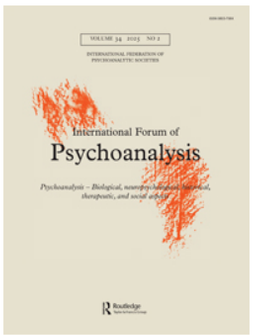

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Self-hate: Theoretical, clinical, and empirical features

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Abstract
This paper aims to provide an overview of self-hate, a concept developed by control-mastery theory (CMT) to describe a set of pathogenic beliefs that share the common core of a deeply negative self-representation and self-evaluation, and that are often at the basis of severe personality pathology. Pathogenic beliefs that support self-hate are developed to adapt to early traumatic relationships that made the person feel unrecognized and unloved for who they are. These pathogenic beliefs make the person feel bad, inadequate, unworthy, and undeserving; in addition, empirical research has shown that they are often associated with relevant transdiagnostic psychopathological factors such as difficulties in mentalization, emotional dysregulation, low self-esteem, deep feelings of shame and guilt, depression, interpersonal problems, and a low level of personality functioning. During psychotherapy, patients with issues related to self-hate can be very challenging, and it can be difficult for therapists to develop a strong alliance with them. We will overview the principal manifestations of self-hate, the features of the traumas at its basis, the empirical research data collected on its psychopathological correlates, and their implications for treatment, stressing the importance of therapists' attitudes and the centrality of corrective emotional experiences.

Key words: *self-hate, control-mastery theory, trauma, severe personality disorders, corrective emotional experiences.*

People who endure chronic hatred toward themselves tend to experience serious mental health problems such as elevated depressive symptoms (Flett et al., 2021), self-injurious behavior (Nilsson et al., 2022), and suicidality (Cheng et al., 2025; Turnell et al., 2019). Interfering with optimal psychological functioning, self-hate has been proposed as a central factor in severe personality disorder (Wilner et al., 2024). Given the pernicious, impairing nature of self-hate, clinicians need to have a comprehensive and empirically supported theoretical framework to guide interventions and help them respond effectively to individual differences in expressions of self-hate. Control-mastery theory (CMT; Gazzillo, 2021, 2023a; Silberschatz, 2005; Weiss, 1993; Weiss et al., 1986) conceptualizes self-hate as the manifestation of a set of pathogenic beliefs that share a common core of a deeply negative evaluation of the Self.

According to CMT, *pathogenic beliefs* (Gazzillo, 2023b; Weiss, 1997) are at the core of psychopathology and can be defined as beliefs that associate the pursuit of healthy and adaptive goals with dangers for the self, other important people, or meaningful relationships. With regard to pathogenic beliefs that support self-hate, the healthy and adaptive goals that are experienced as dangerous are *being oneself* and *being known for who one is*, and the danger feared is that of *being physically or emotionally hurt*. So, if most of the other pathogenic beliefs conceptualized by CMT share the common core that the attempt to pursue a healthy and adaptive goal will harm another person, in the case of self-hate-related pathogenic beliefs, it is not a specific goal that is felt as dangerous. Rather, the simple fact of being oneself is experienced as a danger so that everything a person does is felt as wrong or inadequate. Moreover, the danger associated with being oneself is primarily a threat to the self rather than to another person. The "sin" of these patients is "being as they are."

Among the most common of these self-hate-related pathogenic beliefs – which can be conscious, declarative, explicit, and verbally articulated, as well as unconscious, procedural, and implicit – are: I am unlovable; I am worthless; I am inadequate; I am inferior to other people; I deserve to be rejected; I

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do not deserve protection; I do not deserve care; I do not deserve attention; there is nothing beautiful or good in me; I am a "monster"; I am rotten inside; I am despicable; I do not deserve to be happy; I have tricked other people into liking me; if other people knew me, they would want to have nothing to do with me; I ruin everything I touch; I am a failure.

All these beliefs share the core component that if a person is as they are and shows how they are, this will result in failing, being rejected, ignored, mistreated, criticized, despised, isolated, abused, neglected, excluded, and so on, with all the painful emotions of fear, anxiety, depression, rage, despair, and disgust for the Self that can be associated with these beliefs. For people with strong self-hate-related beliefs, being alone or "non-preferred" means that other people do not want to stay with them because of how they are. Every situation that implies being evaluated, such as getting to know a new person, taking an examination, or saying what they think, tends to be experienced as an anticipated – and potentially devastating – verdict on themselves. Thus, such scenarios imply the risk of having their "inadequacy" or "badness" of "ugliness" exposed and being neglected or despised for it (Fimiani, 2018).

In virtually every emotionally relevant social situation, people with core self-hate-related pathogenic beliefs focus mainly on how much other people will like or appreciate them. For this reason, they rarely feel at ease. In any academic or job enterprise, their main preoccupation is how good, beautiful, or adequate they will appear to others, and they rarely feel confident enough in themselves. Egocentricity and the tendency to compare themselves with others are common features among individuals with self-hate, who can shift from counterphobic exhibitionistic behaviors to withdrawal.

With regard to close relationships, individuals with self-hate-related pathogenic beliefs tend to seek partners that are, for some reason, unavailable, while harboring the fantasy that if these people end up *choosing* them, they will then have evidence that they are not so ugly, inadequate, and bad. However, if such a partner does actually *choose* them, it is not unusual that they stop loving this partner because if that person loves a person like them, this implies that the partner is not so smart, clever, beautiful, and so on. Some individuals with self-hate may be socially isolated while fantasizing about multiple, almost-perfect relationships. For others, loneliness may be a prevailing feeling, even within the context of a close relationship, because they feel that the other person has not really seen how they are, and that if this person will really know them, that person will not love them anymore.

