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Transference-Focused Psychotherapy (TFP) for Narcissistic Personality: Engaging Patients in the Early Treatment Process

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The authors outline the application of Transference-Focused Psychotherapy (TFP), a structured, twice-weekly psychoanalytic psychotherapy, to patients with narcissistic pathology. The operation of splitting-based defenses in the maintenance of the pathological grandiose self that is characteristic of individuals with narcissistic personality disorders is described, as are the obstacles posed by this structure to therapists attempting to establish a viable treatment frame and engage patients in the early treatment process. The narcissistic patient's difficulty tolerating the interpretive process in psychoanalytic psychotherapy is formulated based on the ideas of several writers in the modern Kleinian tradition as well as contemporary object relations theory. An extended case discussion illuminates the foregoing, and several modifications related to tact and timing, drawn from various analytic sources, are outlined to enhance the interpretive process in TFP.

Keywords: narcissism, personality disorders, transference focused psychotherapy, psychoanalytic psychotherapy

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Grace, a 40-year-old single woman, was referred by her therapist of 3 years, who had recently terminated a supportive psychodynamic treatment with the patient pursuant to a suicide gesture. Grace presented as intelligent and attractive, yet quite anxious, describing her presenting problem as not knowing whether or not she should marry Brian, a 48-year-old divorcee, who lived in a city on the opposite coast. The urgency of her request was overwhelming; she needed to know what to do, and I (Barry L. Stern) had to help her, despite her awareness that she had been referred to me for intensive psychodynamic work related to long-standing difficulties with emotion regulation, relationships, and her work. My inquiry about these difficulties was met with an imperious dismissal. In her view, I was asking all the wrong questions, I should have done my homework by having already spoken to her prior therapist, and I should have already understood the nature and history of her difficulties: "Don't you specialize in personality disorders?"

Grace resisted my efforts during the evaluation sessions to learn about her relationships, professional life, family background, and the substance of her prior treatment and its limitations. Grace was reluctant to discuss her suicidality, which had been the impetus for the referral, along with other important details of her life. I wondered initially whether her personality style, emotional life, and behavior would be too difficult to contain in an outpatient treatment designed to promote the exploration and resolution of internal conflicts, rather than provide overt support and guidance. Grace was indignant when I raised some of these concerns with her, stating that she did not understand why they should affect her treatment; she needed was help figuring out whether or not to marry Brian.

Pathological Narcissism and Borderline Personality Organization

Patients with prominent narcissistic psychopathology have long been recognized as posing formidable challenges to clinicians. Their difficulties allowing for a healthy dependency upon and attachment to the therapist, engaging in interpretive work that requires some reflectivity, and tolerating emotional pain in service of growth, pose significant technical challenges. As a result, clinicians working with narcissistic patients frequently report feeling devalued, deskilled, irrelevant, and under attack. The treatment process can readily devolve into a vicious downward cycle involving the patient's retrenchment into a paranoid, hostile stance, generating

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intense countertransference pressures, compromising the therapist's observational and analytic functions, and resulting in stalemates, enactments, and the premature termination of treatments.

What follows is an extension of an empirically supported treatment for borderline personality disorder (BPD) to patients with prominent narcissistic pathology. Our collective clinical experience with patients in the borderline range of personality organization, and two well-controlled randomized clinical trials provide evidence that Transference-focused psychotherapy (TFP; Yeomans, Clarkin, & Kernberg, 2015) is an effective treatment for patients with BPD (Clarkin, Levy, Lenzenweger, & Kernberg, 2004, 2007; Doering et al., 2010). As a syndrome, BPD is characterized by instability of identity, affective lability, impulsive coping, poor anxiety tolerance and subliminatory functioning (Kernberg, 1984), and turbulent interpersonal relationships American Psychiatric Association (APA, 2013). It is our belief that narcissistic patients, particularly those functioning as described above, that is, at the borderline level of personality organization, share core structural features, specifically, identity pathology, resulting from the operation of "primitive" defensive strategies for the unconscious management of intolerable self states and affects. Although narcissistic patients can vary symptomatically, with some more grandiose and some more vulnerable (Miller, Gentile, Wilson, & Campbell, 2013; Levy, 2012; PDM task force, 2006), with some presenting more ego weakness and functional impairment than others (Kernberg, 1984, 2007; Kernberg & Caligor, 2005; Levy, 2012), we view the various narcissistic presentations as particularly styled defensive shells that cover, and, when challenged, reveal a fragmented and otherwise chaotic world of internal object relations. The foregoing has led us to think that TFP, a treatment designed specifically to address the psychopathology of splitting, of defensively segmented or dissociated representations of self and objects, would be effective in the treatment of narcissistic pathology (Diamond, Yeomans, & Levy, 2011; Diamond et al., 2013; Diamond & Meehan, 2013; Stern, Yeomans, Diamond, & Kernberg, 2013).

