The ongoing rewriting of the therapeutic contract in Metacognitive Interpersonal Therapy for narcissistic personality disorder: The case of Mark

Giancarlo Dimaggio[1] and Virginia Valentino[1]

[1]Affiliation not available

August 16, 2023

Abstract

In order to treat persons suffering from narcissistic personality disorder (NPD) it is necessary to agree on therapeutic goals and om tasks to undertake in order to meet them. This is difficult with NPD, as they have difficulties finding meaningful goals to strive for, other than the quest for status. Moreover, in order to change they need to expose themselves to experience painful feelings such as shame, guilt or fear, feelings that they automatically tend to keep at bay. Finally, they have problems forming a benevolent image of their therapists and to harken to it in order to cooperate towards mutually agreed goals and tasks. As a consequence, NPD patients ask for change but hardly engage themselves in the work necessary to achieve it. Therapists therefore need to pay the uttermost attention to drafting, negotiating and continuously updating a reasonable and realistic therapeutic contract. In this paper we describe the story of a man in his thirties with NPD who was ridden with depression, guilt, envy and anger and did not find ways to pursue the healthy and adaptive behaviors he would need to pursue in order to leave a richer social life. The therapist overcame ruptures in the therapeutic alliance and then involved the patient in a process where they set the steps to follow, making sure the patient was convinced they made sense. After a contract was reached progress became possible. Implications for the role of the therapeutic contract in NPD treatment are discussed.

Abstract

In order to treat persons suffering from narcissistic personality disorder (NPD) it is necessary to agree on therapeutic goals and om tasks to undertake in order to meet them. This is difficult with NPD, as they have difficulties finding meaningful goals to strive for, other than the quest for status. Moreover, in order to change they need to expose themselves to experience painful feelings such as shame, guilt or fear, feelings that they automatically tend to keep at bay. Finally, they have problems forming a benevolent image of their therapists and to harken to it in order to cooperate towards mutually agreed goals and tasks. As a consequence, NPD patients ask for change but hardly engage themselves in the work necessary to achieve it. Therapists therefore need to pay the uttermost attention to drafting, negotiating and continuously updating a reasonable and realistic therapeutic contract. In this paper we describe the story of a man in his thirties with NPD who was ridden with depression, guilt, envy and anger and did not find ways to pursue the healthy and adaptive behaviors he would need to pursue in order to leave a richer social life. The therapist overcame ruptures in the therapeutic alliance and then involved the patient in a process where they set the steps to follow, making sure the patient was convinced they made sense. After a contract was reached progress became possible. Implications for the role of the therapeutic contract in NPD treatment are discussed.

How to best treat persons suffering from pathological narcissism or narcissistic personality disorder (NPD)? As of today, the answer does not come from outcome studies, as they are mostly lacking (Yakeley, 2018; Weinberg & Ronnigstam, 2020). What currently have is only a series of principles that some authors have distilled from the literature on the disorder and from their own clinical work. Researchers have neglected

NPD, notwithstanding its prevalence is significant and it is associated with serious levels of suffering, social dysfunction and decline in the second half of life once the dreams of glory of the youth leave room to a sense that paradise has been lost forever and one is doomed to failure.

NPD can be treated (Weinberg, 2023; Weinberg & Ronnignstam, 2020; Yakeley, 2018), the question is: how? In absence of empirically supported treatments, clinicians need principles that guide their action. Weinberg and Ronningstam (2020) have offered pragmatic suggestions for what to do and what not to do when treating NPD, while Dimaggio (2022) have proposed how to tackle with the different aspects of narcissistic pathology. Here we will focus on one aspect which has received insufficient attention, that is how to build, draft and constantly revise a therapeutic contract, one where goals are clear, psychological meaningful and pragmatic oriented, and where patients with NPD understand that doing something is necessary to move towards health and well-being and to restore hope. As Ronningstam and Weinberg (2023) note, "Some therapies proceed without measurable realistic goals", but why is it difficult agreeing on a therapeutic contract with NPD? We offer here a series of hypothesis, based on an understanding of narcissistic pathology. Then, in the description of the clinical story, we will show how the therapist of a man with NPD tried and addressed some of these problems.

Poor awareness of inner states and of suffering

In order to set goals, and devise tasks suited to fulfil them, persons need to have a clear awareness of the ideas making them suffer and of emotions they experience. But many with NPD have poor capacity for self-reflection. They cannot describe their inner experience, in particular suffering and vulnerability. At the same time, they only offer generic reasons for their disappointing outcomes, such as "society does not offer opportunities for a person like me", or "women (or men) are shallow". Consequently, clinicians face difficulty setting reasonable and shared goals, and in designing tasks suited to achieve the desired ends.

Neverending quest for grandiosity. Lack of investment in goals others than the quest for status or for pleasure

NPD often enter therapy feeling empty and bored. Once clinicians explore the reason, patients answer they feel nostalgia for a paradise now lost. They ask to restore grandiosity and they think that would be the only way out from their depression and worthlessness. Clinicians cannot agree on such a goal that would only sustain grandiosity and is unrealistic. Connected to this aspect, is that restoring a sense of a life worth living, requires investing in areas such as intimacy, connection and to experience relaxation and playfulness. Moreover, given that humans cannot take for granted that their strives will succeed, they would better focus on the process of achieving something more than on the result. This means they need to value training, workout and the effort they put while striving to reach an end, instead of focusing on success only. But NPD mostly strives for status and for pleasure, so anything else sounds meaningless to them. Consequently, when therapists try and set goals and tasks in order for example to overcome depression they are not motivated to pursue them as they do not see these will help gain recognition.

Lack of trust in the therapist and ideas that others cannot help

Patients with NPD do experience suffering, which activates their need for help. Problem is that they lack the idea that others are interested or capable of helping them. Their expectation is that if they display vulnerability the other will either a) be uncapable of helping or just will not care; b) will exploit, humiliate or manipulate them; c) will suffer if they show their suffering. The last point seems counterintuitive, but patients with NPD often comes from families where a member had problems such as alcohol abuse, psychiatric or physical illnesses, or faced serious economic setbacks. They learnt that if they display their problems relatives will suffer in turn, which makes them feel guilty. We anticipate this is a central feature of the case described here.

NPD attitude towards the therapist ranges from expecting the therapist has a magic wand so they do not have to display vulnerability, to devaluation and contempt. When therapists try to set goals and tasks, patients with NPD deny any value in their proposal and remain stuck, while at the same time blaming them for lack of progress.

