mindset, or sufficiently interested in considering his. As discussed in Chapters 9 and 10 , we never rush in to challenge non-mentalizing processes by bringing in our own mentalizing perspectives too quickly, for instance by pointing out unbalanced polarities long before patients believe there is a problem. Such attempts are especially risky in the treatment of PN, where we utilize empathic interventions to convey to patients that we are focused on trying to accurately understand their current experiences (pp. 135–141). In this empathic stance, we hope to stabilize rudimentary mentalizing, thereby paving the way for higher-order challenges posed by forthcoming contrary moves.

Second, once we have decided contrary moves are indicated, they should be delivered doggedly. Patients with PN may dismiss our suggestions more glibly or more forcefully than other patients. So we are not daunted from insisting patients consider the pole being left out. It helps to mark our insistence by stating we know we are being a bit "stubborn," and creating some difficulty for patients. We can also distinguish aloud patients' view from our own position, attempting to stimulate patients' curiosity about this discrepancy (*"I'm interested at this moment in how it can be that you and I are seeing this from such different sides"*). In this way, we move beyond a complete stalemate with patients by developing a joint reflective focus around how our attempted contrary move seemed important to us, yet felt unhelpful or harmful to patients. Exploring the two positions in the room and any discrepancies between them tends to uncover important material which can be the target of another round of mentalizing. For example, a "know-it-all" patient who repeatedly refused to take up a therapist's

contrary moves aimed at introducing doubt shared later how remaining staunchly certain about her own appraisals had protected her on many occasions from serious intimate partner violence.

Third, when patients do successfully respond to contrary moves to arrive at a new perspective, we valorize the effort expended to get there, underscoring the usefulness of what has been achieved for life beyond treatment. As discussed in Chapter 5 , we regularly utilize judicious praise to reinforce improvements in mentalizing: “You have really worked out something important here.” When we employ contrary moves, patients sometimes require more support and appreciation for their efforts, in order to buoy up positive experiences within the self, and to tolerate therapeutically induced confusion, disorientation, self-doubt, frustration, or regret. We do this by explicitly appreciating patients’ significant achievement in considering new perspectives on themselves and others: “I’m not sure I would have had it in me to take a hard look at myself in such a challenging situation, as you have just done for yourself.”

Fourth, we bear in mind the aim of a contrary move. With contrary moves, we are not simply trying to introduce new content for consideration, but to enhance flexibility of movement across all polarities. This is akin to enhancing “degrees of mentalizing freedom.” The endpoint is a strengthening of the context-responsiveness of the mentalizing system, with which our patients can now approach other situations. Thus, while we often begin by helping patients reflect on previously absent content at a new pole, we do not stop there. Older, entrenched mentalizing processes will not simply evaporate with isolated instances of rebalancing polarities in the context of therapy. For example, patients who have trouble genuinely empathizing with others will surely continue to struggle with this, even after a therapist helps them to do so in one instance. Hence, we “check out” how patients hold the previously absent perspective that has been generated at the new pole, alongside prior perspectives remaining anchored at the counterpart pole. We assess how patients can now better “hold the balance” across specific polarities in future sessions, and in non-treatment contexts. We work to ensure that what has been added in at the new pole does not entirely supplant important aspects of experience at the counterpart pole. Our hope is that, rather than merely becoming rigidly fixated at the new pole, patients will meaningfully engage with these new dimensions of

experience, in a flexible and dynamic fashion that has the potential to produce real-world change.

Contrary moves with special relevance to pathological narcissism

Throughout the various phases of MBT-N, we frequently deploy contrary moves across each polarity as needed for relieving mentalizing stuck points. There are many possible types of contrary moves, examples of which abound throughout this text and are catalogued here (Table 13.1). Shifting from cognition to affect is a very basic intervention in MBT-N that is discussed thoroughly in other chapters (Chapters 6 & 8). Here we highlight additional contrary move directionalities that are especially important in PN.

Table 13.1 Sample contrary moves in MBT for narcissism

Direction	Sample questions
Automatic → Controlled	"Hang on, we're moving pretty fast here, and I can't keep up. Can you slow down and take me through what happened, really thinking about how you're connecting the dots?"
Controlled → Automatic	"You've laid out five theories you are considering for why you were fired. But what does your gut tell you right now?"
Self → Other	"You believe your wife has no right to demand a divorce. Why do you imagine she might be wanting one?"
Other → Self	"As you focus on your parents' faults and deficiencies, what emotions come up for you?"
In relation to self: Internal → External	"I hear you saying you are fine and don't feel anything as you talk with me. What do you make of your leg tapping, hands fidgeting, and forehead sweating?"
In relation to others: Internal → External	"You worried that she would have no interest in dating you. But what do you make of her saying 'yes,' and smiling when you asked her out?"
In relation to self: External → Internal	"What was going on for you that led you to point out your colleague's faults at the meeting?"
In relation to others: External → Internal	"When you saw your boss crying down the corridor, what did you imagine he was going through?"
Cognitive → Affective	"As you ponder and talk about this, how are you feeling right now?"
Affective → Cognitive	"You're worried your panic will only get worse. Can you think of some way you might help yourself calm down?"
Certainty → Doubt	"You say that you know she only beat you out and got the position because she is more attractive. But that's not so obvious to me. What makes you so sure?"
Doubt → Certainty	"You say that you have no idea what to say about your week, but we both know that you ended up back in the emergency room this week. Is there anything that you CAN be sure about here?"
General → Specific	"I understand you always feel hopeless in some sense, but I am getting the sense that it got even worse the other day. Could you walk me through how things unfolded for you, step-by-step?"
Specific → General	"We reviewed your recent suicide attempt in a lot of detail today. What do you take away from this, that could help you manage yourself better going forward?"

Direction	Sample questions
Fantasy → Reality	"You have this sense that you will someday become a great film director and screenwriter. But I am curious … with no money in the bank, no pages written yet, and your troubles with follow-through, how exactly do you see yourself accomplishing this?"
Reality → Fantasy	"You are so focused on how dismal things are for you right now. Can you let yourself imagine anything new for yourself—how life might lead you somewhere that you can't yet see?"

Self → Other / Other → Self

Patients with PN typically overinflate the importance of their own experience and derogate or overlook others' experiences ("His poor performance on the job is a massive liability for me"). Limited emotional empathy is mobilized regarding others' experiences, except when particular needs, interests, or capacities are activated within the self. Our basic task with these patients is to use contrary moves to either rekindle the vestigial pole of regard for others, or to gently puncture (with concurrent empathic validation) the inflated pole of self-valuation.

We are also ready to apply self/other contrary moves in the opposite direction, as PN is also marked by the tendency to shunt reflection away from self by focusing on grievances against other people (Chapter 7). Patients thus adopt other-directed postures of indignation and grandiosity, when they might benefit from inwardly refocusing to reckon with vulnerable feelings within the self. To help patients tolerate our contrary moves from others to self, we first work supportively to empathize with what it is like to be in the current other-focused orientation. With ample curiosity, we explore how they arrived at this position, and how they may feel reassuringly certain, powerful, or superior there. In this way, we support our patients to eventually try on some uncertainty, and to mobilize their own wonder about mental states they may be ignoring or failing to recognize in themselves.

Certainty → Doubt

Cultivating uncertainty is virtually synonymous with promoting mentalizing. However, as shown just above, establishing doubt is a special challenge in patients with PN because certainty is often associated with psychologically necessary processes of self-enhancement, as expressed in

experiences of superiority, grandiosity, and entitlement (Chapter 2). When uncertain, patients can then experience an unbearable sense of fragmentation and incoherence in the self, for example when they encounter self-doubt, confusion, humiliation, or a sense of themselves as "failing" in some way.

In MBT-N, we monitor current levels of certainty and doubt, attempting to toggle between them depending on the content and context of discussion. As with self/other contrary moves, while pressing to introduce doubt in MBT-N, we remain especially empathically sensitive to the burden undertaken by disrupting rigid certainties, which may be functioning as a last bastion of strength supporting precarious self-esteem. When pathologically certain self-experiences are challenged, we may inadvertently trigger a sudden plunge into psychic equivalence and reactive teleological behavior, which can proceed rapidly toward self-destructive acts to reestablish needed self-coherence (see below).

General → Specific

Generalizations can be lifesaving in the face of trustworthy threat cues: "When someone approaches me alone in a dark alley, I should run." More broadly, generalized mentalizing scripts help to guide us through life so that we do not have to "reinvent the wheel" every time we encounter situations that could be effectively navigated by relying on patterned learning about similar scenarios ("I should smile and make small talk when I meet someone new at a party").

However, we also need the capacity to evaluate specific situations more carefully in their own right. In PN, over-generalizations about Self and Other often impede more adaptive mentalizing in specific contexts, such as when genuine empathy cannot be mobilized toward others ("He's always like that; he's just an asshole"), or when patients are unable to entertain a more nuanced narrative that supports narcissistic functioning. Patients with PN often cling to overly generalizing statements ("I always feel hopeless"), but we can achieve more mentalizing traction by insisting on exploring specific instances, memories, interactions, or aspects of a situation (*"Paint me a clear picture of the last time you felt so hopeless"*).

Fantasy → Reality

A healthy interplay in the mind between fantasy and reality facilitates adaptive processes of play, disillusionment, and accommodation to the inevitable slings and arrows of life. Patients with PN struggle to stably engage these processes because they cling to self-aggrandizing visions, excessively self-critical narratives, and unsustainably perfectionistic expectations of themselves and others. This represents a tragic, deeply entrenched decoupling of the mental realms of fantasy and reality. In MBT-N, we actively track the degree to which "what is" true in the here-and-now is being conflated with, or avoided in favor of, "what might be" the case at some future point in time. We intervene to rebalance this polarity, in the hopes of promoting adaptive accommodation to real-world limitations and disappointments.

When patients adhere to unrealistic expectations, contrary moves often take the form of *reality-based challenges* , discussed earlier as a core technique for managing pretend mode (Chapter 8). We generally do this by introducing reminders of reality that may intentionally or inadvertently destabilize grandiose fantasies. While this process is essential to the management of grandiosity in MBT-N, it often requires an initial approach that is deliberate, sensitive, contingent, and aimed at exploring whatever realms of fantasy our patients are inhabiting. It is as though we first must empathically follow patients up to the "top of the mountain" to appreciate their superior view of themselves, and the inferior world of others below: "Let's have a look around together, and take in the beautiful view from up here." This elaboration of patients' grandiose experience must generally occur first before nudging patients "back down the mountain toward reality," because the self-stabilizing functions of the grandiose mindset must be given their due.

We are reminded of a young man who had failed repeatedly to pass professional exams required to begin his intended career of law, but who sometimes regarded himself as an undiscovered entrepreneurial genius. He often fantasized about "dominating" potential investors in imagined high-stakes negotiations rehearsed in his own mind. When he finally had the opportunity to present his ideas to a room full of real-life potential investors, they turned down his deal. However, the therapist would never have known this from the patient's triumphant narration about the meeting. Despite the therapist's repeated attempts to clarify this issue, only as the

session was nearly at a close could the patient tolerate disclosing that, in fact, a deal had not been struck.

In MBT-N, we seek to empathize with grandiose fantasies, out of sensitivity to their function in providing patients with a psychologically necessary sense of self-coherence. But we can easily become assimilated into these "bubbles" or cocoons, such that grandiose processes are not being mentalized at all, but are only being explored indefinitely within a pretend mode stance. We thus seek tolerable contrary moves to help grandiose patients travel "back down the mountain" toward a more accurate vision of reality, and the place of themselves and others in it.

Suicidal behavior in pathological narcissism

Standard MBT outlines a clear approach to understanding self-harm and suicidality in borderline personality disorder (BPD; Bateman & Fonagy, 2016 , pp. 224–227). It begins with adopting MBT's premise that "dysregulated" hostile or self-destructive behavior in BPD is a response to a transient destabilization of the sense of basic coherence within the self. Recall from Chapter 1 that "good enough" mentalizing supplies us with a story of who we are that makes basic sense, and feels "acceptable" to us because it appears sufficiently coherent. This sense of self-coherence is at some level an illusion, because when we more carefully consider our own subjective experience (*I-mode*), our experience of others (*me-mode*), or our sense of how others are perceiving us (*personalized me-mode*), we find there are lots of bits that do not add up to a coherent or palatable picture of ourselves. Mentalization supplies the flexibility, curiosity, and perspective-taking needed to "paper over" these cracks within our own subjectivity. Mentalizing helps us to retain a sufficiently robust sense of who we are, enabling us to withstand the challenges posed to our current selfhood by the interpersonal and intrapsychic vicissitudes of everyday life.

In BPD, however, insecure attachment processes render a person more vulnerable to cascades of mentalizing collapse, in the face of the painful incoherence and "badness" which emerge within subjective experience. Since mentalizing is offline, survival is often mediated by concrete action (e.g., self-harm, suicidality, sexual behavior, substance use) to destroy the perceived vehicle or source of this pain. The intolerable "alien self"

experience is thus managed by projecting the badness outside of the self, either onto one's own body (e.g., in the case of suicidal or self-injurious behavior) or onto other people (e.g., when patients with BPD experience others as mistreating and victimizing them).

In PN, serious threats to self-coherence cause similarly behaviorally destabilizing disruptions, albeit in a different way. The difference lies in the distinctions around the origin and management of the narcissistic alien self (Chapter 2). Whereas in BPD painful discontinuity is managed by evacuating badness outside the self, in PN, intolerable incoherence is managed by projecting a sense of goodness onto the self (self-enhancement). The self-stabilizing functions of suicidality in PN are exhibited in the empirical literature reviewed next.

Unique empirical features of suicidality in pathological narcissism

Suicidal behavior in BPD is typically ambivalent, conflicted, or unclear in intent, and not lethal. Low rates of lethality derive from a high likelihood patients will be rescued due to having reached out to others for help at some point before, during, or after the self-destructive action. Common models of suicidality and self-harm in BPD agree that these experiences are most often caused by interpersonal experiences of real or perceived rejection, or loss of support (Brodsky et al., 2006 ; Gunderson & Lyons-Ruth, 2008 ; Yen et al., 2005). This means that patients' outward emotional and interpersonal presentations, which often oscillate somewhat predictably in response to interpersonal stressors, are usually reliable markers of increased suicide risk for attentive clinicians (Gunderson, 2014 ; Unruh, 2020).

In contrast, in PN, serious suicidal intent can emerge without any preceding disclosure of distress or overt red flags, resulting in "death without warning" (Apter et al., 1993; Links, 2013 ; Ronningstam et al., 2008). Suicidal behavior in PN tends to be rapid, reliant on more lethal means, and not impulsive, occurring against a backdrop of hidden premeditation and careful planning. Subjective levels of distress prior to suicidal acts are often low, due to the presence of dissociation, meaninglessness, or a temporary sense of agency and self-control from planning the suicidal act (Blasco-Fontecilla et al., 2009). This description is consistent with the employment of attachment deactivation strategies in PN (emotional distancing) to cope with relational distress (Chapter 2).

Accordingly, we do not presume that patients' lack of emotional expression (e.g., minimal apparent distress during therapy sessions) implies the absence of suicidal impulses.

With PN, acute suicide risk is often driven by "narcissistic injuries," or life events triggering an intolerable sense of shame, entrapment, dishonor, or defeat, such that suicide becomes the only imaginable escape. Certain life events are especially associated with suicide attempts in PN, including serious employment or vocational setbacks; imminent financial crisis (e.g., bankruptcy, foreclosure); escalating marital conflict; major personal injury or medical illness; threats to long-cherished hopes and dreams; and loss of valued others who serve a "self-object" function of externally supporting patients' self-esteem (Apter et al., 1993 ; Blasco-Fontecilla et al., 2010 ; Ronningstam et al., 2008). In some accounts of PN, a unifying thread in these disparate destabilizing life events is a real or perceived threat to self-esteem and control (Weinberg et al., 2019).

Shame is another internal experience common to many types of narcissistic injuries that may precipitate suicidal states in PN. Shame is typically evoked by a negative evaluation of self that is prompted by a past or imminent failure (Tangney & Dearing, 2002). Shame proneness generally heightens risk for suicidality and self-harm across many contexts, but it may specifically mediate suicide-related behavior in PN, even though such processes are typically hidden from plain view (Ritter et al., 2014 ; Ronningstam & Maltsberger, 1998 ; Schoenleber et al., 2014).

Suicidal behavior in PN may function to manage shame by reimposing a sense of control, diminishing external stressors that bring to mind imperfection, and disinvesting from roles in which failure is feared. Suicidal behavior may fuel internal control over shame by absenting oneself from internal experiences altogether. Such behavior can also function as a show of strength or triumph over other people who want the person to live; over vulnerable feelings deemed "weak" within oneself; or over fate itself, by taking the decision between life and death into one's own hands. Suicidal acts in PN may also recover a sorely needed sense of control by decisively impinging upon the experiences of others through the suicidal act, as in punitive or revenge-based suicide.

Finally, acute suicidality emerging suddenly in response to intolerable life events must be distinguished from chronic suicidal preoccupation or fantasy, which in PN can paradoxically serve "life-sustaining," self-

protective psychological functions. Some patients with PN maintain a steady control over themselves by imagining that an “escape hatch” is ever-presently within easy reach. Other patients achieve a sense of superiority and control by reminding themselves and others that they possess an unstoppable power to thwart anyone, including clinicians, who may be motivated to prevent their suicide (Maltsberger et al., 2010 ; Ronningstam et al., 2018).

As we have seen, diverse internal processes typically hidden from view can precipitate suicidal behavior in PN, such that suicidal acts can erupt “as if from nowhere.” Inversely, rampant chronic talk, and even active threats of suicide, may not represent acutely heightened risk. Hence, in MBT-N, we collaboratively assess for suicide risk by exploring patients’ internal processes relevant to past and potential future narcissistic injuries. As discussed below, this process is known as *mentalizing functional analysis* .

A mentalization-based model of suicidal behavior in pathological narcissism

The above empirical studies on suicidality in PN can be synthesized with research on attachment and mentalizing to construct a mentalization-based understanding of self-destructive and suicidal behaviors (see Figure 13.2). Suicide risk is lowest in PN when patients’ sense of self is adequately full of positive valuation, and when there are no threats to this inflated self-image (Weinberg et al., 2019). In this state, patients can seem to be in a state of insulation from all psychiatric symptoms, facilitated partly by disconnection from emotions within themselves and in others. Basic mentalizing might appear relatively undisrupted, except that patients may be peripherally aware of diffuse (unmentalized) somatic discomfort, or “existential” psychological distress that is abstract, overly generalized, and not attributable to meaningful experiences within the self.

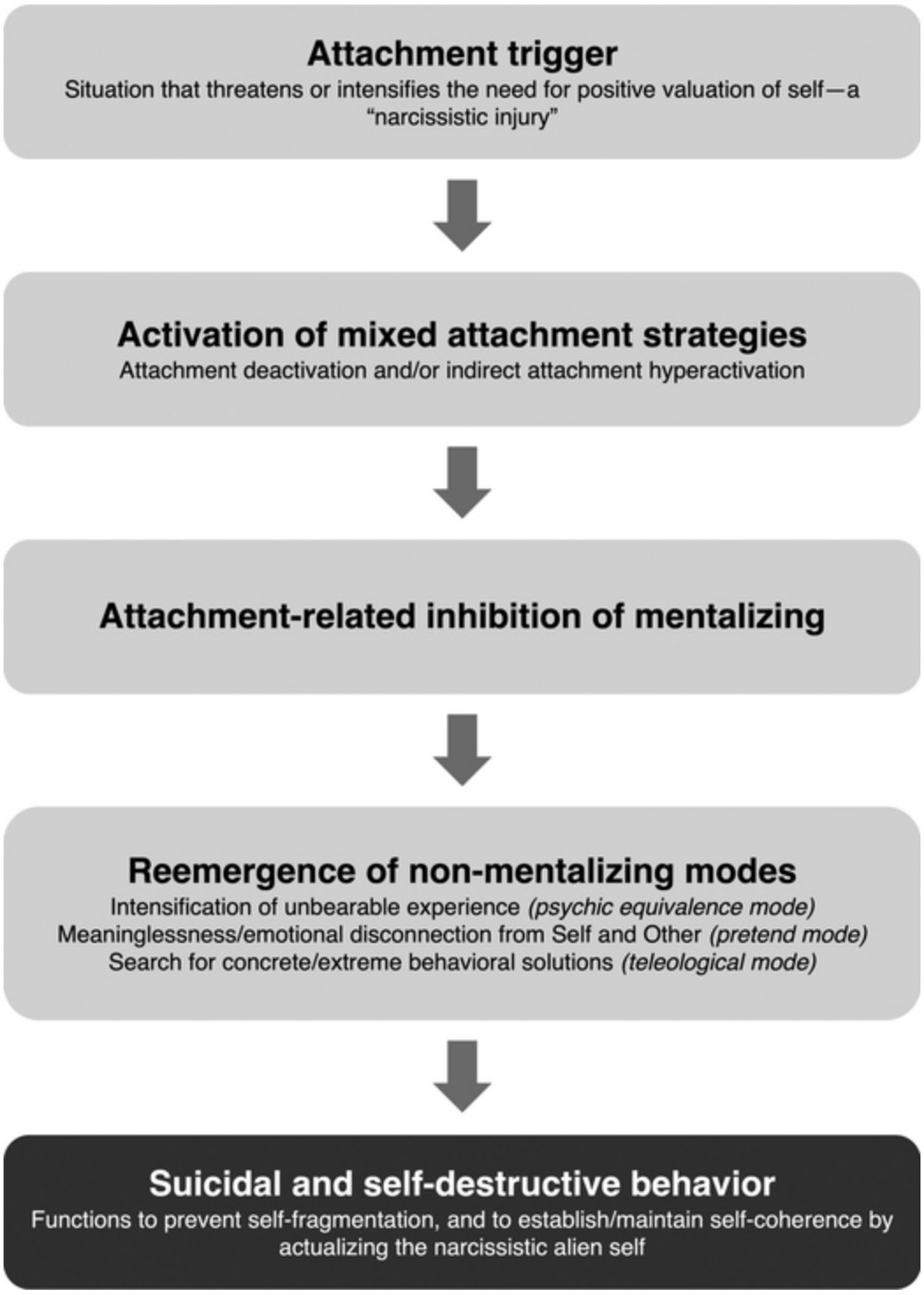

Figure 13.2 Mentalization-based model of suicidal/self-destructive behavior in pathological narcissism.

