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The Interconnection Between Narcissistic Trauma and Eating Disorders

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Abstract

This theoretical review proposes a conceptual model of the links between narcissistic trauma and eating disorders, focusing especially on how young adults with such trauma use defensive communication in relationships. Building on the psychoanalytic views of Kohut (1971) and Kernberg (1975), this paper argues on psychoanalytic and empirical grounds, that narcissistic vulnerability develops from early failures in empathic mirroring and is later organised around chronic shame. Social pressures, intensified by social media and socially prescribed perfectionism (Hewitt & Flett, 1991; Twenge et al., 2014), often push this trauma into the body through strict control of weight and shape. Eating disorders are understood here as psychosomatic defences that give a temporary sense of control while hiding deeper feelings of emptiness and vulnerability (Fairburn, 2008; Garner, 2004). This formulation is conceptual; the review synthesises associations reported in empirical work rather than claiming a single proven causal pathway. Paradoxical communication helps maintain distance from others and protects against expected criticism or rejection. The paper suggests that an integrated approach combining enhanced cognitive behavioural therapy for eating disorders (CBT-E), strategic paradoxical techniques, and compassion-focused therapy (CFT) can address both the behavioural symptoms and the underlying shame. Clinical implications are considered. The model is illustrated with four anonymous individual cases, who are included as illustrations rather than as evidence of narcissistic trauma.

Keywords: *Narcissistic trauma, eating disorders, perfectionism, shame, compassion-focused therapy, paradoxical communication.*

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Introduction

Currently, clinical psychology operates in a social climate that strongly shapes how people see themselves and their bodies. Recent research has highlighted a clear rise in narcissistic traits, particularly among younger generations. Twenge, Miller, and Campbell (2014) showed through cross-temporal analysis that these traits have increased over recent decades. Modern culture emphasises success, perfection, and carefully curated visual images which are reinforced by media and social platforms. As a result, some individuals remain in a state of ongoing comparison with "ideal" standards.

Behind the outward displays of grandiosity, exhibitionism, or relentless pursuit of the ideal, clinicians often encounter a deeper emotional injury, "narcissistic trauma." McWilliams (2011) and MacDonald (2014) describe the grandiose facade (sometimes called the False Self) as a protective structure that covers a persistent sense of worthlessness, chronic shame, and inner emptiness. These experiences usually begin with insufficient empathic mirroring and "attunement" from primary caregivers in early life. One frequent way of managing this pain is somatisation. The struggle for control over fragile self-esteem is transferred onto the body, weight, and food intake. This process lays important groundwork for the development of eating disorders (EDs). Garner (2004) examined the multifactorial nature of these disorders and their strong connection to perfectionism.

People with narcissistic trauma also tend to develop certain patterns of relating to others; they often use paradoxical communication as a defence. In practice, this means sending messages or showing behaviours that do not match their real needs or expectations. The aim is usually to manage distance in relationships and protect psychological safety. Empirical work on narcissism in eating disorders supports this reading. Waller, Sines, Meyer, Foster, and Skelton (2007) found that patients with eating disorders scored higher than non-clinical comparison groups not only on core narcissism but also on narcissistic defences, particularly a "narcissistically abused" or "poor me" style. These defences were more strongly associated with restraint, shape concern, and weight concern than grandiosity itself. In interpersonal terms, the person may proclaim independence while simultaneously testing whether others will notice distress, a pattern consistent with Watzlawick, Beavin, and Jackson's (1967) account of messages that contradict one another at the content and relationship levels. Such double messages keep closeness under control and reduce the risk of exposure, criticism, or devaluation (Kernberg, 1975; McWilliams, 2011). More recent quantitative work supports a dimensional rather than purely anecdotal link. Szymczak, Talbot, Gritti, and Jonason (2023) found that several narcissistic facets were associated with drive for thinness, drive for muscularity, and eating-disorder symptoms in both women and men. Vulnerable or neurotic narcissism appears especially relevant to body shame and dissatisfaction, whereas grandiose features show weaker or more appearance-competitive associations (Szymczak et al., 2023). In community women, vulnerable narcissistic traits predicted dysfunctional eating, and this link was partly explained by perfectionistic discrepancy between the actual and ideal self; grandiose narcissism was not uniquely associated once vulnerability was accounted for (Di Pierro, Di Sarno, Gargiulo, & Madeddu, 2021). These findings do not prove that "narcissistic trauma" as a psychoanalytic construct causes eating disorders. They do show narcissistic vulnerability, shame-prone self-evaluation, and bodily control reliably travel together.