Focus on other as the source of problems and lack of agency over own inner world

Typically, narcissistic discourse if focused on others' misdeed. Patients spend time complaining others are stupid, non-supportive, or source of problems they have to handle. They focus on how colleagues and bosses do not recognize their exceptional qualities, how romantic partners are dull and boring, or how they are bound to take care for their family instead of receiving the support they deserve. They often focus on the wrongdoings they think they have received and protest against parents, relatives, current and past romantic partners, friends and co-workers. They wait for others to repair their mistakes but in so doing, they swing between anger, resentment and despise. None of these attitudes help them moving forward. In parallel, they are deprived of agency (Dimaggio & Lysaker, 2015; Ronningstam, 2020). Put it simply, they do not think and feel they have power over themselves or to ignite changes in the world. They ruminating about past setbacks or about the problems caused by others, but once faced with the idea they could do something they remain powerlessness and paralysed and do not believe that any action can help. They experience anger, frustration, envy and resentment, and if the therapist suggests they have the power to regulate these emotions and to access to a different state of mind, they answer this is not possible, that their mood is the consequence of events that are beyond their control, and so if the world remains the same, and they do think it will stay the same, their mood will not change.

Underlying fragile, unstable and poor self-esteem

In order to change, persons need to trust they can reach the desired outcome, meaning they need a solid-enough self-esteem. But under the grandiose façade, NPD's self-esteem is either unstable of fragile (Mota et al., 2020; Ronningstam, 2020). In particular if they experience vulnerability their self-esteem collapses: "I am weak and inferior". So, they ask for help without disclosing their weaknesses in order to conceal their poor self-esteem. When they are capable of acknowledging their weaknesses, they consider them a sign of inferiority or unworthiness so they fear therapists' judgment and have no faith they can change.

The above listed elements are among the main reasons for why setting reasonable therapy goals and agreeing on the tasks needed to achieve them is difficult when treating NPD. If therapists are unaware of these problems, they are at risk of negative reactions. One typical relational pattern is the patient pressuring for change and the therapist swinging among guilt, shame, frustration and anger. Therapists can insist on adopting techniques such as mindfulness, guided imagery, behavioural homework, with the results that patients disagree with them, devaluate tasks, or comply formally but do not complete any task.

In order to agree on goals and tasks, a series of operations are therefore necessary. First, therapists need to be crystal-clear since therapy onset about what therapy can promise and how it works. Therapists need to state that they need to understand what the therapy goals are before promising anything. They have to frame goals that are realistic, observable and easy to monitor for the both of them. Then they have to make the case that without active effort to change something in own ideas and attitudes, they cannot promise any sustained change, both in the domain of symptoms and in the realm of social relationship. In other words, therapists need to clear that associated symptom disorders or mechanisms such as anxiety, depression or worry will not disappear without effort. So, they have to invite patients deciding if they agree overcoming avoidance, accepting behavioural activation practices and so on.

Metacognitive Interpersonal Therapy for narcissistic personality disorder

Metacognitive Interpersonal Therapy (MIT; as manualized in Dimaggio et al., 2015; 2020) is an empirically supported treatment for a wide array of PD including NPD (see Dimaggio et al., 2017; Popolo et al., 2021). It understands pathological narcissism as featuring: a) problematic ideas about self and others which make them predict that their goals in the relational domain will remain frustrated. For example they predict that if they ask for cares the other will control them or humiliate them; b) limited awareness of one's own beliefs and emotions; c) tendency to intellectualize; d) poor agency in acting according to goals and desires felt to be one's own; e) maladaptive cognitive and behavioural coping strategies; and f) poor capacity to understand what the others think and feel and to empathize with them (Dimaggio, 2022). These elements are at the root of impaired interpersonal functioning and pave the way for comorbidity with anxiety and mood disorders.

In order to deal with NPD, MIT adopts a series of procedures. Some are devoted to build a *shared understanding of patients' functioning* . Therapists try to overcome intellectualizing asking for specific episodes and inquiring for specific thoughts and emotions. Once these are clear to both, therapists try to discover with the patient if the contents emerging in the episodes correspond to relational patterns. For example, they may note that in different moments and with different persons the patient tends to describe himself as searching for recognition but facing others who are spiteful, envious or incompetent. As a result, he swings between seeing himself as inferior in some moments and superior but misunderstood in others. In other moments he can be driven by the quest for autonomy and appraise the others as an obstacle. He then reacts swinging between reactive anger in order to remove the obstacle and resignation and powerlessness. Once patients become aware that these ideas are not necessary reality-based, therapy shifts to operation aimed at *promoting change* , inviting patients to see the world from a different angle, one from which they see more benevolent sides of themselves and of others. In particular therapist try to promote a sense that life makes sense mostly out of goals such as exploration, curiosity, playfulness and sharing, that needs to be added to the focus on competition only.

During promotion of change therapists try to form a working alliance where patients commit themselves to therapeutic tasks, both in-session and in-between sessions. MIT often uses practices such as guided imagery and rescripting, chairwork, role-play and, most often, homework in order to break old patterns and form new ideas about self and others (Dimaggio et al., 2020; Centonze et al., 2023). Therapy is delivered under a continuous monitoring of the therapeutic relationship in order to detect earlier than possible if the patient is seen the therapist under a negatively light and if the therapist is contributing to the problem. Only when alliance ruptures are solved (Muran et al., 2021), work aimed at overcoming symptoms continues.

Finally, therapists pay attention to drafting, agreeing upon and revising the therapy contract. In other words, they pay the uttermost attention whether patients agree with the goals and if they are willing to commit themselves to performing the necessary tasks.

We will describe now the story of the therapy of a man with NPD who, at the beginning of therapy, did not agree on any reasonable goal. This was mostly due to the problems that we highlighted before, that is to: a) poor capacity to describe his inner states and to focus on his healthy wishes; b) lack of investment in healthy goals and over-focusing on social status; c) focus on others as the source of problems; d) a sense of hopelessness and passivity mostly driven by negative views about self and others; e) problems in the therapeutic relationship, as he considered the therapist as an obstacle and someone to envy of despise; e) problematic reactions on the therapist's side, as she oscillated between the drive to defend herself in the face of the patient's devaluation and the drive to be effective.

