227: Pathological Narcissism: Effective Treatment with Mentalization-Based Therapy (MBT)

David Puder, M.D., Joanie Burns, Robert Drozek, LICSW

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Introduction

This week, I am joined by some of the world's leading experts in treating pathological narcissism and personality disorders: Robert P. Drozek, Dr. Brandon Unruh, and Dr. Anthony Bateman. They are co-authors of the recently published manual, *Mentalization-Based Treatment for Pathological Narcissism: A Practical Guide* (Oxford, 2023).

Robert P. Drozek is a distinguished psychotherapist specializing in personality disorders, trauma, dissociative disorders, and addiction. He serves as the clinical director of the Mentalization-Based Treatment (MBT) Clinic at McLean Hospital and as a staff psychotherapist in the Gunderson Outpatient Program at McLean. He is a trainer and supervisor in MBT through the Anna Freud Centre in London and holds a teaching associate position in the Department of Psychiatry at Harvard Medical School. Robert Drozek is a co-founder and co-director ofMBT Boston, an organization dedicated to providing training and supervision in mentalization-based treatment. He has authored multiple publications, including the book, *Psychoanalysis as an Ethical Process*, which explores the role of ethics in psychoanalytic practice. Additionally, Mr. Drozek is the lead developer of mentalization-based treatment for pathological narcissism, co-authoring a comprehensive handbook on the subject, *Mentalization-Based Treatment for Pathological Narcissism: A Practical Guide* (Oxford, 2023).

Brandon Unruh, M.D., is an instructor in psychiatry at Harvard Medical School and the medical director of the Gunderson Residence of McLean Hospital, a specialized residential program for individuals with severe personality disorders. He is also the founding director of McLean's insurance-based outpatient mentalization-based treatment clinic for personality disorders. His clinical approach is anchored in the integration of evidence-based treatments for personality disorder such as dialectical behavior therapy (DBT), mentalization-based treatment (MBT), transference-focused psychotherapy (TFP), and general/good psychiatric management (GPM). He is an MBT trainer and supervisor through the Anna Freud Centre in London and one of the original cohort of GPM trainers established by John Gunderson. He has published on a variety of topics including suicide, personality disorders, spirituality, medical ethics, general hospital

psychiatry, and literature and medicine. He is co-investigator with Mary Zanarini on a randomized-controlled trial studying an MBT group intervention developed to promote flourishing and character virtues in individuals with borderline personality disorder. His academic interests also include the treatment of pathological narcissism, and the relationships between mental health and spirituality and religiosity in both pathological and healthy forms. He is a co-developer of Mentalization-Based Treatment for Pathological Narcissism (MBT-N) along with Robert Drozek and Dr. Anthony Bateman, with whom he co-authored the treatment manual *Mentalization-Based Treatment for Pathological Narcissism: A Practical Guide* (Oxford, 2023) and with whom he regularly teaches and supervises clinicians and systems implementing this model. He co-edited *Borderline Personality Disorder: A Case-Based Approach* (Springer, 2018), a generalist guide for clinicians learning to manage BPD.

Dr. Anthony Bateman, M.A., FRCPsych, is a renowned psychiatrist and psychotherapist recognized for co-developing mentalization-based treatment (MBT) alongside Peter Fonagy. MBT is an integrative form of psychotherapy that combines elements from psychodynamic, cognitive-behavioral, systemic, and ecological approaches, primarily designed for individuals with borderline personality disorder (BPD). Dr. Bateman serves as the Director of Psychotherapy Services and Research Lead for personality disorder at St. Ann's Hospital in North London. His contributions to the field include co-authoring several seminal works, such as *Psychotherapy for Borderline Personality Disorder: Mentalization-Based Treatment* and *Mentalization-Based Treatment for Personality Disorders: A Practical Guide*. These publications provide comprehensive insights into the application of MBT for treating personality disorders.

Narcissistic Personality Disorder (NPD): Prevalence, Epidemiology, and Distinction Between Vulnerable and Grandiose Narcissism

Narcissistic personality disorder (NPD) affects an estimated 1-6% of the general population, with significantly higher prevalence observed in psychiatric settings.

There are 2 main types of narcissism:

- **Grandiose Narcissism:** Individuals with grandiose narcissism display overt self-importance, entitlement, and a significant lack of empathy. They often present themselves as charismatic, confident, and assertive, attracting admiration through their external charm. However, beneath this outward facade, their sense of self-esteem remains fragile and heavily dependent on external validation. This external validation is vital for maintaining their exaggerated self-image. While they may appear self-assured, their emotional reactions are often disproportionate, particularly when they feel slighted

or challenged. Their emotional responses, such as anger or aggression, stem from a need to protect their inflated sense of superiority. Those with grandiose narcissism often come to treatment not by their own choice, but because of external pressures, such as family or others urging them to seek help. This often makes them less likely to seek therapy voluntarily compared to people with vulnerable narcissism.

- **Vulnerable Narcissism:** Vulnerable narcissism, in contrast, tends to be less obvious. These individuals often present as introverted, anxious, or hypersensitive. They struggle with deep insecurity and their self-worth is fragile, often fluctuating dramatically based on external validation. While they still maintain a narcissistic self-focus, they tend to exhibit greater emotional instability, with their mood swinging based on how well they perceive they are being validated or admired. For instance, their self-esteem can rise when they receive positive feedback but can plummet with rejection or criticism. Individuals with vulnerable NPD often experience intense shame and self-doubt, which can lead to outbursts of anger when they feel rejected or unappreciated. The heightened emotional instability seen in vulnerable narcissism mirrors the emotional dysregulation in borderline personality disorder (BPD), leading to potential diagnostic confusion.

Just as individuals with BPD may experience decompensation after relational conflicts, those with NPD can face a significant breakdown when their self-image is threatened. For individuals with NPD, these moments can trigger intense emotional distress, rage, or withdrawal as they struggle to protect their fragile sense of self. Their sense of existence is validated by external perceptions and achievements, so any perceived threat to these external sources can feel devastating. Potential triggers include receiving negative feedback, being rejected or ignored, not being the center of attention, experiencing failure or public embarrassment, being outperformed by a peer, losing social status or prestige, being challenged by subordinates or family members, perceived disrespect from authority figures, being compared unfavorably to others, or social media criticism and lack of engagement.