Upon this backdrop, cascades of mentalizing collapse leading toward self-destructive behavior are set in motion by "triggers" that activate

patients' typical attachment strategies. In PN, as noted above, these challenging events typically take the form of narcissistic injuries that either provoke an acutely intensified need for positive self-valuation, or undermine its supply. The mixed attachment strategies characteristic of PN are then mobilized in an attempt to restabilize coherence within the self-image (Chapter 2). This "dialing up" of unstably functioning attachment strategies impedes accessing and reflecting upon mental states within self and others (*attachment-related inhibition of mentalizing*). One or all three of the non-mentalizing modes come to predominate within psychological operations (Chapters 8 –10), furthering experiences of emotional disconnection, concreteness, and rigidity, which heighten the risk of self-destructive behavior.

While from an external standpoint, suicidal behaviors appear destructive to the self or others, from an intrapsychic vantage point, they function as an attempt to maintain or restore a desperately needed sense of coherence within the self-image (*actualization of the narcissistic alien self*). By moving towards the teleological destruction of the person's biological life, the person prevents the aforementioned narcissistic injuries from infringing on their view of themselves, thus preventing fragmentation and incongruity in the psychological self. At the same time, the person behaviorally reifies the content of the narcissistic alien self, affirming a self-image that is now strong: capable, triumphant, agentic, superior, in control, dying for cherished ideals, or achieving the equivalent status of an admired person—even inhabiting a shared space with them—in death. What once was weak is now made strong: excessively positive elements ill-fitted within the full expanse of self-experience have been extruded into a rigidly positive "story of self being told to the self," which now takes over as the sole behavioral guide.

Mentalizing functional analysis: General aims and techniques

The aims and core techniques of mentalizing functional analysis are outlined in standard MBT, according to a basic stepwise pathway for addressing self-harm and suicidal behavior in BPD (see Box 13.2 ; Bateman & Fonagy, 2016 , pp. 227–233). This sequence can be usefully broadened as a set of general techniques for addressing any behavior deemed by

patients or therapists as problematic, such as disordered eating, substance use, shoplifting, reckless driving, or other impulsive actions characteristic of BPD. Similarly in MBT-N, we utilize mentalizing functional analysis to address suicidal and self-harming behaviors, as well as any maladaptive interpersonal tendencies that cause functional impairment for patients, including attention-seeking, argumentativeness, competitiveness, monopolizing conversations, criticism of other people, avoidance or withdrawal, and retaliation against others.

Box 13.2 General techniques in mentalizing functional analysis

BEFORE commencing mentalizing functional analysis:

Identify the maladaptive behavior to be explored.
Set intention and elicit motivation to collaboratively explore antecedent experiences in the mind.
Empathically explore patients' difficulty revisiting the event.
Manage any psychic equivalence fueling non-collaboration.

Empathically validate current difficulty, divert to less charged topic, and seek opportunities to incrementally reapproach.

DURING mentalizing functional analysis:

Rewind to a point before mentalizing was lost; rewind further as needed.
First elaborate the “lay of the land” (views of self and others) as experienced and managed within stable mentalizing.
Begin micro-slicing forward in time toward the maladaptive behavior, exploring relevant shifts in mental states and collapse into non-mentalizing modes.
Within each “slice” of exploration:

Explore relationships between experiences of self and others.
Mark relevant views about self and others, and any changes associated with shifting or escalating affect.
Elaborate poorly managed affective states which fueled the maladaptive behavior.
Empathically elaborate both affect (what exactly was felt) and its effect (impact within/upon patients).
Focus on conscious, subjective experience of precipitants, rather than underlying vulnerabilities and motives.
Generate reflection on what triggered non-mentalizing modes at the time: psychic equivalent beliefs about self and others; teleological interpretations of others, teleological behavioral solutions to problems in self; pretend mode disconnection from emotions and meaning.
Utilize process-focused interventions to identify/address problems in mentalizing.

AFTER mentalizing functional analysis:

Summarize newly identified problematic events, vulnerabilities, thoughts, and affects associated with mentalizing collapse toward maladaptive behavior.
Seek new perspectives on how to better manage what was previously unmanageable.
Update formulation with newly identified problem areas: rigid beliefs about self or other to be further explored/challenged; painful affects that shut down reflection; disconnection from relevant emotions and desires, and so on.
As relevant, update crisis plan with newly identified management strategies.
Elicit collaboration to remain jointly alert to problem areas going forward.
Proactively, jointly assess current risk level in relation to problem areas, exploring any mismatch between patient and therapist perspectives.

When conducting a mentalizing functional analysis, we first set our intention to *understand* something together about the behavior of concern, rather than to *change* it. While of course we may wish for our patients to cease the concerning behavior, we put aside our wish to persuade patients to do so, or even to solicit patients' agreement that the behavior is bad or problematic. Instead, we seek to understand and elaborate how patients "got to where they got"—how the behavior or its outcome came to be sorely desired or needed, or to feel compulsory, fated, or necessary. Our exploratory methods are precisely informed by our goal of reaching an understanding that exists not only for one party or the other, but rather is jointly worked out and shared at some level between the two minds. We seek an understanding that is highly contingent to patients' experience. This is where troubles arise, because patients heading toward problematic or destructive behaviors are often caught up in non-mentalizing cascades which limit their ability to reflect on emotions, desires, and motivations within themselves and others. Indeed, a principal function of all maladaptive behaviors is to eradicate intolerable experiences of self that were "on the rise" prior to the behavior. So it is not a trivial matter to ask patients to tell us why they did what they did—they often do not know.

Exploring rationales for self-destructive behavior thus uniquely challenges our capacity to stay close to our patients' subjectivity, rather

than filling in the gaps with our own mentalizing about what they could have been thinking, feeling, or wanting. We avoid the sometimes appealing but generally harmful approach of espousing our own sophisticated theory about what was going on for patients, which is compelling to us but not grasped as meaningful by patients themselves. We must not meet patients' (perceived or actual) low level of mentalizing with our own (perceived or actual) higher mentalizing. Rather, we temporarily bracket our own assumptions and interpretations, working to kindle patients' own reflective process about what has happened and why.

While our initial interventions remain highly contingent to patients' current states of mind, our ultimate goal is the stabilization of patients' capacity to reflect upon and tolerate previously unmanageable experiences. This requires a combination of supportive, empathic interventions which facilitate looking back at previously unbearable feelings, as well as more dissonant attempts to challenge non-mentalizing processes uncovered along the way, which contribute to serious risk. Once again, our aim here is not to generate understanding or insight around what caused the behavior, but to stabilize mentalizing within the affective and interpersonal contexts in which it was lost, and which are likely to recur in the future.

In mentalizing functional analysis, we begin by exploring patients' experience at a point in time prior to when mentalizing became destabilized, and before any impetus toward destructive behavior appeared on the horizon. The most common mistake is to fail to track back far enough to establish all key events along the progression toward the behavior of concern. We must "zoom out" far enough to attain a sufficiently panoramic view on patients' mindset before it began hurtling toward the destructive behavior. We then establish some sense of "what it was like" to be at that relatively stable point before micro-slicing forward through time to trace the step-by-step process of mentalizing deterioration, from the standpoint of patients' subjectivity.

We explore within each "slice" of time using a basic mentalizing stance aimed at elaborating the relationship between intensifying affects, external events, and interpersonal processes, such as shifting perspectives on self and others. The core target is to understand how attachment triggers interfaced with unstable attachment processes to activate non-mentalizing experiences of self and others, which subsequently drove patients toward the self-destructive action (see Figure 13.2).

Mentalizing functional analysis of suicidal behavior: Specific techniques in pathological narcissism

Key modifications can augment the effectiveness of mentalizing functional analysis around suicidal and self-destructive behaviors in pathological narcissism (see Box 13.3). These enhancements derive from appreciating specific problems in mentalizing especially common in PN.

Box 13.3 Mentalizing functional analysis of suicidal behavior in pathological narcissism: Additional techniques

Empathize with patients' barriers to openly discussing self-harm, including difficulties recognizing vulnerable emotions or an active need for control over the therapeutic process.

Empathize with the need to preserve suicidal fantasies and control by keeping suicide as a ready option.

Rewind back far enough, explore each "slice" deeply enough, and micro-slice forward slowly enough. Patience and care are required, since triggers for loss of mentalizing are often hidden, and only exposed at risk of pain.
Listen for and explore "narcissistic injuries" that have triggered non-mentalizing processes and intolerable affects:

Reduction in teleological supplies of self-esteem;
Escalation in competitiveness, and a need to display strength;
Poor performance in an arena valued by self or others (e.g., work, competition, social media);
Feeling misaligned with, misunderstood by, or looked down upon by others;
Disruptions in a sense of agency or control over one's self-image, reputation.

Identify teleological self-esteem narratives which fuel the core problem of fragile self-esteem, and a need for the "escape hatch" of suicide.
Explore the baseline need for excessively positive valuation of self, its teleological reliance on externally supplied proof of this value, and the associated vulnerability to intolerable shame and negative self-evaluation:

"I'm trapped." "I'm a total failure." "I can't come back from this." "The job/role/marriage/appearance/good health I lost was everything to me."

Explore the functions of self-destructive behavior characteristic of PN:

Reasserting control over self or others in the face of (perceived or actual) weakness, affirming rigidly encased views of self: *"I'll show them what I'm really made of." "No one can see me sweat."*
Actualizing a sorely needed but excessively positive self-image: *"I'd rather be dead and proven right than have people think that about me." "I should go out by my own hand." "It would be better to give up than fail to live up to expectations."*
Acquiring or protecting an overly teleological source of self-esteem: *"I had to earn that promotion."*

Beware more emotionally detached discussions of events—a sign of robust pretend mode.

Employ extended range of affect elaboration techniques.
"Puncturing" a longstanding pretend mode may cause a plunge into an acutely intolerable psychic equivalence, leading to treatment dropout or sudden suicidal resolve.

When pretend mode is disrupted, respond with liberal support and empathic validation, emphasizing life domains where patients feel a sense of active control and agency.

One obstacle to mentalizing functional analysis in PN is patients' challenges recognizing vulnerable emotions, and openly expressing them to another person. Vulnerable emotions such as shame, envy, or sadness which precipitate suicidal behavior are often subject to patients' harsh internal critiques. Alternatively, such feelings might remain largely nascent or unrepresented in patients' experience (pp. 169–174). As is often the case early in MBT-N, when key emotions along the pathway to suicidality have not yet been mentalized, patients may express an apparently impervious confidence that their safety issues are no longer relevant in their lives. "My suicidality is behind me." "I'll never do that again." "I'm fine now, after getting that out of my system." In these cases, we must somehow find a way to bring our worries about patients' safety into the room, as a target for joint reflection.

Patients may also express a conscious wish to avoid a topic they know stokes uncomfortable visions of themselves: "I'd prefer to leave that in the past," or "I don't want to talk about it." In these instances, we explore

patients' reluctance to share, empathically validating any expressed fears of revisiting truly destabilizing states of mind. Finally, some patients convey a true alexithymia, as in the patient who said with apparent genuineness, "I have no idea why I put the noose around my neck." Thus, when patients with PN are reluctant to explore the suicidal behavior, we temporarily postpone such exploration and first address here-and-now obstacles to self-reflection (see example below). Before mentalizing functional analysis can begin in PN, preliminary work is often required to help patients adopt a posture of openness and collaboration around exploring vulnerable areas.

In some cases, patients actively cling to suicidal fantasies as a paradoxically life-sustaining recourse, or a means of strengthening the self. These patients communicate, "I can always kill myself, and no one can stop me." They are buoyed up through expressing—to themselves (in thought), or to others (in words and deed)—that an inalienable source of agency, self-determination, and control is ever at their disposal, come what may. In these situations, we proceed by recognizing and respecting patients' heightened need for self-governance over fragile mentalizing, first implicitly by modulating our responses and later by explicitly naming this pattern. We affirm the limited nature and scope of our role as therapists *("Not only do I lack the power to stop you from killing yourself; it's also not how I view my role"*), as well as the limits of our own imperfect knowing, resulting in our inability to predict and stop suicidal behavior. We can express our curiosity about the usefulness of therapy, given patients' challenges tolerating basic therapeutic processes, such as mustering a good faith effort to answer questions which amplify discomfort. Another useful strategy is to highlight our own emotional or attentional limitations when we have the sense we are being actively foiled: "I won't be much help to you as long as I sit here worrying that I have no way to assess whether today is the day you may be intending to die."

Clinical illustration: Mentalizing functional analysis of a suicide attempt in pathological narcissism

The following clinical example illustrates core strategies and obstacles relevant to addressing suicidality in the early phase of MBT-N, including the use of many contrary moves and management of patients' need for control.

Michael was a 30-year-old resident in internal medicine with no prior formal psychiatric history referred for treatment following a near-fatal overdose on medications prescribed to him for an uncommon cardiac condition. He was transported in very tenuous condition via ambulance to a local hospital associated with his residency program, on a rare night when several of his own residency classmates were rotating on duty in the emergency room. His colleagues were shocked to discover that Michael was their next assigned patient being rolled in on the stretcher, and worked despite their anguish to bring about his resuscitation. Leading the clinical team that night was the residency program's newly appointed chief resident, with whom Michael had publicly and contentiously competed for a coveted research award as well as the chief resident position. Following medical stabilization and a brief transfer to an inpatient psychiatric floor, Michael was discharged after acknowledging only that he had a "bad night" prior to the overdose, repeatedly proclaiming that he had no suicidal ideation and was safe for release because he "could never imagine" attempting suicide. Due to lingering concerns that his overdose had been driven by suicidal intent, Michael was mandated to enter psychotherapy by his residency program as a condition of being allowed to continue to work. While he had argued to return full-time, his program agreed to let him return only at a reduced pace.

Two weeks later, Michael's new therapist began to inquire during an initial session about the recent overdose, aware of the referring doctors' concern that Michael potentially faced a serious ongoing suicide risk he had not yet owned.

THERAPIST: What exactly happened that led you to end up in the emergency room that night?

PATIENT: I don't really want to talk about it, and I wouldn't know what to say even if I did.

THERAPIST: Oh, OK. So there are two problems with my asking you about that night. *[empathic validation of patient's reticence to discuss the issue]*

PATIENT: They all think I attempted suicide.

THERAPIST: Well, the inpatient doctor who referred you did tell me he had come to believe that, even though you never referred to it in those terms. I'm trying to understand what to make of it all myself. *[marking out two discrepant perspectives within*

the room, and directly stating therapist's current position of not-knowing]

PATIENT: *[angrily]* How would that doctor know why I did what I did?

THERAPIST: Good question *[rolling with the patient's psychic equivalent mind state]* . Do you have any sense of why he might have thought this was a suicide attempt?

PATIENT: Obviously because they found dangerous levels of medication in my blood.

THERAPIST: I heard they did find toxic blood levels that worried them your ingestion might have been intentional. What's your own understanding of how that came to be? *[contrary move from other to self]*

PATIENT: Look, everyone already has their own theories about what happened, and why I did what I did. I'm sure you have yours already, too.

THERAPIST: I was beginning to develop some ideas, but I haven't got very far with them because right now I'm really interested in what *you* are thinking about all of this. I'm not clear about where you are with this yet. *[validates accurate sense of therapist's mind, while also affirming the limitations of mentalizing]*

PATIENT: Everyone thinks this happened because I didn't get the chief resident position and the award. Everyone already has their story, and they are so smug and satisfied with what they are saying about it.

THERAPIST: You don't seem so satisfied by that account of it, by the look of things. What do *you* say about it all? *[continued dogged pursuit of contrary move from other to self]*

PATIENT: You all are the experts, so what does it matter what I think or feel about it? I am now forced to see you for treatment if I want to stay in my program, no matter what I say. But I'm not suicidal. So just tell me what I have to do to get you and everyone else to stop worrying and sign on the dotted line that I'm cleared to go back to work full-time. *[dismissive derogation of therapist's mind]*

THERAPIST: Gosh, you have to contend with a lot of worries and requirements being put on you by others, it seems. What's

that like to be dealing with? *[maintaining empathic focus on elaborating patient's current mindset]*

PATIENT: I'm annoyed. But that doesn't matter because you are all the experts, and you have all the power right now.

THERAPIST: I'm actually not feeling very expert at the moment … certainly not about what's been going on for you. I can imagine, though, it must be enraging that people with some power over your situation right now seem to think they know better than you do about what it's been like to be you *[empathic validation and normalization of the patient's anger]* . Will you tell me when you think I'm doing that with you? *[enlisting the patient's participation in helping the therapist avoid assumptions, in favor of the patient sharing something genuine about his experience]*

PATIENT: I'm not enraged. I'm just a little annoyed. *[downplaying affect]*

THERAPIST: I can see that, and I imagine I would be too. *[continued empathic validation while insisting on elaborating affect]*

PATIENT: Why?

THERAPIST: You said you are required to be seeing me. That makes me think you wouldn't choose to be talking to me if you didn't feel like you had to do it in order to get something you want. That's just a rotten place to be in relation to another one of these so-called "experts" you only just met an hour ago *[empathic validation]* . Yet I also can't just sign somewhere attesting that you're not a danger to yourself, when in truth I have no idea whether you are *[reality-based challenge; contrary move from fantasy to reality]*. How would I actually begin to get a sense of that right now? Can you give me some idea? *[The therapist continues to press for discussion of the overdose and Michael's current level of risk. In a chilling manner, Michael eventually expresses not only reluctance to explore and share his own mind, but an active pleasure in keeping the therapist at an uncomfortable distance.]*

PATIENT: Look, if I ever attempt suicide in the future, it won't be an attempt. I will succeed. And no one will know in advance

when or how I will do it.

THERAPIST: Yes, I imagine that you would be taking control, in some sense, and I wouldn't be able to predict how or when it would happen *[expressing limits of therapist's role, while "allowing" the patient to preserve a sense of control over what the therapist knows]* . But I would like to have some way of knowing what it would take, in general, for things to become so bad for you inside that suicide might begin to actually seem like the best way to take control *[contrary move from specific to general, and from external to internal]*. If things could ever get to that point for you, I would hope that I could help you find other ways of managing what I presume must be pretty unbearable feelings, if any part of you wanted that *[expressing therapist's intention while remaining contingent to patient's need for control]* .

PATIENT: I don't want your help with that. I don't want anyone trying to stop me if it gets to that point.

THERAPIST: It makes sense that in the heat of the moment, when things have already become so unlivable, you may not want anyone looking in or trying to stop you *[empathic validation, staying close to patient's need to maintain control]* . Did it get to that point before your overdose?

PATIENT: I see where you're going here. You can't trick me into talking about it.

THERAPIST: No, I can't, and I'm sorry that it seemed like I was playing a trick. I think that may have come about because I can't shake my own curiosity about what happened for you leading up to the overdose *[empathic recognition of the patient's experience of a struggle for control, while marking therapist's position of continued curiosity]*. But do you mean that even right now as you sit here with me, even though you are being forced into starting treatment together, there isn't a small part of you that might be hoping to find another way to manage terrible feelings? *[contrary move from external to internal]*

PATIENT: Maybe a small part, but I still don't believe you can help me.

THERAPIST: Maybe not … but help you with what, though? I don't have much sense of what I would be trying to help you with. Can we try to take a look at that?

PATIENT: *[slightly smiling]* I'd rather keep you guessing.

THERAPIST: Hmm. I do get a sense that part of you would prefer that. And why would you rather that?

PATIENT: Then you have to be uncomfortable, and I'm the expert who would know better than you. *[expressing grandiosity, and a wish for superiority and control]*

THERAPIST: Well, as I said before, I do see you as the expert here … at least on what it's like to be you. But I also think you are right that telling me so little does make me uncomfortable, because I find myself worrying that I don't really know what's going on for you. I do see how that leaves you more "in charge" of what happens next between us. How does this help you? *[acknowledging patient's desire for control and its impact on therapist, and inviting elaboration of patient's need to keep the self hidden, at a controlled distance]*

PATIENT: I just don't have control over much these days. I've lost a lot recently, despite trying my best.

THERAPIST: That sounds quite painful. I can see how it may help to preserve some control over yourself and others. But doesn't that position also leave you more vulnerable, too … to dying of suicide? If you aren't able to get help for what you're feeling on the inside in such awful moments? *[contrary move from external to internal, and from certainty to doubt]*

PATIENT: I suppose, in theory, if I were to become suicidal.

THERAPIST: Well, we've got a bit of a thorny issue here between us. If you're sure that there's no part of you that can imagine talking about what's going on and receiving help in those moments, then I'm not sure we have an agreement about what we're working on.