We will show how the therapist had to become aware of these problems, overcome them and then agreeing upon a therapeutic contract. The clinical history will henceforth be written in the first person by the therapist (V.V.), last author of this paper.

Presenting Problem & Client Description

Therapist.

I am a 35 years old woman, a CBT psychotherapist since 2018 and I have 6 years of experience with MIT.

Client: Mark is 38 years old and he is a secretary in a medical testing laboratory. He lives in a small town in the South of Italy. When he begins psychotherapy, he feels dull and devitalized, and bears almost no hope for a life with a meaning. He's been depressed for the last few months, he can't figure out why and he tells me that it's been happening to him often in the last few years. Mark asks for professional help because he has trouble waking up, and is lethargic. He has no life plans, nothing amuses him or motivates him to act. Mark claims that all his acquaintances are and moving forward in their lives while he fails to do anything.

Outside work, his days are empty and deprived of pleasant experiences. He has no friends, and finds awkward relating with others. He has had only one romantic relationship, lasting three years, with Luisa, a nurse, who left him two months before he started therapy. Mark reports that Luisa told him she was tired of his

passivity, since he refused to go out, did not maintain social relationships and, above all, did not take any initiative such as asking to go to a restaurant of to organize a trip together. Actually, she complained that he boycotted her. For example, Mark, during their last summer together, did not accept Luisa's invitation to spend the holidays at the beach together and when she left with her friends, he got angry. Or Luisa had organized to spend with him New Year's Eve in Switzerland. On the day before, Mark backed out without providing any feasible alternatives. Mark recounts the loss of Luisa as a painful event but is convinced she will return to him because "*she will find no one to listen to her like I did* ." Yet he has not heard from her since the day she communicated that she had decided to leave him: she never responded to his text messages or phone calls. Depression likely stemmed out of this romantic breakup but, as typical in persons with pathological narcissism, Mark is unable to realize that specific events triggered the negative mood (Dimaggio et al., 2009). Mark and his sister Sandra are orphans: their father died from an accident at work when Mark was 6, and their mother died after 6 months of the onset of cancer, when Mark was 19. Mark's aunt, her mother's sister, had no children and she adopted them both.

Sandra has a cognitive retardation due to brain malformation, and is not autonomous. Physiotherapists and nurses care for her, but not on a full-time basis, so Mark is often the only caregiver, he spends almost all his spare time caring for her. The few times Mark does something for himself, he lies to his aunt and sister: "*I'm doing late at work* ".

Mark refuses the rare invitations from colleagues, out of lack of interest or overt contempt: "*They do silly stuff... pub, beer and chips* **"** . Mark is partially aware of being driven by envy, another reason for avoiding social interactions. He indulges on self-talk filled with anger and contempt for others. During social exchanges he is a silent spectator, a judge or is just hostile. For example, if a colleague asks him for a few hours off, even though he would have a chance to meet his needs, he does not accommodate his schedule.

Mark feels damaged for not having been able to attend university so to have a more rewarding job: "*I could have had a great future and instead I'm after Sandra and in a lab making appointments* ". When his mother discovered she would die soon, she told him he was the sole responsible for Sandra. Mark bears that burden as a duty he cannot escape from, one that comes with frustration at impaired autonomy. He is envious of his carefree peers.

Mark reasons for seeking therapy are vague: "*I want more control over my life* ", but he barely knows what he likes. As many with NPD, he does not know what he likes and prefers, outside the domain of the quest for status (Dimaggio, 2022). Mark also expected that I could "magically" help him and that I would understand everything at a glance. These led me to focus on the therapeutic contract from the very first session, in order to prevent his disappointment.

Case Formulation

Mark suffers from covert narcissistic personality disorder (Pincus et al., 2014), with traits of avoidant personality disorder, and from recurrent depression. He experiences envy, anger and contempt towards "*luckier* " others, because they have reached success or could access to resources he thinks were out of his reach. Consistent with the diagnosis, Mark is prone to guilt (Dimaggio, 2022; Kealy et al., 2023). He spends a lot of time thinking about what he would like but cannot get, he thinks often about his past failures and this rumination paved the road to depression. Mark indulges in fantasies of sabotaging the others, tends to lie for the sake of grandiose self-presentation; he avoids social interactions so to not run the risk of getting busted as the charade he thought he was.

Mark longs to be free and autonomous but, from an early age, he over complied with the demands to take care of his sister. Over time, Mark gave up fancying any future consistent with his core wishes and now he is unable to detect any vital aspect in his soul. After his father's death, Mark's mother completely weighted in on him, making requests for support and help. If Mark just did what he wanted, she become angry and accused of being mean and selfish. When facing his mother's suffering and complains, Mark experienced guilt of the so called "*altruistic* " type, meaning the trigger is the idea that one is enjoying something at the expense of another, or while another is suffering (Gazzillo et al, 2017). As an adult, Mark begins to think he

has no right to do something for his own well-being as that could damage the others: "*If I walk away from home, I am bad and selfish. I better give up so no one will suffer nor criticize me* ". As a result of these ideas, he gives up with the exploratory motive and this is another reason for his recurrent depression.

His never-ending commitment to care for his mother and sister, made Mark loose opportunities for personal and professional growth. As a result, he finds himself trapped into an "*anonymous and boring job* ". Mark has had to squelch the drive toward education, career, and achieving high social status. Mark sees himself as a loser and considers the others as luckier and more able to enjoy life, and for this reason he is envious and belittle them. This is why Mark has never built healthy and lasting interpersonal relationships in his entire life. He somewhat realizes being responsible for his isolation, but he cannot control his tendencies to criticize, derogate and humiliate others.

Mark harbours grandiose fantasies, where he portrays himself as having a successful top-level job allowing him to travel worldwide. Again, as typical of covert narcissism, grandiose fantasies suddenly leave room to a sense of failure as he realizes the life he actually lives. He is self-critical in particular when he acknowledges having lied either for the sake of grandiose self-presentations or in order to spend time on his own without caring for his sister.

