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THE COGNITIVE-BEHAVIORAL MODEL OF CLINICAL ASPIRATION FOR HUBRISTIC SUPERIORITY[†]

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The article presents the results the clinical aspiration for superiority, which suggests: the constant aspiration to dominate in competitive struggle and achieve performance results that surpass the performance of other people or groups of people, the dependence of self-esteem on success in moving towards a goal, the implementation of which gives an advantage over competitors; the ignoring the negative consequences of competitive struggle - conflicts, emotional burnout, psychosomatization and the actualization of the feeling of envy. It was shown tat ciclic model of clinical aspiration for hubristic superiority consisits of the 1) dependence of self-esteem on the achievement of superiority over others, 2) choosing a goal to achieve superiority, 3) object selection for comparison / competitiveness, 4) nonflexible standards for achieving superiority - "rules of competitiveness", caused by 5) cognitive distortions and 6) behavior, associated with competitiveness and achievements giving the opportunity to compare themselves with others, 7) achieving or nonachieving superiority or refusal of comparison or competitive struggle, which lead to 8) narcissistic senses. This model considers as the base of cognitive-behavioral therapy of clinical aspiration for hubristic superiority.
Keywords: *hubristic motivation, aspiration for hubristic superiority, cognitive distortion, envy, narcissistic senses, cognitive-behavioral approach*.

Preface. Considering hubristic motivation as the motives of perfection and superiority that make people assert and enhance their self-worth (self-importance, self-esteem), which outline the mechanism of self-worth enhancement and decline in response to success or failure experienced in transgressive behavior it's necessary to notice that the motive of superiority may have the clinical form. Actual investigation devoted to outline the mechanisms of clinical aspiration for hubristic superiority and promotes its cognitive-behavioral model.

The **purpose** of the article is to theoretically substantiate a cognitive-behavioral model of clinical aspiration for hubristic superiority.

The clinical aspiration for superiority suggests:

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- constant aspiration to dominate in competitive struggle and achieve performance results that surpass the performance of other people or groups of people,

- dependence of self-esteem on success in moving towards a goal, the implementation of which gives an advantage over competitors;

- ignoring the negative consequences of competitive struggle - conflicts, emotional burnout, psychosomatization, etc.

- actualization of the feeling of envy;

The fundamental for the purpose of determining the aspiration for superiority is that self-esteem is based on how much confidence a person has in awareness of the own advantages over others. The problem lies not in the content of the goals of competition or objects for superiority, but in self-esteem based on the achievement of superiority. For example, if someone thinks that he is a loser because of losing a competitive struggle (for example, getting a second place in a sports competition, not first), and also considers himself a loser if he received a “silver award”, then this indicates a clinical aspiration for superiority.

The determination of clinical aspiration for superiority implies to a person seeking to surpass the others, even though this may lead to negative consequences. In the case of achieving superiority, the object of comparison and the significance of the goal depreciates, a new goal of a higher level of complexity is set and a new object is selected for comparison.

The cognitive-behavioral model of the clinical aspiration for hubristic superiority over others is based on research in the field of cognitive-behavioral therapy for perfectionism by Roz Shafran (Shafran et., 2002, 2010) and Sarah J. Egan (Egan et al., 2021), motivation (Kozeletsky, 1988; Fomenko, 2018b), envy (Ilyin, 2014; Klein, 1997; Muzdybaev, 2002), narcissistic disorders (Fomenko, 2014; Fomenko, 2018a).

The model included a number of major supportive factors, including setting goals to achieve superiority and targets for comparison, cognitive distortions, self-criticism, setting higher goals, and choosing new targets for comparison.

At the top of the model in Fig. 1 there is a component “self-esteem depends on the achievement of superiority over others”, which is the initial component in the “launch” of the hubristic aspiration for superiority, i.e. the main problem in the basic model, which determines all other factors which maintain the clinical aspiration for superiority. Self-esteem, being dependent on the achievement of superiority, forces a person to set nonflexible standards for competitive activity or activity to achieve results that are qualitatively or quantitatively superior to those of other people. Nonflexible standards function as the "rules of competitiveness" that they set about how they should act - fight, compete, achieve relatively high results (for example, “I must always come to the finish line first”, “I must rank higher than N”).