Problems in Mentalizing Associated with Pathological Narcissism

Pathological narcissism is closely linked with significant impairments in mentalizing, the capacity to understand and interpret one's own and others' mental states. These impairments can manifest in various ways, especially within therapeutic contexts, impacting self-reflection, empathy, and relational stability.

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Diminished Emotional Awareness and Alexithymia

Individuals with NPD frequently experience alexithymia—the difficulty in identifying and describing their emotions, particularly vulnerable ones like sadness, shame, and insecurity. This blunted emotional awareness often leads to a defensive posture, where they mask vulnerability with anger, superiority, or a detached demeanor. Narcissistic individuals may describe external scenarios but struggle to reflect on their emotional states, making it difficult for them to access or express feelings of vulnerability. This lack of emotional insight hinders authentic self-reflection, impeding their capacity to engage deeply in therapeutic work and develop genuine empathy for others.

Overconfidence in Perspective-Taking in NPD

Individuals with NPD often overestimate their ability to understand others' perspectives. They believe they can accurately interpret others' thoughts and emotions, but this overconfidence leads to misinterpretations and assumptions. These individuals may experience "psychic equivalence mode," where they view their perceptions as absolute truths, reinforcing their belief that they understand others perfectly. This can lead to rigid certainty about their perspective, making it difficult for them to entertain or consider alternative viewpoints. In therapy and relationships, this results in a lack of genuine exploration of others' perspectives, as they focus on justifying their own beliefs rather than seeking to understand others. Their inability to challenge these assumptions causes misunderstandings and conflicts, as they view situations through a self-centered lens, often reacting defensively when their assumptions are questioned. This further isolates the individual, as their view of others becomes increasingly distorted and self-focused.

How Envy Drives Pathological Narcissism: Understanding Its Impact on Self-Esteem and Therapy

Envy exposes a deep sense of inadequacy beneath the inflated self-image. Rather than motivating self-improvement, envy in narcissistic personality disorder (NPD) triggers defensiveness and resentment. These individuals may react to feelings of envy by devaluing others or exaggerating their own achievements to protect their unstable sense-of-self. For instance, in the role play, Dr. Puder lamented, "My best friend got in everywhere and to all the graduate programs that I didn't get into. We studied together, took the same classes, were in the same research lab—pretty much identical in terms of grades and extracurriculars. Yet he gets in everywhere, and I don't get in anywhere. What the heck?" This reflects a painful awareness of being outperformed despite feeling equally deserving. Envy challenges their self-worth and highlights their perceived lack of something essential, as seen when a patient exclaims in frustration, "How could they not see how awesome I would be?"

Rather than using envy as a catalyst for growth, it exacerbates their feelings of inferiority, leading them to externalize blame or feel victimized by perceived injustices. The inability to tolerate feelings of envy often leads them to react defensively or aggressively, rather than using the emotion constructively. For example, in the role play, Dr. Puder directed envy toward the therapist by stating, “I don’t think there’s any way that you could know how this feels because you have obtained the pinnacle of success.” This demonstrates how envy can manifest as comparisons to the therapist, making it difficult for the individual to accept feedback or reflect on their own vulnerabilities. Instead of introspection, envy triggers a need to dismiss or surpass others, reinforcing narcissistic behaviors.

This unresolved envy ultimately impairs emotional growth and interpersonal connection, further reinforcing narcissistic patterns and hindering progress in therapy. A patient might even question the value of therapy itself, saying, “Therapy feels so painful, others seem to enjoy it, but it is so hard for me… I question if I should even do this,” reflecting how envy of others’ perceived happiness can lead to despair and withdrawal from the connection going on in therapy. To move through envy constructively, patients must first acknowledge the feeling without judgment and explore what it reveals about their own unmet desires, transforming it into a tool for self-reflection rather than a source of resentment. This can be followed by identifying small, actionable steps toward their own goals, while simultaneously learning to appreciate and celebrate another person’s unique hero’s journey. The inability to sit with envy and process it in a healthy way blocks emotional development, as it turns potentially constructive emotions into barriers that prevent meaningful change.

Impaired Empathy in Narcissistic Personality Disorder

Individuals with NPD often struggle with empathy, despite believing they understand others’ emotions. However, their understanding is typically self-serving, shaped by envy or an inflated sense of superiority. In the role play, Dr. Puder demonstrates impaired empathy by saying, “Are you laughing at my comment here? I’m trying to pour out my heart, and I feel like you’re making light of this.” This reveals an inability to consider the therapist’s benign intent, instead interpreting the situation through a self-focused lens. When envious, they find it difficult to celebrate or feel excited for others’ victories, as their envy clouds their ability to appreciate others’ success. Similarly, when overly confident in their own perspective, they lack the curiosity necessary to explore what they may be missing about others’ experiences. This inability to acknowledge others’ emotions or intentions was evident when Dr. Puder fixated on his own perception of being misunderstood, disregarding the therapist’s genuine efforts to connect. This failure to step outside their own viewpoint or feel joy for others reinforces relational difficulties and emotional isolation.

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Black-and-White Thinking in Narcissistic Personality Disorder: Difficulty Tolerating Ambiguity and Rigidity in Perception

Individuals with NPD often struggle to tolerate ambiguity in relationships, leading to rigid, black-and-white thinking. They may idealize or devalue others based on minor changes in behavior, causing them to oscillate between admiration and devaluation. This pattern frequently disrupts therapeutic alliances, as they may interpret the therapist's actions in polarized terms, vacillating between idealization and mistrust. For example, in the role play, Dr. Puder quickly shifts to devaluation with comments like, "Is this what I'm getting from Harvard? Is this what I'm getting?" and "Are you laughing at my comment here? I'm trying to pour out my heart, and I feel like you're making light of this." Such statements illustrate how even minor misinterpretations can be perceived as betrayals. Additionally, the patient dismisses the therapist's empathy with, "I don't think there's any way that you could know how this feels because you have obtained the pinnacle of success." These responses reflect how perceived threats to self-esteem or attachment needs activate defensive mental states that disrupt mentalizing, making it difficult for them to accept feedback or reflect on their own vulnerabilities.

