A Mentalizing Approach for Narcissistic Personality Disorder: Moving From “Me-Mode” to “We-Mode”

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Narcissistic personality disorder (NPD) is a prevalent condition that frequently co-occurs with other diagnoses that bring patients into treatment. Narcissistic disturbances are not often the chief complaint, but they complicate the development of an adequate therapeutic alliance. Typical countertransference challenges, combined with stigma related to NPD, result in difficulty for the therapist to relate to these patients empathically. Mentalization-based treatment provides a means for therapists to reach these patients by taking a “not-knowing” stance with interest and curiosity in clarifying and expanding a shared awareness of the patient’s emotional experiences. By understanding the attachment functions, mentalizing imbalances, and problems of epistemic disregard among patients with NPD, therapists can break through the self-centered “me-mode” of the therapeutic dyad, where the typical lack of engagement or power struggles prevail, to a “we-mode,” where the patient and therapist are joined in attention to what happens in the patient’s mind and in interactions with others.

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Concerns about self-esteem, sense of self, and self-image abound in the transdiagnostic clinical management of patients. Despite its prevalence, narcissistic personality disorder (NPD) is inconsistently diagnosed and treated because no evidence-based approach or guidelines for treatment have been verified. Among the challenges in treating individuals who have NPD is the wide variation in dysfunction and severity of the condition (1, 2). Still, patients with significant narcissistic dysfunction populate most clinical settings, usually seeking treatment for co-occurring mood, anxiety, substance use, or other personality disorders (2). Patients rarely present for treatment with chief complaints or dysphoria about the disorder, thereby obscuring narcissistic problems as a therapeutic focus. The increased risk of suicide, marital dysfunction, and vocational difficulties associated with NPD often motivate family members or concerned others to bring patients to treatment (3). Often, treatment for NPD is imposed rather than requested by the patient with the disorder. For these reasons, NPD complicates engagement in an effective therapeutic alliance and decreases the likelihood of recovery from its co-occurring conditions (4).

The *DSM-5* (5) defines NPD with a focus on inflated sense of self, need for admiration, and lack of empathy. Major clinical theories describe the function of NPD symptoms to protect (i.e., split off) a grandiose or ideal sense of self from vulnerable states of inadequacy, depletion, shame, or sensitivity (6, 7). This “mask model” points to dysregulations in self-esteem that drive the need for excessive admiration, feelings of envy and entitlement, as well as aggression toward any threats to one’s self-esteem. This need to preserve a coherent, capable sense of self obstructs shared attention to any needs or deficiencies within oneself as well as any influence from others’ ideas or perspectives. As a result, those with NPD experience unstable means for social cooperation, which is reflected in high dropout rates and frequent aversive countertransference reactions (8). Without a coherent approach to these features of NPD, clinicians are often limited in their capacity to regard patients diagnosed as having the disorder with empathic understanding.

Although no manualized therapy has been formally tested in the treatment of NPD, mentalization-based treatment (MBT) provides a path to understanding the problems these patients face more clearly and benevolently, from the vantage of the patient’s lived perspective. Validated as an effective treatment for borderline personality disorder (BPD), a prototype and severity indicator of personality disorders generally (9), MBT is a basic therapeutic approach that incorporates concepts from developmental psychology in its transdiagnostic formulation of how psychiatric vulnerability forms. Evolving diagnostic protocols broadly conceptualize all personality disorders as problems of identity and interpersonal relatedness (5). In one of the largest, most rigorously designed randomized controlled outpatient psychotherapy trials in the BPD literature (10), MBT yielded recovery, defined as an absence of self-harm, suicide attempts, and hospitalization in a greater percentage of individuals with three or more personality disorder diagnoses than did a generalist approach. These findings suggest that MBT is effective for a range of

personality problems related to difficulties understanding and managing oneself and one's relationship to others.