PATIENT: Well, I do want to feel less depressed.

THERAPIST: I definitely want to hear more about that. But what use would it be if we begin working on your depression, and then you hit one of these states where you seriously want to die, and you have no way of telling me that you're beginning

to prepare the way? Then I guess you would be in charge, but I probably wouldn't be much help to you around the depression at that point. *[expressing the reality of therapist's need for some agreed-upon goals, as well as a plan to collaborate around exploring suicidality] [The therapist continues exploring Michael's enjoyment of his current sense of control over himself and the therapist, as well as Michael's sense of depression that long preceded his overdose. The therapist also names his own uncertainty and worry about Michael's tendency to hide his internal experience, particularly when in crisis. At the end of the session, the therapist gives a brief mentalizing formulation to summarize the relational problem in the therapeutic dyad, underscoring that there are two minds in the room with discrepant priorities about how to manage their conversation.]*

THERAPIST: So it seems that, for us to work together, we're going to need to keep track of a few things as we go. First, you are not likely to ask for my help, or to let on when you are feeling suicidal and hopeless. So I'm going to ask you about that at each session. And yes, you could choose to lie and say that you're okay even when you're not. But as we've seen, that won't really be helpful to you in the long run. So my hope is that we can find some other way to check in about this that doesn't feel so invasive to you. Second, we have to remember that sometimes there's a part of you that not only doesn't want to be found out, but may actively want to keep me guessing, as you put it. You really will sometimes put yourself at greater risk to see someone else squirm. So whenever I feel I'm squirming about something, I'm going to check in with you about whether that's something you may be intending. How does all of that sound?

PATIENT: I don't like any of that. But I have to be in treatment with you if I want to stay in my residency program.

THERAPIST: Alright, so if you can tolerate me nagging you each week to try to find out how you are really doing, and what you might not be able or willing to tell me—

PATIENT: *[interrupting]* What do you mean, what I might not be "able" to tell you? I never said that I was unable to tell you something about myself.

THERAPIST: Well, I tend to think there are lots of things about each one of us that we aren't able to immediately tell another person. For lots of reasons, including that we can't see perfectly into ourselves at any one moment. Or do you have a different sense of being able to see everything about yourself all of the time?

PATIENT: I guess there might be some things I don't see right away.

THERAPIST: What sorts of things?

PATIENT: I mean … People tell me they sometimes think I'm feeling things I don't think I'm feeling. Like in the emergency room and then on the inpatient unit, everyone kept insisting I must be ashamed.

THERAPIST: That's curious. Might that be something we could take a look at together? So that we have something to talk about besides me pestering you about whether there are any suicidal feelings around? That would probably drive us both up the wall.

At each of the next few sessions, the therapist began by asking Michael to share anything on his mind he wished to explore, while also inquiring about the presence of any suicidal thoughts and feelings. The therapist's dogged efforts seemed to incrementally raise Michael's capacity and willingness to spontaneously raise issues of emotional import to him. He still did so in an externalizing way ("Why are other people so stupid?"), but with prompting to elaborate affect, he got better at considering his own mind around various challenges he experienced at work in the hospital. He tolerated the therapist's questions and increasingly took them up for himself. He generally became more curious about his problems. Two months into treatment, the therapist reattempted a mentalizing functional analysis of the overdose, finding Michael much more receptive to discussing his state of mind leading up to it.

THERAPIST: Can we go back to that night of the overdose? Tell me when you first got to feeling so bad? *[rewinding back to identify a point prior to the loss of mentalizing]*

PATIENT: I was okay when I felt sure I was going to win out to become the chief resident and get that research award.

THERAPIST: What was that like, to be so sure of your imminent success? *[affect elaboration of positive feelings within the self prior to their erosion]*

PATIENT: It's hard to remember it now, but I just knew that I had it in the bag. I had done everything in my power to make sure I won. Everyone was about to find out that I was the best. *[not identifying any affective content in self]*

THERAPIST: How did it feel to know without a doubt that you were destined to win? *[pushing for affect elaboration within this state of certainty about self and external outcome]*

PATIENT: Amazing.

THERAPIST: What were you amazed by? *[again insisting on elaboration of affect]*

PATIENT: My own success. It was amazing that I was going to beat the odds.

THERAPIST: So you had been working really hard against some odds. What were the odds? *[inviting reflection about wider context and meaning of the desired outcome]*

PATIENT: I have worked really hard to get to where I am in life. It hasn't been easy. It was amazing to think people were finally going to appreciate that.

THERAPIST: In appreciating you, how did you think others would see you? *[elaborating interpersonal context]*

PATIENT: I just thought that other people would see that I'm smarter than the average person, and the right person for the job.

THERAPIST: And with others seeing you in that light, how might you feel? *[deepening exploration of emotional stakes within the self]*

PATIENT: Maybe I could finally feel proud.

THERAPIST: So, your pride had long been on the line, but in that particular moment, you felt sure that sense of pride was finally within reach *[empathic validation of patient's reflections thus far]* . Moving forward a bit in time, what was the first thing that happened that made you less sure about your success? *[micro-slicing forward through the*

destabilization of self-valuation, looking for progression to non-mentalizing]

PATIENT: Well, it was really sudden when I saw it posted one night that he was chosen for chief resident, not me. But I still thought I would win the research award, and that was the thing I cared about more.

THERAPIST: What did that do to you? *[pulling for affect elaboration]*

Over time in this treatment, the therapist continued to explore with Michael his positive experience of "pride," as well as the deeply painful emotions arising for him when this pride was disrupted. Michael gradually became able to say more about what bolstered and challenged his elusive feeling of "pride." Michael identified triggers for suicide around destabilization of his pride and self-esteem, including feelings of competitiveness, envy, and anxiety about professional failure. Over the next six months, Michael and the therapist came to see Michael's suicidality as more of a faraway threat, paving the way for them to explore Michael's pattern of basing his sense of self-esteem primarily on academic and professional success (pp. 223–228), especially his experience of receiving admiration from others and "triumphing" over them. Michael began to reflect further on his unsustainably lofty expectations for himself in these domains, as well as his neglect of other potential sources of positivity within himself, such as his nascent capacity to connect more intimately with other people, including the therapist.

Therapeutic progress, pauses, and termination

As MBT-N progresses through middle and late phases, patients deepen their capacity for curiosity, reflection, and emotional connection regarding their own minds, our minds, and the experiences of significant others outside of the treatment. There is no standardized or empirically backed timeline for effective completion of treatment, but the consensus across decades of clinical literature is that effective treatment of PN generally requires a longer course than for BPD, often spanning two to four years. The case studies presented in Chapters 14 through 16 illustrate milestones typically reached and challenges that must be managed on the way to a successful end to treatment. Rather than attempt to describe the myriad, idiosyncratic,

and nuanced twists and turns these treatments take, we will describe some of the general challenges that arise in the later phases of our work with patients, as well as the therapeutic strategies we utilize to address these challenges. This general discussion is supplemented by extended illustrations of these processes found in the case material in our remaining chapters.

The vulnerabilities of attachment process and reflective functioning in PN dispose patients to predictable difficulties deepening intimacy and connectedness with themselves and the people who live and work alongside them. For patients with PN, improved mentalizing of self creates a rising tide of awareness of their own problems, and how they have contributed to their own difficulties over time. This can lead patients to experience newfound feelings of regret, and a seriousness about making choices in different ways. Improved mentalizing of others may transform how patients relate to other people, who were previously treated instrumentally as objects rather than subjects with inner lives. Other people begin to command patients' attention, and to elicit their empathy. About three years into treatment, one longtime patient remarked, "I never cared about my boss' feelings, and now I find that I do. Some decisions at work are harder for me, now that I can feel more of what others care about."

Yet these long-term changes are typically bought with a price that not all patients with PN are ready or able to pay. As other authors have noted (Hilsenroth et al., 1998 ; Kernberg, 1993), patients with PN exhibit higher rates of early phase dropout and premature terminations. In MBT-N, we utilize a few key strategies to help patients better manage these hurdles.

First, we are vigilant to detect evidence of iatrogenic narcissistic injuries caused inadvertently by even our most well-meaning interventions; by the act of entering a treatment organized around confronting the self; or by progressing into middle and later phases of MBT-N, when we are more directly challenging of patients' rigid narcissistic functioning. Our therapeutic response is in keeping with the basic elements of MBT-N: we rush in with empathic validation of the legitimate difficulties brought on by self-examination, which can lead to genuine feelings of dismay, remorse, or doubt. We also valorize this process, explicitly sharing our admiration of patients for deciding to stay with these processes: "This work is so difficult, yet important and valuable."

Second, we may grant patients some measure of control over the therapeutic process for a period of time. Sometimes this translates to allowing modification or relaxation of the treatment frame, such as reducing session frequency or duration for a particular window of time if patients directly request a "break" from the therapy. When patients are bracing for a potential narcissistic injury, or struggling with an acute escalation of fragile self-esteem, they sometimes indirectly express a need to temporarily withdraw from the therapeutic work. If the therapy is to be "paused" in this manner, we collaborate with patients to explore this possibility in light of their formulation, rather than unilaterally following either party's preferences.

To consider the role of such "therapeutic pauses," let us return to the case of Michael, the resident discussed above. After two years of working with his therapist and making considerable progress, Michael struggled to pass medical board and licensure exams required to complete his credentialing as a physician. He repeatedly signed up for the exam, dedicated himself to a period of intensive study, and then he canceled. The therapist inquired about Michael's emotions surrounding these matters, with Michael giving voice to significant perfectionistic standards, as well as certainty that he would not pass. As he was gearing up to attempt the exams for a third time, Michael sent an e-mail definitively informing the therapist that he would not return to therapy for an indefinite period while preparing for the exam and awaiting results. The therapist replied by encouraging Michael to stick with the process, also empathizing with core difficulties around shame identified in Michael's formulation, which the therapist imagined might be escalated and making it harder to attend therapy. No reply was received for months. Without intending to pressure Michael, the therapist sent a few emails appreciating Michael's difficult circumstances, wishing him well on the exams, and offering to see him "on the other side."

In this case, the therapist's willingness to "allow" Michael to take an indefinite treatment pause may have allowed Michael some control over overwhelming feelings of anxiety and shame, which might have been intolerable with the therapist looking in from up close. Meanwhile, the therapist's gently empathic messages might have helped Michael to feel like the therapist was holding his struggles in mind, maintaining a bridge for Michael to return to treatment following the crisis. Michael eventually did return to therapy, but only after he had received notice of passing his exams.

This approach—accommodating patients' wishes to provisionally suspend the therapeutic process, while also maintaining some level of connection with them during the hiatus—can make the difference between a temporary pause and a permanent treatment dropout.

As MBT-N progresses through final stages toward termination, we rely broadly on modifications to the general strategies summarized elsewhere for managing later phases and termination of MBT for BPD (Juul et al., 2020). For patients with BPD, termination is typically marked by psychic equivalence mode, manifesting in increased dependency, resurgent abandonment fears, and teleological efforts to indefinitely prolong (or prematurely end) treatment to avoid painful experiences of rejection, loss, and aloneness. In PN, patients often approach termination in pretend mode, through attachment-deactivating strategies to manage the end of a relationship that became surprisingly meaningful to them, against their predictions or even wishes. Patients with PN may insulate themselves through intellectualization, minimization of ongoing challenges, and insistence that treatment has been a definitive success, with no further work to be done. We thus remain alert to our own subjective responses to pretend mode in patients; for example, we might be drawn into an overly cognitive stance with patients in order to avoid feelings submerged within patients and ourselves. We also may need to manage a strong pull to inappropriately prolong treatment, especially if we hold an idealized view that the therapeutic relationship is necessary for patients' ongoing life and psychological growth.

Juul and colleagues (2020) suggest setting a clear, finite endpoint and counting down the end of the treatment: "We have five sessions remaining." During these final sessions, it is helpful to rehearse the upcoming separation by helping patients recognize and reflect upon other limitations in the treatment. In order to encourage patients to openly express their feelings about a looming termination, we can frame the end of each session as a "mini-termination," asking patients to consider, "What have we accomplished today, and what have we not?" Patients can then consider wider limitations of the treatment, expressing feelings of mourning and loss. We respond by empathically validating such emotions, appreciating them as part of the challenging but formative work of termination.

By exploring the imminent loss of the therapeutic relationship, we help patients to challenge grandiose beliefs about their own imperviousness, and

to reflect further on unmentalized vulnerable emotions such as sadness and anxiety. We can also create and share a “termination formulation” with patients, which directly anticipates important relational and emotional processes as targets for joint mentalizing during each countdown session. These formulations typically review the impact of prior experiences of separation and loss, predict where such feelings are likely to surface around termination, reflect upon areas for further attention, and underscore therapeutic gains achieved, which can be retained and extended after treatment has ended.

One final core element in long-term MBT-N is its foundational focus on life outside of treatment. Longitudinal studies of PN demonstrate that major life events occurring outside of the treatment frame (e.g., achievements, disillusionment, formation of durable relationships) are instrumental in shaping change over time, and may provide more impetus for change than psychotherapy itself (Ronningstam et al., 1995). In MBT-N, we thus remain highly attuned to evolving concrete and relational realities within our patients’ lives, not simply to what is discussed in the relatively insulated realm of therapy sessions. We develop clear goals around getting and keeping jobs, pursuing academic and professional advancement, building and maintaining friendships, repairing relational ruptures in valued relationships, and pursuing healthy romantic and sexual intimacy (see pp. 61–64). This focus on generalizing mentalizing gains to the outside world is consistent with common mechanisms of change posited to underlie all successful treatments for BPD, including patients’ social learning about themselves and others through experiences in the non-treatment world (Fonagy et al., 2017). This ethos is also consistent with the empirically established value of “building a life” beyond treatment as an essential element in recovery from personality disorders, as prioritized in generalist treatments for both BPD and PN (Gunderson, 2014 ; Weinberg et al., 2019 ; Zanarini et al., 2010). This emphasis on patients’ everyday functionality serves as a crucial long-term safeguard against “non-treatment treatments”—a manifestation of insidious pretend mode.

14

Case Example: After the “Accident”

Chloe was 28 years old when she sought treatment following a serious suicide attempt by intoxicating herself with benzodiazepines and then throwing herself out of a third-floor apartment window. [1] Upon impact, she sustained multiple long bone fractures requiring extended physical rehabilitation, leaving her with chronic gait disturbances and hip pain. She insisted for some time that her fall had been purely accidental, yet there was no question for doctors and family that it was an intentional suicide attempt. Prior to her “accident,” Chloe had long believed that “the cream always rises to the top,” expecting that her work ethic placed her on an inexorable march toward towering professional success and a picture-perfect romantic relationship. But after successive rounds of trying and failing to realize overly rigid, excessively positive expectations for herself, rather than “rising up,” she somehow “fell down” to her near-death. I (BTU, one of the present authors) met Chloe upon her admission to a multimodal residential treatment program for individuals with personality disorders where I was on staff. We commenced a nearly four-year individual therapy for narcissistic personality disorder (NPD) that relied heavily on core strategies presented within this book.

Background information

Chloe was raised mostly in the southern United States, where her family settled after moving there for her father’s business. Her father was a chief executive at a major company, and her mother was a homemaker, homeschooling all of the children. As the oldest of six siblings with a ten-year spread between oldest and youngest, Chloe grew up feeling she had been tacitly tasked with overseeing the other five children and privately managing her own emotional needs, which she felt were unseen, especially

by her father. Chloe's early perceptions of her father organized around her sense that he was invested in cultivating a powerful public image of self-control, great success, and high achievement outside the home. This contrasted with her experience of him within the home as unpredictably angry and controlling. She regarded her mother as highly emotional and at times behaviorally unstable, such as when she was hospitalized for suicidal ideation when Chloe was fourteen.

As far back as she could remember, Chloe felt great pressure "from inside and outside" to adhere to lofty expectations for academic and professional achievement, which she originally perceived as coming from her father but later felt she had internalized. She concluded this meant having to hide away emotional vulnerabilities that she and her mother shared, to steel herself for a long hard road toward great achievement. Chloe strived outwardly to be highly agreeable, courteous, and diligent. She was initially homeschooled and then went to public and private high school, where she was an excellent student. She graduated a year early, while also holding a part-time job and caring for her siblings after finishing her own work. By age fifteen, she had developed secretive strategies for maintaining control over her weight and appearance, including excessive exercise and laxative use.

Chloe attempted college for short-lived periods in multiple locations, but she always transferred away after struggling to establish stable friendships. She eventually settled for a longer stretch at college in New York City. Her star was finally set to rise as she began working with a famous professor, and she became president of various student groups. Chloe resolved to gain acceptance to medical school, applying for a coveted international scholarship she felt was surely hers to win. Yet when she obtained a B grade in a single class, she developed a growing internal conviction that things would not work out exactly as she expected. Chloe escaped from mounting academic pressure by focusing her increasingly desperate energies on pursuing more clear-cut pathways to financial success and long-term romantic stability. Yet she continued to "hit ruts" with failed attempts to work in finance, complete prerequisites for medical school, and secure a wealthy fiancé. She increasingly fell back on binge drinking and intense but short-lived sexual relationships to soothe her growing sense of failure, and fears of becoming a disappointment to herself and her family.

Licking her wounds after a particularly stinging break-up and another job loss, Chloe eventually moved back to the South to be near her family. She took a professional internship facilitated by her father's business connections, which she felt was beneath her true capacities. Returning to an earlier posture of excessive confidence, Chloe began looking for a higher-level job that stoked her loftier aspirations, but she made the mistake of prematurely quitting the first job before securing another. When the coveted position passed on her, Chloe suddenly found herself with no income, and with no way to save face. Simultaneously, another chaotic romantic relationship was capsizing, and she had returned to problematic drinking to manage painful feelings about ending a recent pregnancy, after it became clear that her partner at the time was not committed to raising a child together.

Chloe felt "beyond redemption," trapped, and unable to imagine any path toward realizing her life ambitions. In this context, she ingested a large amount of anxiolytic and hypnotic medication, drank a half bottle of tequila, and then jumped out of her third-story apartment window with intent to die. She was found by joggers, naked and unresponsive. Chloe sustained serious orthopedic injuries, including pelvic, skull, and foot fractures that required major corrective surgery with hardware placement throughout her body. She avoided psychiatric hospitalization by reporting that the injuries had been due to domestic violence. A long period of physical rehabilitation commenced. Now wheelchair-bound and living in the family home, she felt increasingly ashamed about the state of her life, attempting suicide a second time by drinking a large volume of rubbing alcohol. This time she was psychiatrically hospitalized and reluctantly accepted a recommendation for intensive residential treatment.

The start of the treatment

Chloe's residential treatment program incorporated elements of various evidence-based treatments for personality disorders, including mentalization-based treatment (MBT) in a dual group format: standard MBT group psychotherapy plus a psychoeducational MBT Introductory group. As her assigned individual therapist in the program, my initial responsibility was to work with Cloe to collaboratively develop a coherent

understanding of her problems, in the in hopes of building a commitment for longer-term intensive psychotherapy.

When I first met Chloe, she walked with a visible gait disturbance due to chronic hip and leg pain from her injuries. She nevertheless maintained an unfailing commitment to dressing herself well and blowing out her hair, as if she were heading out for a night on the town rather than living in a psychiatric treatment center. This conveyed Cloe's deep concern about her appearance, and a wish to be viewed as more desirable and accomplished than her peers in the treatment program. While sitting up close to Chloe, her facial expressions seemed unnaturally plasticized into an artificially bright smile that, to me, felt vacant and sad.

In her interactions with others, Chloe made a giant splash, but not in the ways she had hoped. She was interpersonally exacting, evaluating others' behavior according to her own rigid sense of what should and should not happen in a treatment center. Treatment peers rapidly came to regard her as passive-aggressive, sympathy-seeking, and holding herself at a condescending, superior distance. Chloe displayed minimal efforts to empathize with other patients' vulnerabilities and struggles. She clung to her focus on a passive victim role and sought concrete recognition about how much the world had wronged her. She insisted on being perfectly understood, seeing anyone who tried but fell short as incompetent. Chloe struggled to make friends for herself, and she failed to endear herself to clinical staff or counselors. She was disingenuously courteous, couching a seething discontentment with herself and others in Southern formality: "May you please validate me right now instead of whatever you think you are trying to do?" In contrast to her descriptions of herself as lost, anxious, victimized, and needing direction, she came across to others as imperious, demanding, and authoritarian.

In therapy groups and in the treatment milieu, Chloe maintained that she "accidentally fell" out of an open window of her apartment after taking sleeping pills, and that she had no intention toward suicide or self-harm. She continued to claim that her physical injuries were not the result of the fall but instead were due to intimate partner violence, highlighting a story of victimhood at the hands of a powerful abuser. Chloe was highly critical of the treatment program. She seemed much more comfortable enumerating the perceived imperfections of the system, rather than focusing on any emotional challenges within her. She demanded medicalized, concrete

recognition of having been wronged, often insisting on transfer to a local emergency room for non-urgent somatic discomforts.

