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world class training for therapists

When Shame Becomes a Weapon:
Malignant Narcissism, Gaslighting, and the Darker Architecture of Destructive Power

A Two-Evening Clinical Workshop with
Dr Gwen Adshead & Dr Jan McGregor Hepburn

Zoom Webinar
24 September & 1 October 2026, Thursdays
Times:
5:00 pm – 8:00 pm, London UK
12:00 noon – 3:00 pm, New York, USA

CPD hours: 6

Location: Online streaming only
(all our webinar tickets now include complimentary access to a video recorded version for 1 year or 3 years, **depending on the ticket type)**

There are forms of narcissistic organisation in which the suffering of others is not incidental to psychological survival.
It is structural to it.

This is the territory that trauma-informed compassion frameworks were not designed to address. Not because compassion is wrong — but because these presentations do not primarily organise around a wound seeking repair. They organise around power.

The clinical literature on coercive interpersonal systems — Stark's foundational work on coercive control, Hare's research on predatory social cognition, Kernberg's structural analysis of malignant narcissistic organisation — converges on a finding that most CPD settings decline to state plainly: **at the severe end of the narcissistic spectrum, the therapeutic relationship is not merely a difficult relational field to navigate. For some clients, it is a field of operation.**

What you will learn

By the end of this training, you will be able to:

- **Identify narcissistic organisation structured around power and epistemic destabilisation** — distinct from shame-based narcissistic defence requiring compassionate repair

- **Recognise malice as a distinct clinical organisation and move beyond wound-and-defence formulation where the evidence requires it**

- **Identify gaslighting as a structured epistemic technology directed at the therapist's perceptual confidence** — and recognise it before significant erosion has occurred
- **Understand the regulatory function of sadistic behaviour and what it implies about realistic treatment goals**
- Distinguish strategic warmth from genuine contact-seeking in the therapeutic relationship
- Recognise the signs of moral injury in themselves and apply specific frameworks for recovery
- **Map all four sub-spectrum presentations and apply differentiated clinical responses to each**
- **Protect your professional standing when therapeutic relationships become adversarial beyond the consulting room**
- Assess honestly — without therapeutic optimism the evidence does not support — when treatment is clinically viable and when it is not

There are forms of narcissistic organisation in which the suffering of others is not incidental to psychological survival.

It is structural to it.

At the severe end of the narcissistic spectrum, the destabilisation of others — their confusion, their self-doubt, their epistemic disorientation, their gradual loss of perceptual confidence — does not emerge as a byproduct of defensive need. **It functions as a regulatory mechanism. A system that maintains its coherence not through connection, mourning, or reflection, but through the organised management of the psychological states of those around it.**

This is not a presentation that simply makes therapy difficult.
It is a presentation that may appropriate the therapeutic relationship itself — its structure, its asymmetry, its relational expectations, its demand for the therapist's sustained openness — as a vehicle for precisely that organisation.

The consulting room does not change the system.
In some presentations, the system changes the consulting room.

This is the territory that trauma-informed compassion frameworks were not designed to address. Not because compassion is wrong — but because these presentations do not primarily organise around a wound seeking repair. They organise around power. Around the epistemic subordination of the other. Around what the clinical literature, when it is being precise rather than careful, identifies as malice: aggression that is not defensive but regulatory, not reactive but organised, not dystonic but experienced — from inside the system — as entirely appropriate.

Dr Gwen Adshead and Dr Jan McGregor Hepburn have spent decades working at the end of the clinical spectrum where these phenomena are not theoretical.

This training brings that knowledge into the consulting room.

What the Clinical Literature Rarely Names

There is a phenomenon experienced clinicians encounter and almost never discuss in professional settings.

Not because it doesn't happen. But because naming it feels professionally dangerous, clinically presumptuous, or uncomfortably close to moral judgement.

It is this: the gradual realisation that the therapeutic relationship has been subject to a form of assessment — precise, patient, and systematic — that was never therapeutic in intent. That the apparent curiosity about the clinician's approach was intelligence-gathering. That the moments of apparent vulnerability were calibrated disclosures, offered not from genuine exposure but to establish what the therapist needed to see in order to remain engaged.

That the warmth experienced in the early sessions was not intimacy.
It was reconnaissance.

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For some clients, it is a field of operation.

This training names that. Precisely, rigorously, and without sensationalism.