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This special issue of the *American Journal of Psychotherapy* illustrates the expanding scope of MBT to a variety of patient populations and diagnostic groups. MBT provides a simple, relatable approach to treatment for patients with personality disorders, broadly, through a basic focus on improving patients' (and therapists') mentalizing capacities. Mentalization is defined as the way we as humans understand our social interactions in psychological terms by considering the mental states (e.g., emotions, beliefs, desires, intentions) that underpin observed behavior. It allows us to respond to our experience and that of others coherently. Mentalizing enables us to broker and maintain satisfying relationships and to be understood in a way that fuels a positive sense of self (i.e., identity). The stability, flexibility, benevolence, and humility with which we mentalize determines fundamentally how our psychology and personality function.

Recent advances in MBT theory have emphasized the importance of stable mentalization as a foundation for epistemic trust (i.e., the capacity to recognize personally relevant reliable information conveyed in social interchange). Epistemic trust enables us to be open to what we can learn from others in a way that fosters adaptation and growth (11). By managing arousal and attachment intensity, MBT therapists aim to establish joint attention to a patient's experience of others and their own mental states in a "we-mode" that embodies a cooperative effort to understand the patient's world robustly, by combining differing perspectives (12). Understanding the distinctions between one's own isolated view of experience (i.e., "I-mode" or "me-mode") and objective reality, as well as the view from another person's vantage point (i.e., "you-mode"), is a precondition to social collaboration and learning (i.e., we-mode). With MBT's revision to its theory and approach, and its emphasis on stable attachment, mentalizing, and joint attention in we-mode, clinicians can manage the obstacles in treatment of those with severe personality disorders who have handicaps in social learning.

MBT paves a therapeutic pathway to address personality dysfunction related to coping in self- and relational management. It does so in three ways: by stabilizing attachment, broadening reflective capacities about self and others, and enhancing epistemic trust. We aim to elucidate basic understandings of the variations in attachment, mentalizing, and social learning for patients with NPD, who are likely to be dismissive or avoidant in terms of attachment, emotional vulnerabilities, and the perspectives and contributions of others. These characteristic features differentiate the needs of people with NPD from those of people with BPD and impede clinicians' efforts to participate in joint attention with the patient to manage the patient's social world. To address this critical therapeutic challenge in treating NPD, we explain how clinicians can integrate fundamental MBT techniques by using a basic stance of curiosity, not knowing, and empathic validation to foster the development of joint attention in we-mode, exploring and understanding the patient's perspective from his or her emotional shoes before initiating efforts to change the patient's perspective. This MBT conceptualization of NPD, paired with adjustment of its foundational techniques to treat NPD, can be integrated into any pharmacologic and/or psychotherapeutic work to optimize personalized tailoring to the needs of each patient. This MBT adaptation also aims to counteract growing stigmatization of patients with narcissistic pathology that has been caused by broad use and misuse of the concept within the public health sector (13). By aiding therapists to work on an empathic representation of the patient's experience, MBT may destigmatize the problems inherent among those with NPD so that they are better understood by the therapist and more likely to sustain a productive treatment alliance.

MANAGING ATTACHMENT IN NPD: OVERCOMING DISMISSIVE ATTACHMENT

MBT centralizes the instability of attachment and its developmental byproduct, mentalization, as the core dysfunctions underlying personality disorders. MBT's empirical basis is derived from its application to the most severe, disabling, potentially fatal, and costly of all personality disorders, BPD. BPD has been found to be associated with insecure, preoccupied, and fearful attachment styles characterized by hostile or helpless dependency, which neither establishes emotional security nor stable reflection (14). Whereas these hyperactivated attachment states in BPD fundamentally necessitate that MBT therapists maneuver to manage levels of arousal, a hypoactivated attachment pattern is encountered among those with NPD, rendering it difficult for therapists to emotionally engage in a therapeutically productive way. The limited literature characterizing the attachment tendencies among people with NPD reports a predominance of the dismissing style (15), defined by an absence of attachment bids, concealment of distress, and minimization of attention toward attachment figures and experiences. Minimized attachment needs are accompanied by compulsive self-reliance and denial of environmental threats (16). Primary fears of rejection and hypersensitivity to criticism can lead to secondary avoidant attachment behavior (17). This tendency to turn away from caregivers when distressed leads patients with NPD to express the disorder's characteristic symptoms, which function to avoid reflecting on painful affects or experiences within oneself. Research has identified that higher levels of NPD traits are positively correlated with detached affective states, such as shame,

admiration of self, and anger toward the self, and are negatively correlated with states of helplessness (18).