A central focus of the article is the interpretive process in TFP (clearly elaborated in Caligor, Diamond, Yeomans, & Kernberg, 2009; and Yeomans, Clarkin, & Kernberg, 2015), and a discussion of specific difficulties establishing an effective interpretive process with narcissistic patients. Drawing upon the work of several writers working in the modern Kleinian tradition (e.g., Britton, 2004; Feldman, 1993, 2007; Steiner, 1993, 1994), and others also working broadly within an object-relations framework to treat patients with borderline and narcissistic pathology (e.g., Coen, 2002, 2005, 2010; LaFarge, 2000) we have begun to develop a series of adjustments in tact and timing to the standard interpretive technique in TFP (Diamond, Yeomans, & Levy, 2011; Diamond et al., 2013; Stern, Yeomans, Diamond, & Kernberg, 2012). These adjustments are designed to assist our patients in working in the transference and with the interpretive process, and this article is an attempt to further elaborate this evolving theory of technique of TFP for NPD.

Our model of personality disorder is derived from a contemporary object relations frame of reference and posits that as experiences of the self in relation to others are internalized in early childhood, they are organized in the developing mind according to a split between experiences that are rewarding, gratifying, and pleasurable, and those that are frustrating and painful. It is from this substrate of internalized object relations that the self-object dyads we experience in our work with personality disordered patients, and which we track as they unfold in the treatment process of TFP, are derived. The internal array of these self-object dyads, including the dyads that are more prominent, regularly experienced, affectively charged, and those that are defended against, defines the quality of the individual's developing identity, and shapes both the structure (integrated, flexible vs. split, rigid) and outward expression of the individual's personality as revealed to us in the consulting room (Kernberg & Caligor, 2005).

Descriptively, narcissistic personality disorder, a particular variant of the broader category of borderline personality organization, is characterized by an excessive and pervasive preoccupation with the self and its value. Although this preoccupation may be expressed through grandiosity, overt entitlement, arrogance, expressions of envy, and a hunger for admiration and praise, these descriptive features may also be hidden by defensive processes that result in a different surface presentation (e.g., depressive or masochistic), masking the "covert" narcissistic pathology (Levy, 2012; Miller et al., 2013; Pincus & Lukowitsky, 2010; PDM Task Force, 2006). Regardless of its phenotypic expression, we view all narcissistic pathology as characterized by a particular intrapsychic constellation of self and object representations termed the *pathological grandiose self*, in which all that is positively valenced, admirable, and good is assigned to the self, and all that is undesirable and negatively valenced (e.g., feelings of inferiority, incompetence, vulnerability, aggression, and envy) is assigned, through projection, to that which is outside the self (Joseph, 1959; Kernberg, 1984). Despite this typical configuration, narcissistic individuals remain vulnerable, to varying degrees, to experiences of doubt and devastating insecurity that threaten their sense of grandiosity.

The separation of positive/grandiose, and negative/devalued self representations, the use of others through projective mechanisms to manage the latter, the complementary use of others through *introjective* mechanisms to establish the dominant self representation as positive/grandiose, and the control of others through one's hostility or the threat thereof, are not only described in the psychodynamic literature on NPD but are also consistent in many ways with the contemporary clinical and social psychological research that informs the dynamic self-regulatory model or Morf and colleagues (2001, 2011). In other cases, the typical narcissistic dyad is turned on its head, with what appears to be a devalued self, attached to an idealized object. In such cases the grandiosity, control, and difficulty relating to another as an independent subject may be equally profound, and the splitting just as clear, but with the ideal, perceived in the object rather than in the self. The splitting-based defenses of narcissistic patients in the borderline range, and the resulting pathology of identity reflected in the sharp split between idealized and devalued/depreciated parts of the self, represents a profound failure to tolerate a balanced, realistic appraisal of the self and others, regulate self-esteem, and bear the routine disappointments and frustrations associated with adult living.