According to current diagnostic frameworks, anorexia nervosa, bulimia nervosa, and binge-eating disorder are classified as feeding and eating disorders marked by disturbed eating and related psychological distress (American Psychiatric Association, 2022; World Health Organisation, 2022). In the present review they are conceptualised as complex psychosomatic defences. The body becomes the main arena where the person can exercise absolute control and try to regain a sense of stability. At the same time, these patients frequently show high resistance to treatment and often leave therapy early. Reviews consistently place eating-disorder dropout among the highest rates in psychiatry. Fassino, Pierò, Tomba, and Abbate-Daga (2009) reported outpatient dropout ranging from about 29% to 73% and inpatient dropout from about 20% to 51%. In

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anorexia nervosa specifically, DeJong, Broadbent, and Schmidt (2012) found that most studies clustered between 20% and 40%. A later meta-analysis of cognitive behavioural therapy for eating disorders estimated overall dropout at 24% (Linardon, Hindle, & Brennan, 2018). Qualitative syntheses of patient accounts suggest that premature ending is often linked to identity fusion with the disorder, feeling unheard, and disappointment with treatment or progress (Vinchenzo, Lawrence, & McCombie, 2022). These figures matter clinically; resistance is not only a technical obstacle but a defence of a fragile self-structure.

Lunbeck (2014) reviewed the long-standing debate in psychoanalysis between the deficit model of Heinz Kohut and the conflict model of Otto Kernberg. Currently, both perspectives remain relevant for clinical work. Effective treatment of deep narcissistic shame and related cognitive patterns is more likely when cognitive behavioural therapy (CBT) aimed at perfectionism is combined with compassion-focused therapy (CFT). The latter helps create conditions for greater internal safety and acceptance of the authentic self.

Method

This paper uses a blend of theoretical review and qualitative autobiographical interviews. Literature was located through searches in PsycINFO, PubMed, and Google Scholar. Search terms included combinations of the following: narcissistic trauma, narcissistic personality, eating disorders, anorexia nervosa, bulimia nervosa, perfectionism, shame, compassion-focused therapy, and paradoxical communication. Particular attention was given to classic psychoanalytic texts (Kohut, 1971; Kernberg, 1975), empirical work on sociocultural trends in narcissism (Twenge et al., 2014), clinical models of eating disorders (Fairburn, 2008; Garner, 2004), and evidence-based treatment approaches (Gilbert, 2010, 2014; Kelly et al., 2017). Sources were selected if they were peer-reviewed articles, books, or clinical guidelines published in English and if they addressed conceptual or clinical connections between narcissistic dynamics, perfectionism, shame, and disordered eating. Important theoretical works were included even when older, given their continuing influence on research and practice. The material was synthesised narratively to bring together psychoanalytic, cognitive-behavioural, and compassion-focused perspectives. Having obtained ethical approval (PENKUP International Ethics Committee), autobiographical data was collected from four different individuals. Though a small sample, with ecological validity limitations, findings from lived experiences detailed in autobiographical data supported findings from the literature. Where available, meta-analyses and clinical trials were given priority over single correlational studies when estimating the strength of associations among shame, perfectionism, narcissistic traits, and eating symptoms. Among the four anonymous individual cases that were added after the literature synthesis, three of them are summaries of private descriptions, while the fourth summarises a published first-person lived experience essay.

Findings and Discussions

Theoretical and Methodological Foundations of Narcissistic Trauma

The Psychoanalytic Debate: Kohut versus Kernberg

The origins of narcissistic trauma have long been debated within psychoanalysis. Lunbeck (2014) shows how American psychoanalysis shifted classical European ideas about the structure of the ego. Two major models of pathological narcissism emerged. They differ in important ways yet remain useful when considered together: Kohut's deficit model (Self Psychology) and Kernberg's conflict model (Ego Psychology and object relations).

In *The Analysis of the Self* (Kohut, 1971), Kohut argued that narcissistic trauma arises from a chronic lack of empathic mirroring by parental figures who function as self-objects in early childhood. He saw narcissistic development as a separate line of psychic growth. A child's natural needs for grandiosity and idealisation of adults can mature into realistic self-esteem and ambitions when parents respond

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appropriately. When parents are emotionally unavailable or use the child to meet their own needs, the self remains vulnerable and archaic. In Kohut's view, the person with narcissistic trauma lives with a sense of internal emptiness and fragmentation and must repeatedly seek external self-objects to hold the self together (Kohut, 1971). Kernberg (1975), on the other hand, writing in *Borderline Conditions and Pathological Narcissism*, took a different position. He regarded pathological narcissism not as a simple developmental arrest but as an active, highly defensive structure he called the Pathological Grandiose Self. According to Kernberg, the trauma stems from a structural conflict between aggressive impulses and the defences against them. A child raised by cold, rejecting, yet demanding parents uses splitting as a defence. Positive aspects of the self, idealised fantasies, and the image of an ideal parent are fused into an illusion of omnipotence. Weakness, dependency, and damage are repressed or projected outward. The world is split into an idealised "all" and a devalued "nothing." Devaluing others becomes a central way of protecting the self from envy and the fear of dependence (Kernberg, 1975).