In NPD, attachment hypoactivation or deactivation presents a challenge for the therapist-patient dyad, differing from the hyperactivated attachment seen among those with BPD. Narcissistic individuals avoid activating the attachment system by minimizing attention to their own vulnerabilities and need for others, opting instead for a focus on performance, independence, and activity. In turn, the therapeutic engagement is limited, superficial, and often cognitively focused. Although individuals with this hypoactivated attachment style show a cool and collected self-image, their physiology may reveal an activated stress response (19). This dismissing tendency can chill interactions with the therapist through either self-sufficiency or performance as a model patient, at the expense of sharing affective experiences that would reveal vulnerability and need. Alternatively, some of these patients will distance themselves via derogation of the therapist's capabilities, thwarting the therapist's attempts to be helpful. As a result, those with NPD may rigidly hold a position of superiority, expressed through an incessant focus on themselves, diminished regard of others, and devaluing disdain and lack of empathy for others' mental states. This deactivation of attachment, through the elevation of self-regard and dismissal of others, keeps those with NPD stuck in a self-focused isolated me-mode of coping independently with emotional threats, rather than seeking proximity to and empathic support from others, with whom they might collaborate to solve problems and generate alternative perspectives on coping.

TRANSFORMING ATTACHMENT ACTIVATION INTO SEEING ONESELF IN ANOTHER'S MIND

According to Fonagy and colleagues (20), mentalizing capabilities are developmentally fostered by a process of marked and contingent mirroring by caregivers. Caregivers kindle the child's imagination of mental states in oneself and others realistically and flexibly when they convey what they think a child is experiencing in a reasonably resonant (i.e., contingent) but metabolized (i.e., marked) way. This behavior models a way of being "mind-minded" or having others in mind in a benevolent and attuned way that has boundaries and is not merged. Children with avoidant attachment styles show little-to-no distress on separation from caregivers and busy themselves with productive activity. They communicate little distress to caregivers but rather mask distress by showing their capacity to perform or achieve. This sort of presentation influences caregivers to mostly reflect back an understanding of the child's capability and special abilities rather than vulnerability. As a result, the more vulnerable aspects of the child's self remain unattended to and unmentalized in the attachment relationship.

When attachment is deactivated, the representation of self that is reflected by the caregiver to the child is restricted to affirmations of productive or performative behaviors, rather than empathic concern for the child's unrecognized mental states. The absence of mentalized or empathic mirroring by caregivers in the context of an overemphasis on achievement and performance may feed into the formation of a personality that lacks stable capacities for empathy, emotional self-awareness, and coherent authenticity in either self-functioning or functioning in relationships. This mirroring, contingent to a self with only strengths and not flaws, is co-created by the child and caregiver, and then later the patient and therapist, leaving the work of processing vulnerable emotions and corrective emotional support untenable. Therapists may be able to initiate a more productive empathic starting point with patients who avoid activating attachment by understanding the transactional nature of the avoidance. It is crucial that the therapist works to motivate patients with NPD to become aware of their vulnerabilities by being curious and interested in their impact on the patient's sense of self, even when the patient lacks regard for the therapist. The therapist must metabolize his or her own emotional isolation and sense of marginalization in the attachment process. Relating to the patient's experience of a sense of pressure to perform or deliver—all without recognition of his or her emotional toil, needs, or desires—may encourage a dialogue that makes sense of self-sufficient performance in terms of another part of the patient's experience that has been neglected.