Self-hate may lead such individuals to establish close relationships only with people they believe (often unconsciously) to be as inadequate as they believe themselves to be or that make them feel "special" for some reason. Often, certain attributes of a partner may be experienced as countering their feelings of self-hate, yet other aspects of the partner's behavior – becoming more evident as the relationship unfolds – end up easily reinforcing the individual's negative evaluation of themselves. Individuals with self-hate may thus find themselves chronically disconnected or even accepting abusive behavior from a partner.

Such relational difficulties tend to be exacerbated by an elevated sensitivity to other people's negative attitudes toward them, as they attribute to others the same harshly critical or neglectful attitudes they have toward themselves. Compared with the descriptions of adult attachment patterns (see, for example, Bartholomew, 1997; Shaver & Mikulincer, 2014), people with predominant self-hate-related pathogenic beliefs may show relational behaviors that are similar to those shown by people with both insecure and disorganized/fearful attachment, according to their different early and actual experiences and the different ways they try to cope with their negative interpersonal expectations.

Although some individuals with self-hate can be successful in certain pursuits, such as an occupation, many find their accomplishments to be limited. This can be due to a fear of failure and the ensuing negative self-evaluation, and also to the fact that they tend to choose less-than-optimal paths, renounce or sabotage good opportunities, and develop perfectionistic behaviors and grandiose fantasies that eventually impede the completion of relevant tasks.

Because of the intense negative affective experience of self-hate and lack of confidence in both internal and social sources of soothing and support, individuals with self-hate often turn to urgent and sometimes maladaptive emotion regulation strategies. They may use sex, substances, and food as tools for soothing their painful emotional states of depression, anxiety, fear, and "void," and they can harm themselves and adopt risky or self-harming behaviors to feel "alive" or "calmer." At the same time, such behaviors are expressions of their hate for themselves. Indeed, their ability to authentically care for themselves is generally quite limited, and their tendency to ruminate about their "failures" or the "rejections" received by other people, real or imaginary, is generally strong.

From an evolutionary perspective, self-hate is a manifestation of the Sanctity/Degration moral foundation pointed-out by Jonathan Haidt (2012); patients with self-hate, in fact, believe that their

true self is a source of degration and moral corruption for themselves and other people.

The traumatic roots of self-hate-related pathogenic beliefs

As with all pathogenic beliefs, self-hate-related pathogenic beliefs derive from *traumatic experiences*, that is, from experiences that undermined the sense of safety of the person (Fimiani et al., 2020; Fiorenza et al., 2023). Among the most common traumas that are at the basis of self-hate-related pathogenic beliefs are physical abuse, sexual abuse, emotional abuse, neglect, humiliation, being the "unpreferred" child or the "scapegoat" of their family, and experiences of systematic invalidation. If a person, during their developmental period, *feels that they are not recognized and loved for who they are*, then we have the conditions for the development of self-hate-related pathogenic beliefs.

Given that children need to see their parents as wise and good, in a case of disagreement between them and their parents, children tend to think that their parents are right and they are wrong, and equate being wrong with being stupid (Weiss, 1993). When confronted with parents who abuse or neglect them, children easily end up believing that their parents behave in this way because this is the right way to behave and because they deserve this kind of treatment. This thinking is adaptive because it helps children *preserve their attachments to caregivers and allows them to keep considering their caregivers as good enough*.

Moreover, this attribution of responsibility to themselves gives the children a certain sense of *control* over reality. If they are abused or neglected because this is what they deserve, then their world keeps on being just, and if they change, they will not be mistreated in this way anymore. The problem is that it is impossible to become different from what one is; one can change how one thinks, feels, and behaves, but nobody can change what they are. If parents are not able to see and treat their child as good enough, and rather implicitly or explicitly attribute negative qualities to the child, then assuming those negative qualities as part of themselves becomes the only way for the child to be seen and remain attached to their parents.

If most of the other pathogenic beliefs investigated by CMT derive from the child's assumption that "If I do not comply with what my parents do and want me to do, I will hurt them," self-hate-related pathogenic beliefs derive from the assumption "If I do not comply with what my parents think and feel about me, I will not survive." The only alternative to the development of such beliefs would be to accept being helpless in a hostile, unpredictable, and insensitive world.

The adoption of self-hate to resolve the child's dilemma was eloquently highlighted by Fairbairn (1952, pp. 66–67): "It is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil." If you believe that you are a sinner and that a good God (i.e., caregiver) rules the world, then the world is just and safe, and you can hope for some redemption. On the contrary, if you are yourself and devils rule the world, there is no law, hope for protection, or way out from the pain. When you are a child, you need your caregivers; you need to consider them wise and good enough; and you cannot change them.

Moreover, as we will see later, both attachment-avoidance and attachment-anxiety are related to self-hate: in the presence of caregivers who are insensitive to their children's attachment cues or are inconsistent in their responses to these cues, children can unconsciously develop the belief that their parents' lack of a consistent sensitivity to their needs is due to something that is wrong with them. Moreover, as pointed out by Bowlby (1979), in many cases the negative qualities that people attribute to themselves derive from explicit and implicit communications by the parents: a person who feels (unconsciously) guilty for the death of a parent and so feels they are a criminal, for example, can feel guilty of that death because the survived parent or some other important person said to them or suggested that the other parent died because of them.