Externalizing Blame in Narcissistic Personality Disorder: How the Teleological Mode Undermines Self-Growth

Individuals with NPD often externalize blame, attributing their failures or challenges to external factors rather than acknowledging their own role in the issue. This defense mechanism serves to protect their fragile self-esteem and preserve their grandiose self-image. Instead of reflecting on their own vulnerabilities or mistakes, they shift the responsibility elsewhere, which allows them to avoid confronting the deeper emotional insecurities tied to their sense of self. This externalization is partly rooted in the teleological mode, where individuals focus excessively on external achievements (e.g., success, status, appearance) to define their self-worth. In this mode, self-esteem becomes contingent on measurable, external indicators rather than a realistic, internally grounded sense-of-self. When these external markers are threatened or questioned, they externalize blame to preserve their fragile self-worth. This mode prevents them from developing a solid sense-of-self, which, according to Nancy McWilliams, ideally comes from emotional regulation, self-reflection, and integration of both successes and setbacks. By avoiding responsibility and focusing on external validation, individuals with NPD reinforce their reliance on distorted self-concepts and prevent meaningful emotional growth.

Self-Esteem Triggered Mentalizing Failures

Mentalizing difficulties in NPD are often heightened when self-esteem is challenged. When individuals perceive a threat to their self-worth or attachment security, they may shift into

defensive, non-mentalizing modes, resulting in behaviors like devaluation or idealization of others to protect their self-image. Potential triggers for such responses include:

- **Losing a prestigious job or title**, which undermines their sense of status and competence.
- **Aging or changes in physical appearance**, which may threaten their self-image tied to attractiveness.
- **Public criticism or negative feedback**, especially in front of others, leading to feelings of humiliation.
- **Social comparisons** where peers achieve greater success, status, or recognition.
- **Financial setbacks** or losing material possessions that were symbols of their success.
- **A loved one or close friend succeeding in areas they feel insecure about**, triggering envy and self-doubt.
- **Social exclusion**, like not being invited to important events or gatherings.
- **Failing to meet personal or professional goals**, leading to intense feelings of inadequacy.
- **Loss of admiration or attention from others**, especially on social media platforms.

These experiences would be challenging for anyone, but for someone without a strong, stable sense-of-self, they can become truly tragic. This protective response to perceived threats can manifest as entitlement, blame-shifting, or withdrawal in relationships, making it difficult to maintain consistent engagement in therapy. By externalizing blame and focusing on external validation, individuals with NPD prevent themselves from engaging in self-reflection and emotional growth.

Implications for Therapy and Reflective Functioning

These mentalizing impairments are thought to play a role in the developmental pathway of narcissistic pathology. In therapy, enhancing reflective functioning—a core skill within mentalization—has shown promise in improving outcomes for individuals with personality disorders, including NPD. By helping individuals recognize the subjectivity of their perspectives and the potential bias in their interpretations, therapy can support patients in moving away from rigid self-perceptions and developing more flexible, empathetic ways of relating to others.

In sum, the impairments in mentalizing associated with NPD contribute to a self-centered, defensive orientation that challenges therapeutic progress. Addressing these mentalizing deficits, particularly by targeting reflective functioning, enables individuals with NPD to cultivate a more nuanced understanding of themselves and others, fostering greater relational stability and personal growth.

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Aims and Treatment Strategies in the Development of the Mentalization-Based Treatment (MBT) Model for Narcissism

The development of MBT for pathological narcissism (PN) emerged from a need to address the distinctive challenges posed by narcissistic pathology. Built on the foundation of mentalizing theory, MBT for pathological narcissism was adapted to focus specifically on issues like self-esteem regulation and defensive structures that obstruct mentalization (Drozek & Unruh, 2020; Drozek et al., 2023). Clinical observations revealed that patients with pathological narcissism benefit significantly from structured mentalization exercises, which help them build emotional awareness and relational stability. The introduction of MBT groups for narcissism creates a controlled setting for practicing these skills, allowing participants to engage in real-time mentalization with peers facing similar challenges.

This approach counters the misconception that individuals with pathological narcissism are “untreatable” or resistant to change. Positive outcomes from MBT groups have shown that, with consistent intervention, patients with pathological narcissism can experience meaningful growth in emotional regulation, impulse control, and empathy. These encouraging results are documented in a published paper and an accompanying manual, which now provide clinicians with guidance on implementing MBT for narcissism.

Primary Aims of MBT for Narcissism

The primary aim of MBT for narcissism is to enhance the capacity to mentalize across three domains—content, context, and process—which are central to achieving self-awareness and relational resilience:

1. **Content Domain**: This domain focuses on increasing awareness of internal states, such as emotions, thoughts, and intentions. Structured interventions encourage patients to explore their inner experiences and examine how these experiences influence interactions with others. By starting with less emotionally charged content, therapists build a foundation that allows patients to engage with more complex, vulnerable emotions over time.
2. **Context Domain**: The context domain emphasizes situational awareness, helping patients recognize the specific triggers that activate narcissistic processes. By reflecting on how context influences their reactions, patients begin to understand the conditional nature of their responses and can gradually work toward modifying maladaptive patterns. This exploration supports insight into how relationships and self-esteem are influenced by situational factors, providing a basis for more adaptive responses.
3. **Process Domain**: This domain addresses the relational dynamics that shape a patient’s thoughts and feelings in the moment. By examining these interactions in real time,

patients learn to approach relationships with increased flexibility and reduced defensiveness. The goal is to help them recognize and reflect rather than react impulsively, fostering healthier relational dynamics and greater resilience in social situations.