Whereas typical cases of BPD are characterized by extreme and unpredictable shifts in the self and object representations activated in a given moment, the grandiosity that defines the narcissistic structure can lead to inflexibility, in contrast to lability, in terms of the dyad that is active and determines the patient's experience.

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Often a patient will present with a semblance of integration and stability, describing, for example, consistent work at a job, having friends, and an overall positive sense of self. Upon further assessment, however, we may find that the patient's work situation may be compromised in various ways (chronic underfunctioning and/or interpersonal conflicts), and that their social relations may be highly self-serving and/or superficial. We also find in these cases the operation of defenses such as projective identification and omnipotent control, which serve to reject any evidence that would threaten the rigid, stable, narcissistic self-structure. Such a patient might be considered, in the phrasing of Rosenfeld (1987), a "thick-skinned" narcissist, one for whom the projective or splitting processes are so well developed that they constitute a "thick" defensive barrier, allowing little if any oscillation in the dyad of a grandiose-self in relation to a devalued-object, and hence little reclamation by the patient of self-experiences involving weakness, deficiency, or dependency.

The episodes of fragility, disappointment, and self-loathing characteristic of other narcissistic personalities are typically the result of situations in which the patient is forced to confront some aspect of reality, for example, failing to advance at work or the breakup of a relationship, that challenges the splitting off and projection of negative affects and self representations. For such patients, whom Rosenfeld deemed "thin-skinned" narcissists, the narcissistic structure is more fragile, and the projective processes less consistently effective, resulting in the unwanted awareness at times of the negative experiences of the self that the patient so stridently had attempted to project.

The grandiose self is thus conceptualized as compensatory in that it can be thought of as a structure superimposed upon the divided sense of self described in the general case of borderline personality organization, providing a semblance of integration with various degrees of effectiveness. Functioning in this manner, the grandiose self works to shield the narcissistic patient from the sense of inferiority and defect, and, at a deeper level, what is often experienced as a horrific sense of emptiness, vacuity, and annihilation, that is the subjective core of the individual with an unconsolidated self.

The defensive processes used to support the grandiose self include an array of splitting-based defenses common to borderline personality organization, including omnipotent control, idealization/devaluation, externalization, and projective identification. Idealization allows the patient to feel mirrored by the individuals and institutions in his milieu deemed worthy of his company and communion. Paradoxically though, the patient needs to concurrently devalue those same individuals to stave off the awareness of any humiliating deficiency in the self, as well as feelings of envy, the impulse to destroy the good perceived in others, that the patient feels he himself does not possess (Kernberg, 1984; Klein, 1957; Rosenfeld, 1971). Unconscious as well as conscious feelings of envy are a dominant experience and threat for these patients, a feeling that is often avoided by the patient's chronic devaluation of others. These defensive strategies leave the narcissistic patient feeling isolated and lonely, and with an internal sense of emptiness that results as the nurturing social intercourse that builds self-esteem and a sense of a life shared and enjoyed with valued others, is absent. In total, these defenses complicate the treatment process by contributing to an illusory self-sufficiency. In place of truly reciprocal relations with independent others, the narcissistic patient's self is structured on the use of, and dependency upon others as an extension of the self through projective mechanisms, and for the recruitment of narcissistic supplies, both of which contribute to the difficulties frequently experienced by clinicians attempting to make helpful and sustained contact with these patients.