Similar psychoanalytic concepts

The core of this concept of self-hate can be tracked in Freud's (1914) idea that a person's self-confidence is rooted in their perception of being loved by their mother; children who do not feel loved by their mother tend to develop negative beliefs about themselves.

Adler (1932) was one of the first authors who stressed the relevance of feelings of inferiority in psychopathology and rooted them in early negative experiences such as organic problems and illnesses, the experience of being hated by the parents or not treated by them as capable adults, and the comparison with other siblings.

Ferenczi (1933/1988) pointed out how children who are sexually abused by their parents tend to "identify with the aggressor," that is, to internalize the negative view of themselves conveyed by the abusive behavior of their parents. As a consequence, they tend to develop feelings of guilt and shame for the abuses they were the victim of, as if they were the cause of those abuses.

Horney (1950) also stressed how difficulties in the parent–child relationship that do not make the child feel recognized and loved may hinder the development of the true self of the child and favor the development of an ideal self; the comparison between the real and the ideal self can give rise to phenomena of self-hatred directed toward those features of the real self that are not in line with the ideal self, that is, with how a person believes that they need to be to not feel alone and helpless in a hostile world.

As previously pointed out, however, the psychoanalyst who was closer to the formulation of the concept of self-hate as conceived in CMT was Fairbairn (1952), who underlined how the child, to gain a sense of control over their reality, internalized their "bad objects," that is, those objects who are not able to make them feel loved or feel that their love is accepted. This internalization is responsible for the attribution of the "badness" of the object to the self.

Sullivan (1953) also thought that those aspects of the child's emotional life that cause anxiety in the parents are experienced as a "bad me," or in more extreme cases as a "not-me" (dissociated), while the "good me" is based on those aspects of the self that the parent welcomes and appreciates.

This idea is also in line with Winnicott's (1970) assertion that "good-enough" caregiving facilitates the developmental emergence of the child's true self, and that a parent's repeated mishandling can result in the child's conviction that there is something abnormal in them, in compliance with the parent's negative attitude.

Similarly, Kohut (1977) stressed how a child who cannot benefit from adequate self-object experiences, in particular experiences of a mirroring self-object, cannot develop an adequate regulation of self-esteem and realistic personal ambitions.

Bowlby (1982) also emphasized how a positive view of the self and positive expectations about others are connected to a secure attachment in childhood, in that the perception of the physical proximity and emotional availability of one's caregivers is a key factor in the development of self-esteem. If a child experiences that their caregivers are there when they need them, they can develop the belief that they are good enough and that other people are good enough (see also Mikulincer, 1995).

However, much more than attachment theorists, CMT authors (Gazzillo et al., 2020) stress the role of unconscious egocentric and omnipotent inferences in the development of these pathogenic beliefs: if a parent abuses, neglects, mistreats, or is insensitive toward their children's needs, the child needs to make sense of this in a way that preserves a good-enough view of their parents and a degree of control on reality; for this reason, the child ends up believing that the cause of the mistreatments they are victim of is the way they are.

These kinds of inference are clearly influenced by the pre-mentalizing way of thinking that is typical of childhood: a child cannot think that the mistreatments they are victim of derive from the specific set of beliefs and feelings that guide the behavior of their parents and from the personal history of their parents: children think that parents mistreats them because they do not love them, and that they do not love the child because the child does not deserve love – an example of psychic equivalence and teleological stance (Allen & Fonagy, 2006). In turn, these kinds of traumatic and adverse experience inhibit the development of mentalization because the ability to mentalize would lead these children to believe that their parents hate them. Finally, parents who show abusive behavior have generally low mentalizing abilities, so that they cannot help their children develop this ability (Schwarzer et al., 2021).

CMT hypotheses on self-hate-related pathogenic beliefs are different from Freud's (1917) and Klein's (Klein, 1939) hypotheses about depressive feelings of self-hate. CMT does not hypothesize that such a deeply negative view of the self is necessarily connected to the unconscious aggressiveness of the person. Rather, CMT stresses the role of real negative experiences with caregivers and of children's (unconscious) inferences in the origin of self-hate without excluding the possible influence of genetic or temperamental factors that can increase the emotional sensitivity of the child to such experiences.

Four different lines of action for dealing with a pathogenic belief

Although pathogenic beliefs are formed in adaptation to traumatic experiences, they are often psychologically painful and profoundly constricting in their influence on a person's behavior. CMT thus emphasizes that individuals are motivated to reduce the burden and impact of their pathogenic beliefs, despite their adherence to them. Indeed, from a CMT perspective, internal conflicts often reflect one's management of pathogenic beliefs, in that one may adhere to a belief while simultaneously seeking relief from or disconfirmation of it.

A person can develop four different lines of action to deal with a pathogenic belief, such as self-hate-related beliefs: (1) they can comply with their belief and describe themselves and act in *compliance* with it, (consciously or unconsciously) hoping to find people who will contrast that belief; (2) they can try to defy that belief (*non-compliance* with the belief), hoping that their important people will support

them in thinking that they can think or feel better about themselves; (3) they can *identify* themselves with their traumatizing caregivers and treat other people as they were treated, (consciously or unconsciously) hoping that these other people will act as role models by showing that they are resilient in not developing the same kind of pathogenic beliefs (a strategy based on turning passive into active and mediated by the compliance with the pathogenic belief); or (4) they can behave with their important others in a way that is the opposite of that of their traumatizing caregivers (*counter-identification*) and support a positive idea of the other person, (consciously or unconsciously) hoping that the other will benefit from their behavior so they can regard their past frustrated needs as legitimate (a strategy based on turning passive into active and mediated by the non-compliance with the pathogenic belief). These strategies shape the affective experiences of the person, their attitudes and behaviors, and how the person can unconsciously *test* their pathogenic beliefs in their close relationships in order to disprove them (Gazzillo et al., 2019).