Malice as Clinical Category

The word malice rarely appears in clinical training. It belongs, we tend to feel, to moral discourse — to courts, to journalism, to the language of victims. Its clinical avoidance is understandable. It is also, at this end of the spectrum, costly.

Kernberg's structural analysis identifies a specific configuration in which aggression is not defensive — not a response to perceived threat, not a breakdown of emotional regulation, not the desperate striking-out of a wounded self. It is ego-syntonic. Experienced as justified. In some presentations, experienced as pleasurable.

This is malice in its clinical sense: aggression that has become organised, stable, and morally coherent from inside the system that generates it. The cruelty is not a symptom the client is seeking to address. It is, from their internal perspective, an appropriate response to a world that has consistently failed to recognise their status.

Formulations organised around pain, woundedness, and compassionate repair are not wrong exactly. But they are — at this end of the spectrum — dangerously incomplete. The intervention that would reach a client organised around shame may, with a client organised around malice, function instead as confirmation that the therapeutic relationship is a space in which ordinary relational power can be suspended in the client's favour.

Gaslighting as Epistemic Technology

The popular use of the word gaslighting has diluted something clinically important.
In its cultural iteration, gaslighting has come to mean roughly: lying, denial, or making someone feel confused. What the clinical and coercive control literature actually describes is something considerably more structured and considerably more damaging.

Gaslighting at the malignant end of the narcissistic spectrum is not confusion-creation. It is the systematic dismantling of the target's epistemic confidence — their trust in their own perceptions, memories, emotional responses, and capacity for accurate judgement. It is a sustained interpersonal technology whose function is the replacement of the target's internal authority with the perpetrator's version of reality.

When this enters the therapy room — and it does — it is aimed at the therapist.

The therapist who leaves sessions doubting what they observed. Who questions their clinical memory of what was said. Who wonders whether the threat they registered was real, or whether they are — as the client has gently suggested — unusually reactive, insufficiently boundaried, or perhaps not quite the right fit for this particular presentation.
This is not countertransference confusion.

This is a precision instrument being used against the person in the room.

Sadistic Regulation: The Function of Cruelty

The psychoanalytic literature distinguishes between cruelty as a defence against annihilation anxiety and cruelty as a stable regulatory mechanism. In the latter, the infliction of pain, humiliation, or psychological distress in another person serves a specific internal function: it produces a felt sense of power, coherence, and aliveness that the individual cannot reliably generate through other means.

This is sadistic regulation. It is not the same as anger, volatility, or calculated revenge.

It is the use of another person's suffering as an internal stabiliser.

In the therapy room, this may be subtle. The pleasure taken in the therapist's visible uncertainty. The satisfaction of a well-placed observation that lands as humiliation. The particular quality of engagement that follows a successful destabilisation — warmer, more present, more apparently collaborative — because the regulatory need has been met and the system has temporarily stabilised.

Therapists who recognise this pattern retrospectively often describe a specific and disorienting realisation: the sessions that felt most productive were the sessions in which they had been most effectively diminished.

Understanding the regulatory function of cruelty changes the clinical question entirely. It is no longer sufficient to manage the behaviour. The question becomes: what is this person using this behaviour to regulate — and is there a realistic clinical pathway toward alternative regulation that does not require another person's suffering as its raw material?
In some presentations, the honest answer is uncomfortable.

Moral Injury and the Therapist

There is a form of damage that clinicians working with this population carry that has not been adequately named in the training literature. It is not burnout. It is not secondary traumatisation. It is not compassion fatigue.
It is moral injury.

The concept — developed initially in military psychology — describes what happens when an individual is systematically exposed to relational dynamics that violate their moral framework, and is unable to act in accordance with their values in response. It disturbs their core sense of right and wrong, of what should and shouldn't happen. So the trauma infiltrates other areas of life and the shame felt about what has been done to them can get into their whole way of functioning. The sufferer is then in danger of the defences of permanent grievance or permanent denial.

For therapists working with malignant narcissistic organisation, the mechanism is specific. The client's internal moral cosmology — in which their destructive behaviour is experienced as justice, in which the therapist's appropriate limit-setting is experienced as persecution, in which genuine cruelty is narrated as

legitimate grievance — requires the therapist to bear witness to a sustained inversion of the moral framework that underpins therapeutic practice itself.

Over time, this produces not simply discomfort but erosion: of the therapist's confidence in their own moral perceptions, of their sense of professional purpose, of their capacity to trust the framework that makes the work meaningful.
This is the damage almost never discussed in supervision.