TFP and Narcissistic Personality Disorder

TFP is a twice-weekly psychodynamic psychotherapy that is designed to analyze the defensive processes that maintain the patient's split sense of self, with the ultimate goal of better understanding the needs for those defensive processes and of helping patients tolerate a more realistic, adaptive integration of positive and negative (i.e., complex) representations of self and other (Yeomans, Clarkin, & Kernberg, 2015). The pretreatment stages involve a careful extended evaluation designed to determine the patient's level of personality organization as well as his or her phenomenological diagnosis, that is, whether the descriptive features of narcissistic pathology, including grandiosity, a heightened sense of self importance and entitlement, need for admiration, interpersonal difficulties, lack of empathy, and so forth, are present. Assessment of the rigidity of the patient's defensive system, the extent to which predominantly primitive or splitting-based defenses are employed, as well as the nature and quality of the patient's object relatedness, is essential to the structural diagnosis. Also critical is an assessment of the quality of the patient's internalized values system (e.g., the presence or absence thereof; capacity for guilt and remorse; presence of antisocial tendencies) and aggression (self- and other-directed, including self-injury/suicidality), both essential features in determining the severity of the patient's pathology within the spectrum of borderline personality organization (Kernberg, 1984, 2007).

Upon completion of the evaluation and the discussion with the patient of his or her diagnosis, the therapist must initiate a discussion with the patient of the conditions under which each particular TFP treatment can succeed. We recognize that discussion with the patient about his or her diagnosis is a controversial concept, but in general we have found that many patients with narcissistic disorders are grateful to have a diagnostic framework within which to understand their often baffling and contradictory self-experience and interpersonal difficulties if the diagnosis is presented with tact, empathy, and respect for the limits of what the patient can tolerate. The discussion of the treatment contract in TFP is designed to set realistic and mutually agreed upon parameters related to patient-specific behaviors that represent resistances to psychological exploration and pose a threat to the patient or therapist's safety, and to the conduct of TFP (e.g., severe substance abuse, self-injury/suicidality, eating disorder). Part of the treatment contracting process also involves an agreement concerning the patient's engagement in some structured activity (a job, educational or training program) while he or she is in treatment, so that the treatment itself not support secondary gain of the illness in the form of a passive, defensive retreat from life. Having patients engaged in life outside of treatment forces them to confront their capabilities and limitations and to bring into the treatment the conflicts associated with submission and collaboration, as well as struggles over ambition/striving, and the related impulse to retreat.

Interpretation, the core technique of the TFP treatment process, involves elements familiar to all analysts (i.e., clarification, con-

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frontation, and interpretation proper), along with a particular emphasis linked directly to our understanding of borderline pathology and tailored to the goal of integrating the split-off self- and object-representations that we view as the core of the disorder. In short, the process involves repeatedly identifying the actors or roles, as expressed in the dominant self-representation experienced and enacted by the patient in the treatment process, in relation to the therapist. Said differently, with what internal representation of self is the patient identified at any moment in the treatment process, and how is that self representation linked, and by what affect to a representation of the therapist? The therapist works to track the emergence of these dyads, and the shift in how the patient and therapist are figured in the moment-to-moment process (for a full discussion of interpretation in TFP, see Caligor, Diamond, Yeomans, & Kernberg, 2009). As one example of a negatively valenced, surface dyad that we often encounter, the narcissistic patient will evince an attitude of indifference, superiority, or arrogance, diminishing the therapist's efforts to understand and/or interpret. At such moments, the therapist both registers the patient's affect, often contempt, and also experiences himself in the countertransference as ineffectual, devalued, and irrelevant. As the therapist begins to draw the patient's attention to how the therapist is being figured and experienced, and how the self is being experienced in relation to the therapist (superiority, condescension), one of several things may begin to happen. In one instance the patient may become further ensconced in the grandiose self, denying his derogatory, imperious attitude and dismissing the therapist's efforts to draw any attention to what is happening between them. Alternatively, upon being confronted, the patient's conscious experience may shift, so that he comes to view himself in the weak position, a victim in that moment of a rejecting and persecutory therapist with malevolent and destructive motivations, seeking not to help but to dominate and humiliate.

It is crucial to emphasize that, as with all of the personality disorders in the borderline range, narcissistic patients are identified with both roles, with both the superior and the inferior, aggressor and the victim, although each identification is experienced at different times and at various levels of conscious awareness. The experience of such dissociation between various self-representations has been conceptualized in the psychoanalytic literature on narcissism as a result of splitting processes (Feldman, 1997; Joseph, 1978; Kernberg, 1984; Kernberg & Caligor, 2005), and from within the nonclinical study of cognition and consciousness in terms of how to understand the accessibility of the subliminal (Erdelyi, 2004). The patient's identification with the aggressor is indeed often enacted without any awareness, or is justified as "self defense." At the same time, although the patient may appear entitled, grandiose, self-assured, and not in need of any help from the therapist, leaving the therapist feeling irrelevant and devalued, it is crucial to bear in mind that the patient is also identified with a weak, depreciated self, no matter how unconscious that self-representation may be at any given moment.