Self-hate-related pathogenic beliefs, together with their related emotions and lines of action, tend to give rise in clinicians – as in the important others who are in a close relationship with patients with core self-hate beliefs – *intense emotional reactions* that vary from boredom, disgust, contempt, and rage to compassion, tenderness, and protectiveness; from inadequacy, fear, guilt, and shame, to pride and satisfaction with the self. These emotional reactions can be useful for understanding the pathogenic beliefs the patient is working on, the emotions experienced by the patient and their important others, the emotions that the patient would have experienced, and the emotions that these patients would have liked their important others to have experienced in the traumatic interactions that gave rise to those pathogenic beliefs (Gazzillo et al., 2022a,b; Racker, 1957).

This view is in line with the totalistic view of countertransference proposed by authors such as Heimann (1950) and Kernberg (1965), and with the idea of a "concordant countertransference" and of a "complementary countertransference" proposed by Racker (1968). In other words, CMT authors think that the feelings experienced by the therapists during a session with their patients are shaped both by their personality features and personal experiences, and by the patient's feelings and inner dynamics; and patients' feelings and inner dynamics involve both the feelings connected to their self-representations active in that moment and the feelings associated with their object-representations active in that moment.

However, CMT authors (Gazzillo et al., 2022; Racker, 1957) stress that what therapists feel during a session can also be understood as a function of both the inborn human empathy and ability of the "embodied simulation" (Gallese et al., 2007) of the intentions conveyed by their interactive partners, and by the structural pairing of human motivational systems during interaction. To give an easy example: when I see a person who is in danger and look for help (attachment system), I can experience both their feelings of fear and need for help, and the feelings of tenderness (care system) stirred up in me as a human being. In a similar way, when I interact with an enraged person, I can feel both their rage and my fear.

For example,[1] one of my patients was a 40-year-old man who had the pathogenic beliefs that he was stupid and doomed to fail because his father, a physically and verbally violent man, had always told him that he was stupid and that he would not be able to accomplish anything in his life. During the patient's eight years of treatment he oscillated between: (1) thinking and saying he was stupid, feeling anxious and depressed for this reason, ruminating on these thoughts and feelings, and acting foolishly, which tended to stir up in me emotions of tenderness and care, which were something he had needed to receive from his father; (2) saying that he was "a little genius" or "the holy Mary" and arrogantly relating to other people while feeling an excessive pride, which tended to stir up in me emotions of rage and contempt deriving from the excessive nature of these feelings compared with the patient's actual accomplishments – feelings similar to ones experienced by the patient's father, and the feelings that the patient was afraid to stir up in other people; (3) responding to almost any of my interpretations for an entire year by saying "these are your usual psychoanalytic bullshits" while feeling contemptuous and annoyed, which stirred up in me reactions of fear, disorientation, shame, and guilt that were similar to ones that the patient experienced with his father; (4) and being very supportive with his pupils, even though he did not always think that they were particularly bright. I felt this activity was something good – this was what he hoped that both his father and I could feel toward him.

[1]The clinical cases presented in this paper were treated by this first author; their clinical presentations have been disguised to protect their privacy. All these patients gave their consent to the first author to write about their sessions.

The fact that each pathogenic belief of a person can give rise to these four different lines of action/testing strategies underlines how it is impossible to identify patients' pathogenic beliefs on the sole basis of their behaviors and emotions. It is crucial to know their traumas, understand how they made sense of them and how they make sense of their experiences, and consider the emotions expressed by the patients and experienced by the clinician.

Primary and secondary self-hate-related pathogenic beliefs

It is important to note that patients can develop pathogenic beliefs that are apparently signs of self-hate but derive from other *primary pathogenic beliefs*. For example, one patient believed her desire for a satisfying love relationship was doomed because she could not be loved. However, this belief derived from a core belief that if she had a more satisfying love relationship than her mother, who had separated from the patient's father when the patient was very young and was not able to find another man, then her mother would have felt humiliated and envious of her. In this way, the patient's belief that she could not be loved derived mainly from survivor guilt. She believed herself to be unlovable because she believed that, if she had felt lovable and worthy, she would have humiliated her mother; her feeling unlovable was a secondary, derived belief.

Another patient believed that he was worthless because everyone in his family thought they were worthless. When he started to question this belief and to believe that he had some skill, he felt "separated forever" from his "poor family," and his father, with mixed feelings of relief and sadness, said to him: "You are the only person in this family who does not have self-esteem issues." Thus, the patient's sense of being worthless was largely an expression of separation/disloyalty guilt, that is, of his belief that, by feeling worthy enough, he would have hurt his family members and lost his sense of belongingness to his family.

Another patient felt "bad" and misbehaved because, when she was a child, she realized that by being "bad" she was able to relieve her depressed mother by behaving in such a way as to push the mother to punish her; when she behaved adequately, her mother remained depressed and withdrawn in her room. In other words, this patient's feelings of being bad emerged from a sense of responsibility for her mother, reflecting omnipotent responsibility guilt rather than a primary hatred of the self (Gazzillo et al., in press). She needed to feel bad and behave in line with this belief to vitalize her depressed mother.