Key Treatment Strategies in MBT for Narcissism

MBT for narcissism employs several specific strategies to support these aims:

- **Structured Emotional Regulation**: A structured approach to emotional regulation enables patients to stabilize their emotional responses, an essential step before deeper mentalizing work can occur. This focus on managing impulsivity and regulating emotions helps patients build continuity in therapy.
- **Scaffolded, Stepwise Approach**: MBT utilizes a stepwise approach, beginning with less emotionally intense topics to establish a secure foundation. This method allows patients to feel safer before exploring more vulnerable emotional areas, promoting gradual engagement with complex emotions.
- **Empathy and Perspective-Taking**: Strengthening empathy and perspective-taking skills is essential for helping patients understand the impact of their behavior on others. Therapists work with patients to distinguish between intention and impact, fostering a nuanced understanding of interpersonal dynamics.
- **Contingent and Marked Validation**: Therapists employ contingent validation to acknowledge patients' emotions without reinforcing narcissistic self-enhancement. This technique involves validating the patient's feelings while subtly challenging underlying assumptions, promoting curiosity and alternative perspectives.
- **"Reflect, Not React"**: A core strategy in MBT is teaching patients to "reflect, not react." This approach encourages patients to pause and consider their thoughts and emotions rather than responding impulsively. This skill is especially important for managing tendencies like perfectionism and attention-seeking.
- **Educational Component on Narcissistic Traits**: An educational aspect is incorporated to help patients understand the roots and impacts of their narcissistic traits. By contextualizing their symptoms, patients can reduce self-stigma, facilitating better engagement with mentalizing exercises.

By targeting these three domains—content, context, and process—MBT for narcissism aims to cultivate a balanced and resilient self-concept. This structured, reflective approach enables patients with PN to improve their self-awareness, interpersonal empathy, and emotional regulation, fostering lasting change in their relationships and sense-of-self.

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Role of Group Psychotherapy in the Treatment of Narcissism

Group psychotherapy plays a critical role in MBT for narcissism, providing an interactive space where individuals can observe, reflect on, and engage with others in a structured setting. Group members have opportunities to receive immediate feedback and witness the mental and emotional states of others, which supports the development of empathy. This format is particularly valuable for individuals with pathological narcissism, as it allows them to engage in real-time interpersonal exchanges that challenge their usual relational patterns.

In MBT groups, the focus on mentalizing within a peer environment fosters a deeper understanding of one's own and others' perspectives, which is essential for improving relational stability. Over time, participants gain the ability to maintain a more balanced view of themselves and others, cultivating resilience against shame-driven responses and enhancing their capacity for empathy. This group dynamic has proven effective in helping individuals with pathological narcissism achieve substantial and lasting interpersonal growth.

Abstract Discussion and the Need for Concrete Clarification

Patients with NPD often engage in therapy through abstract discussions. They might speak in generalizations or offer broad insights about themselves or others, such as "I am the sort of person who always strives for perfection," or "Her problem is that she is too codependent." While these statements provide some self-perception, they can avoid deeper emotional engagement and maintain a self-enhanced image.

What to Say Next: Facilitating Concrete Exploration

To move beyond abstract discourse, it is essential to guide the patient toward concrete experiences and specific events. This involves asking open-ended questions that encourage the patient to describe actual situations and their behaviors within them. For example:

- "Can you walk me through what happened during that interaction?"
- "What did you say to her when she expressed her feelings?"
- "How did you feel in that moment when she responded to you?"

These questions help ground the conversation in reality, allowing both the therapist and the patient to explore the nuances of their experiences.

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How to Say It: Emphasizing Empathy and Non-Judgment

When prompting the patient for more detailed information, it is crucial to maintain a stance of curiosity and empathy. The therapist should avoid judgmental tones or leading questions that might provoke defensiveness. Instead, use a gentle and supportive approach:

- “I'm interested in understanding more about that situation.”
- “It might help to look at what specifically happened so we can explore it together.”
- “Let's consider how that interaction unfolded from both perspectives.”

This manner of communication fosters a safe therapeutic environment where the patient feels heard and validated, reducing the need to rely on defenses.

Applying Reflective Function to Enhance Mentalizing

The goal of these interventions is to strengthen the patient’s reflective functioning—their ability to understand and interpret their own and others’ mental states. By focusing on factual clarification before delving into feelings (“facts before feelings”), the therapist helps the patient build a more accurate and less distorted narrative of events.

Once the concrete details are established, the therapist can guide the patient toward reflecting on their internal experiences and the perspectives of others involved:

- “What was going through your mind when that happened?”
- “How do you think she might have felt in that situation?”
- “What does this interaction tell us about your relationship with her?”

This process encourages the patient to consider multiple viewpoints and recognize the complexity of interpersonal dynamics, which is often a challenge for individuals with PN due to their self-focused orientation.

Outcome: Building a More Balanced Self-Perception

By integrating reflective function into therapy, patients begin to articulate a picture of reality that is less dictated by their needs for self-enhancement. They develop greater self-awareness and empathy, which are critical for improving interpersonal relationships and reducing narcissistic processes. Over time, this approach can lead to meaningful changes in behavior and emotional regulation, supporting the overall goals of treatment for pathological narcissism.

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Prevalence of Anger-Related Emotions in Pathological Narcissism and Expanding Emotional Awareness

Many individuals with pathological narcissism display anger as a predominant emotion within their narratives. This often accompanies behaviors of self-enhancement, such as devaluing others, emphasizing personal strengths, or recounting instances of being mistreated, casting others as the problem. These tendencies help the individual maintain a sense of superiority and protect them from feelings of vulnerability.

Response: Using the Affect Elaboration Pathway in MBT

In response to this prevalent anger, MBT introduces the affect elaboration pathway specifically tailored for pathological narcissism. This approach encourages individuals to broaden their emotional awareness, moving beyond anger to consider a wider range of feelings, including more vulnerable emotions like sadness, insecurity, or desires for connection.