In *Psychoanalytic Diagnosis*, McWilliams (2011) brought these views together by distinguishing two clinical presentations: the grandiose (overt) narcissist and the hidden (covert or depressive) narcissist. Despite vastly different outward behaviour, both types share a similar internal experience of emptiness, reliance on external validation, and intense fear of being devalued. Similarly, McWilliams (2011) emphasised that this internal split generates pervasive shame. The confident or defensive outer presentation is a covering for an unhealed primary wound. Shame is fuelled by the constant risk of exposure and the fear that others will see the flawed non-ideal self (MacDonald, 2014; McWilliams, 2011). Failures are experienced not simply as mistakes but as evidence of total personal worthlessness. When direct emotional expression is blocked and the need for validation remains unmet, the psyche looks for other routes of compensation. Control over the body and eating behaviour is one of the most common.

Sociocultural Prerequisites and Multidimensional Perfectionism

Individual psychological defences do not develop in isolation from wider social changes. Twenge, Miller, and Campbell (2014) reviewed cross-temporal evidence on narcissistic traits and argued that increases observed among young people, especially in North American student samples, reflect a broader cultural movement toward individualism, self-promotion, and the public performance of success. Their 2014 paper synthesised earlier work, including Twenge and colleagues' cross-temporal meta-analysis of Narcissistic Personality Inventory (NPI) scores, which had reported a rise of about one-third of a standard deviation in U.S. college students between the early 1980s and the mid-2000s (Twenge, Konrath, Foster, Campbell, & Bushman, 2008). Twenge et al. (2014) found this shift in sociocultural foundations; parenting and educational practices that emphasise uniqueness, media that reward self-display, and economic conditions that prize competitive self-branding. Later research updates presented interesting findings: Scores appear to have flattened or declined after the Great Recession in some U.S. samples (Twenge et al., 2021), and a recent global analysis of NPI data from 1982 to 2023 found no continuing worldwide increase (Oberleiter, Stickel, & Pietschnig, 2025). The clinically useful point remains even if mean "trait scores" are debated, the cultural demand for visible perfection has not receded, and that demand is highly relevant to body-related self-worth.

Social media platforms intensify the pressure. Their design prioritises visual content and the display of perfection. People continually compare their own bodies and everyday lives with carefully edited images of others. Experimental and longitudinal meta-analyses show that exposure to appearance-ideal images on social media has a negative effect on body image, and that appearance-based social comparison is a central mechanism (Holland & Tiggemann, 2016; de Valle, Gallego-García, Williamson, & Wade, 2021; Saiphoo & Vahedi, 2019). A scoping review of social-media use among young people reached the same conclusion: comparison, thin- or fit-ideal internalisation, and self-objectification mediate the path from platform use to body-image concern and disordered eating (Dane & Bhatia, 2023). Under these conditions, the underlying

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anxiety of feeling inadequate or flawed is usually through the body. Restrictive dieting, rigid food rules, and weight-control strategies become attempts to meet perceived social standards of perfection.

These pressures also reshape perfectionism itself. Perfectionism here does not mean high personal standards alone; it refers to a rigid system in which self-worth depends on meeting unrealistic criteria, whereby shortcomings are signify total failure of the "self." Hewitt and Flett (1991) showed that perfectionism has three dimensions. *Self-oriented perfectionism* is the demand that one must be perfect, *other-oriented perfectionism* is the demand that other people must be perfect, while *socially prescribed perfectionism* is the belief that others demand unrealistic standards and will grant acceptance only if those standards are met perfectly. Socially prescribed perfectionism is particularly damaging; for example, research has repeatedly linked this form of perfectionism to a range of psychological difficulties, including disordered eating behaviours aimed at satisfying perceived social demands (Hewitt & Flett, 1991; Bardone-Cone et al., 2007). Meta-analytic evidence now makes this pathway more precise. In children and adolescents, total perfectionism ($r = .25$) and perfectionistic concerns ($r = .31$) are positively associated with eating-disorder symptoms (Bills, Greene, Stackpole, & Egan, 2023). In anorexia nervosa, maladaptive perfectionism is significantly higher than in non-clinical comparison groups (Hedges' $g = 1.00$; Dahlenburg, Gleaves, & Hutchinson, 2019). For binge eating specifically, perfectionistic concerns show a small-to-moderate association ($r+ = .27$), and socially prescribed perfectionism itself is associated with binge eating ($r+ = .23$; Vacca, Ballesio, & Lombardo, 2023). Interventions that target perfectionism also reduce disordered eating with large effects in available trials, although samples remain limited (Robinson & Wade, 2021). Taken together, socially prescribed and concern-based perfectionism are among the more robust psychological correlates of eating pathology, which supports their place as a bridge between narcissistic shame and bodily control.