Cognitive distortions that support the clinical aspiration for superiority include dichotomous thinking, musts attitudes, attention selectivity, overgeneralization, double standards, dramatization, emotional thinking, labels, personalization, mind reading, and prophetic thinking. Let's consider each of them individually.

Dichotomous thinking ("all or nothing / black and white thinking"). People with a clinical aspiration for hubristic superiority constantly assess their position in competitive struggle in accordance with the rules of dichotomous thinking, for example, believing that they have lost, having received second place in the competition. This leads to over-self-criticism and generalization of failure or success, which further strengthens the self-esteem which depends on the aspiration superiority.

The musts attitudes: "Must" and "Have to", - contribute to maintain the clinical aspiration for hubristic superiority. These attitudes are an enactment of rules and can be used as impulse towards competitive struggle or a reason to reprimand oneself if competitiveness is avoided for some reason ("I should be earning more than N, not wasting time").

Selective attention (noticing one's failures and devaluing advantages). This distortion involves focusing on your every defeat, mistake, or missed opportunity, even if insignificant, while ignoring your competition partner's advantages and your own previous achievements and victories (e.g., "the fact

that I was not appointed head of department, but N, shows my incompetence," while ignoring your own positive work experience, past successful project solutions, and all factors favoring the appointment to the position of N).