Therapists initiate this process by asking questions that prompt exploration of underlying feelings. For example:

- “So, when he called you a ‘loser,’ what emotions did that bring up for you?”
- “How did that make you feel about yourself?”

These questions facilitate a deeper examination of the emotional response, helping patients acknowledge feelings they might otherwise suppress or overlook. This approach supports the patient in recognizing the layered emotions beneath their anger, fostering a richer emotional awareness that can improve self-understanding and interpersonal relationships.

Reflective functioning (RF) refers to the ability to recognize and interpret mental states, both in oneself and others, with nuance and depth. When assessing RF, low ratings typically indicate responses that are self-centered, simplistic, or lacking in complexity, while higher ratings reflect a sophisticated understanding of the interplay between thoughts, feelings, and behaviors.

For an individual with NPD who solely expresses anger, their RF will be rated low. This type of response often reflects a rigid, concrete mental state that overlooks alternative emotions or perspectives. Self-focused expressions that include self-enhancing or other-devaluing statements often indicate limited mentalization, revealing a minimal capacity to reflect on more vulnerable feelings, such as hurt or insecurity, that might underlie the anger. These responses

can seem rote or one-dimensional, with little explicit reference to the mental states of others, consistent with descriptors of low RF in the manual.

In contrast, a response that integrates a range of emotions—such as shame, disgust, guilt, sadness, and insecurity—demonstrates a more advanced RF. For example, if the individual acknowledges feeling insulted but also considers whether their anger masked a sense of inadequacy, this would reflect higher RF. Such a response shows an awareness of the complexity of mental states, an understanding of the defensive nature of certain emotions, and consideration of how these feelings influence their perceptions and actions. This type of nuanced reflection aligns with higher RF ratings, where respondents show an effort to “tease out mental states underlying behavior” and recognize diverse perspectives.

Encouraging individuals with pathological narcissism to explore these underlying emotions facilitates mentalization by fostering a more balanced self-concept, ultimately strengthening reflective function.

Disconnection from Self and Others: The Role of Pretend Mode in Pathological Narcissism

In pathological narcissism, patients frequently exhibit a disconnection from their authentic emotions and desires, often engaging in therapy from a cognitive, detached stance rather than an emotionally grounded one. This phenomenon, referred to in MBT as “pretend mode,” presents a significant barrier to therapeutic progress. In pretend mode, patients intellectualize or theorize about their experiences without genuine emotional involvement, reinforcing defensive structures and limiting opportunities for self-reflection. This detachment hinders the patient’s capacity to form meaningful connections with others and undermines the potential for true mentalization—the ability to understand oneself and others in terms of mental states.

The Reflective Functioning (RF) Manual provides valuable insights into the characteristics of low RF, which closely align with the features of pretend mode. Low RF responses tend to be superficial, self-focused, and lacking in emotional complexity. A patient in pretend mode may discuss events abstractly, often omitting references to their own emotional responses or personal vulnerabilities. According to the RF Manual, such responses lack depth and fail to recognize the range of internal experiences, thus meriting a low RF rating. They reflect a limited capacity for mentalization, as the patient often disregards the mental states of themselves and others, focusing instead on external, intellectualized narratives.

Interventions to Disrupt Pretend Mode and Reconnect with Authentic Emotions

To counteract pretend mode, MBT utilizes a range of interventions that aim to re-establish an emotional connection and facilitate higher RF. Rather than engaging with the patient’s

intellectualized narrative—which often perpetuates pretend mode—therapists guide the conversation toward the patient's immediate experiences and emotions. These techniques are consistent with the RF Manual's criteria for moderate to high RF, which involve recognizing multiple mental states, conflicting emotions, and situational influences.

Effective interventions include:

- **Moving from general to specific**: By asking patients to provide concrete examples (e.g., "Can you give me a recent example of this?"), therapists help them ground their narratives in real-life events, thereby promoting a more authentic exploration of emotions. This shift away from abstraction encourages patients to connect with their actual experiences, fostering a richer understanding of their emotional responses.
- **Directing attention to present affect**: Encouraging patients to articulate their immediate feelings or desires (e.g., "Could you try to put words onto what you are wanting right now?") interrupts the intellectualized discourse and directs attention to current emotional states. This focus on the present helps patients break away from detached reflections and re-engage with genuine emotions.
- **Naming what is absent**: Pointing out missing emotional content—such as saying, "You're sharing a lot of insights, but I can't tell what you're feeling as you sit here with me"—raises awareness of the emotional gaps in the patient's narrative. This prompts the patient to consider their lived emotional experience, enhancing the capacity for self-reflection and mentalization.
- **Directly challenging pretend mode**: In MBT, 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. This can involve the therapist self-disclosing their own emotions ("I am feeling a vague sense of dread right now"), making a humorous comment, saying something bizarre or strange ("I am not really in the room right now"), directly contradicting patients' perspective; or highlighting an aspect of reality that patients are ignoring or minimizing ("I know you're extremely hopeful that you will get back together with your ex. Do you ever think about the fact that she's actively dating other people?").

These interventions work collectively to "pop the bubble" of pretend mode, reconnecting patients to their authentic selves and enabling genuine therapeutic work. The RF Manual emphasizes that high RF is marked by an awareness of emotional complexity, conflicting feelings, and the mental states of both self and others. By guiding patients in pretend mode to reconnect with their immediate affective experiences, MBT supports the development of higher RF, promoting a balanced and cohesive sense-of-self. This progress is essential in treating PN, as true mentalization—and, consequently, the ability to form meaningful relationships—requires an emotionally engaged and reflective stance.

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What is psychic equivalence and how does it emerge?