The therapeutic relationship: early ruptures

One reason for the early problems in the therapeutic relationship is Mark's poor ability to describe his internal states, a typical feature of NPD. For example:

M: "*Yesterday I was just like this... like this chair, cold and still. I think things I don't do, but I don't know why. And in the end, I've been satisfied for a lifetime... but am I really satisfied?* "

T: "*Ok Mark, can you recall a moment in which you felt like this? Let's try to understand what you mean when you describe yourself as the motionless chair...* "

M: "*I don't know... maybe it's always like this... or when I returned home the other day... but I wasn't doing anything at all particular...* "

T: "*It was Wednesday, right? We're talking about the moment you entered home after work... what did you think? What did you feel?* "

M: "*I wasn't thinking about anything. I was empty! I told you!* "

Mark cannot describe what he thought and felt, nor understand what he wants. He focuses more on others than on himself, which is common in narcissism. He only complains about his difficulty in facing everyday life. As a result, I experienced bored and confusion and a sense of just being an audience when he speaks without any emotion. This leads me to think about something else, sometimes I want the session to end as soon as possible because I cannot understand what Mark asks from the therapy. I realized that I had to explore what Mark thinks and feels and understand what he wants from therapy and the reason to ask for help, instead of remaining silent, passive and most of all distracted.

T: "*So Mark, I understand that you feel that things are not going well in your life and it has been like this for a long time but we need to goals and figure out how we want to get there. What do you think?* "

M: "*I don't know what I want, I'm sick and I definitely long for a different life. Now I don't know what to tell you doctor! You have to take care of it, do what you want and hurry up, as time passes* ".

T: "*I understand that you expect therapy to be something magical. Almost as if I could understand everything and offer you solutions. But I can't guess what you think, feel and above all what you want to get from these sessions. We need to discover it together!* "

M: "*What should we do...? I don't know...* "

T: "*We need to understand what you really want from therapy and figure out how to get there together. What do you think? And, in general, I need first to all to better understand what you think and feel in certain*

situations ".

M: "*A skilled therapist understands everything by intuition and you ask me instead that we must collect episodes. I can't get the sense... Wait, what did you say? We must discover? Do we want to be explorers of the forest?* "

Mark responds to my attempts to cooperate with sarcasm and humiliation. I feel belittled and not taken seriously as a psychotherapist. Furthermore, his attitudes become blatantly arrogant, for example he laughs at me or talk to me without even looking at my face. At that point, I realized it was pointless letting him humiliate him. As a first step I started breathing regularly in order to regulate my sense of hurt and anger. Then I tried to see things from his perspective, not taking his offenses personally. I figured out he was spiteful out of some self-protective mechanisms I had to discover. In MIT we consider that patients are guided by rigid problematic expectations on how others will react when we express our wishes, and we name those structure "*maladaptive interpersonal schemas* " (Dimaggio et al., 2015; 2020). Guided by those patterns, patients predict how others will react to our need to be, for example, cared for, appreciated or supported. In order to protect themselves from the negative responses they expect, patients adopt maladaptive coping mechanism (Lazarus & Folkman, 1984). Very likely arrogance and spite part of Mark's coping strategies. I needed to explore if that was the case. Mark is again derogating me in the middle of one of the first sessions, and I take it as a chance to explore the underlying reasons.

M: "*Where are you going for vacations?* "

T: "*I'm going to Greece* ".

M: (sarcastic) "*... and you'll come back tanned, eh? Anyway, doctor, Greece. It's so trivial, it's trendy. You go to Mykonos, like everyone else, right? I already know! How trivial.* "

Repairing the rupture

I have to acknowledge that Mark was not the sole responsible for the strains in our relationship (Muran et al., 2021), I played a role as well. I have just disclosed an aspect of my personal life that was not necessary. Moreover, I could have seen his reaction of envy and contempt coming in discovering I was about to go for a vacation he never had. In that moment, however, my need to be appreciated by others, a mechanism that I know is my shield against humiliation, took control. After having acknowledged my contribution to the relationship rift, I took this moment as a chance to explore Mark's inner world first, and then try to repair the rupture.

T: "*Mark, how do you feel while you tell me these things? Maybe I'm wrong, and tell me, gently, if that's the case but I think that a moment ago, when I told you that I was going to Greece, something happened* ".

M: "F*or a moment I thought that you too are going on vacation and I still don't know what the hell to do in my life* ".

T: "*I understand, so it's possible that discovering I was about to enjoy vacations... made you feel some emotion, negative ones I mean... and then you feel the need to making fun of me?* "

M: "*Yes, probably... indeed, I envied you!* "

T: "*Ok Mark, now it's clear to me ... in your eyes I am another person who does things that you would yearn to do but you can't...* "

M: "*Exactly. Same old story* ".

T: "*I'm sorry, Mark. I didn't want to make you feel this way. But this may be a signal that you really would like to do something nice in your life, right?* ".

M: "*Maybe... but I can't* ".

It is clearer now that Mark's contempt is a mean to shield himself against powerlessness and inferiority. According to MIT we would define that reaction as *schema-driven.* Once we cleared the air in our relationship and we realized that Mark was driven by envy, there is more room for further reflection.

T: "*What do you mean, Mark?* ".

M: "*I really have no idea what I'd like to do* ".

Beginning to draft a therapeutic contract

Mark is paralyzed, devitalized and I feel powerless. I realize now that if I try to push it towards what I consider a healthy direction, it would be counterproductive. Mark would probably feel even more controlled and dominated and still do not figure out a way out from the cage he lives in. It is therefore necessary to try and have Mark commit himself to doing something in order to live a different live and eventually overcome depression. My awareness of these needed passages, is a first step towards an explicit formulation of the therapeutic contract.

T: "*Mark, I listen to your stories, you kind of live always the same day, and this is just frustrating. I would like to help you find a way out, but I have a sense of pushing you to do something to get out of it almost against your will. If this is the case, I'm making a mistake* ".

M: "*Yes, I know. I've always been sick. I told you! Can't see any solution* ".

T: "*Yes, I know, but... in order to support or help you get somewhere I have first to understand what is the direction you would like to follow, I can't fortune-tell it on my own. What do you think about it?* "

M: "*I... I don't know... sounds useless... nothing ever changes...* "

T: "*I imagine, you've been down for ages. Of course you are discouraged! But I am confident that if we connect with that part of you that wants to change the course of your life, and we know it exists, that could help us finding a way* ".

M: "*Ok, let's see what you* propose" (in this passage Mark is not sarcastic anymore, he is really curious about my ideas).

T: "*You told me that you would like to have an aperitif with your colleagues, go to clubs that often play live music in the evening. What do you think if we get ready to do something?* "

M: "*I could ask a colleague of mine if he wants to have dinner together on Friday evening* ".

T: "*Excellent. So you try? And we will see together what will happen* ".