Two major concerns for the therapist are to neither reinforce a "good patient" tendency, where the patient eagerly studies the ideas of the therapist to literally mirror the therapist's mind in an overly contingent way, nor to assertively criticize or pathologize the patient's point of view as flawed and selfish in an overly marked way. Often, therapists can get caught in a you-mode dynamic with patients who have NPD, confronting the patient with their clinical opinions and focusing mostly on how the patient appears on the outside to others.

The MBT model suggests that therapeutic interactions always begin with a focus on marked contingent mirroring of whatever emotions are shared by the person with NPD and resistance of the temptation to insist on considering the perspective of others prematurely, even though that is a desirable focus to eventually develop during MBT. When therapists can provide genuine recognition of the patient's perspective, they are less threatening, which in turn stabilizes the patient's ability to manage their sense of self. Furthermore, the therapist needs to be authentically curious and respectful about emotions that may be destructive to social connections, such as envy, disdain, disgust, rage, and grandiosity. Understanding the context of these emotions, that is, how they may arise, in an effort to protect one's self-esteem or eliminate attention to distress, may enable both the therapist and patient to consider the effect of narcissistic patterns on the patient's life over time. After empathically validating the patient's point of view, the therapist can then explore how the patient's narcissistic tendencies affect the therapist or the therapeutic relationship so that there is a shared experience between the therapist and patient that can be observed from different vantage points that coexist rather than compete. Ultimately, the goal is to be joined in we-mode, collaborating on a shared understanding of the dynamic between the patient and clinician. Premature insistence that those emotions are to be corrected, and on more socially

acceptable affects, will only repeat the dynamic of demanding achievement and productive performance that originated the mentalizing difficulties of patients with NPD in early life.

MENTALIZING DEFICITS IN NPD: AVOIDING AFFECT AND OTHERS THROUGH A SELF-ORIENTED COGNITIVE FOCUS

The narcissistic tendency to view negative affective experience, self-doubt, and flaws in self and others in a dismissive, threatening, and derogatory way impedes empathic understanding of oneself and others. Adults with NPD or pathological narcissism show neurobiologically undermined empathetic deficiencies (21) and alexithymia as well as impairments in metacognition and emotion recognition (22, 23).

Nonmentalizing modes occur for all people under pressure and emotional stress. Mentalization deficits are conceptualized in terms of nonmentalizing modes (e.g., pretend mode, psychic equivalence, and teleologic stance), as well as in unbalanced states, where either cognition or affect, internal or external aspects of experience, and focus on self or others predominate at the exclusion of its complimentary balancing pole. Pretend mode is a state in which self-expression is not grounded in a genuine experience of self. Because those with NPD often only consider and share the accomplished or applauded aspects of self, the so-called false self or pretend mode is seen, whereas the painful, disappointing aspects of self are not shared and therefore not mirrored in a metabolized and sympathetic way. Because contingent and unmarked or literal mirroring is privileged in narcissistic dynamics, those with NPD may not tolerate divergent or diverse perspectives, so a tendency toward psychic equivalence, that is, absolute certainty that what one thinks is reality, predominates. Finally, because interior private thoughts are not well mentalized or regarded empathetically by others, a sense of needing to see proof of how one feels, or what one believes, called a teleological stance, is often seen in a vain, superficial status-oriented estimation of self-worth and valuation of others.

Fostering mentalizing of others may be threatening for patients with NPD prior to the work of mentalizing oneself more fully; hence, therapeutic work should initially focus on self-experience. MBT recommends that the therapist initially side with the patient's perspective to expand, stabilize, and enrich it as an essential starting point. Establishing an empathic and resonant view of the patient's point of view and emotional states, extending to the most vulnerable dimensions of the patient's experience, is the prerequisite to the core work of any therapy. Only after this is accomplished, which may take a lengthy period of being in we-mode or in joint attention heavily weighted to the patient's point of view, can a more flexible, realistic, and benevolent view of others' minds be conceived. When patients with NPD transition from a sense of self-sufficient agency in I-mode to attention to "what happens to me" or "how this affects me" in me-mode, they begin to acknowledge their sensitivity to others. The me-mode, which expands intersubjective dimensions of emotional experience, is an important precursor to we-mode for those with NPD.