In our initial individual therapy sessions, Chloe presented as highly verbal and articulate about a wide range of subjects that notably excluded her own affective experiences. In relaying her initial history of presenting difficulties, she was vague and evasive when I asked her to clarify feelings and motivations underlying important moments in her life trajectory (e.g., why she left one school for another, her emotional states prior to her "fall" from her apartment window). She made frequent threats to leave treatment at the drop of a hat, usually in response to her perception of inadequacy, unfairness, or weakness in others. My attempts at basic empathic validation of her experience felt highly tenuous to me, laden with anxiety because they seemed precariously contingent upon how precisely I could align myself with Cloe's perspective, rather than introducing independent perspectives of my own. When I raised questions to clarify her experience, Chloe was dismissive of my curiosities and doubled down on her own certainties. She found my attempts at validation pathetic, batting them away with criticisms. Yet I was still left with an enduring sense that she desperately wanted to feel accurately seen and understood. Rather than seeing our fledgling relationship as a tool that could be useful to her, she seemed to view *me* as a "tool," in another sense of the word. At best, I was harmlessly bumbling and incompetent; at worst, I was an active critic looking down on her, judging her failures, and withholding validation she was owed. I was struck by how pervasively her mind seemed organized around judgmental thoughts about herself and others, and how difficult it was for her to adopt a curious stance toward her own and others' internal worlds.

After an initial assessment phase, I shared my impression that Chloe's core difficulties could be understood through the lens of NPD. Utilizing a variety of psychoeducational approaches and materials (see Chapter 3), I attempted to contextualize the diagnosis empathically and collaboratively, as though we were "trying it on for size" together. Chloe related vaguely to a general notion of unstable self-esteem, but she did not initially embrace the diagnosis more extensively. I took this a sign that I had not yet established myself in her estimation as a trustworthy source of new information about her internal and interpersonal world, who had earned what MBT calls *epistemic trust* (Chapter 1).

Consistent with basic early phase technique in mentalization-based treatment for narcissism (MBT-N), I modified my stance to optimize the contingency of my interventions to Chloe's current experiences. In lieu of directly introducing my own perspectives about her experience "from the outside," I sought primarily to empathically understand and elaborate her own perspectives from the *inside* , especially where it seemed that Chloe needed to maintain a sense of being "in the right" to maintain a high view of herself. This meant not directly challenging her overly rigid, non-psychological explanations of what caused her fall ("My incompetent doctors prescribed me the wrong medications"), or her dismissive responses to her milieu peers trying to connect with her ("These people can't understand me"). I "rolled with" her views of herself, of others, and of me, empathizing with where this all left her. At the same time, I did not simply serve as a passive or purely validating mirror for Chloe. Instead, I entrenched myself within MBT's basic not-knowing stance, remaining on the lookout for more modest opportunities to introduce wedges of uncertainty into Chloe's rigid views (see Chapters 9 & 10).

PATIENT: Rather than having a session today, please just get my bags so I can pack up *[derogation of therapist's role]* . I think I need to leave.

THERAPIST: Oh? What's happened to bring you to that decision?

PATIENT: Therapy groups this morning were just … I can't even put it into words. These other people here can't understand me.

THERAPIST: What can't they understand about you?

PATIENT: They are so limited. They haven't had the kind of experiences I have had. And let's face it: they are rather slow, and they don't care about themselves the way I do.

THERAPIST: That may be what *they* are like, but what is it about *you* that they can't understand? *[exploring patient's process of arriving at the rigid perspective]*

PATIENT: Look, I have been very successful in ways these others here won't ever be. I was headed to medical school and applied for the Rhodes Scholarship. These people here haven't even dreamed of attempting those things. At least you went to Harvard, according to the research I did on you. That at least gives you a chance.

THERAPIST: I am not sure that's helping me right now very much … *[humorous challenge]* . But what makes you think that would be so important?

PATIENT: I just think my problems are really complicated, and maybe only someone who has some extra brain cells can help.

THERAPIST: It sounds like your sense is that it would take a pretty special person to help you. And—am I wrong, or do I hear you losing hope that anyone might come along with the right stuff to help? *[empathic validation of indirectly expressed affect]*

PATIENT: Look, it's nice that you're trying here, but I just don't think you can do anything for me.

THERAPIST: It does seem like right now like I am not being helpful *[remaining contingent with what the patient has been expressing]*. But all of this again leaves me wondering: help you with *what* , exactly?

PATIENT: *[heavy, dismissive sigh]* All of my problems.

THERAPIST: You see, that's just it *[seizing an opportunity to "stop and stand" on not-knowing]*. What are your core problems, as you see them? I do sense that you have some pretty serious problems, but every time I try to put them into words, you feel like I'm not getting them right. So you'd better tell me exactly what your problems are if you are planning to leave, so we can at least think together about how you might get better help somewhere else.

PATIENT: If you can't tell by now, then you really can't help me. It was a mistake to ever come here.

THERAPIST: Hang on a minute. When you did want to come here, what were you hoping to find when you got here?

PATIENT: Help for my problems, of course. You wouldn't understand the kind of help that I need.

THERAPIST: Maybe not. But could you share what makes you so sure of that?

PATIENT: I just have a sense of it. Look, again, it's nice that you're trying, but I just don't think you can help me with my problems.

THERAPIST: That's the second time you've said that. Is there something a bit nice about me trying, even though I'm failing? *[interpersonal affect focus of the tacit relational process]*

PATIENT: Most people give up on me. They don't keep trying like you do.

THERAPIST: Hmm. Earlier I was wondering if your biggest problem was being stuck with the likes of me. But now I am sensing that one of your "core" difficulties is that, despite all your efforts, no one is up to the task of understanding and helping you. I really would like to keep working on that together: sorting out what you might need help with, since as we've seen I haven't been able to produce answers on my own that have been satisfactory to either of us. I am afraid I will need your help every step of the way, if I'm to be useful.

In the above ways, I tried to keep my initial interventions "within" Chloe's established perspectives about her presenting problems and her experiences of the treatment. That meant hovering close to her repeated descriptions of the therapeutic situation as futile and hopeless, not pushing to prematurely amplify affect (which might endanger mentalizing), and remaining vigilant to micro-mentalizing when it occurred. Although Chloe often minimized her problems, I perceived this as reflecting her need to remain at a safe distance by maintaining high self-regard and dismissiveness toward others. By consciously orienting myself around understanding her perspective, I was aiming to engender a sense of epistemic trust in Chloe, to utilize as the springboard for stimulating increased curiosity toward what seemed like opaque and contradictory experiences of herself and others. I believe this helped to minimize unnecessary conflict in our relationship, which might have toppled her fragile mentalizing and precipitated treatment dropout. Secondarily, I was also attempting to establish some shared channel in which we might connect up our perspectives on the work we might do together (*"I will need your help every step of the way"*). Here, I hoped to facilitate a we-mode experience of sitting alongside one another, with mutual curiosity while engaging in a joint task of working things out together.

To catalyze further alliance and epistemic trust, I wrote and read aloud to Chloe a "treatment letter," also referred to as a mentalization-based formulation (Chapter 4). The formulation incorporated three major areas:

(1) what I had come to understand about how Chloe viewed her problems within herself and her relationships; (2) how I was thinking about her problems and our treatment goals through the lens of pathological narcissism (PN) and associated mentalizing vulnerabilities; and (3) some foreseeable challenges around our therapeutic task and relationship.

Mentalization-based Formulation for Chloe

Chloe, you came to treatment after your body was broken almost beyond repair by your fall out the window, at a time when you felt inside that *you* were broken and beyond repair. Your confidence in yourself had become eroded through a series of events you perceived as unsalvageable failures at work and in relationships, giving way to intolerable feelings of failure and hopelessness that somehow coincided with your nearly fatal fall out the window. How all these areas connect is not totally clear to me yet.

Our initial conversations have also revealed your longstanding desire to be strong, effective, capable, competent, appreciated, and respected for your efforts and achievements. You have worked very hard to maintain these positive feelings about yourself, and to ensure that others also view you in this way. But we have started to see that this project of feeling good about yourself has not always worked to keep away more vulnerable feelings like self-doubt, hurt, shame, and loss. These painful emotions appear to be crucial parts of your experience, but they also do not fit easily alongside the positive views you hold of yourself.

We have seen that, in order to maintain positive feelings about who you are, you have had to engage in various behavioral pathways. First, you keep up your academic and professional accomplishments, in order to fuel your sense of being specially accomplished. You also hold back vulnerable feelings, only showing others how courteous, intelligent, and strong you can be on the outside. Furthermore, you often point out problems and limitations that you perceive in others (including me), which helps you focus away from painful sources of shame within yourself.

In these moments, others seem to be little more than critics to be managed, or inferior intellects to be dismissed—hardly people with whom you could discuss your vulnerable feelings. No wonder you feel so alone, so beyond the pale of help, and so unmotivated to discuss your painful feelings. No wonder you have chosen relationships in which you feel more assured of yourself, either through your association with a successful person, or through a sense of superiority over other people. In light of these downsides to your interpersonal approaches, we could explore over time whether there might be other ways to support good feelings about yourself.

In our relationship, sometimes you seem like you are working to ensure that I see you in a positive light. It is as though you feel like I will only appreciate you if I see you as superior, in comparison to the other patients here, or in relation to me. At other times, when I don't provide you with sufficient acknowledgment and praise, you can devote significant energy into proving that you are "right." Moving forward, when this occurs, I will nudge you to look at aspects of yourself and others which you may be leaving out. I hope you will do the same with me when *I* seem to be leaving something important out, which also will happen.

During your first few weeks here, both of us have been wrestling with the question of whether or not treatment can truly help you change. At times, you feel certain that you are a hopeless case, and that I see you in the same way. From my perspective in these moments, I am often thinking about how daunting this work must be feeling for you, and how you have come to feel so hopeless.

Our treatment is going to focus on examining the many different dimensions of your experience, like the mirrors within a kaleidoscope. Feelings and thoughts can look broken up, blurry, or too overpowering of the rest of the picture. But sometimes through changing how we look at

something (mentalizing), things come together to form a clearer picture. We will look more closely at your ambition, strength, and high standards, as well as your tendency to doubt and criticize yourself, to the point of becoming hopeless. We will consider what may be going on inside of you when you are criticizing others, and how other people may be experiencing you in these interactions.

The good news is that you have demonstrated a real determination to get yourself to this treatment, to get better, and to make your way through the challenges this treatment has already posed.

Chloe responded well to the above formulation. She expressed her agreement with most of its content, her sense of "intrigue at having so much to work on," and an active drive to "master" the problems laid out therein. In the next several sessions, we focused on developing a personalized set of suggestions for Chloe, utilizing some information from the MBT psychoeducational group, about when and how to attempt to adopt a mentalizing stance.

Utilizing the principles of mentalizing functional analysis around examining suicidality (Chapter 13), Chloe and I progressively were able to explore together what internal states had contributed to her "fall" out the window. She began to speak about experiences of "hating myself and feeling like a failure"—self-states she had not expressed in her original accounting of events leading to residential treatment. Over several months, she progressed from initially calling it an "accidental fall" to saying it "might have been a suicide attempt," to admitting she had texted her brother beforehand as a "cry for help," and ultimately to fully owning that she had "jumped" and thrown herself out of the window with an intention to die. Chloe eventually developed a meaningful narrative around her suicide attempt, sharing with other patients that she had been struggling with intense feelings of shame, and that she had indeed attempted to kill herself. Chloe's story increasingly came to express a powerful sense of tragedy and sadness—feelings that had previously had only been nascent and barely discernible within her experience.

In these ways, Chloe and I developed a shared, empathic stance toward this crisis point in her life: "Something really tragic and important has happened to you here. We need to try to better understand this together." This stance paved the way for us to approach other problems in Chloe's life that, up until this point, she had never been able to openly acknowledge and explore.

Months 6–12 of treatment

Chloe discharged from the residential program at six months and stepped down into a six-month outpatient program involving ongoing individual therapy, family therapy, and various group therapies, including MBT and dialectical behavior therapy. I continued to see her for twice-weekly individual sessions and psychopharmacology. She lived with a small group of other graduates from our program in a community apartment, accepting a job working as an administrative assistant in a neighborhood medical clinic.

While Chloe seemed dedicated to longer-term treatment, her stance within both individual and group therapy sessions seemed consistently dismissive and devaluing toward me and her peers in the program. I focused our work at this stage by using MBT-N's affect elaboration strategies to reflect upon her aversion to vulnerability in herself and others (Chapter 6). This involved helping her identify, tolerate, and reflect upon more vulnerable emotions within herself and others, which had previously been inaccessible due to her insistence on excessively positive narratives of self. While she was improving at expressing her vulnerable feelings, she struggled to see the value in this therapeutic goal. At times, having just described more vulnerable feelings in herself in a manner I experienced as poignant, she would abruptly pivot to antagonizing and mocking vulnerabilities she perceived within me. In the process of pointing to vulnerabilities within a weaker other, Chloe seemed to reconstitute a view of herself as supremely strong, impervious, and "above" any need others may have to actually feel and express their feelings. In one illustrative moment, she had just described herself as feeling lost, when I began experiencing the urge to cry.

PATIENT: There you go, looking like you're about to cry again.

THERAPIST: Yes I notice I am feeling a bit that way, too *[validating patient's observation]* . What's the impact of that on you?

PATIENT: It reminds me that you're such a sap. You can't even manage your own feelings. Don't they train you to do that in therapy school?

THERAPIST: It could be that I need more training … But what gave you the sense that I couldn't manage my feelings just now?

PATIENT: What do you mean?

THERAPIST: It seems you saw me begin to tear up, and somehow that meant to you that I was having a problem managing my feelings.

PATIENT: Well, it looked like you were going to cry in front of me.

THERAPIST: Yes, I believe that I was … and? What was that like for you? *[affect elaboration]*

PATIENT: You seemed weak.

THERAPIST: What is it like to be sitting here with a therapist who seems weak? *[dogged pursuit of affect elaboration, using a contrary move from other to self]*

PATIENT: Well, I don't want to be like that, and I don't want you trying to make me like that.

THERAPIST: Make you like what, exactly?

PATIENT: So weak that I could just cry in front of someone.

THERAPIST: Just remind me what is weak about that, exactly?

PATIENT: It's just weak. I don't think you are going to agree with me about this, since you are the one who's about to cry.

THERAPIST: You imagine I might not see it as so weak?

PATIENT: Yes, and that makes you even weaker. I don't want to be that way.

THERAPIST: You know, I sometimes see it that way within myself, too. At other times, though, I wonder if it might be more of a strength. *[provoking curiosity about alternate perspective; contrary move from certainty to doubt]*

PATIENT: *[suspicious but curious]* What do you mean?

THERAPIST: Well, just now, for example: let's rewind back to try and understand what went on between us that led me to feel moved, and to you critiquing me for it. *[directing focus to relevant relational process in the therapeutic relationship]*

PATIENT: I'm not interested in that. Why would I want to understand what happened for you?

THERAPIST: I hear that you may not want to understand that, but you did seem interested in critiquing it a moment ago. I wonder why you felt inclined to do that. It seems like you think there are some problems for someone like me who doesn't always hold back their feelings.

PATIENT: Yeah, people can take advantage of you.

THERAPIST: I suppose they could. Has that happened for you? *[empathic elaboration]*

PATIENT: Look, when I was a kid, there was a time when I used to cry all the time. My mom cried a lot, too, and my dad showed us that was no way for either of us to be.

THERAPIST: What was that like?

PATIENT: I just learned not to cry. It was as simple as that.

THERAPIST: Can we go back for a minute? You said you cried all the time before you learned not to. What was going on for you?

PATIENT: Lots of feelings, but I just had to bury all of that when my dad made it clear I shouldn't be like that.

THERAPIST: Like I should just bury what I was feeling a minute ago, when you were telling me I shouldn't be like that? *[inbound relational tracer]*

PATIENT: Well, don't put it like that.

THERAPIST: Like how?

PATIENT: Like I'm doing the same thing to you that my dad did to me.

THERAPIST: I'm thinking more about how you might do to *yourself* what your dad did to you. Like when you went out that window.

PATIENT: *[long pause]* I was struggling around that time, and I was crying more than I had in a long time. I mean, I'd lost my dream job, my engagement, and my baby. *[stiffens up]* But I wasn't trying to bury you just now.

THERAPIST: What *were* you doing with me just now, do you imagine? When you called me a sap, what were you feeling? *[mentalizing the relationship—exploring emotional process and desires]*

PATIENT: *[beginning to tear up]* I was irritated, but I also just didn't know what it meant. I thought that maybe, by crying, you were trying to get me to cry with you or something.

THERAPIST: I can understand that, as it wasn't obvious why I was beginning to cry *[empathic validation of patient's experience of therapist]* . I wonder what you might be feeling now. It looks a little different to me than irritation *[affect elaboration of patient's current experience in the therapeutic relationship]* .

PATIENT: I just had the thought that maybe you were feeling sad for me.

THERAPIST: And what was that like?

PATIENT: I don’t usually like it when people are sad for me.

THERAPIST: Including yourself, right? What does happen for you when you are sad?

PATIENT: I just think others will see me as soft and weak, but I need to be strong. People might criticize someone who is soft.

THERAPIST: Is that what you were doing with me earlier?

PATIENT: Maybe a little.

THERAPIST: And how did that help you in the moment?

PATIENT: I felt pretty strong when I was calling you weak.

THERAPIST: What about that made you strong?

PATIENT: I felt like I could still have your respect. Between the two of us, I was being the strong one.

THERAPIST: And what about right now: have I lost your respect because I was being soft and feeling sad? *[presentation of therapist’s emotional experience to challenge and check out patient’s evolving perceptions]*

PATIENT: I guess not. I mean, I’m not a total monster, and I know that you’re not perfect.

THERAPIST: That seems important, actually: a little vulnerability might be acceptable between us. I wonder what’s helping you hold onto some respect for me here, even though I wasn’t being strong in the way you’ve always thought you needed to.

PATIENT: I don’t know. Maybe that’s starting to change a little.

As Chloe became more capable of tolerating vulnerable feelings that arose spontaneously in our sessions, she gradually elaborated a previously nascent sense of sadness in relation to losing her pregnancy, her job, her engagement, and with those things, her aspirations for herself. Our goal remained mentalizing a progressively broader range of Chloe’s emotional experiences, including the private experiences of pain, shame, and longing that often did not “fit” her more grandiose self-narrative.

The second year of treatment

After one year of treatment, Chloe had reached several treatment milestones typical for the early phase of MBT-N. Her capacity for basic mentalizing of her own emotional experiences and previously reflexive behaviors had

improved. With improved self-mentalizing, she had become more receptive to understanding herself through the lens of narcissistic vulnerabilities, embracing the NPD diagnosis and increasingly speaking with self-aware humor and pathos about both grandiose and vulnerable sides of herself. Chloe would even make jokes about how "full of [herself]" she could be at times, but then in the next breath, she would lament the impact this had had on herself and other people. In the therapeutic relationship, she was able to tolerate increased challenges from me to look beyond her own immediate perspective and consider what might be "missing" in her experience of Self and Other.

With these changes unfolding, the time had come to focus more on Chloe's professional functioning and relationships outside of treatment. I perceived significant problems in both areas. While Chloe had eagerly accepted a work requirement as a contingency of our treatment, her initial jobs were fraught with difficulties. She left her first job as an administrative assistant at a neighborhood medical clinic because she felt like the work was beneath her. She took a second job at another medical clinic, but she was fired for working beyond the contours of her assigned role, failing to complete required tasks she deemed as "menial," and garnering complaints from customers about her abrasive style. Simultaneously, Chloe struggled to make friends at a local church she had begun attending, where she felt unappreciated for her volunteering efforts and received feedback that she was "too intense" for others. She was also growing impatient with her fruitless search for a romantic partner. Starting early on in the dating process, Chloe developed idealized expectations of these relationships which her suitors could not match, making them targets of her rage and devaluation.

I viewed Chloe's ongoing instability within her jobs and dating relationships as stemming from interpersonal problems characteristic of pathological narcissism. When she felt unappreciated or mistreated, she became impervious to feedback and empathically disengaged from others. She spoke in a dismissive and condescending manner, demanding that her friends, partners, and co-workers behave exactly in accordance with her wishes. I worked to generate a shared focus within our sessions around mentalizing these relational problems "outside the room." In one illustrative session, we explored Chloe's anger toward her partner after he delayed his

return from a bachelor party to spend more time with his friends, resulting in him having less time to spend with her.

PATIENT: He said very hurtful things. This was our worst fight. I'm wondering if I should end it. I think this time I really will.

THERAPIST: Can we slow down a bit? What is it you're reacting to?

PATIENT: I want him to take responsibility for the fact that he could have made another decision to come back to me sooner.

THERAPIST: It would feel better if he acknowledges he made a choice between extra time with his friends and seeing you?

PATIENT: No, that isn't it. He kept saying he *wished* he could have gotten back sooner and seen more of me. *[mockingly]* "I wish, I wish, I wish." I mean, I don't care what he is wishing for when I am so hurt. He could have *done* something to prevent this, but he's portraying it as though it just happened: it was up to his friends who wanted to stay longer, and he didn't want to be selfish.

THERAPIST: It does seem a bit like the only thing that would have made you feel better is if he did what you wanted by giving up the extra time with his friends. *[drawing attention to teleological demand]*

PATIENT: *[more hesitant]* Look, I didn't need him to give it up. I just needed him to recognize that there were consequences to his choice. Like saying, "I'm sorry, because I was looking forward to seeing you and sharing time with you. I know this matters to you. I want to recognize you've been patient all weekend for this, and I know that it's been hard for you . …" *[loudly lamenting]* I was so patient all weekend!

THERAPIST: Yes, tell me about that. What were you patient with?

PATIENT: *[anguished]* You should already know what's it's like for me by now!

THERAPIST: How would I know, though? You haven't told me yet . … *[underscoring patient's expectation of perfect mind-reading]*

PATIENT: Fine, I'll make it obvious. It's like fasting! It's like someone took away my bread, and I'm thinking, "Fuck you, I want my bread!"