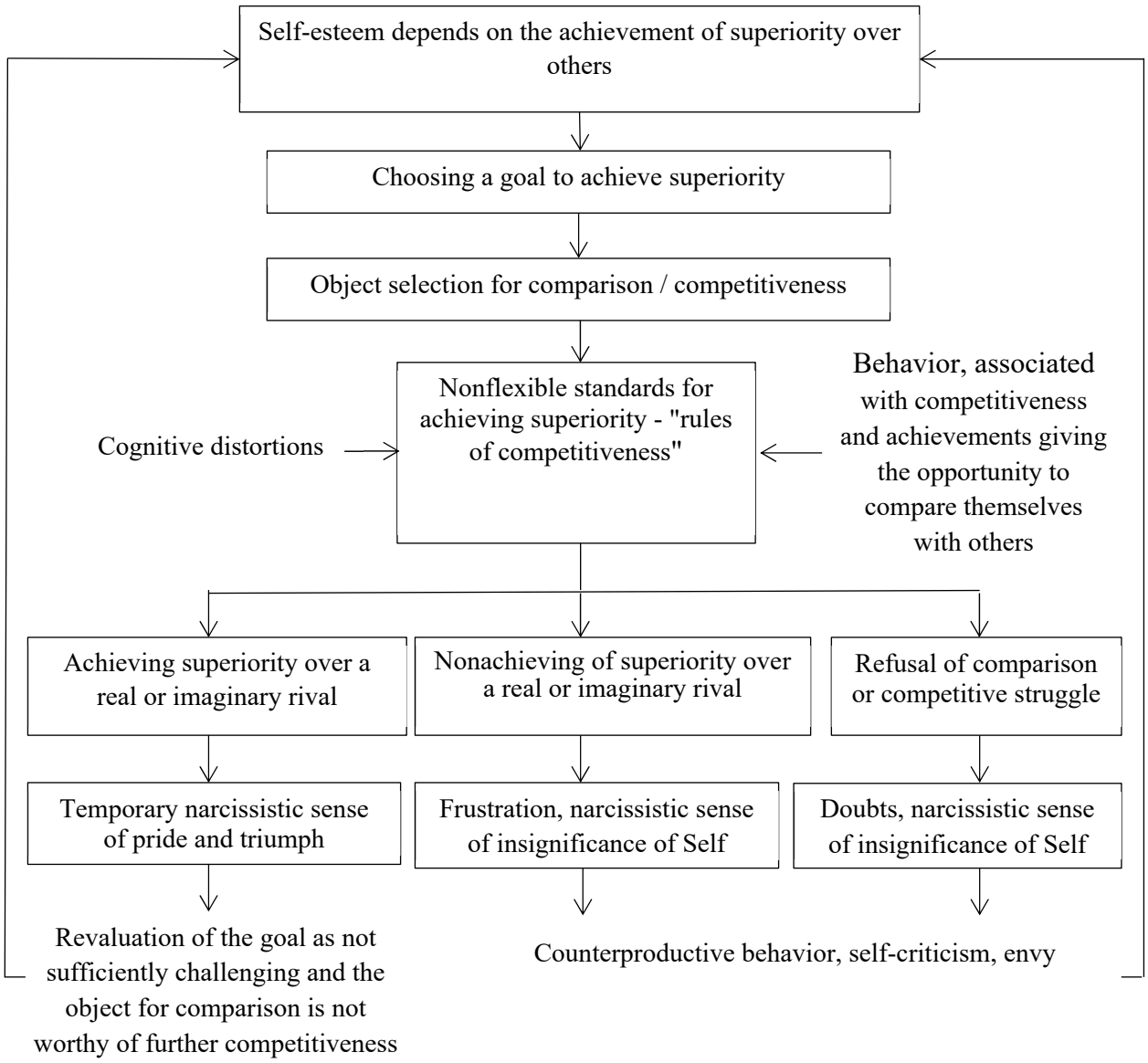

Fig. 1. Model of clinical aspiration for hubristic superiority.

Overgeneralization involves situations where a person takes just one example to describe themselves as a whole (e.g., "Since I didn't win the award this year, but N did, that tells me I'm a failure in life").

Double standards are a style of thinking that involves having different sets of standards for oneself and for others (e.g., "It's okay for others to lose, but I should never concede the palm of first place").

Dramatization as a distortion of thinking is represented by "what if"-assertions that lead to imagining a worst-case scenario that causes anxiety (e.g., "what if I am no longer called up for the national team and my career as an athlete is put to rest because I lose this competition?").

Emotional thinking - a distortion of thinking in which a person views a situation based on feelings rather than facts (e.g., "I'm worried, so I know I'll perform worse than N at a project presentation").

Labels are distortions associated with self-critical thinking, where a person has thoughts and feelings that they have not achieved superiority (e.g., in relation to themselves: "loser", "loser", "screwed up",

"worthless", "fool" and in relation to the opponent (competitor): "upstart", "impostor", "snooty", "smartass", "sycophant" and a number of crude statements, the content of which depends on the context of the competitive situation).

Personalization - distortions that imply taking full responsibility for events and results, in which it is actually distributed, without taking into account all factors influencing the result (for example, "if my company did not win the tender, it is entirely my fault" or "if my team lost, then I am primarily to blame").

Thought reading - a distortion that occurs when a person assumes they can guess what others think about them (e.g., "I know my performance was the worst because the audience sat there looking bored and many were staring at their smartphones").

Prophetic thinking - distortions that include a strong negative prediction about the future (e.g., "I know I'm going to lose," "I'm sure I won't finish first").

Thus, noflexible standards of achieving superiority due to the stylistic features of thinking, described above, determine the demonstration of competitive behavior or avoidance of attempts to achieve superiority. In the first case superiority can be achieved or lost, in the second case - refusal to fight - a person is overcome by doubts not only about his own competitiveness but also about the correctness of the decision to refuse to compete.

In the case of achieving superiority over others, there is a temporary satisfaction, what we call narcissistic pride and triumph, the thirst for which is the driving force of the hubristic aspiration for superiority, however this state is quickly followed by desolation, caused by a reevaluation of one's achievement, standards and object of competition ("no big deal" or "anyone can beat that N"). Thus, even when superiority is achieved, satisfaction does not come in full, and the self-esteem based on achieving superiority, reinforced, dictates higher standards, more difficult goals, requires comparing oneself with even stronger "opponents," creating a vicious circle. Redefining the "rules of competition" as not tough enough (once enforced) leads to the person never feeling good enough, but instead feeling like a failure (a narcissistic feeling of self-insignificance).

More often, however, people with a clinical aspiration for hubristic superiority feel frustration as a result of failing to meet competition standards, leading to self-critical thinking (e.g., "I'm a loser"). The emergence of this condition does not depend on whether defeat in competition actually occurred or whether the feeling arose as a result of mental comparison of oneself to someone else. The consequence of this is the reinforcement of the notion that a person can only deserve respect if he or she is superior to others.

Another result of evaluating competition is a refusal to attempt to compete or to compare oneself with others because of intense anxiety and worry about one's competitiveness. Just as the refusal of high aspirations in goal-setting preserves self-esteem, so does the refusal to compete against a stronger opponent or to compare oneself to a better opponent provides a delay from self-criticism and self-deprecation.