Clinical and Psychological Dimensions of Narcissistic Trauma

Eating Disorders as Somatic Compensation

Diagnostic manuals treat anorexia nervosa, bulimia nervosa, and binge-eating disorder as clinically significant feeding and eating disorders rather than simple habits of over/under-eating (American Psychiatric Association, 2022; World Health Organization, 2022). Work with the Eating Disorder Inventory-3 (Garner, 2004) demonstrate that these conditions are maintained by several interlocking difficulties; interpersonal distrust, problems identifying internal emotional states (interoceptive deficits), and strong personal perfectionism. These features overlap closely with the core of narcissistic trauma.

When internal security is lacking and vulnerability feels constant, people look for a domain where control seems absolute. The body and food intake often become that domain. Fairburn (2008), in *Cognitive Behaviour Therapy and Eating Disorders*, identified the over-evaluation of shape and weight as the central maintaining mechanism. In a healthy person, self-worth is usually spread across different areas of life. In someone with an eating disorder, self-worth becomes entirely tied to weight numbers and the ability to control the body.

In anorexia nervosa, restriction and weight loss are often experienced as signs of uniqueness, self-discipline, and independence. These experiences temporarily cover the sense of inner emptiness. In bulimia nervosa or binge-eating disorder, episodes of loss of control over food can be viewed as the breakthrough of the same repressed emptiness and emotional hunger that Kohut described. Clinical and empirical work supports this reading. Shame and pride cycles are strongly connected to binge-purge sequences; restrictions can produce a brief sense of moral superiority, while bingeing is typically preceded by spikes in negative affect and followed by intensified shame (Goss & Allan, 2009). Ecological momentary assessment shows that negative affect reliably rises before binge episodes, even if affect does not reliably fall afterwards (Haedt-Matt & Keel, 2011). The binge, in other words, is often an attempt to discharge unbearable emptiness,

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loneliness, or self-contempt rather than a simple failure of dietary restraint (Fairburn, 2008; Waller et al., 2007). A large meta-analysis of 195 studies found medium-to-large associations between shame and eating-disorder symptoms (rs = .40–.52), with the strongest effects for body shame (r = .55) and shame around eating (r = .59; Nechita, Bud, & David, 2021). Self-criticism shows a medium association with disordered eating (r = .37), while self-compassion is inversely related to both disordered eating and self-criticism (Paranjothy & Wade, 2024; Turk & Waller, 2020). These effect sizes justify treating shame and self-attack as empirically central maintaining processes, not only as psychoanalytic inferences.

Linehan (1993) observed that compulsive patterns such as purging or objective binge episodes frequently arise from severe emotional dysregulation. The person feels intense affective distress and shame linked to narcissistic anxiety. Without adequate internal means of self-soothing, food or its restriction is used as a substitute for emotional regulation. The symptoms conceal the original trauma and make it worse by increasing isolation from genuine relationships (Linehan, 1993). Newer work has extended this account. Linehan's later formulation of dialectical behaviour therapy continues to treat bingeing and purging as learned solutions to overwhelming affect in the context of invalidating environments (Linehan, 2015). Adapted DBT and related affect-focused treatments for eating disorders have produced reductions in binge–purge frequency and improvements in emotion regulation (Safer, Telch, & Chen, 2009; Wonderlich et al., 2014). Together, the evidence suggests that eating symptoms often function as a rapid, if costly, method of regulating shame and emptiness when more relational forms of soothing are unavailable.