THERAPIST: So, like you were being starved for something so basic after working so hard. *[empathic validation of impression]*

PATIENT: Yes. *[pause]* But I know that sounds extreme.

THERAPIST: It sounds extremely awful. But what was it like when you were being starved in this way? *[impression-specific affect elaboration]*

PATIENT: Like I had nothing good left inside. Just an empty pit.

THERAPIST: And what was it like inside that pit? *[inviting elaboration on expressed affect]*

PATIENT: It was shameful. I couldn't find anything good within myself.

THERAPIST: No wonder you were searching so desperately for some crystal-clear words of appreciation. You were down in a pit of shame! *[empathic validation of teleological demand]* But it does seem like your vision of your partner was a bit narrow.

PATIENT: *[softly]* What do you mean?

THERAPIST: Because since it wasn't in this exact zone, it's like he wasn't trying.

PATIENT: But he couldn't get why this bothered me. He couldn't see that being away, and enjoying his time with his friends, took so much from me.

THERAPIST: How do you know he didn't have any sense of that?

PATIENT: He didn't tell me.

THERAPIST: So when he didn't tell you exactly what you needed to hear, you felt like you knew what was in his head?

PATIENT: I did not feel like I was appreciated.

THERAPIST: Yes. And when you felt unappreciated, what was the trouble for you in that experience?

PATIENT: It's like he was sitting idly by while I was in pain.

THERAPIST: How did you know that he could see exactly what you needed?

PATIENT: I just knew it. It was clear from what he was not saying. *[psychic equivalence]*

THERAPIST: I can see why that would be such a problem for you. I worry it is doubly bad because it is bound to happen again and again.

PATIENT: *[more curious]* What makes you say that?

THERAPIST: Well, I tend to think that no one feels appreciated all the time for the things only they know they are doing. Or do you see that differently?

PATIENT: No, I see what you're saying. But I just feel like I'm failing at something when someone isn't appreciating what I've done, or what I've been through.

THERAPIST: Is it ever possible to appreciate those things for yourself? *[contrary move from reality to fantasy, and from other to self]*

PATIENT: I wouldn't know how.

THERAPIST: Really, no idea? It seemed to me you had *some* sense that you had accomplished something very difficult, when you were so angry at your partner for not appreciating what you'd been through *[highlighting positive mentalizing]* . Or did I get that wrong?

PATIENT: No, I guess you are right. I was a little proud of myself.

THERAPIST: Let's think about how you might hold that a bit longer next time, just within yourself. Can you think of some way?

As illustrated above, I tried to help Chloe notice how her experience of herself and others would narrow whenever she felt unappreciated and unseen. Chloe thus remained stranded on an island of dismissiveness, entitlement ("You should already know what it's like for me"), devaluation of herself ("I can't find anything good in myself"), and disinterest in others ("I don't care what he is wishing for when I am so hurt").

While Chloe and I made some headway around exploring these interpersonal patterns in relationships outside of treatment, the most impactful interpersonal explorations were increasingly centered around her responses to my mind "inside the room." This progress showed itself in her evolving response to my attempts at empathic validation. During the first year of our treatment, as discussed earlier, Chloe had been dismissive of my expressions of empathy toward her more vulnerable emotions, while also mocking *my* attempts at emotional expression. Over time, however, she began to experience my empathy as a genuine personal response to her emotional states, which might have value in their own right, simply in virtue of being hers.

A poignant example of this involved a particularly rigid me-mode narrative absorbed as a kind of creed transmitted to her by her father. Chloe

had become very angry with me for not accurately understanding something about her, and she proceeded to criticize everything about me, and everyone else. Amidst a stream of derisive judgments, she slipped in a statement about her father always saying, “The cream always rises to the top.” For the second time in the treatment, I felt deeply sad for Chloe, and I found myself tearing up just as I had done early on in the treatment. As she had done then, she noticed my emotion, and her reaction seemed to deactivate any burgeoning emotional closeness between us: “I can’t believe this. Now I have to take care of you again?” I replied quietly, “It seems there’s no vulnerability allowed in here for either of us.” Without apparently registering my comment, she resumed her critique of everything for a moment, but she eventually just sputtered to a halt. Something in her seemed to relent, giving way to a deep, mournful wail that continued for several minutes. Through tears, Chloe shared that, no matter how hard she tried, she felt like her father would never accept her, and she would never accept herself, unless she rose “to the top” in all areas of her life. Unlike the last time that (my) sadness and tears had entered the room to divide us, this time sadness and tears (mine *and* hers) seemed to align us as a pair of interrelated minds (we-mode).

This episode prefigured Chloe’s many successive shifts toward vulnerable emotional expression and deeper closeness in the room with me. In reflecting back at the end of the treatment, Chloe noted this moment was among the most impactful.

> “When you and I both cried after I told you that my father consistently told me ‘The cream always rises to the top,’ I felt like you truly were in the struggle with me. And I felt that if someone as accomplished as you could see the problems with me trying to live out that statement, then the solution to my life was not going to be simply working harder to rise to the top. Sometimes you can do everything in your power, and you don’t get what you want. I felt such sadness, yet such relief, after sharing that vulnerable moment together.”

After this episode, Chloe became more curious about her tendency to base her self-esteem on this excessively positive aspirational vision. She began to share about ways that the “cream always rises to the top” narrative had long been compelling and protective for her, while also leaving her with a chronic sensitivity to even the smallest cues of failure. Chloe became more interested in reflecting upon what I thought, felt, and said about her. Thus began a crucial process of decoupling Chloe’s sense of self-worth from impossibly high external standards and achievements.

The third and fourth years of treatment

The later phase of Chloe's therapy focused heavily on addressing her core problem of contingent self-esteem (Chapters 2 & 10), and the various ways this problem manifested in the spheres of professional functioning and close personal relationships. Amid ongoing struggles to reach her ideals, Chloe began working toward more active compassion and patience with herself. These changes were galvanized in part by the deepening of our therapeutic work, but also by a series of life experiences outside the treatment organized around her return to an active religious faith and church community. Interestingly, as Chloe consolidated a religious aspect within her sense of identity, she experienced greater flexibility in her tendency to rigidly base her self-esteem on professional success and romantic connectedness.

Chloe's family had been Protestant Christians who attended church throughout her childhood. Throughout her later adolescence and early twenties, she had distanced herself from active religious identification and practices. At the beginning of our treatment, she expressed a vague belief in God, but she did not experience this being as relationally near. During the second year of treatment, as we increasingly focused on the importance of pursuing friendships and social community, Chloe decided to return to church for the first time in years. She threw herself into the life of a local Christian church that attracted many young professionals, immediately offering herself as a volunteer greeter at Sunday services. She became attached to a number of male "friends" whom I imagined, on the basis of her descriptions of their interactions, wanted to date her. Although she joined a women's group dedicated to studying Christian scriptures, she had trouble connecting stably to female peers at the church. She felt highly competitive toward them, in professional achievements and in their interactions with desirable men at the church. As Chloe discussed her church experiences with me, it seemed to me that she was not much concerned with deepening her spiritual practices; she appeared more motivated by seeking admiration and praise, and by feeling superior to other parishioners. She believed in an abstract God, but she related to this divine mind in a depersonalized, distanced manner—the same way that she approached other human minds.

However, two significant events deepened our discussions about Chloe's religion, and her own sense of relatedness to the mind of God. The first event was her discovery that I identify as a Christian. She learned this when listening to online recordings of some public talks I had given on the interface between Christianity and psychiatry/psychology, where I suggested the presence of useful interconnections. She seemed pleased and intrigued to learn more information about my personal life, and to share in a religious identification with me. She excitedly asked personal questions about how I had come to this religious identity and how I maintained it, working as I do within a profession where active religious identification by psychiatrists and psychotherapists is relatively rare.

While I did not answer all of these personal questions, we gradually arrived at a shared acknowledgment that we each welcomed a broader perspective framing our therapeutic work. Importantly, this wider frame felt like it existed "above" both of us; it was not helmed completely, nor fully understood, by either one of us. This joint sense of an imminent Otherness —a "divine third," so to speak—interacting with our work was not something either of us could explain in totality, yet Chloe correctly sensed this was important to each of us individually. This led to an unforeseen but powerful we-mode experience, in which Chloe felt that we were two minds partnered in a therapeutic process through a shared notion of God having some hand in what we were doing. This orientation thus discouraged rigidity, since it involved an inherent uncertainty about "what God might be up to" in her life (and in our therapy) at any given time. This growing side-by-side alignment became important within Chloe's own understanding of her change process. While later looking back at our work together, she commented on the positive impact of feeling free to discuss her faith with someone whom she felt valued this aspect of her development, and shared it on a personal level.

The second event was the sudden disappearance of her previously constant thoughts of suicide, following an "epiphany" she reported having while sitting in her church listening to a message on the theme of grace. Chloe came to session one day excitedly proclaiming that this experience led her to a newfound "knowledge" that she would never again become suicidal. In that transformative moment, she felt certain that God had permanently changed her into a person who would never again consider suicide. I puzzled about how to respond to this, as it seemed overly

idealizing—a throwback to Chloe's forced optimism at the beginning of treatment.

Eventually, I told Chloe that I do believe people can be changed in all sorts of ways, but there could be danger in setting up a perfect standard for herself of never being suicidal again; she could then fail that standard simply by experiencing a mere suicidal thought or feeling. I also worried that her increased emphasis on her faith could be a response to learning about my own personal faith—perhaps a kind of narcissistic twinning, or a need to align with what she had heard me discuss outside the treatment as a key source of my own identity. It seemed to me that she might be struggling to define her own views about faith in relation to my position about faith, or what she thought she understood about my position.

Yet Chloe persisted in attributing great importance to the changes she perceived as happening that day. Her new attitudes about faith evolved and deepened despite my skepticism about how best to understand it. She developed an abiding understanding of her epiphany as not something she had earned by her own strivings, but rather something that God had achieved in her that she was now trying to live out in a fresh way. I gradually recognized that Chloe was describing a sense of self-worth and identity that was much less contingent on performing up to anyone's standard. She was also exhibiting a decreased need to maintain complete dominance over her own experience—to "be her own master," to impose rigid standards onto herself, and to maintain explanatory control over all that was taking place within herself. She appeared to be opening herself up to a deep transformative influence by an ultimate Other, God, at the same time that she was becoming more open to input from peers, professional managers, and me. I relied on basic mentalizing techniques to explore how Chloe was understanding and relating to these changes in her perceptions.

THERAPIST: Tell me more about how you imagine God sees you. *[affect elaboration of others' mental states]*

PATIENT: I read in the scriptures about all the broken women who came to Jesus, and how he loved them and did not condemn them. I have felt like a broken woman in the past, when I've failed at so many things. I used to condemn myself for those failures. But that's not how I think God sees me.

THERAPIST: And what difference is that making in your life day-to-day? *[contrary move from fantasy to reality—from how the patient*

imagines God sees her to her real-world lived experience]

PATIENT: I try to think that how God sees me may be closer to who I really am than how I see myself sometimes. *[beginning to cry]* If I can be broken and fail, but I am still accepted and loved by God, then maybe He is right, and I am just struggling to see myself clearly. I don't have to throw myself out that window again.

THERAPIST: This is quite a change in how you view yourself. But it looks like there is a real feeling here, too. What are you feeling as you think in this new way about your worth? *[impression-specific affect elaboration]*

PATIENT: I feel sad, and grateful. And excited.

THERAPIST: Quite a mix! Tell me more about each.

PATIENT: Well, I'm sad because I spent a long time thinking that I really was a failure, through and through. And I get sad when I remember that the person who jumped out the window is still me. But I feel grateful because, in another sense, that person is not me anymore. I'm excited to try to live into this new vision of what my life can be. Notice that I said "live into," and not "live up!" *[smiling, in reference to many past conversations about trying to "live up" to impossible standards]*

THERAPIST: What happened to your nervousness about failing? Where has that gone?

PATIENT: Oh, I'm still plenty nervous, and I still think that I fail all the time.

THERAPIST: But how are you managing that now?

PATIENT: Well, I know that how God sees me isn't how I've seen myself. And now I am thinking that God's view of me may even be *truer* than my own view of myself. So I'm trying to take that in, to "hold it up" when I am being so critical of myself. It's messy and not easy, but I believe that it's a real change. I know you've been skeptical of this change in me, but I've also heard you in those talks saying you believe something like this for yourself.

THERAPIST: What is that like, thinking that you and I might be seeing ourselves, and God, in similar ways?

PATIENT: Well, it reminds me that I am not alone in some special category of being uniquely bad or screwed up. I think we're all in that imperfect category in some sense. And God is holding us all up, in a love that's based in who I am, not what I do. Obviously, what I do still matters, but I don't have to insist on being perfect. My worth doesn't depend on that anymore.

It increasingly seemed to me that Chloe was describing a relatively secure and dynamic relationship with an attachment figure, rather than a pathologically passive, hyper-religious, or idealized relationship I had feared she might embrace. From her perspective, God's view of her profoundly affected her beliefs and feelings about herself, softening her need to find external fuel out in the world for maintaining an excessively positive self-regard (pp. 223–228). She saw this not simply as a one-way relational movement, but as mutual and bidirectional: her own mental states (e.g., longings, needs, wishes) interacted with and elicited a loving response from God.

However these experiences might be understood by the reader, Chloe increasingly cultivated a solid sense of spiritual identity and values. She and I came to see this as a powerful alternative source of self-esteem that counterbalanced core narcissistic vulnerabilities. This spiritual "identity consolidation" coincided with Chloe developing a greater acceptance of her imperfections, buffering her from crisis whenever she struggled to satisfy her own or others' hopes and expectations.

Chloe's religious transformation also correlated with continuing professional growth and relational maturity. Rather than seeing her father as a distant source of criticism and judgment, she began to regard him as a vulnerable man toward whom she felt a newfound empathy and identification. She imagined herself alongside him, working through shared self-esteem challenges. Her father reached out to me to confirm significant improvements in their relationship; he expressed his gratitude for our work together. As Chloe decreased her need to extract appreciation and agreement from others, she made slow but steady progress in building several long-term friendships. In the area of work and vocation, she practiced greater humility around occupying more limited professional responsibilities, patiently accepting that she needed to manage those tasks well before advancing in status. For the first time, she left a job on a

successful note after already lining up a new position at a technology firm. She developed a productive long-term relationship with her new manager, who eventually promoted her and encouraged her to pursue further professional training. By the time the treatment ended, Chloe had been working for a major company for more than a year, earning a salary that allowed her to take over financial responsibility for all personal and treatment expenses from her parents.

Perhaps most importantly, Chloe could now regularly reflect on her internal experiences related to a broad range of issues: her unstable self-esteem, her longing to better connect with others, and the ways in which she could still get in her own way. As she increasingly considered the various functions our relationship served for her, she saw that she sometimes still relied on having an admiring, supportive man to keep her self-critical thoughts at bay. She recognized that she had historically "used men as binkies," referring to the toys given to pacify an inconsolable child. She expressed genuine regret over how she had overly depended on men as a means of regulating her self-esteem, rather than viewing them as "ends in and of themselves." In moments when Chloe felt unappreciated or dismissed by her romantic partners, we practiced calling these perspectives to mind; over time, her rough edges within romantic relationships softened. When she imagined the "perspective of God's grace"—the idea that her worth was independent of any success, appreciation, or admiration from other people—she was more likely to receive spontaneous kindness and interest from her partners. She could more readily trust and enjoy these gifts, knowing they had been freely given rather than coerced.

For much of our treatment, I remained skeptical about Chloe's conviction that her suicidal ideation had been permanently eradicated during her epiphany in the church. Yet as the therapy was ending, Chloe pointed out that, in fact, she had not thought about suicide once since that day. She playfully teased that perhaps *I* had been wrong about just how much change was possible for her through opening herself up to God. She had worked so hard to see how she both underestimated and overestimated herself—now we were laughing together about the possibility that I had underestimated both her and God.

While I had feared that Chloe's religious identity was initially driven by a self-enhancing overidentification with me, it had blossomed into a trustworthy source of positivity and balance within herself, and in her

relationships. She became more appreciative of both our sameness and separateness, extending this position toward friends, family, and romantic partners. More and more, Chloe was experiencing gratifying moments of genuine we-mode interaction, without needing to control or fuse with the other.

Termination

After nearly four years of working together, Chloe decided she had completed what she had come to the residential program to achieve. She moved back home across the country to be closer with her family, while continuing to pursue long-term professional growth and a healthy romantic relationship. Six months after our final session, Chloe wrote to me with the following update:

> "I am finding that my life is fuller and fuller on my own than I imagined it could be. I don't know if I will ever find a partner or be perfect in all the ways I had thought I needed to be, but I am crafting a life that I love, regardless. I see that I can still be a collaborative person who really values teamwork and relationships, instead of just doing things on my own to ensure that 'the cream rises to the top.' I even turned down a high-stakes job that would have burned me out because you helped me see that my intense tendencies in relationships, my competitiveness, my need to be perfect—those parts of me can be understood and nurtured, rather than placed on pedestals like I've done for so long. I can now see that sometimes I just don't know what I'm doing in my life, and that's OK. It's not a total failure I cannot tolerate. You've helped me make peace with vulnerabilities and imperfections in myself and others. I'm so incredibly grateful. I have a life worth living because of God's grace, and all of our work together."

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[1] I have modified demographic and identifying information about this patient in order to disguise their identity. The patient has reviewed this chapter and granted written permission for it to be published in its present form.

15

Case Example: I-mode, Me-mode, and We-mode in Clinical Process

Jane was 32 years old when she contacted her community physician asking to start psychotherapy. [1] Referral information stated that Jane "requested to talk to a 'top' clinician about herself to see if she could understand herself and her life better." She had done some research, worked out that she needed mentalization-based treatment (MBT), and decided that I (AWB, one of the present authors) would be the best person to consult. She was aware of her abilities and limitations, but she needed someone to use as a sounding board for her ideas. She wanted to see a lead clinician because she had been to see "ordinary" therapists in the past: "They were never able to enlighten me about understanding myself. I need someone intelligent."

Jane explained that, by now, most of the people with whom she had attended university already had partners, and some had children. She herself had no intimate relationships, as her standards were high. And yet she had a nagging worry that life was passing her by. She suspected that only a few sessions would be necessary to work out how to address this. The rest of her life, she thought, was going well.

The start of the treatment

In our first session, Jane questioned me to ensure that my qualifications were as stated in the information she had been given. I explained my experience and interests to Jane without hesitation, and I asked her to also say what sort of clinician she thought she needed, as it was important for us to sort out if we could work together. "What kind of therapist are you seeking?" "How did you come to that idea?" "You are someone with high standards of others?" "What measures are you using?" My aim here was to generate a joint agreement about the focus of therapy, and to create an atmosphere in

which openness about and interest in each other's subjective experience was part of the work. At the outset, I engaged in some affective self-disclosure with Jane (Chapter 11): "I feel on trial a little here . …" "What if I stumble? Will you be able to tell me?" Here, I was trying to encourage Jane to reimagine and react to the experience of another, in this case me, who may have a distinctly different state of mind than she expected. Jane shared that therapists in the past had not helped her very much. "They seemed to have less intelligence than me. Some were quite dumb."

Taking a not-knowing stance, I again asked Jane to reflect further on this experience: "Wow, that is quite a statement. Tell me more. How did you work that out?" Jane explained that most therapists only told her things about herself that she already knew. I injected some modest self-deprecating humor. "I might be the same, I suppose. So I better watch out for unintelligent comments, and saying things that you already know. I sure can make dumb comments sometimes. Let me know if I start to make them a lot of the time!"

As reviewed in Chapter 4 , the aim of initial mentalization-based treatment for narcissism (MBT-N) sessions is to make an agreement and plan about treatment. Patient and clinician work together to jointly develop a "formulation" that makes sense to both parties. The MBT formulation puts forward a model for understanding the patient's problems, is framed within a mentalizing model of the mind, and provides the patient with a sense of being recognized as a person with their own strengths and weaknesses. The formulation forms the foundation of treatment and indicates that the target of treatment is establishing effective mentalizing.

In this early phase of my work with Jane, I began to notice that Jane was primarily monitoring how much other people were recognizing her talents and abilities. As the starting point for Jane's MBT formulation, I said something like the following to Jane, as illustrated pictorially in Figure 15.1 . In this particular formulation, I utilized the developmental trajectory of mentalizing described in Chapter 1 , which distinguishes between I-mode, me-mode, and we-mode functioning.

“You might think that I am about to do something unintelligent, but it might help our work together. Can I draw out where we have got to? Here is a circle that is you. You are confident about yourself, in terms of your intelligence and abilities at work. You appreciate that you are better than most of those around you. But you have a concern that there is something missing. I am going to label this as ‘I-mode,’ since it is your experience of yourself.

At times, other people have not appreciated your talents. This has come up at work, and also in your friendships. Here is another circle that shows how you see others—people you have worked with or friends. What shall we put in there? Friends: you can work out what they think about you, and that they appreciate your abilities. But you are unsure what they have that you don’t, which allows them to have relationships and build a family. So I am going to put in two circles here. You have tried to work this out, in the hopes that you can develop what they have, but you come up with a bit of a blank. You say there is a gulf between you and others. You also think some do, and some don’t, appreciate your abilities. This adds to the gulf. I will call this ‘me-mode’—how other people’s minds work, how they think about you, and whether that matches how you see yourself.