Even if it looks like we have a real agreement, I still have to make sure that Mark does not covertly see me as dominant or controlling. So, I explore that with focused questions:

T: *"One last thing, Mark. How do you see me right now while I'm asking you to really try and invite a colleague for a dinner? Or while I insisted that new action is necessary in order to change?* "

M: "*Hmm ... You tell me to do things, like everyone else... but at least you're telling me that I can choose or at least that we can think together. How to say... you are not really forcing me* ".

T: "*Oh, good. Well, this is ok, but if in some moments you have the idea I am giving you kind of orders... just let me know, it will help us* ".

In the first passages we can trace what the reasons were, for lack of agreement on objectives and tasks, coherently with what was anticipated in the introduction: 1) Mark was focused on others, including the therapist, and dwelt on feelings of envy and contempt, instead to focus on the problems he had; 2) Mark was completely distant from his desires for him: he no longer even knew what he liked to do, he was only attracted by the desire to redeem himself in society so as not to lose in comparison with others; 3) Mark believed that his well-being depended on events and not on his actions, thus remaining a spectator of himself and often

feeling depressed and understimulated. I had to understand if Mark wanted to work on these aspects, in the direction of what we were understanding to be fundamental for him: the freedom to explore freely. Mark wanted to revitalize himself but I couldn't give him any indications, to preserve our relationship and not be yet another person who imposes himself on him. he should have started acting himself but did he want to? Also, did Mark want to get in touch with the pleasure that can come from doing activities for the sheer fun of it? above all, Mark wanted to get in touch that the emotions that he always tried to push away?

Course of Treatment

Defining a clearer contract in the contest of a shared case formulation

As we just described, Mark is both depressed and disconnected with his vital drives. He is unable to set a direction and, consequently form a reasonable plan. Once ruptures in the therapy relationship has been repaired (Muran et al., 2021), I give him reasons for why we need to set together goals that make sense to him, and then devise strategies suited at achieving them. I also made clear that we needed to make sure he would explicitly commit himself to tasks, otherwise we would end up again in a cycle where I push him and he discounts my proposals. This time Mark accepts to explore new avenues. He tries taking time in-between sessions exploring his inner world: "*What do I want in this situation? What is my own perspective? I feel . . . how?* ". He understands that every time he gives up on doing things it's because he foresees that his sister will suffer and he sees himself as bad. He notices more and more often that the emotion he feels is guilt and also sees more and more clearly the envy towards others.

A necessary step now, is helping Mark figure out that is negative ideas about himself and the others are just perspective, and are not necessarily true. He now reports more episodes and these helps observing recurring patterns in his interpersonal relationships. As a first step I offer him a summary of what occurs to me as being the structure of his narratives:

T: "*Mark, it seems that things tend to go in similar ways in the different encounters you have. You told me that earlier you arranged a dinner with your colleague but then you didn't show. Thursday, you planned to go to the cinema alone and then you changed your mind and ordered pizza and eat it home. In both cases it seems that you are driven by curiosity, but suddenly either you start focusing on Sandra home without you or on your aunt who will be overburden by caregiving, At that point you see yourself as mean and selfish and feel guilty. Then you give up with your plans and resort to be the caregiver, which alleviates guilt but deprives you of vital experiences. Mostly you are blocked by the idea you will make the other suffer if your give room to curiosity and exploration. . . is that correct?* "

M: "*Exactly, it's true!* "

T: "*You believe so much in the idea: you are the villain who hurts others, so you have no right to do things you like* ".

M: "*Things would really go like this, so it's better that I don't do anything anymore* ".

T*:* "*You often give up. You only find kind of a solution, that is lying in order to prevent blame or facing disappointment in the face of people you love. I remember that time you went out but only after having said something unexpected at work happened and you would have just be back home later than usual* ".

M: "*I said half the truth* ".

T: "*Yes, but basically you didn't allow yourself to say: I will be out because I need, you were justifying yourself! But that time I noticed you felt free, at least for once. It means that you have the capacity to experience freedom and curiosity, it just lasts so shortly in your mind, sudden over-run by guilt. But it's there, it's a part of you* ".

M: "*I was a little happy but then I felt guilt as usual. No no, better not doing anything. . . it's less risky* ".

T: "*For you acting is a risk! You can do protect yourself from guilt and idea of being mean and selfish but. . . can you see now it comes to a cost. That is devitalization, anger and ultimately depression? Is it correct?* "

M: "*It's me! I always mock the others for the things they do, trips, going out to the restaurant, but fact is that at least they give it a chance... I was thinking about it last night on the bed... and I told myself that mine life is miserable, that I'm miserable compared to others (slumping on the chair)*

T: "*This is important! So would we agree that not acting shield you from guilt but then paves the road to unhappiness? And moreover, if you give up with your autonomy, you don't feel good. You spend countless hours ruminating about it, filled with anger and frustration and a sense of failure. At the end you just feel sadder and miserable. You measure yourself against others, you consider them better than you and you see yourself even more as a failure ...*"

M: "T*he others... and their bloody lives...* ".

T: "*... what are you feeling right now when you say 'their bloody lives?'* "

M: "*Envy. I envy everyone. Now I see it clearly. Like it happened with you, remember? I don't want to... but it's beyond my control* ".

Now that we agree on this reconstruction, the next step is helping Mark realizes that these ideas are not necessarily true, but are learnt. Put it simply, I tell him that on the one hand it is human he cares for his sister and aunt. But on the other hand he made the hypothesis that his tendencies to give up with autonomy in order to prevent moral criticism and to not experience guilt were more than a normal human reaction, but a learnt pattern. Therefore I ask him if he can recover autobiographical memories which could help understand where this pattern stem from. Mark recalls his mother's harsh face when she ordered him not to go out and stay with his sister. He also recalls his mother's indignation when she made normal adolescent requests, such as playing soccer, participating in board game sessions or staying in the village square on Sunday mornings.

The result was that any enthusiasm vanished he felt guilty and gave up. Consequently, Mark never gave himself a chance to act autonomously and live social experiences that usually adolescents live. Now, as an adult, he feels powerless and paralyzed, and everything looks to him beyond his reaches. The roots for his current sense of stillness and boredom, and for his anger and envy is now clear to the both of us.