In the example below of a clinical interchange, the therapist attempts to elicit an understanding of a patient's self-absorbed tendency to dominate conversation in social situations:

> THERAPIST: You thought that was an interesting way to spend the evening, for your wife as well?
>
> PATIENT: That, I don't know.
>
> THERAPIST: If I try to put myself in your wife's shoes, I imagine she was completely worn out and felt dragged along. She got to see friends, which she enjoys. Might it have been exhausting for your wife to just sit there getting more and more tired, and not be involved in the conversation?
>
> PATIENT: All of that's possible.
>
> THERAPIST: You don't really know.
>
> PATIENT: I'm not my wife.

In this example, premature exploration of another's point of view falls flat and does not engage the patient's interested imagination of how others are feeling. Prioritizing what happened for the patient as a primary focus, building a more coherent narrative of a situation from the patient's perspective and then linking such an expanded exploration to the alternative experience of others would be required in MBT.

EPISTEMIC DISREGARD AS A CLOSURE TO SOCIAL LEARNING

Fonagy and colleagues (11) have extended the formulation of personality disorders in general as a problem of epistemic trust, which is the capacity to believe in the authenticity and personal relevance of information presented in an interpersonal context. This notion explains the rigidity of thinking in individuals with personality disorders that obstructs not only stability but also change related to learning from social interactions. Because of a tendency toward epistemic mistrust, individuals with severe personality disorders have limited learning through experience, despite repeated patterns of interpersonal instability.

Epistemic mistrust disrupts one's ability to discern information that is trustworthy and productive from information that is erroneous, threatening, or irrelevant. Epistemic regard is attributed to others when they are seen as both authoritative, reliable, and benevolent. Those with NPD will see their therapists as incompetent, irrelevant, or malevolent, especially when the therapist is critical of the patient's point of view in an effort to change the NPD-related problems at hand. In contrast to patients with BPD, those with NPD and antisocial personality disorder seek respect over caregiving (24); therefore, bids for competence, rather than attachment construed in the usual sense, may be more prominent in social transactions than for patients with BPD. Power dynamics may keep the interchange with a therapist stuck in one-upmanship.

BOX 1. Recommendations for the treatment of patients with narcissistic personality disorder (NPD)

- Patients with NPD enter treatment for a variety of mental health problems, rarely for concerns about narcissism.
- Clinicians can come to understand common countertransference and stigmatizing feelings that may reduce their natural curiosity in the patient's reported experiences. These countertransference feelings can be reconsidered from the perspective of understanding the patient's deficits in attachment and mentalization.
- By understanding the patient's experience of seeking status over attachment and dismissing others as a way to maintain a coherent and positive sense of self, the therapist can pave a path to connect with the patient's internal experience.
- Expanding focus on affective experiences and concerns of others can be achieved only by first engaging the patient in "me-mode" (i.e., relating to the patient's experience of how others have an effect on them) to mark their perspectives as personal and subjective. Then, after the patient can acknowledge their own intersubjectivity, the therapist and patient can consider the subjective experiences of others, engaging alternative perspectives in "me-mode" versus "you-mode," which can be combined into a shared "we-mode," which provides a more mentalized, realistic, and flexible perspective on reality.
- Clinicians can foster epistemic trust by expressing competence and empathic understanding (rather than competition or criticism) of the patient's current adaptations as a basis for kindling the patient's interest in learning from the social environment of treatment.

Therapists must first demonstrate competence, while also providing ostensive cues that communicate an attitude that the patient has something to offer. Patients who do not feel that what the clinician has to offer is good enough may remain in epistemic disregard, even when showing up for treatment. It is of utmost importance for mentalizing that clinicians avoid a one-up, one-down interpersonal dynamic—independent me-modes, where the patient and therapist are both rigidly stuck in their independent point of view—and aim to achieve a side-by-side stance of looking at situations in a shared we-mode.