Other patients can believe that if they are spontaneous, they will be rejected, not because they believe that they deserve to be rejected but because they believe that if they behave spontaneously, this will be "too much" for other people to stand, a manifestation of a burdening guilt connected to a concern for the wellbeing of other people (Gazzillo & Leonardi, 2024). In cases such as these, self-hate-related pathogenic beliefs are *secondary beliefs*, that is, pathogenic beliefs deriving from other beliefs.

In contrast, we can also find *secondary pathogenic beliefs that are derivatives of primary self-hate-related pathogenic beliefs*. For example, one patient – who realized in childhood that the only way she could receive positive regard from her father was by meeting his expectations – developed the pathogenic belief that if she did not meet the expectations of relevant others, in particular men, they would feel disappointed and become critical of her (disloyalty guilt). She believed that meeting other people's expectations was the only way she could be loved, which implied "renouncing" herself. She was not afraid of hurting others by disappointing them; she was afraid that she would not be loved if she disappointed others. For this reason, her disloyalty-guilt-related pathogenic belief was secondary to her primary, self-hate-related pathogenic belief that she could not be loved for who she was.

In a similar way, a patient who grew up feeling that the only way she could be seen and appreciated was to take care of her parents and try to make them feel happy developed the pathogenic belief that she must and could make other people feel happy by taking care of them (omnipotent responsibility). However, the danger she felt was not that other people would have felt unhappy if she had not taken care of them, but that if she did not take care of other people, nobody would have loved her because she had nothing good to be loved for (self-hate).

In cases such as these, a core, primary self-hate-related pathogenic belief is associated with *secondary* pathogenic beliefs that reflect different types of interpersonal guilt. The ability to distinguish between primary and secondary pathogenic beliefs – that is, between core pathogenic beliefs and pathogenic beliefs that are derivatives of the core ones – is crucial for therapeutic purposes because, to be helpful, therapists' interventions must first address their patients' primary pathogenic beliefs in a way that aligns with the line of action/testing strategy adopted by the patient at that moment of the treatment.

Moreover, most patients have multiple primary core pathogenic beliefs that are hierarchically organized. Core self-hate-related pathogenic beliefs,

when present, are generally *hierarchically superordinate* because, being centered around how a person is, they affect the person in any situation. In other words, in contrast to other beliefs related to interpersonal guilt, self-hate poses a more constant danger to the individual than a danger based on an if–then contingency.

Nevertheless, it is common for different types of pathogenic belief to co-occur. A typical association, often found in patients with severe personality disorders, is that between self-hate and survivor guilt. These patients have the core belief of being bad, worthless, inferior, inadequate, and "rotten." However, when they start to develop more positive beliefs about themselve during treatment, they discover that having a better view of themselves, and becoming consequently happier and more successful can make them feel guilty because this might stir up feelings of humiliation and envy in some of their important others.

Empirical research data

Several empirical research studies (Faccini et al., 2020; Leonardi et al., 2022, 2023) have shown that self-hate-related pathogenic beliefs are associated with childhood traumas and tend to be stronger in people who reported experiencing sexual, physical, and emotional abuse and neglect.

Self-hate has also been found to be associated with feelings of shame and guilt, low self-esteem, and dissatisfaction with one's own body, with depression and state and trait anxiety (Faccini et al., 2020; Leonardi et al., 2022, 2023),with the severity of trauma-related guilt (McCue et al., 2024), and with physical and mental illness (Faccini et al., 2020; Rossini et al., 2025). Moreover, self-hate has been correlated with the tendency to ruminate (Fimiani et al., 2021; Leonardi et al., 2020), and with perfectionism (Hewitt et al., 2017), emotional dysregulation and difficulties in mentalization (Leonardi et al., 2025), and interpersonal problems (Santodoro et al., in press); and is a key predictor of imposter syndrome, fear and distress about success, and self-sabotaging and submissive behaviors (Fimiani et al., 2021, 2024).

Self-hate has also been linked with insecure attachment styles, with impaired personality functioning and borderline personality features (Leonardi et al., 2022, 2023, 2025), with the sense of an inner void (Santodoro et al., submitted for publication), with the severity of symptoms of posttraumatic stress disorder (McCue et al., 2024), and – among individuals receiving psychotherapy – with lower self-ratings of the therapeutic alliance (Faccini et al., 2020).

Research regarding human basic emotional systems (Faccini et al., 2020), as conceptualized by Panksepp and Biven (2012), found self-hate-related pathogenic beliefs to be positively correlated with the sadness/attachment, fear, and rage systems, and negatively correlated with the seeking/expectancy and play systems. In contrast with other kinds of interpersonal-guilt-related pathogenic beliefs, self-hate was not associated with the care system, empathy, and altruism. Finally, self-hate-related pathogenic beliefs were associated with activation of the sympathetic nervous system (Rodini et al., in press).

Overall, these empirical data stress the relevance of self-hate-related pathogenic beliefs for the understanding of many features of psychopathology, and in particular of severe personality pathology, such as difficulty in mentalization, emotional dysregulation, tendency to ruminate, low self-esteem, deep feelings of guilt and shame, self-sabotaging and submissive behaviors, and overall personality functioning. Moreover, they show how self-hate is related to a hyper-activation of the sympathetic nervous system, of the attachment, rage, and fear motivational systems, and to a deactivation of the exploration and play systems.