Psychic equivalence is a phenomenon in which individuals equate their internal experiences and beliefs with external reality, perceiving their subjective emotions as objective truths. This cognitive distortion is common in personality disorders like borderline personality disorder (BPD) and is particularly prominent in narcissistic personality disorder (NPD), where rigid self-focused beliefs can lead to the devaluation of others. Research on mentalization and attachment theory provides insight into several key factors that contribute to the emergence of psychic equivalence:

1. **Attachment and early development**: Secure attachment experiences in early development are foundational to the capacity for mentalization—the ability to understand oneself and others in terms of mental states. However, individuals with insecure attachment histories often struggle with this skill. When caregivers provide inconsistent, dismissive, or intrusive responses, children may lack sufficient experiences of having their emotions accurately mirrored. This deficit in reflective interaction leads them to experience thoughts and feelings as undifferentiated from reality, resulting in psychic equivalence. For example, a child who feels anger but lacks validation may grow up assuming that their anger reflects others' intentions, rather than merely their perception.
2. **Developmental factors and the failure to mentalize**: Psychic equivalence is part of what MBT describes as prementalistic modes of functioning—modes of cognition that antedate full mentalizing abilities. In these modes, thoughts and feelings are either overly concrete (psychic equivalence), detached and hypothetical (pretend mode), or understood only in terms of physical actions (teleological mode). These modes can emerge when an individual's mentalizing capacity is compromised, often due to developmental delays in achieving self-other differentiation. Consequently, under stress or emotional arousal, they revert to perceiving their subjective states as tangible truths.
3. **Trauma and emotional dysregulation**: Trauma, particularly early in life, has a profound impact on mentalization. Emotional arousal during traumatic experiences can reinforce the association of feelings with absolute truth, as trauma often disrupts the ability to distinguish between inner states and the external world. This heightened emotional reactivity contributes to psychic equivalence by making intense emotions, such as fear or anger, seem like reliable indicators of external threat or hostility. Studies show that trauma survivors, particularly those with BPD, may interpret strong emotions as direct reflections of others' intentions, without questioning the subjectivity of these feelings.

In summary, psychic equivalence is rooted in developmental experiences that limit the capacity for mentalization. Secure attachment, emotional validation, and the opportunity to reflect on one's inner world are critical in preventing this rigid mode of thinking.

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Devaluation of Others and the Role of Psychic Equivalence in NPD

In narcissistic personality disorder (NPD), patients often maintain rigid, devaluing views of others, frequently emphasizing their own superiority. This tendency to view others through a fixed, critical lens reflects the MBT concept of psychic equivalence. For individuals with NPD, this mode of thinking results in equating their negative evaluations of others with objective reality, leaving little room for alternative interpretations. This cognitive rigidity and conflation of subjective experience with fact hinder reflective function, demonstrating a minimal capacity for self-reflection or empathy toward others' mental states.

Psychic equivalence, by encouraging a single, unchanging view of others, blocks the development of mentalization—the ability to understand oneself and others in terms of mental states—and reinforces maladaptive structures. Individuals in this mode may find it difficult to consider that others could have intentions or feelings different from their own perceptions. This limits flexibility and empathy in relationships, as they are often unwilling or unable to see beyond their own perspective.

Response: Interventions to Disrupt Psychic Equivalence and Foster Reflective Function

To address this rigidity and encourage a shift toward mentalizing mode, MBT employs a trajectory of interventions designed to gradually introduce nuance, empathy, and self-reflection. Each intervention corresponds with the RF Manual's criteria for higher RF, which involve recognizing multiple perspectives, exploring the underlying motivations for rigid views, and appreciating the complexity of relationships.

1. **Empathic validation**: Beginning with empathic statements, such as, "It sounds like this was a really challenging interaction," helps build rapport and reduces defensiveness. This approach establishes a safe space where the patient feels understood, enabling them to consider alternative perspectives without feeling criticized. It also models for the patient an alternative way of engaging with emotions and conflicts, fostering an environment where flexibility in thinking is more possible.
2. **Inviting articulation of their process**: By asking patients to describe how they reached their rigid views (e.g., "What clues you in that she was trying to humiliate you?"), therapists encourage patients to reflect on the assumptions underlying their certainty. This exploration aligns with the RF Manual's moderate RF levels, where individuals begin to acknowledge that their perceptions are influenced by internal states and may not always reflect objective reality. This process disrupts the equivalence between perception and fact, nudging the patient toward seeing their beliefs as interpretations rather than absolute truths.

3. **Examining the impact of certainty**: Encouraging patients to reflect on how their rigid views affect them (e.g., “How does it affect you when you focus so much on her deficiencies?”) helps them see the broader consequences of psychic equivalence. This reflection can illuminate the negative emotional and relational impacts of their beliefs, potentially motivating them to reconsider their approach. As the RF Manual notes, awareness of how one’s own mental states affect behavior and relationships is central to higher RF, as it fosters insight into the role of these beliefs in perpetuating conflict or dissatisfaction.
4. **Encouraging nuance**: Introducing questions that invite complexity, such as, “Is she always so critical of you, or are there times when she treats you more positively?” helps patients expand their perspective. This intervention challenges black-and-white thinking and opens the possibility that others might have mixed or variable intentions. This greater flexibility is a hallmark of moderate to high RF, where individuals demonstrate an ability to hold multiple, sometimes conflicting views about others.
5. **Offering a therapeutic perspective**: Finally, sharing an observation, such as, “I know you see her as treating you poorly, but sometimes it has struck me that you can be a bit aggressive to her as well,” encourages the patient to consider how their actions and demeanor influence their relationships. This feedback invites the patient to reflect on the interaction from a more relational perspective, a characteristic of high RF that requires recognizing the impact of one’s own behavior on others’ responses.

Fostering Higher RF and Moving Toward Mentalizing Mode

Together, these interventions aim to disrupt psychic equivalence by fostering a more balanced, flexible, and empathetic approach to relationships. In shifting from a fixed, self-focused stance to a mentalizing mode, patients with NPD can begin to appreciate the diversity of mental states in themselves and others, achieving higher levels of RF. This process is essential for effective therapy, as it allows individuals to replace defensive, devaluing patterns with genuine self-reflection and connection. By enhancing reflective function, MBT enables patients to form more meaningful interpersonal relationships and to develop a more integrated sense-of-self that embraces complexity and change.