Findings from Anonymous Interviews

The researcher included the following four anonymous individual cases as illustrations to support the thesis behind this paper, not as conclusive evidence. Three of those are anonymised summaries of private descriptions. The fourth is a summary of a published first-person essay narrative of lived experience. Details that could identify the individuals included in this paper were excluded in the process to maintain anonymity. None of the individuals directly used the term narcissistic trauma; the researcher introduced the concept as an interpretation based on individual narratives. Note: The names used (*Sarah, Sylvia, Regina, and Claire*) are pseudonyms to preserve anonymity of the individuals whose narratives are used in this paper.

Sarah's case:

Sarah claimed that she did not always view her body as a problem until during her early adolescence. Her mother then began comparing her with other girls and returning to the idea that she had been a "large" baby. Shame followed, then dieting, but her weight increased, and teachers also commented that she should lose weight. Separately, her mother shamed her for poor marks in mathematics, yet she was denied tutoring. In addition, her mother withheld food from her until she completed a specific number of exercises; these stretch further even when the subject had been passed. Peers alternately accepted and rejected her. She was left with the fear of people, the sense of being watched and judged, and shame about her body, including stretch marks, her skin, and shape. She mentioned that she did not understand what she did to deserve such treatments. For this person, shame about the body and about not being good enough came from a close adult. Food became both a punishment and an attempt to put things right.

> *"My mother withheld food until a set number of exercises was finished." Shame about my body, and about not being enough, came from a close adult. I was left with a fear of being watched and judged, and with the sense that I did not know what I had done to deserve it.*

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Sylvia's case:

Sylvia believed that her eating difficulty developed from school where she was humiliated because of her appearance, not only by children but also by adults saying that people like her were not needed. When she later grew quickly and became very thin, the bullying did not stop. She came to believe that the problem was her body, and that the right shape would bring love and worth. Her parents at times told her to diet, and once she had lost weight, they told her she must gain weight. Sylvia's body became a spectacle like everything thing was wrong with it. Later, while studying psychology, she recognised how contradictory these demands were and stopped measuring herself against an external standard. She now describes recovery as protecting the girl who heard those comments, who do not need to earn the right to like herself through her body. Her self-worth was viewed through the lens of her appearance, while the standard kept contradicting itself. The change she describes began not with an ideal weight, but with separating the self from other people's evaluation.

> *"In every state, my body was treated as wrong." My parents told me to diet, and once I had lost weight, told me I must gain. Worth was tied to appearance, while the standard kept contradicting itself. I now describe recovery as protecting the girl who heard those comments, and as no longer having to earn the right to like herself through her body.*

Regina's case:

Regina saw herself as "chubby" and thus avoided certain diets she perceived to be linked to weight gain. Her parents regularly commented on her appearance, her mother called her fat, while her father made jokes of how she is not pretty like her mother. They also made derogatory comments regarding her complexion. During Regina's adolescence stage, the dieting became stricter, developing the fear of food and anxiety of missing exercises. For several years, eating was the focus for her. This was followed by a break in control, compulsive overeating, and a period of bulimia, with strong shame after each episode. Bulimia receded after she entered a relationship. It has not returned, but periodic overeating remains. Parental evaluation of the body became an obsession with appearance. Control later broke into a cycle of overeating and shame. The relief she describes coincided not with a further diet, but with a relationship.

> *"My mother called me fat." My father joked that they had expected a pretty daughter who looked like her mother. Parental evaluation of my body became an obsession with appearance for me. For several years, life revolved around eating; control later broke into bulimia and strong shame after each episode. Relief coincided not with a further diet, but with a relationship.*

Claire's case:

Claire's case is that of a published first-person narrative. Clare experience low self-esteem in her youthful age having obsession with magazine images. This led to regular jugging and running, and this quickly turned into gym obsessions. A coach invited her to the fitness-bikini competition, and she was presented as healthy lifestyle personnel. In the process, preparation was severe and extreme push to achieve desired body frame was viewed as being discipline. Praise from others reinforced the training regime. In that setting, loss of menstruation and unsafe pre-competition practices were treated as normal. Claire would interpret her lapses as personal weakness and judged other people's bodies harshly. When restrictions (intentionally limiting oneself of certain food and behaviour due to severe dissatisfaction with own body) failed, Claire began to lose control. Dietitians and psychologists helped only in part. An interest in brief strategic therapy led her into training. Claire does not claim to have recovered completely but currently managing her condition. She describes remission as a life no longer organised by fear, guilt, and eating problems, after which she began helping others. Control of the body supplied social proof of worth, and the surrounding

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culture presented harm as normal. The way out she describes began with losing control, not with a stricter regime.