However, it is worth noticing that these studies are conducted with self-report measures, and many of them are cross-sectional. Future studies should involve clinician-rated and observer-rated tools and the collection of longitudinal data. Moreover, in future studies, we want to test the clinical hypothesis that self-hate gives rise to stronger feelings of guilt in people with a higher sociotropy/anaclitically orientation and to stronger feelings of shame in people more narcissistically/introjectively oriented. In our opinion, the first group tend to feel guilty because they believe that their nature makes other people suffer, while the second tend to feel shame because their nature makes them feel inferior to and worse than others.

Implications for treatment

According to CMT (Gazzillo et al., 2021; Weiss, 1998), patients are powerfully motivated to become aware of and disconfirm their pathogenic beliefs to pursue more boldly and freely the healthy and adaptive goals that they are hindering. Moreover, they are intrinsically motivated to master the traumas at the basis of these beliefs and to find the corrective emotional experiences they need to disprove their pathogenic beliefs, master their traumas, and pursue their goals. This implies that patients come to therapy with a generally unconscious and more or less articulated *plan* composed of the *goals* they want to reach, the *pathogenic beliefs* they want to disprove, the *traumas* they wish to master, the

experiences they need to disprove their pathogenic beliefs and master their traumas (*tests*), and the *insights* they may wish to acquire.

A systematic procedure for formulating the patient's plan starting from the first two to ten sessions, the plan formulation method (Curtis & Silberschatz, 2022), has been developed and shown empirically to be reliable. Moreover, several empirical research studies have indicated that the interventions of the therapist – irrespective of their theoretical orientation – that supported patients in carrying out their plans were associated with positive therapy outcomes (Silberschatz, 2017; Silberschatz et al., 1986a). From the perspective of CMT, to help patients disprove self-hate-related pathogenic beliefs, therapists must help them become aware of their pathogenic beliefs, how these are hindering them in the pursuit of their goals, the traumas from which such beliefs originated, and how self-hate helped them to adapt to those traumas.

More importantly, therapists must provide patients with the *corrective emotional experiences* (Alexander & French, 1946) they look for, moment by moment. Indeed, some patients may respond minimally to explanatory or insight-oriented interventions and may instead rely mainly on corrective emotional or relational experiences to master their self-hate-related pathogenic beliefs and associated traumas (Weiss, 1993). The central role of corrective emotional experiences in psychotherapy has been stressed by several authors, from Alexander and French (1946) to Castonguay and Hill (2012) and Wachtel (2014); however, differently from these authors, CMT stresses how patients look actively, albeit unconsciously, for the specific corrective emotional experiences they need moment by moment by testing their therapists, so that therapists should understand and pass their tests in order to provide them with these experiences (Weiss, 1993).

Tests are defined as communications, attitudes, and behaviors (unconsciously) aimed at disproving pathogenic beliefs, mastering traumas, assessing the degree of safety of therapeutic relationships, and obtaining corrective emotional experiences (for a review, see Gazzillo et al., 2019). To pass patients' tests, clinicians need to respond to these tests in a way that is experienced by patients as a disconfirmation of the pathogenic belief tested. In order to do so, therapists can use their communications, attitudes, and behaviors. It is possible to hypothesize that a testing dimension is present in every communication, attitude, or behavior proposed by patients; however, it is much more likely that patients are testing when they make demands and requests, when they stir up strong feelings in their therapists or push them to do something; and when they act more provocatively and foolishly than usual.

Several empirical research studies (Fimiani et al., 2022; Gazzillo et al., 2025; Horowitz et al., 1975; Silberschatz, 1986b; Silberschatz & Curtis, 1993) have shown that trained raters can reliably identify the presence of testing, the kinds of test proposed, the pathogenic beliefs tested, and the ability of the therapist to pass patients' tests on the basis of the analysis of the transcriptions of therapy sessions. Moreover, these studies also showed that when therapists are able to pass patients' tests, patients show, both immediately and after one week, that they are less anxious and depressed, bolder in tackling their issues, more able to work on their problematic patterns of experiencing and relating, more able to oscillate between experiencing and reflecting on their problems, more insightful, more able to recover previously "warded-off" contents, and more therapeutically productive. The ability of therapists to pass their patients' tests was also shown to be correlated with therapeutic alliance assessed in the same session by an external observer.

The core component of the corrective emotional experiences that patients with self-hate-related pathogenic beliefs need is the experience of *being seen, loved, respected, trusted, and cared for as "normal" and "valid" human beings, and the experience of being in a relationship with an authentic, reliable, and self-confident person*. These are only general indications, however, because each patient, in the different moments of their treatment, looks for specific corrective emotional experiences that are shaped by the goals they are trying to pursue, the pathogenic beliefs they are working on, the traumas they are trying to master, and the testing strategies that they are using.

Different methods can be used to pass their tests, from interpretations to empathic validations, from self-disclosures to suggestions or confrontations. Although the therapist's use of confrontation might on the surface seem incompatible for a patient with considerable self-hate, it may demonstrate care when a patient implicitly asks for protection by talking about putting themselves in risky or self-damaging situations (transference-testing by compliance with the pathogenic belief). Confrontation may also help the patient see that they did not deserve abuse when the therapist intervenes as the patient is behaving like their abusive parent (passive-into-active testing by compliance with the pathogenic belief).