But perhaps we need another circle, for relationships others have but you don’t. Let’s call that ‘we-mode’: being with someone who you think ‘gets’ you, you ‘get’ them, and you both know that you understand each other. This could be with a partner, or also with some people at work. I call this we-mode to remind us that this mode is about being with someone, feeling comfortable, and being able to engage in a joint task. You are suggesting that this is hardly present for you, whether at work or in your relationships. I will put a cross here. We need to work out how to rub out that cross.

It looks like there is a mismatch going on between how you are, how others are, and how they are with you. I think that sounds very general and perhaps unintelligent, but it gives us the ballpark in which we can work so that we put together the detail. You mentioned meeting together for a few sessions. It will probably be more than a few. I suggest that we agree to meet for three months of weekly sessions, in which we focus on I-mode and me-mode initially. Then we can review things, and we will both have a chance to work out if we are a good match for further work.”

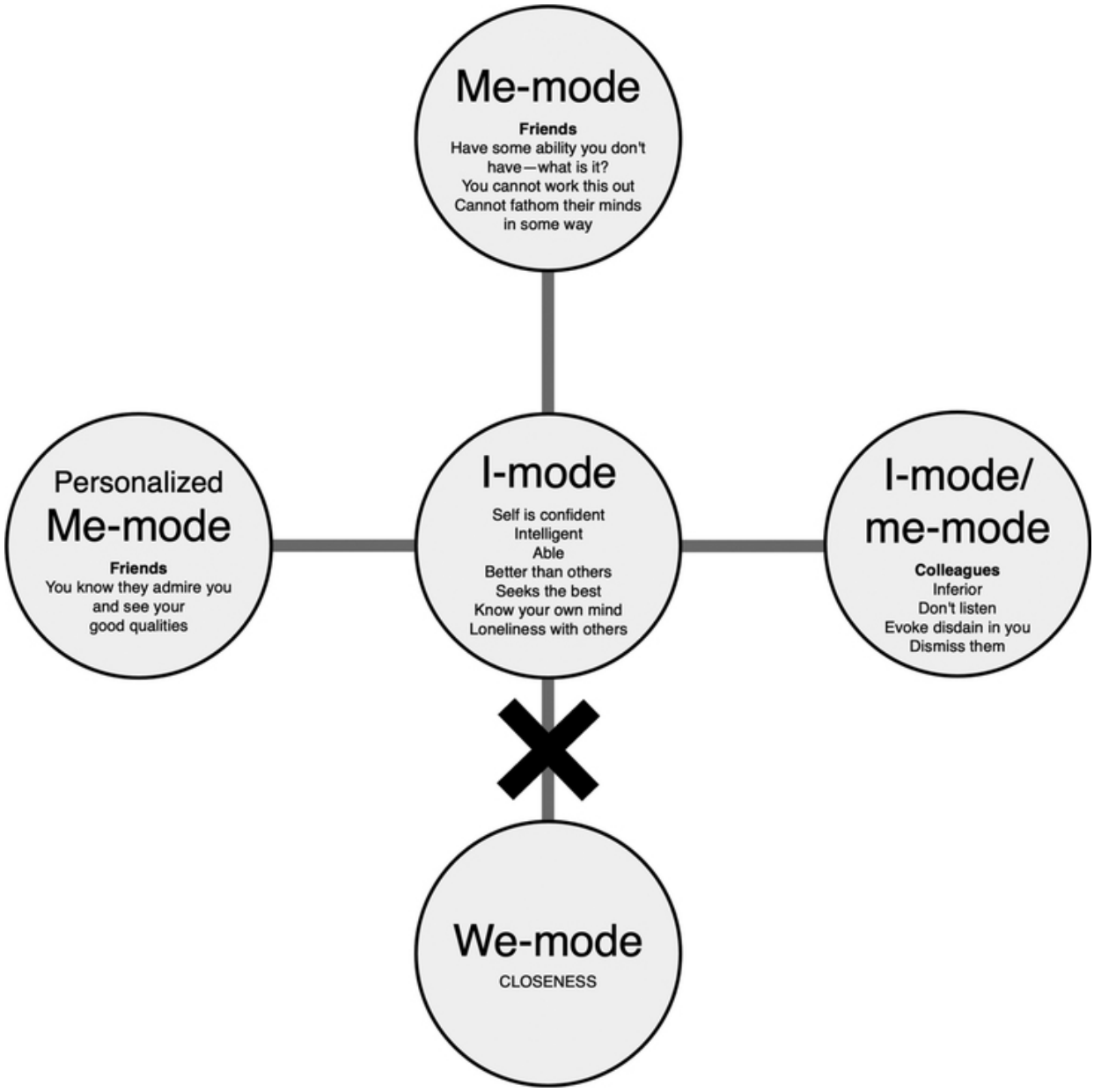

Figure 15.1 Initial MBT formulation of Jane's relationships in diagrammatic form.

In proposing an initial three-month period of treatment, I was trying to be sensitive to Jane's narcissistic vulnerability, aiming not to activate any sense of weakness, shame, or personal failure that might have challenged our therapeutic alliance. Jane agreed, and so we organized two sessions of MBT introductory material, basing the content on Jane's formulation, and on her reading about MBT. In particular, we focused on Jane's appraisal of mental states in herself and other people—the self/other polarity of mentalizing, a sub-component of I-mode and me-mode functioning. Alongside this, I also

noted that Jane employed cognitive processing to great effect, with less emphasis on her own and others' affective experiences (Chapter 13). Jane also extensively utilized what I referred to as "bubble mode" (pretend mode; see Chapter 8), leading her to feel alone wherever she was, and with whomever she was interacting.

At this stage, my aim was simply to "map out" Jane's mentalizing processes, rather than to rebalance or change these processes. I provided Jane with a written summary sheet depicting some key pathways that her problems with relationships took in her everyday life (see Figure 15.2).

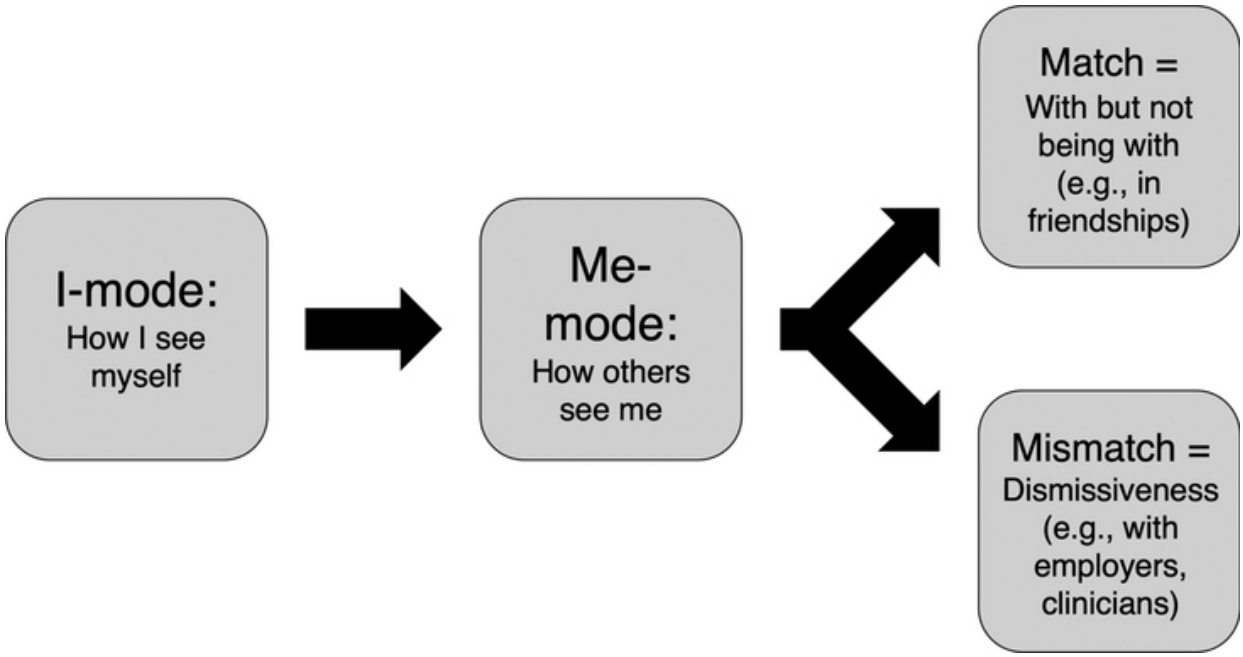

Figure 15.2 Key pathways for Jane's interpersonal challenges.

Initial sessions

Jane worked in finance and found "better" jobs quite easily, leaving posts on a number of occasions when her employers implemented policies with which she disagreed. On two occasions in the last two years, she had taken out a case against her employer for mismanagement of her work, but she settled each case prior to a court hearing. She had also changed therapists twice in the past, each time because she appraised them as being inadequate for her needs. Using self-deprecating humor again, I continued to mention the ever-present danger of me not being therapeutically adequate for her, particularly

as she understood so much about herself already. I was careful not to overdo this self-deprecation, to ensure that Jane did not feel teased, criticized, or patronized. However, I also wanted to maintain a sensitivity to the "elephant in the room" (Chapter 11): Jane had strong tendencies to activate dismissive attachment strategies, and she was constantly monitoring interactions to make sure the other person reached her standards of intelligence and ability. I was aware that, at some point, we would have to identify and explore this dimension of our relationship more fully. I decided to wait until the therapeutic alliance was stronger to directly take this up with Jane.

Jane talked about her past experiences and how they influenced her. She appeared to be balanced in her appraisal of her upbringing, seeing some aspects of her childhood and adolescence as helpful, and others as interfering with how she approached herself and others in life. I listened quietly to her story, mostly asking questions to increase her self-reflection. Crucially, I began to get a picture of someone whose self-evaluation was highly positive, although this was all rather fragile.

Addressing the fragility of narcissism

The longer that I worked with Jane, I felt acutely aware that I stood in a highly delicate position in relation to her narcissistic processes. I needed to establish an empathic and compassionate perspective on Jane, irrespective of her dismissive and disdainful attitude, while also keeping a close watch on any derisive or reactive feelings that I might experience in our interactions. In the terms utilized in Jane's formulation, I tried to balance empathic validation of Jane's self-narrative, or I-mode, with recognition of more nascent dimensions of Jane's experience (pp. 169–174), which was *fragility* in Jane's I-mode and experiential self. In effect, Jane had to experience a me-mode—in this case, *my* subjectivity and mental states—that matched perfectly her I-mode subjective experiential self. Without that, the mental threat of failure would be so painful, and perhaps shameful, that it could only be managed by avoiding and dismissing the source of pain: in this case, me (see Figure 15.2).

Accordingly, in order to affirm and elaborate Jane's I-mode experience, I worked to metaphorically "sit alongside" Jane and consider her life from *her* perspective. Consider, for example, an excerpt from our discussions about Jane's experiences with her previous therapists and employers.

THERAPIST: I am picking up that you have a clear view about yourself that has built positively over time, and that your employers and other therapists did not always see you in the same way. It is quite an issue, when you are left being so misunderstood. Despite all your efforts to advise people at work, and to get support from therapists, I can see why you end up looking elsewhere. *[empathic validation, reinforcing and scaffolding Jane's I-mode narrative]*

PATIENT: It still surprises me that my employers are so dumb. They are not worth working with. The current ones are just the same. I always seem to end up with so many dumb people around me. *[rapidly defaulting to a dismissive response]*

Here, Jane seemed to be "matching" my representation with her own view, accepting that I saw her life the way that she did. Jane continued to share about her employers not appreciating her talent. I listened carefully not just to the content of Jane's narrative, but also to "how" Jane held her beliefs about herself—her level of certainty, the presence or absence of doubt (Chapter 4).

THERAPIST: *[humorously]* I know what you mean. You are very clear. I have the same thought sometimes. But then I think that it is me, and they probably think the same thing about me! We all end up seeing each other as dumb. *[trying to open up a channel from me-mode to jane's I-mode]*

PATIENT: *[reactively]* Do you think it is me, then?

THERAPIST: I was more thinking we can all be dumb sometimes. But there was something a little sharp in how you said that. Can you say what happened in you just now?

PATIENT: I suddenly had an image of being a dumb person. Hmm … there is something a bit dark in there. I suppose the other possibility is that it is me who is dumb, and they are not dumb. Or maybe I attract dumb people generally. Do you think they see me as dumb?

THERAPIST: Well, I don't know. It is something for us to work out. Can you say what made you think there is something about you being dumb, and what is so dark? *[inviting elaboration around a possible "chink in the I-mode armor"]*

PATIENT: It does seem to happen all the time, doesn't it? I think I am pretty good at working it out, though. *[moving back to a self-reliant I-mode, and away from personalized me-mode, when she imagines others seeing her as dumb]*

THERAPIST: Absolutely. They do not appreciate your talent, and you are very clear about that *[supporting patient's I-mode]* . But there is something in this that keeps playing on my mind *[forecasting affective self-disclosure]* . I worry that, while you and I are aware of your abilities, there is something nagging away beneath the surface for you. At times, you seem a bit less sure of yourself: wondering if others view you as dumb, and feeling like there *is* a bit of dumbness in you—something that you see as dark. I have been thinking about this lately, and I am concerned that I could be missing something by not bringing it up. *[engaging in affective self-disclosure]*

In this interchange, I was sensitively challenging Jane's I-mode by expressing my own emotional experience, to be considered alongside Jane's perspective. Earlier in the session, Jane had begun to articulate a sense of inner darkness associated with feeling "dumb." I was able to explicitly focus on that, since I was wondering about this topic as well. Through engaging in affective self-disclosure, I attempted to acknowledge the "elephant in the room" surrounding Jane's potential insecurities, thus speaking to nascent emotions in Jane's experience (pp. 169–174). This provided us with a shared point of focus, laying the groundwork for future experiences of we-mode.

Affective self-disclosure to address narcissistic processes

I have suggested that I-mode and me-mode functioned in a specific way in Jane's experience. In the earliest phases of treatment, these modes unfolded synchronously rather than interactively. When others' views of her *(personalized me-mode)* cohered with Jane's self-experience *(I-mode)* , Jane was able to feel a temporary sense of self-coherence and stability. However, whenever others' mental states *(me-mode)* contradicted her own perspective *(I-mode)* , Jane encountered a massive threat to her experience of herself, such that she was forced to engage in avoidance, dismissiveness, and withdrawal in order to preserve a continuity of selfhood (Chapter 2). Her I-mode was thus protected, but at a severe cost: change and flexibility in social

interactions became impossible for Jane. She was unable to have the sorts of relationships that she saw other people having, and which she desperately craved.

As the therapy progressed, I began to increasingly address Jane's rigid "need for matching" in relational dynamics. I utilized a range of approaches along these lines, most notably the technique of affective self-disclosure discussed in Chapter 11 . Specifically, I worked to express my affective experience in relation to Jane's nascent mental processes, presenting an independent perspective *(me-mode)* that remained empathic with Jane's inner struggle *(I-mode)* . In this way, I tried to doggedly present Jane with an "unmatched" experience, but in a manner that would not overwhelm and destabilize her. To illustrate:

Several sessions after the appointment mentioned above, Jane disclosed that she was feeling increasingly miserable. She attributed this to the therapy: "It's not doing me any good." There was more darkness. I initially took a not-knowing stance to explore this, so that we could talk together with open minds about whether the treatment was helping.

THERAPIST: This is important. Help me understand how you came to your sense that therapy is "not doing any good."

PATIENT: I was sitting at home and thinking that nothing much has changed. Two friends who are a couple invited me over to supper. They put their two-year-old son to bed, and they seemed so comfortable together. I just thought, "I cannot have what they have." But that is what I came to therapy for in the first place! That is when it felt dark again.

THERAPIST: What did they have?

PATIENT: They are so easy with each other, and obviously different when they are together than when I see them by themselves. They just seemed to be in harmony. I was looking in, and they weren't being exclusive or anything. They are really open and inclusive. I wanted to leave, but I managed to stay.

THERAPIST: So you were seeing this thing that you want, but you felt like you could not have it. What was happening inside of you to make you want to leave? Indeed, this is what you came to therapy to sort out.

PATIENT: I don't know. I just wanted to get away, I suppose. I felt dumb again, and that dark feeling.

THERAPIST: You know, as I imagine you in that situation, I am impressed that you remained there. Yet it makes me feel rather sad. Sad that you can only see yourself as being shut out from what others have, particularly in this situation of people being together, which is something that you really want. It seems so lonely and dark in there.

In this session, I engaged in affective self-disclosure by expressing my emotional response (e.g., sadness) to Jane's nascent emotions (e.g., involving loneliness, darkness, and not being with others when she is in their presence). I was trying to join Jane in her vulnerability by creating a shared position. However, in this particular instance, Jane responded by saying that she was not bothered much anymore, and she thought that it was only a matter of time before she met someone. I pointed out that Jane suddenly seemed to jump away from something significant, but to no avail. Her dismissive strategies were activated, and she had returned to a self-protective stance. This brings me to a final maladaptive pattern with which Jane struggled in treatment: a tendency toward pretend mode, such that she appeared to be in therapy, but in fact she was not. Jane had shifted into pretend mode.

Strategies to address pretend mode

In Chapter 8 , we emphasized the importance of recognizing and intervening to block and undermine the development of pretend mode. For Jane, her mental states often functioned in isolation from the external world. Her imagination could become untethered from reality, decoupled from the external, and so anything became possible. Given Jane's goals of developing closer relationships, this concerned me, since her capacity to orient effectively to the mental states of others appeared to be dramatically reduced when she was in pretend mode. In Jane's case, pretend mode became a safe retreat that protected her I-mode, which was built around unrestrained grandiosity and brilliance that was not firmly anchored in the real world.

In my appointments with Jane, I tried to address pretend mode by working in Jane's current experience, including encouraging embodied mentalizing within sessions, rather than focusing on past experiences (pp. 176–179, 187–188). I also attempted to stimulate Jane's reflection about the present interaction between the two of us in the session itself (Chapter 12). Finally,

when these approaches were ineffective at disrupting the pretend mode, I would progress to utilize the "challenge" technique discussed earlier in the book: a surprising, irreverent, often provocative comment that helped Jane to access her own emotional states, or to consider my mental states (pp. 189–194). For example, in the aforementioned session where Jane expressed her concerns about lack of progress in therapy, I tried to reapproach the issue by returning to a focus on our current relationship.

THERAPIST: I am wondering about our relationship, as you were saying that you were not sure this was helping. Have I been a dumb already in this session? *[attempting to create a relational process]*

PATIENT: No!

THERAPIST: Tell me when I have been, as we agreed that we would both say if we thought the other person was being dumb.

PATIENT: Not sure that you have been. You seem to listen to me most of the time, and you don't lose your focus on me. I don't think that is why therapy is not working.

THERAPIST: What do you make of it not working?

PATIENT: Hmm … I am not so sure, but I don't think I am ever going to have what they have. I think that I am starting to have that feeling again. *[Jane proceeded to give a long explanation about her childhood and relationships with parents to explain her inability to change. I decided to intervene using a mild challenge.]*

THERAPIST: You say that I seem to listen to you most of the time, but this is one time when I am not. To me, you seem to have gone off into your own world again, just at the moment we were trying to work out who is dumb around here, and what is in this dark that you experienced. *[emotion- focused challenge]*

PATIENT: *[coming out of her detailed explanations]* I hate the idea I am dumb, and that you see me like that. It frightens me. OK?

THERAPIST: Can't we all be dumb at times?

PATIENT: Have you been sitting there and thinking I am dumb, then?

THERAPIST: Oh wow, no. I am thinking more about you being so frightened to be seen as dumb, and how that makes you hide. But when you do, it is dark. You are alone, and that is terrible.

In this interchange, I was attempting to open up Jane's recognition and acceptance of her personal fragility, while balancing it with some awareness that it is not disastrous, and it is survivable. As I explicitly acknowledged Jane's nascent emotions related to feelings of vulnerability (e.g., surrounding self-experiences of dumbness and darkness), Jane was able to represent a broader range of her own mental processes, and to feel safe enough to acknowledge these openly in the context of our relationship.

In light of these explorations, Jane and I updated the personalized me-mode "Friends" bubble in her original MBT formulation (Figure 15.1). We agreed to start examining how Jane's friends saw her, as well as the facets of herself that she showed them (and did not show them) in their interactions. We also began to prioritize analogous processes in the therapeutic dynamic: the aspects of herself that she revealed in our relationship, how I saw her, and how she *experienced* me as seeing her in our sessions together. We were transitioning into a phase in the treatment involving a greater sense of mutual acceptance and trust.

Conclusion: The groundwork for we-mode

This chapter covers the early phase of my work with Jane. By working together to think about mental states, Jane and I cultivated a collaborative mentalizing process, generating increasingly complex representations of what was happening within the therapeutic relationship, and within Jane's relationships in the broader world. Over time, this process challenged Jane's tendency to organize her mind through pretend mode processes. Jane began to take the risk of identifying and differentiating mental states in herself and other people, thus laying the essential mentalizing groundwork for an experience of we-mode or "we-ness" at the level of social cognition. As Jane has experienced glimpses of we-mode in therapy, she has commenced to take advantage of moments of we-mode in her life outside of the treatment: showing increased vulnerability to other people, learning from and enjoying "mismatches" with others, and starting to build relationships where she feels like she belongs.

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[1] This patient is disguised and bears no identifiable features to any individual. However, the clinical discourse depicted derives from transcripts of session material and may therefore appear a little

messy.