The behavior associated with competition and achievements giving the opportunity to find own advantages over others in view of clinical aspiration for hubristic superiority includes:

- *competitive behavior* involving the planning, preparation, and implementation of actions to compete with others in meaningful activities (learning, work, sports, hobbies, play, interpersonal communication, etc.) or impulsive competitive behaviors in other activities (e.g., a city car driver trying to outrun a hypercar on the highway);

- *comparisons*, which includes comparing one's own achievements with those of other people; unlike the normal hubristic aspiration for superiority in which the comparison object is adequate to the competitive situation, in the clinical form it is impossible to reach a favorable position in comparing oneself with others and the person chooses inadequate objects for comparison (for example, a woman far from the fashion and showbiz world compares parameters of her appearance with such of models in glossy magazines, or city car driver trying to outrun a hypercar on the highway);

- *seeking approval* as an attempt to test how well one is progressing toward a goal that gives one a sense of superiority (e.g., a student bombs the teacher

with questions to demonstrate his interest in the subject in order to get approval and the opportunity to be considered the best student in the group).

Counterproductive behavior is considered as a factor that reduce fears about one's low competitiveness or allows to feel more comfortable with one's superiority over others. Examples of counterproductive behavior include making a list of one's advantages over an opponent (rewards, accomplishments, resources), over-preparing for a situation in which one's advantage will be evaluated (an interview, an exam, a sports competition, etc.), leading to overwork.

In addition to the counterproductive behavior, clients with clinical aspiration for hubristic superiority expose themselves to self-criticism in order to avoid failure and "raise their level," which reinforces the belief that self-esteem must be based on the aspiration for superiority, actualizing envy and hubristic motivation for superiority, which again starts the cycle of clinical aspiration for superiority.

Conclusions. According to our results the clinical aspiration for superiority suggests: the constant aspiration to dominate in competitive struggle and achieve performance results that surpass the performance of other people or groups of people, the dependence of self-esteem on success in moving towards a goal, the implementation of which gives an advantage over competitors; the ignoring the negative consequences of competitive struggle - conflicts, emotional burnout, psychosomatization and the actualization of the feeling of envy. It was shown tat ciclic model of clinical aspiration for hubristic superiority consisits of the 1) dependence of self-esteem on the achievement of superiority over others, 2) choosing a goal to achieve superiority, 3) object selection for comparison / competitiveness, 4) nonflexible standards for achieving superiority - "rules of competitiveness", caused by 5) cognitive distortions and 6) behavior, associated with competitiveness and achievements giving the opportunity to compare themselves with others, 7) achieving or nonachieving superiority or refusal of comparison or competitive struggle, which lead to 8) narcissistic senses. This model considers as the base of cognitive-behavioral therapy of clinical aspiration for hubristic superiority.

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КОГНІТИВНО-ПОВЕДІНКОВА МОДЕЛЬ КЛІНІЧНОГО ПРАГНЕННЯ ДО ГУБРИСТИЧНОЇ ПЕРЕВАГИ

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У статті представлені результати клінічного прагнення до переваги, що передбачає: постійне прагнення домінувати у конкурентній боротьбі та досягати результатів діяльності, що перевершують показники інших людей або груп людей, залежність самооцінки від успіху у просуванні до мети, реалізація якої надає перевагу перед конкурентами; ігнорування негативних наслідків конкурентної боротьби - конфліктів, емоційного вигоряння, психосоматизації та актуалізації почуття заздрощів. Показано, що циклічна модель клінічного прагнення до переваги складається з: 1) залежності самооцінки від досягнення переваги над іншими; 2) вибору мети досягнення переваги; 3) вибору об'єкта для порівняння/конкуренції; 4) негнучкі стандарти досягнення переваги - «правила змагальності» 5) когнітивними спотвореннями та 6) поведінкою, пов'язаною з суперництвом та досягненнями, що дають можливість порівнювати себе з іншими, 7) досягненням або недосягненням переваги або відмовою від порівняння чи конкурентної боротьби, що призводить до 8) нарцисичним почуттям. Ця модель розглядає як основу когнітивно-поведінкової терапії клінічне прагнення до губристичної переваги.
Ключові слова: *зарозуміла мотивація, прагнення до губристичної переваги, когнітивне спотворення, заздрість, нарцистичні почуття, когнітивно-поведінковий підхід*.

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