However, one of the more powerful tools, and sometimes also *the only and most effective tool* a therapist can use for providing corrective emotional experiences to patients with self-hate-related

pathogenic beliefs, is their overall *attitude* (Sampson, 2005; Shilkret, 2006). It is not rare, in fact, for these patients to feel that their therapist's interpretation or proposed use of a particular technique is a sign that the therapist is or feels superior to them, does not like what they are doing or saying, or is trying to protect themselves from close and authentic contact with the patient. The centrality of the therapists' attitude can be illustrated by some responses provided by several patients with self-hate-related pathogenic beliefs after the end of their successful treatments, regarding the question of what they thought was of help to them.

David, a 40-year-old man, came for psychotherapy after previous psychotherapy of 11 years and four years of pharmacotherapy, and with a diagnosis of major depression, generalized anxiety disorder, obsessive-compulsive symptoms, paraphilia, and narcissistic personality disorder. After eight years of treatment, he said that what was more helpful to him was his therapist's "laissez-faire and confident attitude." By this, he meant that the therapist accepted – without criticizing him and without too much exploratory work – the fact that he could arrive earlier or late at his sessions; that he could forget some of them or pay them late; that he could ask his therapist to terminate one session early and to use the bathroom of the clinician's office to change his clothes at the end of some sessions; that he could call his clinician by telephone during the summer or send him text messages; that he could try to work as a gigolo; or that he could not come to sessions for weeks and then come back as if everything was normal. He could be very warm and tell his clinician nice things, while at other times, he could be very demanding and pessimistic. He had a very "informal" way of talking and relating with the therapist. His therapist had realized pretty early in his therapy that this patient needed this kind of laissez-faire and confident attitude.

David spent the first 40 minutes of his first interview with the therapist by asking the therapist if he was not too young and inexperienced to be of help, with the therapist replying that together they would see if he could have helped him. Then David started comparing the new therapist's clothes and office with those of the previous therapist, emphasizing that the previous therapist had had better clothes and a better office located in a richer part of the town; then he stressed the special relationship that he had had with the former therapist, clearly implying that he thought it impossible that the new therapist would be able to establish a similar relationship with him. And when the therapist asked why he had decided to end the previous treatment, David replied that, according to the therapist, there was nothing more to do: now it was he who had to do something to get better. At the end of those long 40 minutes, this had stirred up feelings of inadequacy and disorientation in the new therapist, who calmly and smiling said:

> I can see that in this room there is one person that is evaluating another person by comparing him with a third one, and the outcome of this evaluation is very poor. I can also see that today the person under evaluation is me, but I am wondering if it has never happened to you to be in that position.

At this point, David, clearly relaxing, started to talk about his relationship with his mother and brother, saying that that was the origin of all his problems: since he had been very young, his mother had compared him with his older brother, saying that his brother was brighter, more outgoing, faster, and more extraverted. David should have been like him if he wanted to do something in our world. This treatment made him believe that his way of being was wrong and that there was nothing to do because he could not change how he was. He could have strived to act differently, but his way of being was wrong, and he could never have been enough. Moreover, David felt that what his mother said was true because this is how people should be to be successful in society, something that he also found confirmed in his school years. The patient's response was evidence that the therapist, with his interpretation, had passed an important passive-into-active test by compliance: David was identified with his mother and was treating the clinician like his mother used to do with him, hoping that the therapist could act as a role model for him and show him that it was possible to deal with such treatment without developing the same pathogenic belief of being unworthy.

At the beginning of that third session, as soon as he lay down on the couch, David said to the clinician: "Now, you know everything that you need to know to help me. Now, I have nothing more to say to you. You must say something that will make me feel better." The therapist replied: "Well, tell me what comes into your mind, and as soon as I think I have to say something useful for you, I will do it." He said: "No, you did not understand; I am not going to say anything. I have told you what I had to say. Now you have to say something to me."

The therapist felt a great deal of pressure and thought that the patient was trying to understand if he was adequate. The therapist replied: "I have the impression that you are treating me like your mother treated you and that now I have to show that I will be able to be the good therapist that you want me to be." And the patient then said: "Don't you think that you are doing the same thing? You

think that psychotherapy should be conducted in a specific way, and you want me to be the good patient that you have in mind." At that point, the therapist was surprised, and after some moments, he thought the patient was right. So, he told him: "OK, you are right. Now, let's find a way of working together that can be felt as good enough by both you and me." The patient then relaxed and started to talk again about his relationship with his mother. That was a transference test by noncompliance: David was trying to understand if the therapist could accept *his* way of being without making him feel that he was wrong.

During the first year of his treatment, one of the more important topics that was discussed was David's way of dealing with new potential girlfriends: when he started to go out with them, he used to offer them dinners in the more exclusive restaurants of the town, and then drinks in beautiful bars, and then he felt that he had to "fuck them" for hours. However, he was so worried about his "performances" that he was never able to reach orgasm. After some days spent in this way, however, David felt very tired and worried about running out of money, and for this reason, he "disappeared," stopping replying to the girls' messages and phone calls. Then, after more or less one week, when he felt he had recovered some energy, he tried to contact them again, but they were so disoriented and hurt by his behavior that they did not want to have anything else to do with him.

David thought that he could not hope to be liked by them without showing off, so that when he was tired, he believed that spending time with them was dangerous for him. However, his behavior pushed these girls to reject him, and he felt that this was a confirmation of his belief that he was "wrong." This was one of the very rare situations when the therapist decided to both interpret what he was doing and to confront him: he said to David that these girls were not rejecting him because of how he was, but because he *behaved* like a "jerk." He had to find the courage to be himself with them, because only by doing so could he realize that other people would not reject him. David mused about what the therapist had said and went out of the office.