> *"Loss of menstruation and dangerous pre-competition practices were treated as normal." Control of the body supplied social proof of worth, and the surrounding culture presented harm as normal. The way out began with loosening control, not with a stricter regime.*

What the four individual cases share is not a diagnosis of narcissism. None of the individuals used the term narcissistic trauma. What they share is shame that organises self-worth, contradictory demands about the body, and the use of the body as the condition for acceptance. In Sarah's case, her parent made her feel shame while food was used as punishment and reward. In Sylvia's case, the standard reverses: her body was shamed when thicker as well as when thinner, thus affecting her perception of self-worth. For Regina, parental evaluation became an obsession with appearance; control then resulted to bingeing and shame. For Claire, bodily control functioned as social proof of worth, harm regimes were normalised as being discipline, and remission began when control was loosened rather than intensified.

These patterns are the reason these individuals are interpreted in the view of narcissistic trauma and eating disorders. Narcissistic trauma, in the sense used in this review, is not grandiosity as such. It is the injury that follows when early mirroring fails and the person is left with chronic shame, a fragile sense of worth, and a need to hide the non-ideal self (Kohut, 1971; McWilliams, 2011). For each of them, acceptance is made conditional on the body. That is close to socially prescribed perfectionism; the belief that others will grant worth only if an external standard is met (Hewitt & Flett, 1991). The eating symptoms then do the work that a more coherent self cannot do. Restriction, dieting, checking, and when control breaks, bingeing become ways of managing shame, emptiness, and the fear of exposure (Fairburn, 2008; Nechita et al., 2021; Waller et al., 2007). The accounts also show why a response organised only around stricter dietary control is unlikely to meet the problem. Where relief appeared, it was linked to separating worth from other people's evaluation, to relationship, or to loosening control, not reaching an ideal weight. This does not establish that the individuals had narcissistic trauma, nor that paradoxical communication was present. It shows why that interpreting is worth testing; the body is being used to hold a self that feels unacceptable.

Paradoxical Communication and Interpersonal Dynamics

Narcissistic trauma and its somatic expression in an eating disorder also shape how the person relates to others. The direct expression of real needs is perceived as dangerous because it risks rejection or devaluation. As a result, paradoxical communication strategies are often used to manage closeness and distance. Watzlawick, Beavin, and Jackson (1967), in *Pragmatics of Human Communication*, pointed out that every message operates on two levels, the content level (what is said) and the relationship level (how the message is meant to be taken). A person with narcissistic trauma may construct interactions in which these two levels conflict or cancel each other out. The result is ambiguous relational dynamics that keep others at a safer distance. Yaniv (2012) noted that flexible interpersonal engagement and the capacity for role reversal depend on cognitive flexibility and empathy. In the presence of deep shame, these capacities are often restricted by rigid defences.

A client may openly insist on complete independence and state that no help is needed. The unspoken message, however, can be a test of whether others will notice the distress. Erickson (2014) and Nardone and Barbieri (2010) have both examined such patterns clinically. Erickson showed how paradoxical behaviour can be a way of handling interpersonal resistance. Nardone and Barbieri (2010) observed that in eating disorders these patterns help maintain the systemic balance of the problem; the person influences family members through the symptoms while presenting a picture of self-sufficiency, which in turn increases isolation.

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Integrated Psychotherapeutic Strategies

Bypassing Resistance via Strategic Paradox

Current practice guidance recognises enhanced cognitive behavioural therapy for eating disorders (CBT-E) developed by Fairburn as a first-line psychological intervention for many adult presentations (American Psychiatric Association, 2023; Fairburn, 2008). CBT-E focuses on the mechanisms that keep the disorder going; rigid dietary rules, distorted beliefs about food and the body, and the narrowed self-evaluation that places almost exclusive importance on shape and weight (Fairburn, 2008). Treatment includes behavioural stabilisation, nutritional rehabilitation, and carefully designed behavioural experiments.

Clients with a strong narcissistic structure often show marked resistance. Direct challenges to their thinking can be experienced as criticism, devaluation, or an attempt by the therapist to take control. In these situations, it can be helpful to draw on techniques from brief strategic therapy (Nardone & Barbieri, 2010; Erickson, 2014). Brief strategic therapy does not argue with the client's need for control. Instead, it treats attempted solutions as part of the problem and uses indirect, often paradoxical tasks to interrupt the perceptive–reactive cycle that maintains the symptom (Nardone & Watzlawick, 2005; Nardone et al., 2005). Comparative work has found brief strategic therapy superior to CBT on binge frequency, weight, and global functioning at one-year follow-up in a small, randomised trial of women with binge-eating disorder and comorbid obesity (Jackson, Pietrabissa, Rossi, Manzoni, & Castelnuovo, 2018). For a client who experiences ordinary CBT formulations as an attack on competence, this less confrontational route can preserve the therapeutic alliance while still destabilising the symptom.