Once a pattern is understood, time is ripe to try and break it and this happens with specific work, which includes a behavioral component (Lewinsohn, 1974). Does Mark want to commit himself acting in order to fulfill his wishes? Will he accept to expose himself to feeling guilty and face the idea of being mean and selfish but then access a different idea of self as being as motivated by a normal, human drive for new experiences and a richer sociality? This is time to redraft the contract in order to see whether we agree on behavioral experiments aimed at breaking the patterns and exploring new and healthier directions. Also in this case I have to seek an explicit agreement because patients with NPD, as mentioned previously, have the tendency to act little, to remain in their situations even if they generate pain, and they cultivate the expectation that change is impossible or that it is generated by others. Mark, as a victim of these beliefs, had to grasp the disadvantage of this position and take responsibility for his well-being and life-changing. Let's see if he agrees otherwise I would have had to remain in a position of closeness and listening but which would not have favored any change in his life.

Reformulating the contract in order to promote change

Having identified the maladaptive pattern and understanding why Mark gives up, isolate himself, lies, thinks negatively of himself and of others we are now in the position to try and do something different in order to promote change. Overall, a clear and fully agreed upon contract is necessary in order to prevent backsteps or falling again in the position where the therapist pushes for health and the patient derogates her work or thinks nothing will help him. Uhis applies to all patients who suffer from narcissism and above all with Mark: considering his schema, I would have become someone who limits him and does not support him in his choices.

Behavioral experiments ((Lewinsohn, 1974; Levy & Scala, 2015) were the first candidate in order to promote

this change, given how much Mark was stuck in his everyday life. This is how the exchange went:

T: "*So Mark, we're seeing what we're calling an interpersonal pattern driving you, it's very strong and it's crushing you and shutting you down.*"

M: "*Yes...* ".

T: *"But we discovered your desire to explore is there and is strong. If you want, we could do something to support that part of you that wants to live a richer life. First we would need to figure out something concrete you would like to do, but then don't out of guilt and the idea of being mean and selfish* ".

M: "*This is a part of the job that is on me, correct? But... am I able?* "

T: "*I think you can... but mostly... you really need to live... would you try?* "

M: "*I guess so!* " *(smiling).*

T: "*I see you smile. Do you like the idea then?*"

M: "*Yes, at least I'm moving towards something* ".

T: "*Let's assume that some things will be more challenging than others or that we will discover that some things you really don't like. Most important you have to be aware that you will face guilty once you act for yourself, we can't escape that, are you aware of that? I mean you will see yourself as mean and selfish and feel the compulsion to give up. Would you feel like trying?* ".

The contract is now easier to draw up. Mark agrees to try to incorporate activities into his life like sports or studying languages that he loved as a child, three times a week. This idea improved his mood already in the session, now he is convinced that committed action is necessary and useful.

This moment is important for patients with NPD, like Mark, who have been so stuck in oscillating between harboring grandiose fantasies and existential paralysis. But in order for a contract to be realistic a very important part was telling him, or any other patient with NPD, that experiments come with a cost and therapeutic success depends on facing negative ideas and feelings about themselves and not give them the power to control their action. Thanks to this clarity, Mark is aware that in order to overcome stagnation he will have to expose himself to ideas and feelings that will hurt. Will Mark still think it is worth the price?

M: *"Are you telling me that I have to do those things that I never do, that will make me feel bad but that all of this will help me?*

T: *"Yes... basically, yes"*

M: *"... I don't know... do you know that it's not convincing?"*

T; *"I understand it well. I'm telling you that taking action will make you feel guilty. But I remind you that it will also make you feel free to think about what you want to do and actually do it. You have so many pending wishes waiting to see the light..."*

M: "*Maybe we'll find out that I'm a failed artist... or an intellectual* " (smiling).

T: "*Why not?* ".

In practice, on the one hand, Mark knows he has to act, he feels more and more that he wants to do it and he also begins to have clear ideas and this excites him, as can be seen from his answer. On the other hand, however, he is frightened by the idea of feeling bad emotionally, of feeling a sense of guilt. To help him, I remind him of an episode in which a sense of guilt leads him to give up everything. I need this to point out to him that it's automatic to feel guilty as soon as he does something and that it's automatic for him to give up but that this doesn't help him because he gets more and more depressed. I also need it to ask him if he wants to bear the weight of the guilt, even if it's unpleasant because there's no alternative.

T: "*So Mark, from what you told me yesterday we noticed that it is automatic for you to give up on yourself. Last night Sandra wrote to ask you where you were".*

M*: "Yes, I really felt that my legs loosing strength and my heart pounding ".*

T: "*And how did you see yourself at that moment? "*

M: "*Selfish. As usual. I'm out and she's locked up at home I felt she was suffering, blaming... I blamed myself actually and so I came back home ".*

T*: "By now we know this idea: you feel responsible for others since you were a child! "*

M: "*It seems that my mother gave birth to me to help her, Sandra and me? What happened to me? ".*

T: "*Look Mark, it's natural for you to give up on yourself in order not to feel like this but now we're seeing that you don't want to do it anymore. Do you feel like working on addressing the blame? ".*

M: "*That is? Does this mean I have to feel more guilty? ".*

T: "*Strange as it may seems... yes! If you would seize a change to live freely we have to face that sense of guilt and deprive him of power ".*

I explain to Mark the need to work on the schema to rewrite it. At MIT this phase is crucial because it weakens the pattern and strengthens the healthy parts. I propose to Mark the "role play technique" and I explain why.

T: "*I thought we could do something together here in the session to bring out the pattern and the sense of guilt and try not to succumb. We will do it here together so that you can then acquire strategies to re-propose even alone in your life ".*

M: *"What should we do?"*

T: *"Let's re-propose you and I a scene among those we know and that have contributed most to making you feel like a bad person. you will be Mark and I for example mom. We repropose here, as if it were a theatre, the same things that happened at the time in order to give it a different meaning. What do you think?"*

M: *"Okay, let's try to be actors come on".*

Mark agrees to work on the scheme and himself chooses the scenes to be rewritten among those with the greatest emotional load. During the role-play session, we stand facing each other and I play the role of Mark's mother, angrily accusing him of being an ungrateful and selfish son who does not attend to the needs of the family and ask asked Mark to retort. Here's what happens at a certain point in the performance:

T (while I am the mother, simuling an expression of anger): " *Where would you like to go? To play? And tomorrow you want to go to the Spanish course? But how can you even think about it! Who thinks about Sandra? You really are the worst brother in the world".*