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Case Example: William the Firefighter

William presented to individual therapy when he was 48 years old. [1] An Air Force Veteran and former captain in the fire department, William had not worked for the past decade, after he attempted suicide by shooting himself in the stomach. With no history of depression, this attempt seemed to come "out of the blue," and William was medically retired despite his protestations. Since that time, William's alcohol use had progressively increased. His wife worked as a high-powered attorney, and William would spend his days at home alone: drinking several pints of vodka each day, posting political rants on Facebook, and watching reruns of old television shows from his youth, when he felt like his life actually had some potential. Now jobless and without direction, he felt like a complete loser—he had not even been able to succeed at killing himself. At the start of therapy, William was diagnosed with narcissistic personality disorder (NPD), given his tendencies toward superiority, arrogance, argumentativeness, and seemingly "attention-seeking" behavior, in which he would wield his intelligence, anecdotes, and elaborate vocabulary to pursue the approval and admiration of others.

Background information

William was born and raised in the Bronx, the youngest of three children. His father worked in a shoe factory, and his mother was a stay-at-home mom, raising the children and volunteering her additional time at the local library. His father was kind and extremely passive, especially in relation to his mother, whom William saw as volatile, intrusive, and painfully self-centered. She required nearly constant deference and attentiveness from William and his siblings, regularly demanding that they tell her how much they loved her, and how wonderful she was. She was also easily insulted. If

she ever sensed that her children were judging her, or feeling upset with her in any way, she became quickly enraged, screaming at them and slapping them in the face until they "got back into line" and affirmed their adoration of her.

William remembers himself as a defiant but highly secretive child. His earliest memory was of throwing all of his stuffed animals out of his crib, his mother retrieving them and placing them back in the crib, and then him gleefully tossing the stuffed animals out again. He would repeat this process over and over, infuriating his mother. School became yet another venue for William to rebel. He never felt especially skilled academically, receiving poor grades on his earliest assignments. Hurt and offended by this, he began to intentionally *not try* to succeed on the assignments. As the bad grades rolled in, he never alerted his parents to his failures, instead feeling a sense of power and satisfaction as he reminded himself that his mother was completely unaware of these pivotal events in his education. When she inevitably did find out, there was the predictable rage, screaming, and attacks against William: "How could you keep something like this from me?!" These moments were the icing on the cake for William. They generated a palpable experience of triumph, excitement, and even pride at his ability to thwart and control his mother, to drive her crazy.

At school, William was bullied and targeted by the other children, fueled by his social awkwardness and his strange clothing, which—due to his family's poverty—his mother sewed from scratch. This led to a powerful sense of separateness and isolation from his peers that would remain with him throughout his life. Rather than engage with others and risk the rejection that inevitably ensued, William retreated to an elaborate fantasy life. He read science fiction novels written for adults, reveling in his hidden intellectual abilities. He watched hours upon hours of television, identifying with the heroic main characters and the adoration they received. Perhaps most poignantly, he fantasized about becoming severely injured and maimed. All of the people who criticized and rejected him (e.g., teachers, fellow students, his mother) would finally feel guilty for how they had been treating him, and they would care for him in his condition of pain and fragility.

Once he turned seventeen years old, in the ultimate act of rebellion against his mother, William secretly enlisted in the Air Force, waiting to inform his parents until just days before he was scheduled to leave. His

father was quietly supportive; his mother was incensed, and crushed. Thus began the upward trend and trajectory of William's life. The military provided him with a clear, discernable set of instructions about how succeed in life. William worked as a tactical aircraft mechanic, and for the first time in his life, he began to actually *try* at something. He was fastidious in his performance of tasks, internalizing the standardized protocols and following them to a tee. He finally felt like he was good at something, and he was able to achieve a reliable, consistent sense of self-esteem. He quickly rose in the ranks, ultimately attaining the designation of Chief Master Sergeant.

This pattern continued into his thirties, when he transitioned back into civilian life and started a career in the New York City Fire Department. Once again, William's perfectionism paid off. He was promoted to the level of Captain, second-in-command to the department Chief. As he became more and more successful, William began to "find his voice," developing his skills at verbal and written communication, and especially at *argumentation* —his ability to use reason, rhetoric, and vocabulary to support his viewpoints and positions, and to vanquish anyone who might disagree with him, or advocate an inferior perspective.

Throughout these achievements, William never quite figured out how to navigate the interpersonal dimensions of all of these contexts and roles. While his supervisors trusted and valued him, he felt fundamentally separate from his peers and supervisees. This did not bother William much, as he enjoyed a strong sense of pride at his status as a "non-traditional" firefighter. While his colleagues were focused on superficial interests like hanging out together at barbecues and sporting events, he was investing in things that *really* mattered in life: deepening his knowledge about politics and world events, expanding his vocabulary, and (at work) developing policies and procedures that actually saved human lives. When he was not working, William thus spent much of his time alone—drinking alcohol, surfing the Internet, and watching television.

In his early forties, when responding to a fire alarm in a high-rise apartment building, William met Catherine, the woman who would soon become his wife. Catherine was a highly successful lawyer, a junior partner at a large Manhattan law firm. On paper, they were an unlikely pair, but they connected around their shared ambitiousness, hardheadedness, love of politics, and tendencies toward argumentation and intellectualization. They fell quickly and passionately in love, and they were married within months.

Over the next several years, the carefully constructed edifice of William's life started to crumble. Citing his rigidity and demandingness, his supervisees began to complain about him, resulting in his transfer to another firehouse. In this new role, he did not know any of his firefighters and lieutenants, and they resisted his attempts to instill order onto their shifts. He became even further ostracized and isolated there, and his alcohol use steadily increased, such that he was drinking nearly continuously outside of his 24-hour shifts. While he never drank on the job, he often drank *up to* his shifts, such that he would sometimes be detoxing and smelling of alcohol while he was working. Despite William's confidence that his work performance was not impaired, his colleagues and supervisors began to notice. Then came the extended medical leaves, admissions to treatment programs, and arrests for driving while intoxicated. It was in this context that William decided to take his own life, shooting himself in the stomach with one of his many firearms. The doctors were able to save him, but he suffered severe nerve damage, leaving him disabled with a permanent limp. Unable to show his face at work, he simply never returned, and he was forced to retire on a medical disability. As the smoke began to clear, William began to realize that his supervisees were right: he was a complete failure, a nobody. All of his successes were trapped in the past, and there was nothing that he could do to regain a sense of his own value. While his wife Catherine continued her upward rise in the legal world, he resigned himself to drinking every day. This was where William found himself at the start of the therapy: ashamed, broken, and unable to access a sense of himself as actually mattering in his own life.

The start of the treatment

I (RPD, one of the present authors) met William while he was attending a residential treatment program for uniformed responders with substance use disorders, where I was asked to complete a diagnostic consultation and provide treatment recommendations. William was tall, slender, and well-dressed, walking with a noticeable limp from his suicide attempt. His posture was almost concave, as if he was turning inward and trying to hide himself. And yet he spoke confidently and articulately, in an intellectualized, somewhat robotic manner where there was no emotion to

be found. After several meetings, I shared my impression that he likely met full diagnostic criteria for NPD, reviewing these criteria with him and considering examples from his experience that seemed consistent with them (Chapter 3). William saw the relevance of the diagnosis, for which he was immediately grateful. He had long felt that the idea of "depression" did not fully explain the circumstances of his suicide attempt, which he saw as a desperate effort to escape from humiliation and shame. He thus quickly came to idealize me as being the only person who ever gave him the correct diagnosis, who was knowledgeable and courageous enough to name his personality-related problem.

We began to discuss the possibility of working together in a psychotherapy. I explained that, since there are not currently any evidence-based therapies for NPD, we often adapt for NPD approaches that have been empirically validated for other disorders. I introduced William to mentalization-based treatment for narcissism (MBT-N), the treatment protocol outlined in this book (see also Bateman & Fonagy, 2016). We discussed the idea of mentalizing—*our ability to "read," access, and reflect on mental states (e.g., thoughts, emotions, desires, attitudes) in ourselves and other people* . I outlined the challenges in mentalizing associated with NPD (Chapter 2), sketching out how MBT might address William's challenges—namely, by attempting to "stimulate mentalizing" around the emotions and interpersonal dynamics that had historically caused him the most difficulty, under the assumption that improvements in this capacity would lead to improvements in William's psychiatric symptoms and overall functionality. William expressed an interest in moving forward with this approach, and we agreed to work with each other in a twice-weekly psychotherapy. William already had a psychiatrist who provided mostly psychopharmacology for him. I communicated with her, to update her about his diagnosis and the recommended treatment plan.

We started our work together by developing a shared understanding of the priorities for William's treatment (pp. 61–64). While William expressed his desire to ultimately "stop drinking" (more on that later), he shared that the most important thing in his life was his relationship with Catherine, which he felt like he was destroying through his secrecy, dishonesty, and non-communicativeness *around* his drinking. The pattern would proceed as follows. After some short-lived stretch of sobriety, William would relapse on alcohol while Catherine was at work, drinking large quantities of vodka

over a brief period of time. Catherine would return home to find William severely intoxicated—smelling of alcohol, slurring his words, and virtually immobilized. Catherine would understandably confront him about being under the influence, but William indignantly denied having relapsed, attributing his condition to side effects from his prescribed psychiatric medications. This was maddening to Catherine, resulting in intense conflicts between them. Similarly, when Catherine traveled for work, William would essentially "go dark": not answering phone calls, not responding to texts, and spending all of his time drinking. Catherine would become panicked about this, worrying that something had happened to William, thus making it nearly impossible for her to focus on her work. She would return home to find William familiarly incapacitated, and the conflicts would once again ensue.

I agreed that this pattern seemed like a viable initial focus for the therapy. I then wrote a draft of William's mentalization-based formulation—a written document that summarized William's core interpersonal challenges, as well as his related difficulties in mentalizing that could serve as the target of treatment (Chapter 4). I provided William with a written copy of the formulation, and we worked together to edit and revise it. See here for a distilled version of William's initial formulation:

> William identifies difficulties with dishonesty, secrecy, and non-communication as his primary goals for treatment. He prioritizes these because of the negative impact they have on his relationship with his wife, Catherine, whom he loves. It appears that, when William relapses on alcohol, he is unable to "own" that relapse, instead becoming either argumentative or withdrawn in his communications with Catherine. Several problems with reflectiveness appear to be at play here. First, William can become quite rigid (what he calls "strident") in his perceptions of these interactions, focusing on his "rights" to drink alcohol and the unfairness of Catherine trying to control him. Furthermore, William often experiences such interactions concretely—for reasons that are not yet clear, it feels to him like he literally *cannot* acknowledge his relapse to Catherine. And finally, William appears quite disconnected around these matters: disconnected from Catherine's emotional states, since he finds it difficult to anticipate and empathize with the distress that his behavior causes in her; and disconnected from a full range of his own emotional states, since he struggles with identifying relevant emotions and desires that might be related to his behavioral patterns of secrecy and dishonesty.

At the outset of the treatment, William displayed a highly superficial explanation of the patterns in question, simply stating that he related to Catherine in this way because alcohol "worked" in alleviating his emotional distress, and he wanted to continue experiencing this emotional relief. I

shared that this did not fully add up to me. William's desire to self-medicate did not explain why, *once* he had relapsed, he refused to acknowledge it, and why he did not maintain contact with Catherine when she was away. Utilizing mentalization-based treatment for narcissism's (MBT-N) affect elaboration strategies (Chapter 6), I inquired about William's emotional experience of Catherine confronting him about the relapses. William described his intense feelings of shame and humiliation in these interactions: his sense that he had failed Catherine yet again, and that there was something bad about *him* that meant he would just continue failing, at sobriety and at life. At such times, acknowledging his relapse did not even feel like an option for him. Even though Catherine already knew he was drinking, to actually say the words "OK, I drank" felt psychologically impossible, tantamount to an obliteration of the self (see pp. 32–33).

I observed that William sometimes seemed to smile as he told me these stories, inviting him to reflect on his emotional states in these moments. He initially denied having any particular feelings, but I continued to highlight the smiling when it arose. William gradually acknowledged some sense of pleasure and pride at besting Catherine, in making her so upset with him. Usually he felt so powerless in their relationship, and like such a loser in relation to her. And yet when he was drinking (and when Catherine was so enraged with him for drinking), he was able to experience himself as powerful and strong. *Passively* powerful, but powerful nonetheless.

William also saw the relevance of these emotions during Catherine's business trips. While William initially attributed his non-communicativeness to the fact that he was often intoxicated and passed out, I observed that there had to be *some* moments, perhaps prior to starting to drink, in which he was cognizant enough to reflect upon the consequences of his actions. William confirmed this, explaining that he would sometimes consider reaching out to Catherine to let her know that he was OK, but something inside of him would not allow him to do this: "It would be like letting her win. I cannot do it." I asked William to say more about this feeling, which led once again back to this issue of power: "Well, it's not like I feel great, like *I* am winning. But I guess I am resisting her, and there is something satisfying about that. It's a nice to have a little bit of power for a change." [2] I also invited William to reflect on Catherine's experiences here.

THERAPIST: If I were to "press pause" on these moments, and to ask you how Catherine might be feeling at the time, what do you

think you would say? *[affect elaboration of another person's mental states]*

PATIENT: I wouldn't be thinking about it.

THERAPIST: No, I understand that. But even if you are not thinking about Catherine, I bet you still have some assumptions about what she could be feeling. *[doggedly encouraging reflection about the other's experience]*

PATIENT: Well, of course. I know that she gets really worried about me.

THERAPIST: Worried about what? *[inviting further elaboration of identified feeling]*

PATIENT: Worried that I am drinking again. That I have fallen over and cracked my head open. That I'm dead, that I've burned the house down. It really could be anything.

THERAPIST: What are you feeling as you say those words, Will? *[affect elaboration of patient's current engagement in the therapeutic activity]*

PATIENT: I feel terrible. How can I just keep doing this to her? No matter what I've done, I have always tried to be a decent person, and this just sounds so *indecent* .

Through these discussions, I was attempting to help William move beyond a mechanical explanation of his alcohol use ("I drink because it works"), to elaborate the *psychological* dimensions of such patterns: his desires for power; his need to resist and rebel; his sense of weakness and shame; and his consideration of Catherine's emotional states. With these mental states now "on the table," I employed context-focused interventions to try to stimulate William's refection about his own agency in these dynamics (pp. 147–165). I asked William if he wanted to take steps to try to alter these patterns. He responded, "Well, I guess I have to," proceeding to consider what it might look like for him to respond in different ways in these scenarios.

Within one to two months, William's behaviors along these lines notably shifted. While he still found it quite difficult to explicitly acknowledge his relapses to Catherine, *he stopped denying them* , thus tacitly admitting to drinking and sidestepping the arguments that had always followed his denials. He also began to not simply respond to Catherine's communications while she was away, but to initiate text and phone

communications throughout the day each day of her trip—asking her about her travels and letting her know how he was doing. Rather than experience these interchanges as a demeaning acquiescence to Catherine's demands, William felt a sense of autonomy and mastery about "taking ownership" of the communications himself. To reinforce William's improved mentalizing here, I encouraged him to consider the impact of these shifts on Catherine (pp. 94–95). He reflected upon Catherine's potential feelings of relief and comfort, and her growing freedom to engage in her work without having to think about him all the time. In turn, these developments made William feel better about himself, and gratified that he was contributing to Catherine's experience, rather than acting as a burden on her.

Months 6–12 of treatment

As William's secrecy and dishonesty decreased, he expressed his wish to improve the quality of his relationship with Catherine. Even when William was not drinking, they bickered almost constantly about topics that William identified after the fact as "trivial": the meaning of a particular word, their opinions about politics and religion, or the best driving route to some destination. While these discussions often took the shape of playful verbal sparring, at other times, they escalated into full-on arguments, resulting in yelling, name-calling, and estrangement in the relationship. William was most concerned about instances when he felt like Catherine was treating him unfairly and unjustly, for example when she insisted on giving large sums of money to her family members against his protestations, or when she criticized him for his manner of completing some household task (e.g., doing the laundry, cleaning the bathroom, making the bed). In such moments, William would become defensive and argumentative with Catherine, "digging in his heels" and enumerating all of the reasons why he was justified (and why she was unjustified) in the situation in question. [3]

We explored these disagreements in detail, with the aim of helping William to gain a deeper understand of his own participation in them, so that he could potentially subvert their progression. William would begin by describing the context and content of the argument, and I would inquire more directly about William's emotional experience here (*"What was that like for you?"* ; *"How did that feel when she said that to you?"*). William

would usually respond by providing some further assessment, criticism, or defense of his position, such as “She’s just dismissing my perspective,” or “There are many ways to make the bed. Her way isn’t the only right way.” Rather than continuing along these lines, I attempted to draw William’s attention to what he was *not* including in these responses to me.

THERAPIST: Are you aware that I am asking all of these questions about your emotions, and you are just sharing more about your “ideas” about the situation? *[calling attention to patient sharing impressions rather than feelings]*

PATIENT: That’s just what I do. I don’t do well with emotions.

THERAPIST: Well, of course I know that. But as you were just responding to me, were you in touch with the fact that you were not really answering my question?

PATIENT: I guess not.

THERAPIST: So just to ask you again: when Catherine was critiquing your method of making the bed, what did that feel like to you? *[impression-specific affect elaboration]*

PATIENT: Well, not good, obviously.

THERAPIST: Not good? *[inviting elaboration of vague feeling state]*

PATIENT: Of course not! I mean, I may not be able to do much, but at least I can make a foolish bed.

THERAPIST: I see … so it sounds like it feels a little insulting—the idea that you can’t even make a bed. *[empathic validation of impressions]*

PATIENT: It *is* insulting. Wouldn’t you be insulted?

THERAPIST: Well, perhaps. But tell me more about this feeling: what does this bring up in you, to be insulted in this way? *[continued impression-specific affect elaboration]*

PATIENT: It’s irritating! I can make a simple bed!

THERAPIST: Of course it’s irritating. Could you say more about this feeling? *[inviting elaboration about expressed affect]*

PATIENT: I worked my whole life to make something of myself, and I do not deserve to be treated like a child, especially by my own wife. This is not the way that it was when we first started dating each other.

THERAPIST: That makes a lot of sense. You feel quite irritated with Catherine: she’s treating you like a child, rather than like her

husband. *[empathic validation of more elaborated emotion: feeling + impression]*

PATIENT: Exactly.

THERAPIST: Now you mention that this is not how Catherine used to treat you when your relationship first started. Could you tell me more about how she was with you, back when you first met? *[shifting focus to a more nuanced dimension of patient's experience]*

Through attempting versions of this process repeatedly over time, we were able to help William gradually elaborate a broader array of his emotional states, including feelings of hurt, sadness, embarrassment, and shame, or what William referred to as "diminishment." Noticing the possible relevance of what MBT calls "teleological mode" in William's experience here (Chapter 10), I observed that these feelings appeared to be directly triggered by things that Catherine said to him. For William, such comments seemed to signify how Catherine *saw* him, namely as incompetent and severely impaired: "This gives Catherine a profound amount of power over you, William. If she sees you in a certain way, then you automatically feel ashamed, and you have to fight back against her." He agreed with this, but with a sense of futility: "This is the way that it's been my whole life. I'm almost fifty years old. Do you really think you are going to change me at this point?"

Despite William's discouragement, William gradually began to alter his approach in his interactions with Catherine. When Catherine offered constructive feedback to him, William started to actually *receive* the feedback, without either rejecting it or capitulating to it. Internally, he would often still feel injured by Catherine, but for reasons that he could not quite explain, he was somehow able to "hold his tongue" without leaping into the conflict. On his own, William developed something like a cognitive method for regulating himself in such moments, telling himself, "She's being petty. If I start arguing with her, then I would be sinking down to her level." While I felt skeptical of William's method here (he was just "transferring" his superiority from the outside to the inside), I decided to keep this to myself for now and appreciate William's functional improvement. He was becoming far less defensive and argumentative, and this was clearly impacting the quality of his relationship with Catherine. They were arguing less, being more affectionate with each other, and

starting to have longer stretches of time when they were able to enjoy each other's company without conflict.

Personally, I attributed these improvements to our emotion-focused work in the therapy. At the start of treatment, William's emotions did not *exist* in any meaningful sense. There were only Catherine's comments and his responses, the latter of which flowed automatically from the former, as if by reflex. By working together to identify, elaborate, and express William's emotional states (as well as their potential connection to Catherine's emotional states), we were starting *to create and maintain* William's internal world, which was then able to serve as a something of a reflective "buffer" between Catherine's comments and his response. In this way, William was starting to develop a sense of agency and autonomy that was not strictly determined by other people's perceptions of him.

The second year of treatment

Despite William's progress during the first year of therapy, his alcohol use continued, generating Catherine's concern as well as my own. I shared my worries about this, also strongly recommending that William attend some form of mutual help group, such as Alcoholics Anonymous (AA) or SMART Recovery meetings. William agreed to these recommendations in sessions, but he rarely followed through with any degree of consistency. When I raised the question of his attendance, William proceeded to devalue these meetings. None of the people there knew how to help him; he had nothing in common with these people; and they said the same thing every time they spoke, just talking about "going to meetings" and "getting a sponsor." He had tried these things before, and they never worked for him. He did not know what was going to help him with his drinking, but he knew what was NOT helpful to him: these meetings.