One useful approach is "prescribing the symptom." The therapist legitimises the client's need for control and then gives paradoxical instructions about how the rituals should be conducted. Once the symptom becomes an explicit therapeutic task, it loses some of its private power and its function as a secret form of resistance. This can open space for further therapeutic work. The logic of the intervention is well established in the brief-therapy tradition. Watzlawick, Weakland, and Fisch (1974) described symptom prescription as a second-order change strategy; if the problem is maintained by attempted solutions, placing the symptom under instruction removes its spontaneous oppositional character. Haley (1976) and Erickson's brief hypnotherapeutic work used the same principle with resistant clients (Erickson, 2014). In eating-disorder practice, Nardone and colleagues apply structured paradoxical prescriptions so that restriction, checking, or binge planning becomes a task performed for the therapist rather than a private proof of omnipotence (Nardone & Barbieri, 2010; Nardone & Watzlawick, 2005). When control is temporarily granted and then scheduled, the defence is harder to use as an unspoken relational weapon.

Healing Shame via Compassion-Focused Therapy

Behavioural stabilisation through CBT and strategic techniques is important, but the deeper problem of chronic shame requires additional attention. Compassion-Focused Therapy (CFT), developed by Gilbert (2010, 2014) offers a useful framework. Gilbert describes three affect-regulation systems: The threat system, the drive/achievement system, and the soothing/affiliation system.

In clients with both narcissistic trauma and an eating disorder, these systems are typically unbalanced. The threat system is overactive because of ongoing shame and fear of exposure (MacDonald, 2014; McWilliams, 2011). The drive system is recruited for perfectionism and strict dietary control. The soothing system remains underdeveloped, often because of early deficits in empathic mirroring.

Gilbert (2010) points out that standard cognitive restructuring is often not enough. Clients may understand the logic of more balanced thoughts yet still feel fundamentally inadequate. CFT introduces compassionate-mind training that helps the person develop an internal "Compassionate Self" capable of meeting self-criticism and shame without immediately turning to grandiose defences. Training typically includes

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soothing-rhythm breathing, imagery of a compassionate other and a compassionate self, and practices that differentiate the inner critic from a wiser, motivated stance that wants the person to be well. The aim is not to dismantle ambition but to give the drive system a safer base, so that standards no longer have to function as a shield against annihilation (Gilbert, 2014; Goss & Allan, 2014).

Neff (2003) has operationalised a related construct, self-compassion. Unlike self-esteem, self-compassion does not depend on external achievement or comparison. It rests on three elements: self-kindness rather than harsh self-judgement; a sense of common humanity rather than isolation; and mindfulness rather than over-identification with painful thoughts and feelings (Neff, 2003, 2023). These elements are clinically important for the present population. Self-kindness offers an alternative to the inner attack that follows any deviation from dietary or appearance rules. Common humanity counters the narcissistic conviction that flaws are unique and therefore non-shareable. Mindfulness reduces fusion with shame states so that emptiness is noticed without immediately being acted out through restriction or bingeing. Because self-compassion is not contingent on being special or successful, it can support self-worth in the very situations where grandiose defences usually take over (Neff, 2023). Complementary evidence from trauma-exposed clinical samples shows that higher self-compassion is associated with less repetitive negative thinking and can weaken the impact of threat-based beliefs on rumination (Omoregie & Amanze, 2025). That finding is relevant here: narcissistic trauma, like other forms of relational injury, keeps the person caught in loops of self-monitoring and self-attack. Strengthening self-compassion is one way of loosening those loops without demanding an immediate surrender of control.

These ideas fit well with Gilbert's approach. A randomised controlled trial by Kelly et al. (2017) found that adding group-based CFT to outpatient eating-disorder treatment produced meaningful reductions in self-criticism, body dissatisfaction, and overall symptom severity. Broader quantitative reviews point in the same direction. Turk and Waller (2020) meta-analysed 59 studies and found that higher self-compassion was associated with lower eating pathology ($r = -.34$) and lower body-image concern ($r = -.45$); self-compassion interventions outperformed control conditions for eating pathology ($g = 0.58$). A later systematic review of compassion-focused approaches in clinical eating-disorder samples reported reductions in core psychopathology, shame, and self-criticism, while noting that relative efficacy versus standard CBT is not yet settled and that samples are still predominantly adult women (e.g., Kelly et al., 2017; subsequent CFT-E reviews). Self-compassion is therefore an empirically supported adjunctive target. It is not present evidence, a replacement for first-line CBT-E. When the soothing system becomes more accessible through the therapeutic relationship, the need for a grandiose facade or paradoxical communication tends to lessen (McWilliams, 2011; Yaniv, 2012). This shift makes it possible for the person to begin integrating earlier traumatic experiences and to move toward a more genuine acceptance of the self.