External Standards for Self-Worth: The Role of Teleological Self-Esteem

In some individuals, self-worth and self-esteem are closely tied to external standards, leading to significant self-criticism when they fail to meet these standards. This phenomenon, described in MBT for narcissism as teleological self-esteem, occurs when a person’s sense of self-worth is dependent on achieving specific external goals or maintaining particular roles (Drozek et al., 2023). For example, a patient might believe, “I am worthless because I lost that job,” interpreting the external failure as a direct reflection of their intrinsic value. This mode of thinking is rigid and can prevent a more balanced and internalized sense of self-worth, leaving the individual

vulnerable to significant emotional distress when external achievements or validations are lacking.

Teleological self-esteem aligns with teleological mode, one of the prementalistic modes of functioning in MBT. When in teleological mode, individuals require tangible, external evidence to validate their internal feelings or self-concept. When applied to self-esteem, this results in a dependency on external achievements to feel worthwhile, undermining the ability to maintain a stable self-concept independent of circumstances. Research indicates that such externalized standards are often associated with low RF, as described in the Reflective Functioning Manual, where responses tend to be concrete and overly reliant on external markers without introspective reflection.

Interventions to Encourage Internalized and Reflective Self-Worth

To address teleological self-esteem, MBT interventions focus on promoting reflection and helping patients question the perceived necessity of external validation for self-worth. These techniques are aimed at fostering a more balanced and internally grounded sense-of-self, aligning with higher RF, which emphasizes awareness of the subjective nature of mental states.

1. **Empathic validation**: By validating the patient's experience (e.g., "So at this point, you feel like you absolutely need to get your old job back."), the therapist acknowledges the importance the patient places on the external standard. This step creates a supportive environment in which the patient feels understood, laying the foundation for further exploration of their beliefs.
2. **Exploring emotional meaning**: Encouraging the patient to examine what the external factor represents emotionally (e.g., "This sounds so important. Can you tell me more about what makes this the perfect job for you?") allows them to explore underlying motivations and feelings. This approach aligns with higher RF, as it prompts the patient to move beyond surface-level interpretations and consider the deeper significance of their goals and standards.
3. **Examining the impact of externalized standards**: Helping patients reflect on the consequences of tying self-worth to external achievements (e.g., "How does this impact you—to not have the only thing that would make you feel good about yourself?") fosters insight into how teleological self-esteem may be limiting or damaging. This intervention encourages patients to consider how this dependency might affect their overall well-being and stability.
4. **Explicating the link between external achievements and self-worth**: By explicitly linking the external factor to the patient's sense of self-worth (e.g., "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."), the therapist helps make this dependency more conscious. This awareness can motivate the patient to explore alternative sources of self-worth.

5. **Questioning the permanence of external validation**: Inquiring about the sustainability of external achievements as a source of self-esteem (e.g., “So if you were to get your job back, would it make you feel good about yourself permanently, once and for all?”) challenges the patient’s assumption that external validation can provide lasting self-worth. This prompts reflection on whether an internalized sense-of-self might offer more stability.
6. **Gently offering an alternative perspective**: Carefully sharing an alternative viewpoint (e.g., “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.”) introduces the possibility of developing a more balanced, intrinsic sense of self-worth. This approach aligns with high RF by promoting awareness of mental states as subjective and encouraging flexibility in self-concept.

Integrating Reflective Functioning and Teleological Self-Esteem

The Reflective Functioning Manual suggests that higher RF involves the capacity to reflect on the subjective and provisional nature of one’s own beliefs, rather than seeing them as absolute truths. By helping patients question the rigid link between external factors and self-worth, MBT supports the development of higher RF, fostering a more resilient and internalized sense-of-self. These interventions enable patients to gradually replace teleological self-esteem with a stable, reflective self-concept that can endure regardless of external achievements or failures. This shift is crucial for achieving therapeutic progress, as it allows patients to maintain self-worth independently, facilitating healthier and more balanced interpersonal relationships.

Introduction to the Role Play: Exploring Mentalization in Narcissistic Patients

This section delves into a role play exercise designed to demonstrate how mentalization-based treatment (MBT) can be effectively used with patients exhibiting narcissistic traits. The therapists, Dr. Puder and Mr. Drozek, simulate a session to highlight the common challenges of working with individuals who maintain rigid, black-and-white views about their relationships. Narcissistic patients often present with a sense of certainty and negative judgment toward others, which can serve as a defense against underlying feelings of inadequacy and vulnerability.

In the role play, Dr. Puder portrays a patient struggling with intense anger and resentment towards his wife, whom he perceives as unfairly critical despite his efforts. Mr. Drozek, in the role of the therapist, utilizes MBT techniques to explore the patient’s rigid perspective without directly challenging it. By staying attuned to the patient’s experience and gently guiding him to reflect on moments of connection in his relationship, the therapist aims to introduce subtle

uncertainty into the patient's narrative. This approach helps to expand the patient's mentalizing capacity, encouraging him to move beyond his defensive certainty and consider alternative perspectives.

The role play illustrates key principles of MBT, such as the importance of empathic validation, the use of a non-confrontational stance, and the gradual exploration of the patient's subjective experience. This technique fosters a therapeutic environment where the patient feels understood, allowing for deeper emotional exploration and the potential for meaningful change.

Drozek:
Okay, so this approach really stems from Anthony's formulations about treating personality disorders more generally. We didn't do anything entirely new here. The most common form of certainty you'll see in many individuals with narcissism involves a negative judgment of the other person. For example, "My wife is too critical of me." That's often the kind of negative judgment we encounter. In MBT, we wouldn't challenge that perspective immediately; instead, we would start by saying, "Okay, tell me more. In what ways is she so critical?" You guide them to build their case and then explore the impact on the patient. For instance, "Wow, so when she treats you that way, how does that affect you? What feelings does that bring up for you?" We don't challenge it at first because the goal is to align with their perspective. But if we only do that, we're not truly helping patients to develop a more flexible outlook. So, we have to take it further, which is what Anthony has envisioned.

Puder:
Okay, let's jump into this. I'll be the narcissist here, alright?