This workshop will discuss it — including specific strategies for recognising moral injury, naming it without shame, and addressing it before it becomes the primary reason an experienced clinician quietly withdraws from clinical work.
The Predatory Gaze: Strategic Warmth and the Therapist as Target

This is the territory that experienced clinicians recognise immediately when it is named — and almost never name themselves.

The presentation that enters the consulting room and reads it with a precision that has nothing to do with therapeutic curiosity. That assesses the clinician's attachment style, their need for therapeutic progress, their vulnerability to particular forms of approval or guilt, their professional anxieties — and files all of it systematically.

The warmth that follows is not connection. It is the deployment of what has been learned. The apparent intimacy is calibrated to what the therapist needs to experience in order to remain engaged — and that this relational system will exploit.

Understanding this does not require suspicion of every client who presents with warmth.
It requires the specific clinical literacy to distinguish between warmth that is seeking contact and warmth that is seeking advantage.

That distinction is learnable. This training teaches it.

The Sub-Spectrum: Four Presentations

The Subtle Manipulator operates through charm and intellectual dominance, reorganising the therapeutic frame without any single identifiable transgression. The most likely to deploy strategic warmth with sophistication. The most likely to mislead experienced, empathically attuned clinicians.

The Paranoid Controller maintains dominance by positioning the therapist as perpetually persecutory. The therapeutic relationship never stabilises — because destabilisation is its function. A destabilised therapist is a manageable one.

The Grievance Architect is organised entirely around having been wronged. The grievance is not incidental to the self — it is the self. Destructive behaviour is not experienced as aggression. It is experienced as justice.

The Aggressive Defender presents at the overt end: hostility as the primary relational mode, cruelty that is structurally organised rather than impulsive. The aggression here is not a breakdown of regulation. It is regulation.

Across all four: shame metabolised into grievance, grievance organised into power, power maintained through the epistemic and psychological subordination of others.

Beyond the Consulting Room: Professional Safety

At the severe end of the malignant spectrum, risks to the therapist extend beyond the consulting room. Formal complaints constructed as instruments of retaliation. Reputational attacks across professional networks. Attempts to recruit supervisors or professional bodies into the client's grievance narrative — deploying the same strategic intelligence that operated in the therapy room, now directed at the therapist's professional standing.

These are documented patterns that are almost never discussed in training settings.
This workshop discusses them — because the therapist who understands these dynamics in advance, who knows that what is happening to them is nameable and documented and not a reflection of clinical inadequacy, is a significantly more resilient clinician than the one who encounters them without preparation.

Dr Gwen Adshead and Dr Jan McGregor Hepburn bring together forensic psychotherapy, psychoanalytic thinking, and decades of experience at the severe end of the clinical spectrum.

This training will not make this work comfortable.

But it will make it navigable — with clarity, with precision, and without the false reassurance that compassion alone is sufficient for every clinical encounter.

Some wounds don't ask to be healed. They ask to be reckoned with.

About the speakers

Dr Gwen Adshead is a forensic psychiatrist and psychotherapist with over three decades of experience working in secure psychiatric settings with individuals who have committed serious harm. She has worked extensively with trauma survivors, perpetrators, and individuals whose capacity for mentalisation and narrative identity has been profoundly disrupted.

Gwen is Honorary Professor of Forensic Psychotherapy at Gresham College, London, and former President of the International Association for Forensic Psychotherapy. She is co-author of The Devil You Know: Stories of Human Cruelty and Compassion and a leading voice on the intersection of attachment, trauma, and moral development.

Known for her forensic precision, ethical seriousness, and refusal to simplify the complexity of human suffering, Gwen brings rare clarity to clinical territory where language, identity, and overwhelming experience intersect.

Dr Jan McGregor Hepburn is a psychoanalytic psychotherapist, supervisor, and trainer for the British Psychotherapy Foundation. She served as Registrar of the British Psychoanalytic Council for 15 years and currently chairs the Professional Standards Committee. Author of Guilt and Shame: A Clinician's Guide (nscience), Jan was awarded the BPC Lifetime Achievement Award in 2023 in recognition of her outstanding contributions to the profession. Her teaching is known for its clinical depth, clarity, and engagement with the emotions therapists find most difficult to address—shame, envy, hatred, and the complex defensive structures they create.

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