Limitations

Firstly, “narcissistic trauma” is a clinical-theoretical term rather than a DSM-5-TR or ICD-11 diagnosis. Empirical literature more often measures grandiose and vulnerable narcissistic traits, shame, and perfectionism. The model offered here treats those measured constructs as the closest available operationalisation of the psychoanalytic account; it does not equate them.

Secondly, most associations cited above are cross-sectional. They support covariance among narcissistic vulnerability, shame, socially prescribed perfectionism, and eating symptoms, but they do not establish temporal or causal order.

Thirdly, the proposed combination of CBT-E, strategic paradoxical techniques, and CFT has not been tested as a single protocol in people selected for narcissistic trauma. Each component has a separate evidence base of uneven strength: CBT-E is first-line for many adult eating-disorder presentations (American Psychiatric

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Association, 2023; Fairburn, 2008); CFT and self-compassion interventions have promising adjunctive data (Kelly et al., 2017; Turk & Waller, 2020); brief strategic and paradoxical methods rest on a smaller and more clinic-based literature (Nardone & Barbieri, 2010; Jackson et al., 2018).

Fourthly, sociocultural claims about a rising "narcissism epidemic" remain contested (Twenge et al., 2014; Oberleiter, Stickel, & Pietschnig, 2025). The safer claim is that appearance-based social comparison and socially prescribed perfectionism are well-replicated correlates of body-image disturbance.

Finally, autobiographical data used in this paper is limited by ecological generalisation. Clinical anecdotes and the author's personal observations are therefore not used as evidence. Future work needs prospective designs, clearer measurement of vulnerable narcissism in clinical eating-disorder samples, and dismantling trials that test whether adding shame- and compassion-focused work improves CBT-E outcomes for highly defensive, shame-prone clients. The four anonymous individual cases illustrate shame and contradictory bodily evaluation; however, their clinical records were not checked, and their narratives did not contain the term "narcissistic trauma." Any link to that construct is the author's interpretation.

Conclusions

This review examined the connections between narcissistic trauma, eating disorders, and defensive interpersonal patterns in young adults. Drawing on Kohut (1971) and Kernberg (1975), as interpreted by Lunbeck (2014) and extended by McWilliams (2011), narcissistic trauma can be understood as a combination of early emotional deficit (insufficient self-object mirroring) and active ego defences. The central affective experience that keeps these mechanisms active is chronic shame (MacDonald, 2014; McWilliams, 2011). The anonymous individuals point in the same direction without confirming the construct; shame and contradictory standards organised around the body, and relief associated with separating worth from appearance, with relationship, or with loosening control rather than with a stricter regime.

Empirical work by Twenge et al. (2014) shows that sociocultural changes and strong appearance-related demands push psychological defences toward bodily perfectionism. Socially prescribed perfectionism, as described by Hewitt and Flett (1991), plays a particularly destructive role. Eating disorders can therefore be conceptualised, in line with current diagnostic and clinical frameworks, as a psychosomatic attempt to manage a narcissistic deficit. Weight and shape become the primary focus of control (Fairburn, 2008; Garner, 2004). Emotional dysregulation (Linehan, 1993, 2015) leads patients to use eating symptoms as a substitute for affect regulation. At the same time, paradoxical communication, described by Watzlawick et al. (1967) and linked to empathy regulation by Yaniv (2012), protects vulnerability but often increases relational strain and isolation.

Working with the resistance typical of this group of clients requires flexibility. Combining standard CBT protocols with strategic paradoxical techniques (Erickson, 2014; Nardone & Barbieri, 2010), especially the prescription of the symptom, can stabilise behaviour and reduce rigid defences. Integrating compassion-focused therapy (Gilbert, 2010, 2014) and the self-compassion framework of Neff (2003, 2023), supported by the trial findings of Kelly et al. (2017) and related clinical evidence on self-compassion after trauma (Omoregie & Amanze, 2025), offers a direct route to addressing narcissistic shame. Activation of the soothing system, reduction of self-criticism, and greater psychological safety create better conditions for restoring a more coherent sense of self.

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