Drozek:
Cool.

Puder:
Well, it brings up rage for me, Bob. Absolute rage.

Drozek:
Okay. Tell me more. What's the rage about?

Puder:
It feels so disrespectful, you know?

Drozek:
Yeah, yeah.

Puder:
I'm working my butt off, you know? I do the dishes, and then I hear criticism. It's like, "Hey, I'm doing a lot here."

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Drozek:
Absolutely. So you're working really hard, putting in so much effort, and it's enraging that she would speak to you that way.

Puder:
Yeah, exactly what I said, Bob. Good—you're repeating back to me exactly what I'm saying.

Drozek:
(Laughs) I know.

Puder:
Is this what I'm getting from Harvard? Is this what I'm getting?

Drozek:
Well, that's fair. I'm just curious—has she always been this way?

Puder:
Wait, are you laughing at my comment here? I'm trying to pour out my heart, Bob, and I feel like you're making light of this.

Drozek:
I'm sorry, I apologize. I thought you were joking with the Harvard comment. I appreciate that.

Puder:
No, I was joking (laughs).

Drozek:
Okay, just to be clear—let's keep going. Has she always been this way?

Puder:
No, I mean, in the beginning—maybe the first six months—she was very supportive. Then something flipped.

Drozek:
I see. And when she was more supportive, how did she treat you?

Puder:
Oh, everything was positive, warm, and full of gratitude.

Drozek:
Now I'm curious—this past week, were there any days when she was better, maybe kinder, than usual?

Puder:
Yeah, maybe.

Drozek:
Okay. What did she do on that day?

Puder:
She greeted me with a hug. That was nice.

Drozek:
Yeah? What was that like?

Puder:
I don't know. It was... nice, you know?

Drozek:
It sounds nice. I appreciate you putting words to it because it seems like you work incredibly hard, and it doesn't feel fair that she's critical. Yet, there are these moments where she's kinder, warmer, and you see a different side of her. That must be confusing.

Feedback and Analysis

Unruh:
What we just saw was Bob responding to you, David, without challenging or questioning your initial perspective. That's a core principle in MBT, particularly when treating narcissism. It's important to start by aligning with the patient's subjective experience. Bob did not question or criticize but instead asked clarifying questions to explore how you arrived at your perception of your wife as critical.

Unruh:
Even though Bob might have thought, "This sounds overly certain or rigid," he didn't press on that immediately. Instead, he used reflective questioning to introduce some nuance, asking about moments when your wife was supportive. The aim here is to slowly shift the patient from a position of certainty to one of curiosity—getting them to see that maybe things aren't always black and white. That's where mentalizing begins, by opening up space for different perspectives.

Bateman:
Exactly. The goal is to expand the patient's field of discovery. You start with a very narrow focus—"My wife is critical"—and gently expand it by exploring other moments and experiences. This is done from a not-knowing stance, where you accept the patient's perspective without challenging its validity. It's about creating space for exploration, not dismantling their views outright.

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Reflection on the Role-Play

This role play exercise demonstrates how MBT can be a powerful tool in working with narcissistic patients who are entrenched in rigid, defensive patterns. By adopting a stance of empathic validation and non-confrontational curiosity, the therapist begins to gently unravel the patient's certainty and defensive posturing. This approach is crucial in treating individuals with narcissistic traits, who often struggle with a disconnection from their authentic emotions, as highlighted earlier in the document.

The technique of mentalization—exploring the patient's feelings without immediately challenging their narrative—aligns with the broader theme of helping patients move beyond pretend mode. Narcissistic individuals often intellectualize their experiences to avoid confronting deeper vulnerabilities, keeping them trapped in self-reinforcing cycles of blame and resentment. By shifting the focus from an externalized, black-and-white perspective to a more nuanced exploration of internal states, MBT helps patients reconnect with their genuine emotional experiences.

Ultimately, this role play underscores a central theme of the document: the importance of creating a therapeutic space that allows for the gradual development of reflective functioning. In doing so, patients can begin to recognize and tolerate a wider range of emotions, fostering a more cohesive and resilient sense-of-self. This shift is essential not only for reducing pathological narcissistic defenses but also for building the capacity for meaningful interpersonal relationships, which are often compromised in individuals with narcissistic pathology.

Resources:

Bateman, A., & Fonagy, P. (2013). Mentalization-Based Treatment. *Psychoanalytic Inquiry, 33*(6), 595–613. https://doi.org/10.1080/07351690.2013.835170
Bateman, A., Fonagy, P., Campbell, C., Luyten, P., & Debbané, M. (2023). *Cambridge guide to mentalization-based treatment (MBT)*. Cambridge University Press. https://a.co/d/3UAQ98X

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Drozek, R. P., Unruh, B. T., & Bateman, A. W. (2023). Mentalization-based treatment for pathological narcissism: A handbook. Oxford. https://global.oup.com/academic/product/mentalization-based-treatment-for-pathological-narcissism-9780192866134?cc=us&lang=en&

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Fonagy, P., Target, M., Steele, H., & Steele, M. (n.d.). *Reflective-functioning manual: Version 5 for application to Adult Attachment Interviews*. University College London, Sub-Department of Clinical Health Psychology.

Upcoming trainings/conferences on MBT for narcissism featuring Bob Drozek, Brandon Unruh, and Anthony Bateman:

Understanding Narcissism: From Healthy to Disordered

Offered virtually through Harvard Medical School
Thursday 1/30/2025 through Friday 1/31/2025
Registration:
https://cmecatalog.hms.harvard.edu/course/understanding-narcissism-healthy-disordered

Mentalization-based treatment (MBT) for Narcissism Training

Offered virtually through the Anna Freud Centre in London
Wednesday 2/5/2025, Friday 2/7/2025, and Saturday 2/8/2025
Registration:
https://bookings.annafreud.org/s/event/a4VQ5000000Nok5MAC/mentalizationbased-treatment-mbt-and-narcissism-training?filters&chatterGroupId&utm_source&utm_medium&utm_campaign&sort=Asc