He spent the next session without saying one word. At the end of that session, he woke up from the couch and said: "Now you have seen how boring I can be; I am a person who has nothing to s.y. At that point, his therapist, who had thought that his silence could be a test, replied: "It is perfectly ok to remain silent here." David did not remain silent in any other session.

Over time, the therapist realized more and more clearly that David's primary way of testing his core belief was to do everything in his own way, and that he had to accept this as "one of the many possibilities of life." The only kinds of interpretation that he could accept were those that connected his deep feeling of inadequacy with his relationship with his mother and brother and with his symptoms: he was depressed when he thought that he had shown his inadequacy; he was anxious when he had to do something new because he was afraid that this would reveal his inadequacy.

His compulsions, mainly checking behaviors, were his way of controlling whether he had done everything "in the right way." His paraphilia was a controlled "dramatization" of his submissive, sadomasochistic relationship with his mother: he was able to have orgasms only with prostitutes with gender dysphoria (male to female) that insulted him while he was practicing oral sex on them. Moreover, his narcissistic behaviors were an attempt at becoming what his mother would have liked him to become, and also to make other people feel as inadequate as he felt in relation to his mother. In providing a treatment-by-attitude that would help him overcome his self-hate, the therapist had to remain calm, self-confident, and supportive without losing hope that David could get better. This was what the patient meant by the "laissez-faire attitude" that he found helpful.

A second patient said, "What has helped me the most has been that you treated me like a normal person even when I played crazy." This patient, during her development, was the victim of multiple severe traumas, from physical and sexual abuse to systematic and harsh criticisms and devaluations received from her mother and her brothers. When she had first come for therapy, five years earlier, she had been diagnosed with borderline personality disorder with narcissistic, dependent, and histrionic traits; moreover, she had a drug addiction, did not have any close relationships, and had lost her job.

During the first two years of her treatment, she tested the therapist in different and contradictory ways, mediated mainly by acting-in and acting-out: she came to every session and on time, hoping the clinician would appreciate her for this; she could describe in idealized ways her drug abuse, her risky behaviors, and her inability to protect herself, hoping the clinician would be able to protect her without making her feel "completely wrong"; she could shift from asking the therapist if he trusted her ability to go back to a "normal life," which her clinician believed was possible, to asking the therapist if he cared about her and then crying and accusing the therapist, without any apparent reason, of not being able to stand her any more, just as her mother used to do with her. When she said that she "played crazy," she was thinking about these moments. And when the therapist told her during

one of the very first sessions that she was always afraid of being rejected, she responded: "No, doctor, I believe that I am a *rejection*."

Another patient, whose mother repeatedly rebuffed his needs and molested him, said, in a follow-up interview, six months after the end of his four-year, twice-a-week therapy, that:

> ll the people important to me thought that I was an asshole, and so I had learned to feel like an asshole and to behave as an asshole; you treated me like a normal person, and so I have learned to see myself and to behave like a normal person.

In a follow-up interview, one year after the end of his treatment, another patient said: "You know that I have problems with my face in the mirror; well, what helped me the most in our therapy was that you were a merciless mirror; this was also what was more difficult for me to stand." This patient did not like his face in the mirror because it was never as beautiful as he wanted it to be, which was an expression of his profoundly negative view of his whole self that derived from systematic devaluations received from his father. He was afraid that, by seeing him as he was, the clinician would devalue him as his father had used to. He had to endure this fear and expose his true face/self in therapy to have the experience that, even though he was not perfect and another person could see his "flaws," this did not mean that he was stupid, ugly, and worthless, as he believed.

Much more than by specific kinds of technical intervention, patients with self-hate core beliefs can be helped by the overall loving, respectful, and self-confident attitude of their therapists.

Conclusions

As shown by both clinical experiences and research studies, patients with core self-hate-related pathogenic beliefs tend to have severe clinical and personality problems, and tend to test their beliefs from the very beginning of their treatment, sometimes by engaging in provocative actions and often in contradictory ways (Gazzillo et al., 2021). Their self-hate often derives from multiple severe relational traumas that have hindered their development of a basic feeling of safety. For this reason, they test their therapists from the first moment of their encounter, looking for multiple and clear evidence that they can trust them, that their pathogenic beliefs are beliefs and not "a fact," and that they deserve to be recognized, accepted, and feel loved.

To help patients with these issues, therapists must be able to clearly understand and formulate their plan for therapy from the very beginning, and, in many cases, the more important tool that they can use for disproving their self-hate-related pathogenic beliefs and providing them with the corrective emotional experiences they need is their overall attitude. Actual relational experiences for these patients are generally more important than any kind of interpretation. The therapist's attitude must be authentic, welcoming, warm, and self-confident, and can also be mediated by modifications of the setting: an increase in the length and frequency of sessions, the use of touch (Tanzer et al., 2025), a more confidential way of talking and relating, the possibility of extra-session contacts, and so on.

In most cases, good psychotherapies help patients with these issues become more capable of pursuing the healthy and adaptive goals that were previously obstructed by their pathogenic beliefs and develop better control over their self-hate-related pathogenic beliefs. However, to some extent, the task of dealing with self-hate often lasts for an entire lifetime.

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Patient anonymization

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymization policy.

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