As we entered our second year of working together, the frequency and severity of William's alcohol use was increasing. In any given month, he would drink for twenty out of thirty days, such that it was becoming nearly impossible for him to function at any meaningful level. I helped to facilitate a range of ancillary treatments for William: inpatient detox admissions, partial hospitalization programs, and residential stays. William relapsed soon after discharge from all of these programs. I began to seek out

consultation from different specialists at my facility, in the areas of personality disorders as well as substance use disorders. The personality disorder consultants recommended that I terminate with William given his problematic alcohol use, assuming that he would not be able to benefit from therapy until he was sober from alcohol. The substance use disorder specialists recommended that I refer William to more intensive forms of support (e.g., sober living facilities, long-term residential programs), but he declined this, insisting that he would not engage in any form of treatment that would separate him from Catherine.

During one of William's few sober periods, I met with him to express my concerns. I reviewed the substantial evidence base for the psychosocial treatment of alcohol use disorder (Kelly et al., 2020), which essentially includes individual therapy, along with attendance at (and participation in) mutual help group meetings. Employing MBT-N's relational technique of affective self-disclosure (pp. 247–258), I shared that given the severity of William's alcohol use disorder, I was concerned I was participating in a treatment that was harming him. William attempted to reassure me, explaining that I had helped him more than any other therapist he had ever seen, and that he was doing "much better" than he had been when we started meeting together. I responded that, even if that were so, it would be unethical for me to continue seeing him for therapy unless he began attending mutual help groups. If he started attending meetings and still drank excessively, then at least we would know that his continued difficulties were not being caused by his lack of utilization of evidence-based treatment. William tried to argue with me about this, but I planted my feet: I could only keep treating him if he started attending meetings.

William finally acquiesced, largely out of his "respect" for my professional opinion and a desire to continue working with me. We negotiated a set of specific expectations along these lines. William would attend a minimum of three meetings weekly, and these would be the same meetings every week, so that he could get to know the other members. These meetings would only be during the day; he could thus continue to spend time with Catherine during the evenings. He would attempt to speak at the meetings, enabling people to get to know him. And he would obtain a sponsor, with whom he would try to develop a relationship. William began "auditing" different meetings throughout the city, taking notes on their strengths and weaknesses until he ultimately identified a specific group that

he could tolerate: a daily, early morning AA meeting frequented mostly by intellectual, agnostically inclined members who rarely talked about “God” and “prayer,” and so were less likely to inspire William’s disdain.

For the first time since we started working together, William finally had a context where he was interacting with human beings other than Catherine. I inquired about his manner of relating to others in this context, and William described a largely superficial and disengaged interpersonal approach. He would arrive to the meeting early, but he kept mostly to himself, checking Facebook on his phone and occasionally making comments to the other members about impersonal topics like the weather or world events. When he attempted his obligatory sharing at the meetings, he would offer intellectualized discourse about positive “topics” relevant to sobriety (e.g., self-care, productive activity). However, he never shared about any challenges in his life, related to alcohol or related to anything else. When I drew William’s attention to this fact, he responded plainly:

> “I would never talk about my problems at one of these meetings. I would never talk about my problems *anywhere* , except for here. It is like looking at a picture in a frame—all you can see is the picture itself. You know there is a backside, but you never get to see it. That is never going to change. These meetings are not helpful to me. They are helpful to *you* , and I will go to them to keep my agreement. But they are never going to do anything for me.”

Interestingly, despite his lack of engagement at the meetings, William’s alcohol use dramatically decreased. His periods of sobriety grew longer and longer, extending from a few days to a few weeks to months at a time. When William did drink alcohol, whereas formerly he would binge for one week straight, now he drank for one to two days at a time, and in markedly reduced quantities. William was finally starting to be sober more often than he was intoxicated. I drew attention to this shift, and William was adamant that this was completely unrelated to his meeting attendance: “It is a coincidence. It has nothing to do with the meetings. I just made the decision to start trying again, mostly for Catherine but also for you.”

I raised the topic of William pursuing employment. Now that he was drinking so much less, it seemed likely that he could successfully engage in some sort of vocational role. William agreed that it was probably time to move forward in this area, but he was not quite ready yet. “I just need a little bit more time to get my legs under me. I promise you that I will do something by the end of the year.”

Thus far in the treatment, William had the tendency to idealize me and our work together. However, as William progressed in his sobriety and overall stability, his stubbornness and rigidity manifested themselves more prominently in our sessions. This came out most strikingly when I would ask William to elaborate on his various statements about himself and his life. Rather than doing so, he would "dig in his heels" and refuse to say anything more, resulting in therapeutic stand-offs. In one such instance, William was sharing about some weekend when Catherine was travelling for work, and he was left at home by himself. I asked William about his mood and emotions over this period, and he responded by saying, "Prosaic." When I invited him to say more about this feeling, William held firm: "I already told you: prosaic. It was prosaic." I explained that I wanted to learn more about his *feelings* that weekend, and I was still having trouble fully grasping what he was getting at here. William suggested that I consult the dictionary about this. If I looked up the word, then I would understand exactly what he was feeling.

I tried a range of different strategies in such moments, including explaining my therapeutic rationale for wanting William to elaborate on his experience; highlighting William's stubbornness and rigidity (p. 204); inviting reflection on the pattern itself (pp. 259–302); and observing similarities between this pattern and other relationships in his life (e.g., in his arguments with Catherine; see pp. 240–242). None of these techniques worked very well, resulting in William's further stubbornness and more intellectualized, cognitive support of whatever position he was endorsing at the time. Mostly out of desperation, I ended up arriving at an approach that felt less like an "intervention" than a surrender: simply naming and expressing my emotional experience of the interaction itself, which MBT-N terms an *emotion-focused challenge* (pp. 287–288). So, in the "prosaic" example mentioned above, I finally said something like:

THERAPIST: I am noticing myself feeling quite frustrated with you right now. I am really wanting to argue with you—to try to convince you that you are being somehow stubborn and unfair. *[emotion-focused challenge]*

PATIENT: I am not trying to be difficult. I simply used a word, and I really feel like that is the best word to describe my experience. Words have meaning! I didn't create the meaning of these words. I am just using them.

THERAPIST: No, I am aware that words have meaning, William. I think the thing that frustrates me is that I am trying to understand *your* experience, and I feel very shut out by you. *[further elaboration of the emotion-focused challenge]*

PATIENT: I am not trying to be difficult, Bob.

THERAPIST: Is that really true, though? *[counterintuitive challenge]*

PATIENT: *[laughing]* Well, maybe a little . …

THERAPIST: Yes! Tell me about that. *[inviting further elaboration of patient's expressed desire]*

PATIENT: Well, I do feel like *you've* been being quite difficult with me. I gave you my word. I gave it to you several times, but you just didn't seem satisfied with that.

THERAPIST: I see, so it felt like I was not happy with you, and with what you were giving me. *[empathic validation of patient's impression of the therapist]*

PATIENT: Well, you weren't, were you?

THERAPIST: I guess not completely. To be honest, I just wanted to hear more about what it was like for you when Catherine was away. "Prosaic" is a lovely word, but I wanted to hear more about *you* . *[affective self-disclosure in response to the patient's past engagement in the therapeutic activity]*

PATIENT: But I worked very hard on that word.

THERAPIST: I see, you worked hard to arrive at that word. What was that like for you, to work so hard on something, and for it to not be enough for me? *[attempting affect elaboration around an impression possibly associated with more vulnerable emotions]*

PATIENT: Just upsetting. And hurtful . …

In these circumstances where William became more stubborn and argumentative, we discovered there was usually some "softer" emotion or desire being activated for him in the interaction in question (pp. 121–126): for example, feelings of hurt and insecurity, or the desire for some specific sort of response from me. Whereas my efforts to "pursue" such emotions usually just exacerbated William's rigidity, if I simply communicated how *I* was feeling in the interaction, our dynamic seemed to "open up" somehow. William relayed that I came across as more authentic in such moments, and he found it harder to struggle with me when I was acting "like a real

person” with him. William became somewhat sheepish and apologetic, and in turn more flexible and capable of reflection with me. Rather than getting caught up in the content of William’s arguments (e.g., as he and Catherine did), this enabled us to explore and reflect on the interpersonal and affective processes unfolding between us in the present moment.

William’s ability to experience his more vulnerable emotions began to expand. We saw this in his relationship with Catherine where, rather than focusing primarily on his criticisms of her, he was able to access feelings of hurt, sadness, and insecurity. When discussing his experience at AA meetings, instead of simply emphasizing his philosophical critiques of the Twelve Steps, he could express uncertainty about how to share at the meetings, and his fears that if people were to know him more fully, they would reject him.

For me, the most powerful example of William’s increased vulnerability came one morning when, for reasons I cannot remember, we were discussing his suicide attempt. Something sounded a bit different that day, and I asked some follow-up questions about the circumstances surrounding the attempt. William shared that, after one particularly long period of leave, he had gathered his strength enough to return to work, in the hopes of finally being able to attain some sobriety and salvage his standing in the department. While puttering around in his office on his first day back, William overheard some of his firefighters making fun of him: “He’s just a drunk, a loser. Nobody likes him. Nobody respects what he has to say about anything. How long is it going to take before he starts drinking again and gets shipped off to treatment?” William was humiliated, and devastated. He was able to pretend that he did not hear these comments, and he finished his shift. In something of a fugue state, he returned home. Using one of his many firearms, he shot himself in the stomach.

As William disclosed this in our session, he began to cry—an exceedingly rare occurrence for him. I was floored. In our two years of working together, William had never spoken about these circumstances, which portrayed a much more vulnerable picture of William. Upon considering this issue later, William explained that he had not planned to withhold this information from me. It just held too much shame for him, and so the words just stayed where they were: inside of him. My sense is that, as William was able to explore and represent the “messier” parts of his experience in therapy, he gradually developed a more complex, elaborated

picture of himself and his life, and to feel safe enough to share that picture with another human being.

The third year of treatment

True to his word, as William approached his third year of therapy, he began looking for work. He found several jobs that interested him, and he ended up applying for a role as a part-time dispatcher at a local ambulance company. In the job interview, the administration was so impressed by him that they offered him a job as a supervisor in the dispatch department, which he accepted. William has excelled in that role, attending work consistently and not under the influence of alcohol. In our sessions together, William described a mix of pride and shame about this: pride that he was contributing in a meaningful way to the community again, and that the administration recognized his strengths as a leader; and shame that he was "only" working at an ambulance company, which of course had less prestige than the fire department.

Throughout the year, our work focused on deepening the nature of William's communications with other people, and on strengthening his core sense of self-esteem. In the area of communication, whereas William was able to share openly and meaningfully with me, he continued to remain quite superficial and intellectualized in his communications with others, including Catherine and fellow members at AA meetings. William was quite comfortable sharing his *ideas* about things, but he was much less drawn toward expressing his emotional states, or discussing matters that might betray weakness or vulnerability. I began highlighting this pattern with William much more actively, sharing my sense that this approach could be having the effect of "keeping people at bay," and limiting his potential for closeness in his relationships. He responded with a smile: "Of course. That's the whole point!"

This led us directly into the topic of *motivation* —namely, the extent to which William felt personally motivated to alter these patterns of social and emotional avoidance (pp. 155–158). William reported that he was actually quite motivated to shift these approaches in his relationship with Catherine, since he was deeply aware how his tendencies toward intellectualization and argumentativeness created strain on their relationship. He was far less

interested in shifting his stance in AA. At a cognitive level, William recognized how his avoidance contributed to his alcohol use disorder, since he was failing to develop relationships with others that might sustain him in his recovery. However, at a more visceral level, William experienced a powerful aversion to sharing about himself with members of AA: “I do not like these people, and I do not want to be close to them. I will do it because I have to, but not because I want to.”

In exploring with William how he might begin to communicate more openly with others, I was quite humbled by how difficult it was for him even to *imagine* what such communications might look like. For example, when discussing what William might say in response to Catherine’s criticisms of him, William could only conceive of expounding on why she was unjustified in holding her belief. I worked hard to redirect him here.

THERAPIST: William, what do you feel when she attacks you in this way? *[impression-specific affect elaboration]*

PATIENT: This is just how she is. People have complained about her at the firm for the exact same issue.

THERAPIST: But what do you FEEL? *[doggedly pursuing internal processes]*

PATIENT: I mean, upset of course. It’s just constant criticism. Like she’s so perfect, and I am this incompetent invalid.

THERAPIST: I see: so upset that she is always criticizing you, and relating to you as if you’re not competent? *[empathic validation of more elaborated emotion: feeling + impression]*

PATIENT: I know that I cause a lot of trouble for her, but I cannot be that bad.

THERAPIST: It sounds like you can feel like she is really not giving you the credit that you deserve . … *[inviting elaboration of an affectively laden impression]*

PATIENT: Oh, she definitely is not giving me any credit. I spend all of this time cleaning the house, but all I hear about is what a bad job I am doing. And now that I’m working again, I bring in a lot more money. It’s not the same as her salary, but it’s still a pretty major contribution. It would be nice to get a little bit of appreciation for a change.

THERAPIST: You really want her to appreciate you—to recognize how much you are contributing financially, but also how much

you help out in general *[empathic validation of more elaborated desire]* . What emotions does that bring up in you, when you don't receive that appreciation from Catherine? *[moving from desires to emotions]*

PATIENT: *[pausing]* I think that I end up feeling quite sad about it, actually. And maybe even a bit lonely.

THERAPIST: So there's a sadness in this for you, and even some loneliness *[empathic validation of a broader array of affective processes]* . Could we look more closely at this feeling of sadness *[inviting elaboration on a specific feeling state]* ?

As William became more adept at identifying these sorts of feelings, he took the difficult step of trying to share his emotions and desires with Catherine. This started with him writing texts to her. But then he gradually began to actually *talk* with Catherine about how he felt when she criticized him (e.g., hurt, insecure, sad), and about what he would most want in their interactions: namely, some explicit recognition of his efforts in their life, which would show that she saw him in a more positive light. These communications had a significant impact on the quality of William's relationship with Catherine. While Catherine could be quite headstrong and stubborn, she softened and became quite tender when presented with William's vulnerability. So William sharing in this way helped to decrease Catherine's criticisms of him, allowing patterns of mutual affection and connectedness to become more prominent in their interactions.

I also worked with William to strengthen his ability to focus on Catherine and *her* emotional life (pp. 131–135). We developed a handful of strategies for him to inquire about Catherine's day ("What did you do at work today?"; "How are things going with the managing partner?"), and to empathically resonate with what she shared, rather than simply giving advice or sharing his ideas about "what she should do" in different situations. Given William's tendency toward concreteness, I wrote down these strategies for him in step-by-step instructions. William began attempting these approaches at home, which led Catherine to feel more "seen" by William, and that he was more emotionally present with her and her experiences. All in all, as William made strides toward (a) sharing about himself at a greater level of depth, and (b) attempting to know and validate Catherine more fully, their relationship improved significantly. They argued

less frequently and reported decreased estrangement from one another. They also experienced extended periods of positive connectedness, where they enjoyed each other's company and engaged in activities they both valued, such as travelling, shopping, going on road trips, and even just watching Netflix together on lazy days.

Things have proceeded much more slowly in William's interactions with people in AA. As in his relationship with Catherine, I invited William to simply imagine what it might look like to share about himself in a more meaningful way at his meetings. He could not really do so, so I utilized MBT-N's technique of "marked advice-giving" to prompt him more actively along these lines (pp. 157–158).

THERAPIST: Have you ever considered mentioning the fact that you drank one day last week, and maybe saying a little bit about how that happened? *[marked advice giving]*

PATIENT: I would never say anything like that. I don't even know these people!

THERAPIST: Well that totally makes sense. God forbid that you should share about your drinking at an AA meeting . … *[attempting a humorous challenge]*

PATIENT: I know that it sounds crazy . …

THERAPIST: "Crazy" how? *[inquiring about an area of potential nuance in patient's perspective in psychic equivalence]*

PATIENT: That I can't even do a basic thing like sharing at a meeting.

THERAPIST: Are you still willing to give it a shot? *[inquiring about mental states surrounding the future behavioral possibility]*

PATIENT: I am willing, but I can't make any promises.

THERAPIST: OK, well that is fine. So just let me know: if you were to actually share that you drank last week, what might that sound like? *[inviting patient to imaginatively enter into the process of behavioral change]*

PATIENT: Well, I could say that I had a difficult time last week, but I was able to get things back on track, and I am feeling much better now.

THERAPIST: That is definitely a good start. But William, are you aware that you basically just told me nothing about yourself and your life? *[offering a reality-based challenge]*

PATIENT: Well, I did say that I had a difficult time.

THERAPIST: But what about saying *how* that time was difficult—what you actually did. *[continued pursuit of marked advice giving]*

PATIENT: I could say that I was struggling with some depression, and I did end up drinking one day last week. But it only lasted for one day, and I am feeling much better now.

THERAPIST: How did it feel to say that, William? *[affect elaboration of patient's experience engaging in the therapeutic activity]*

PATIENT: Humiliated. *[pause]* Embarrassed. *[pause]* Small.

THERAPIST: Small. Tell me more about that feeling. *[inviting elaboration of previously expressed feeling state]*

As we "practiced" William discussing his difficulties, he began to implement these approaches at the meetings themselves. He described minimal emotional impact from doing this, but he agreed to continue trying, and he committed to sharing openly at meetings at least twice monthly. William slowly deepened his connections with people at the meetings, making two friends there: one fellow uniformed responder (a retired police officer) with whom he felt like he had a lot in common, and a co-worker at the ambulance company who also happened to be in recovery. Thus, while William was not able to feel very connected to AA groups *in general* , he was able to feel more connected to these two individuals. They attended meetings together, went out for coffee during the day, and got dinner together sometimes, all while actually sharing with each other about their lives and relationships.

As we now approach the end of our third year of therapy, William's alcohol use has dramatically decreased, compared to when we started working together. He now drinks on two to four occasions each month, down from approximately twenty days each month. While Catherine would like William to remain completely abstinent from alcohol, William is quite content with drinking at this level of frequency, especially since his alcohol use has not interfered with his work, or his ability to manage his life overall. William has also made notable strides in developing a stronger sense of self-esteem and self-worth. He feels like he is able to make a genuine contribution to his work environment, and that he brings a high level of professionalism to his supervision of the other dispatchers. He feels proud that he has decreased his alcohol use so significantly, and that he has maintained his commitment to continue attending AA meetings despite his

objections to them. He also sees himself as a success in therapy, since he has been able to make progress in a range of problem areas (e.g., dishonesty, withdrawal, argumentativeness, avoidance) that have plagued him throughout his life.

People who know William (e.g., family members, his psychiatrist, other AA members) regularly compliment him on how much he has improved. Even Catherine, who can sometimes focus more on William's challenges than on his progress, acknowledges how far he has come, and how grateful she is for his resilience in repairing his life since his suicide attempt. William himself takes comfort in his awareness that he is genuinely useful as a husband, through his loyalty, care, and contributions to their household. Despite his shame about his diagnosis of narcissistic personality disorder, from a "big picture" perspective, William also sees himself as a good, "decent" person who has a strong motivation to contribute to the lives of other people. I tend to agree with him in this appraisal, which provides him with something of a "core" sense of self that is able to withstand some of the emotional and interpersonal challenges that can still beset him in his day-to-day life.

William's self-esteem can still be powerfully affected by other people's perceptions of him (pp. 196–197, 210–214, 223–228). This comes out most strongly in his relationship with Catherine, especially when she is criticizing him for his alcohol use, or his performance of household tasks. As I mentioned earlier, while William is now able to "hold his tongue" in such moments, he can still privately *feel* quite resentful of these attacks, and bad about himself for spurring them. Utilizing MBT-N's process-focused interventions for teleological self-esteem (pp. 223–228), I have raised the question to William: "Could you ever imagine having a sense of self-worth, even when Catherine is angry at you, and judging you negatively? The idea that you might have a natural, intrinsic value, independently of the qualities you possess, how other people see you, or your ability to perform well at some specific task?"

William has struggled with even contemplating such a proposal. "It is like trying to imagine a square circle, or an invisible color. It confounds me. It is beyond the scope of my comprehension." And yet I have continued to pursue the issue with William. For reasons I cannot fully explain, even if William cannot conceive of the idea his intrinsic worth, I feel like there is

something very important about him *trying* to conceive of it, regardless of how he happens to be feeling about himself at the time.

I have not had much success in this endeavor. And then, the other day, it occurred to me to ask William a new sort of question: "What about somebody else? Can you imagine someone other than YOU being a worthwhile person, regardless of their performance, or whether or not someone is mad at them?"

William thought about this for a while, and then he responded slowly. "This makes me think of my father. He was so kind, and so good. He had a sense of grace about him, a quiet dignity no matter what was happening around him. Even when my mother was berating him, and demeaning him, and breaking him down, I know that he had value. I *know* that he did. He would just sit there passively, but she could never take that away from him." William began to cry. "And I guess, if he could have that value as a person, then maybe I could, too."

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1 I have modified demographic and identifying information about this patient in order to disguise their identity. The patient has reviewed this chapter and granted written permission for it to be published in its present form.

2 The perceptive reader will observe important parallels between William's interpersonal patterns with Catherine and his rebellious, power-oriented relationship with his mother. While William and I recognized these similarities, since I was working within an MBT framework rather than a traditionally psychoanalytic one, I devoted only minimal technical attention to highlighting and exploring the historical "sources" of William's contemporary relational patterns (see pp. 176–179).

3 During the period of the treatment described in this chapter, I regularly recommended couples therapy for William and Catherine to address their marital difficulties. While William was willing to participate, Catherine declined any such referrals, given William's continued alcohol use and her skepticism about the utility of psychotherapeutic support. Since that time, they have proceeded to productively engage in couples therapy, to highly positive effect.

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