By using these MBT principles, therapists are more able to empathize with patients who have NPD and to validate understandable aspects of the client's experience. From that position, they can better stimulate curiosity about mental states:

> THERAPIST: I get that you searched the entire Internet for the "best" experts. I would probably do the same. I wonder how this impacts our relationship. What are your thoughts on that?
>
> PATIENT: I just want the best.
>
> THERAPIST: Tell me more about what happens for you when you are with the best?

In this conversation, MBT encourages the therapist to ground the conversation in a real experience of the current or recent treatment while holding in mind what happens when it is the "best" from the patient's perspective. Expanding the patient's awareness of what happens when other do not meet their standards is a step towards discussing how to anticipate the possibility that the therapist will do so as well. Getting the patient to anchor his or her evaluations in specific examples and reactive emotional or interpersonal processes is the goal, rather than changing the patient's mind to mirror the therapist's. Once in a reflective we-mode, the patient might be able to explore what happens when the best is not available or disappointments occur, and evaluation of others replaces an understanding of the mental states underlying the interactions between the patient and others.

In working with those with NPD, therapists can facilitate a transition from a self-contained individualistic I-mode, where others are seen as vehicles or obstructions to one's own agenda, to me-mode, where the patient begins to mark or distinguish their impression of how reality or other people affect them as personal and subjective (i.e., how people affect me). Then, after entering "me-mode," where the patient perceives their own intersubjectivity, the patient can entertain the personal perspectives of others, in we-mode, to enrich their appreciation of reality and other people. In transition from I-mode to me-mode, and then to we-mode, epistemic trust and learning from others becomes possible.

CONCLUSIONS

To summarize this basic MBT approach to the treatment of NPD, we propose a few basic strategies (Box 1) to assist clinicians in adjusting their preliminary stance so they can tailor therapy to the particular attachment hypoactivation, self-oriented cognitive mentalizing tendencies depleted of appreciation of affect or others, and epistemic disregard encountered among individuals with NPD. NPD's characteristic attachment style creates several challenges for the therapist trying to increase the patient's mentalizing. The underdeveloped affect representation of self and others, lack of empathy and devaluing of other people, and weak bond between therapist and patient challenge the therapeutic process. The MBT model teaches that instead of trying to convince, push, or impose on the person with NPD, the therapist needs to first demonstrate a capacity to be with and expand the patient's emotions and perspectives. These emotions and perspectives may often include difficult states for the therapist to empathize with, such as contempt for others and grandiosity. Curiosity about the context in which these emotions arise may uncover distress and insufficiency that might be understood more clearly by the therapist and patient over time. The mentalizing perspective teaches that change in patients' minds often starts with a shift in the therapist's mind first, because the therapist can sustain mentalizing, even when the patient does not.

Over time, with good enough empathic validation, MBT approaches can enable the therapist and patient to consider emotional, affective experiences more authentically, coherently, and benevolently. Among the many reasons better mentalized emotions are so helpful for people in general, and for people with NPD in particular, is that recognizing multiple aspects of one's (and others') feelings, in itself, has regulatory effects. Enhanced self-representation eases getting what is needed from others more reliably, which may then transform

the patient's view of others as useful, worthy, and interesting. A more detailed application of the MBT technique for NPD has been described by Drozek and Unruh (25), whose case report demonstrating the use of MBT for a patient with borderline personality disorder and NPD is included in this special issue of the *American Journal of Psychotherapy* (26). Research on the efficacy of psychotherapeutic interventions for people with NPD is needed. MBT's tools for understanding the unique attachment process, self-regulatory style, mentalization imbalances, and underdeveloped capacity for joint attention and social learning of those with NPD can be used by clinicians to establish a more productive starting point for collaboration and social learning in treatment of these patients.

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