M: (changes expression, voice becomes feeble, lowers shoulders) "S*o I have to stay at home? but I... but I... I would like to... "*

T: " *You don't have to want anything, of course. You have to stay here. At most, you study at home".*

Mark becomes silent and sad, he sighs and looks at the ground, a sign that something is activating him. for a moment I step out of the role and ask him what he is thinking and feeling and he tells me that he sees himself as really bad and that he feels terribly guilty. At this point I ask him if he wants to go further and when he agrees I ask him to adjust the emotion and I encourage him to stand up, open his shoulders, raise his head and push him to feel strong, close to his right to be free to do what he wants in life. I invite him to breathe and take some time to stand up to the other authoritarian (which is me playing his mother) and then he says:

M: *"Mom, I'm sorry you don't understand and you're angry, but it's important for me to go out and be with my friends and I have the right to do that".*

T: *"Friends?"(I turn around and walk away, as if I don't want to listen to him anymore).*

M: *"And you don't even understand that learning languages is important for my future. I also think I'm good at it, why not do it?"*

The more Mark opposes his mother, the more I accuse him and the therapy room becomes a real emotional gym.

T: (still like the mother) "*Right? To do what you want instead of thinking about us? And what happens to the duty of a son? The duty of a brother?"*

M: (who changes expression for a moment and becomes fragile again but I ask him to regulate himself and breathe, to feel strong) "*I understand by now that you don't understand what is important to me. I understand that I cannot expect this from you. I have to think about myself"*

After this sentence Mark bursts into tears and sits down on the chair. we explore what is happening and we notice that he feels sad that his mother does not really understand him but he is also aware that he has to detach himself from her authorization and that he can no longer submit and, above all, he begins to question his nature as a son and selfish brother.

I ask him if he wants to try one last time to talk to me as his mother, he accepts, puts me up in front of me and looking at me he concludes:

M: "*Mom, I hope this is the last time. it's not right that you talk to me like that and it's not right that I don't live freely. I want to do it, I want to build my future. this doesn't mean abandoning you: I'll try to stay close to you as much as I can and maybe it won't be enough for you but I won't give up on me".*

The session ends with Mark's surprise that he managed to handle his mother's accusations and with the agreement to dedicate ourselves to other episodes as well. After three rewriting sessions, always with role plays, of other episodes, (for example the one in which the mother accuses him of Sandra's suffering during a period in which she was getting worse) Mark believes less in the idea of being a bad person, he can see how an idea that does not correspond to reality and it is said that he is not really responsible for his sister. Moreover, Mark now masters the sense of guilt: he checks its activation and the intensity he feels in his body and, with these weapons in his hand, I ask him if he wants to put them into practice in his daily life too. Basically I ask him if he wants to plan further activities during the week knowing that at the right time he could have taken the blame instead of giving up. Mark tells me that he agrees and, to my surprise, he tells me that one thing he would like to do is tell his aunt the truth: instead of justifying himself or lying, he would also like to try and tell Sandra that, for example, he won't be back later the work because he has to go out with colleagues or that he would like to stay out for the night on the weekend and take a little trip. I welcome this idea from Mark and support him, encourage him: I'm sure he can do it even if I expect moments in which guilt will be felt.

Moreover, Mark decides to intensify his outings with colleagues and downloads a dating app because he finds it easier to explore the relational and sexual world now that he feels freer to manage his time and, for example, to come home late without having to justify every time. He goes to the gym and thinks he would like to take up some sport, and after a while he opts for tennis. He also takes some Spanish lessons but has realized that evidently he is no longer as passionate about foreign languages as he was as a teenager. This is good because thanks to the experiment he had clearer ideas about his actual preferences than him, so he could decide that he liked tennis, but not learning Spanish. And most importantly, neither goal was pursued by the pursuit of grandeur, he was just exploring whether he enjoyed these activities. He has also discovered that he loves art: he would like to attend painting or theater courses, even if they are in the evening, and he still finds it hard to leave Sandra alone, a sign that his pattern is still partially active. Right now, it makes more sense for him to play tennis early in the morning before going to work.

Outcome and Prognosis

After a year and a half, Mark is no longer depressed and devitalized, and many features of NPD have faded. The most evident change is that he now tries and pursues some personal goal: he acts without giving up and does not lie anymore. Mark hold now more benevolent ideas of himself and of others: he now describes himself as entitled to do what he wants, freely, and others as possibly supportive and sometimes encouraging. He is not anymore flooded with images of his aunt or sister suffering and blaming for being selfish and leaving them alone. In fact, he shares his ideas with them, and to his surprise, they often support him.

Grandiosity is decreased. Mark is considering the possibility of graduating and then changing jobs to earn more but he doesn't do it to catch up with others: he just feels he wants to have more economic independence and, in general, to be able to do more things for himself. He also he engages in activities just for the sake of having fun and exploring and not necessarily for purposes of personal value. For example in tennis he tells me about the physical effort, the fun with the people he meets, he often loses but lives it with serenity.

We are currently considering that Mark lives alone after having searched for a foster care home for Sandra, though this is momentarily on hold, given that Sandra had serious health issues which both made Mark worry on a reality basis and triggered his schema-driven guilt. As for social relationships, Mark wants a romantic relationship and to have friends and is aware that he must learn that to satisfy these desires he must control his tendencies to denigrate others and give less space to thoughts full of envy and resentment. In this regard the contract has changed. The goal is to have more social, intimate ties, based on sharing and the first agreed task is to try to refrain from expressing critical, devaluing comments or implementing passive-aggressive strategies. Now that he takes more space to go out, he has more opportunities to see other people, especially colleagues, and therefore has more opportunities to prove himself. In a recent session he tells me that he met a colleague of his, Lara, in a wine bar, with whom he has been spending a lot of time lately. While they were having dinner, a friend of Lara's joins them and talks about her holidays and her latest purchase: a jet ski. Mark tells me:

M: "*So, let's be clear. I bit my tongue and didn't say anything to him, but he slammed his jet ski in our faces! she told how cool and fun she was .... Lara looked at him with dreamy eyes (* imitating her*). I defy anyone not to tell him four!" (* smiling*)*

T: *"And you? How did you feel at that moment?"*

M: *Oobviously, the envy started... it was all there! But I swear I didn't tell him anything..."* (he smiles again)

T: *"Did you notice that contempt was starting and did you regulate it? Was it difficult"*

M: *"Yes, but all in all, I didn't feel I was worth less because I've never seen a jet ski in my life..."*

This is just one example of the work Mark is doing on his way of relating to others. Even in therapy, he is more open and clearer, collaborates in defining goals and tasks and does not perceive me as a threat. Even with me he undertakes to regulate his tendency to devaluation, he warns me when he feels the urge to do so and we talk about it together.

Clinical Practices and Summary

Treating patients with NPD and pathological narcissism requires an ongoing attention to drafting, agreeing upon and revising a clear, realistic and reasonable therapeutic contract (Dimaggio, 2022; Weinberg, 2023). Goals need to be shared and clinicians have to make sure that patients commit themselves explicitly to the tasks needed in order to reach their therapy goal. In the story we have described, drafting such a contract was problematic because of a series of maladaptive mechanisms. The patient had poor awareness of his inner world, he blamed the others for his problems and believed that change did not depend on him, did not trust his therapist, and often treated her with contempt.

From the first session it was necessary to agree upon a contract, and continuously renegotiate it. The contract

was fundamental in making the patient active towards his problem. We argue that without this continued attention, the therapy would have been at risk of stalling or drop-out. Generalizing from a single case is a longshot, but aware of this, we suggest that effective treatments for NPD would benefit from an ongoing focus on the therapeutic contract. In particular therapists need to learn how to: a) detect the absence of agreed goals and tasks; b) point out to patients that absence of this agreement will make the success of the therapy unlikely; c) identify core wishes that can motivate patients to commit themselves to operations aimed at change; d) help them realize that change comes with a cost, in terms of having to face negative feelings and ideas without avoiding them; e) accepting to continue to act even when negative feelings and ideas emerge, as long as they become able to overcome them and eventually experience a sense of curiosity, playfulness and vitality.

References

Centonze, A., Popolo, R., Panagou, C., MacBeth, A., & Dimaggio, G. (2023). Experiential techniques and therapeutic relationship in the treatment of narcissistic personality disorder: The case of Laura. *Journal of Clinical Psychology: In Session*

Dimaggio, G. (2022). Treatment principles for pathological narcissism and narcissistic personality disorder. *Journal of Psychotherapy Integration* , *32(4*), 408.

Dimaggio, G. & Lysaker, P.H. (2015). Commentary: "Personality and Intentional Binding: An exploratory study using the narcissistic personality inventory". *Frontiers in Human Neuroscience* ,*9* , 325 doi:10.3389/fnhum.2015.00325

Dimaggio, G., Montano, A., Popolo, R., & Salvatore, G. (2015). *Metacognitive interpersonal therapy for personality disorders: A treatment manual* . Routledge.

Dimaggio, G., Ottavi, P., Popolo, R., & Salvatore, G. (2020). *Metacognitive interpersonal therapy: Body, imagery and change* . Routledge.

Dimaggio, G., Salvatore, G., MacBeth, A., Ottavi, P., Buonocore, L., & Popolo, R. (2017). Metacognitive interpersonal therapy for personality disorders: A case study series. *Journal of Contemporary Psychotherapy* , *47* , 11-21.

Dimaggio, G., Carcione, A., Nicolò, G., Conti, L., Fiore, D., Pedone, R., Popolo, R., Procacci, M. & Semerari, A. (2009). Impaired decentration in personality disorder: A series of single cases analysed with the Metacognition Assessment Scale. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice* , *16* (5), 450-462.

Gazzillo, F., Gorman, B., Bush, M., Silberschatz, G., Mazza, C., Faccini, F., Crisafulli, V., Alesiani, R. & De Luca, E. (2017). Reliability and Validity of the Interpersonal Guilt Rating Scale-15: A New Clinician-Reporting Tool for Assessing Interpersonal Guilt According to Control-Mastery Theory. *Psychodyn Psychiatry*Fall;45(3):362-384. doi: 10.1521/pdps.2017.45.3.362. PMID: 28846509.

Kealy, D. et al. (2023). Testing and treatment-by-attitude in psychotherapy for pathological narcissism: A clinical illustration.

Journal of Clinical Psychology

Lewinsohn, P. M. (1974). A behavioral approach to depression. Essential papers on depression, 150-172.

Mota, S., Humberg, S., Krause, S., Fatfouta, R., Geukes, K., Schröder-Abé, M., & Back, M. D. (2020). Unmasking Narcissus: A competitive test of existing hypotheses on (agentic, antagonistic, neurotic, and communal) narcissism and (explicit and implicit) self-esteem across 18 samples. *Self and Identity* , *19* (4), 435-455.

Muran, J. C., Eubanks, C. F., & Samstag, L. W. (2021). One more time with less jargon: An introduction to "Rupture Repair in Practice". *Journal of Clinical Psychology: In Session* , *77* (2), 361-368.

Pincus, A. L., Cain, N. M., & Wright, A. G. C. (2014). Narcissistic grandiosity and narcissistic vulnerability in psychotherapy.*Personality Disorders: Theory, Research, and Treatment* , *5* , 439–443. https://doi.org/10.1037/per0000031.

Popolo, R., MacBeth, A., Lazzerini, L., Brunello, S., Venturelli, G., Rebecchi, D., Morales, F.M., & Dimaggio, G. (2021). Metacognitive interpersonal therapy in group versus TAU+ waiting list for young adults with personality disorders: Randomized clinical trial. *Personality Disorders: Theory, Research, and Treatment* .

Ronningstam, E. (2020). Internal processing in patients with pathological narcissism or narcissistic personality disorder: Implications for alliance building and therapeutic strategies. Journal of Personality Disorders, 34(Suppl.), 80–103. https://doi.org/10.1521/pedi.2020.34.supp.80.

Ronningstam, E., & Weinberg, I. (2023). Narcissistic Personality Disorder: Patterns, processes, and Indicators of Change in Long-term Psychotherapy. *Journal of Personality Disorders* , *37* (3), 337-357.

Weinberg, I. (2023). Building hope for treatment of narcissistic personality disorder. *Journal of Clinical Psychology: In Session*

Weinberg, I., & Ronningstam, E. (2020). Dos and don'ts in treatments of patients with narcissistic personality disorder. *Journal of personality disorders* , *34* (Supplement), 122-142.

Yakeley, J. (2018). Current understanding of narcissism and narcissistic personality disorder. *BJPsych advances* , *24* (5), 305-315.