In tracking the self-object dyads as they emerge in the treatment process, the therapist must also be mindful of the layering of dyads, that is, which dyads on the surface defend against another at greater depth. An example of such layering would be the manner in which the negatively valenced dyad of the self-sufficient, grandiose self in relation to a depreciated, dependent object defends against a positively valenced, "idealized" dyad of, for example, a dependent and perfectly nurtured self, linked with longing, to an thoroughly admiring, caring, and loving parent.[1] Similar to the negatively valenced, persecutory dyads often encountered on the surface, the defended-against "idealized" dyads are equally extreme in their characteristics, and equally influential in the patient's distorted experience of reality.

Although the treatment of narcissistic pathology is complicated by the tenacity of the patients' defensive processes, and by the enactment of their entitlement and grandiosity through the avoidance of life tasks and age-appropriate responsibilities in their lives outside of treatment, we have found that if the therapist works with the patient to construct a mutually acceptable treatment frame, the interpretive process, through both its containing and communicative function, can be used to access breaches in the patient's fantasy of omnipotence and to begin to examine the shifts in self and object representations as they play out with the therapist. The consistent exploration of these patterns can help patients become increasingly familiar with the parts of themselves that they have to acknowledge and integrate in order to move toward a sense of self and others in which positive and negative, aggressive and libidinal, hateful and loving affects are increasingly integrated.

Case Example

Upon presenting to my office, Grace was in a state of withdrawal, unable to face herself, her internal, emotional life, and with a very limited capacity to engage with her colleagues, friends, romantic partner, and therapist. As noted above, the evaluation with Grace was challenging. Grace did not allow me to direct the initial interviews, stonewalling my inquiries, demanding that we move immediately to a more supportive, problem-focused approach related to her current crisis. The very presumption that I might know what questions to ask her seemed to offend her sense of autonomy—she would tell me all that was important to know. Grace's control was also manifest through her dismissal of me and through the intensity of her anger at my questions, which served to maneuver me in the sessions away from material, particularly aspects of herself and experiences of me, that to her felt threatening.

What I did learn about Grace in those initial sessions was that she was a well-educated accountant who quit her first job in response to intense performance anxieties (exacerbated by periodic alcohol abuse) and interpersonal tensions. Subsequent jobs were characterized by her functioning below the level of her ability, with problems related to attendance and reliability, interpersonal conflicts, and a chronic sense of dissatisfaction. Grace managed to titrate her contact with the demands of reality and their associated frustrations by working for several years as a consultant, from home, on her own schedule, earning just enough money to support herself. Periodic meetings with clients caused immense stress, with cycles of obsessive scrutiny of the calculations and tables required for her reports to prevent her being blindsided by an error becoming revealed. This work situation afforded her a general sense of relief from scrutiny and conflict, but at the expense of her working

[1] Note that we do not presume that these dyads are historically accurate; rather, they reflect internal representations of earlier experiences, now reworked through the individual's present motivations, wishes, and defenses.

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limited hours, well below her earning potential, and the self-loathing and low self-esteem that accompanied this awareness.

Grace's interpersonal difficulties were significant. She had a small group of friends with whom she was in regular contact, but no relationships of significant emotional depth, and a long history of unstable and unsatisfying friendships, replete with stories of fights, falling outs, and failed attempts at repair. She reported few emotional supports other than two single female friends of approximately her age, whom she both clung to, and yet frequently devalued as "hopeless" and "losers." Grace's feelings about other friends who were more successful in love and work were characterized by disdain for them and their partners, alternating with a painful sense of inferiority. Bitterness and envy figured prominently on the palette of Grace's affects. Before meeting Brian, Grace had never in her life had a satisfying, long-term romantic relationship. She reported being sexually promiscuous in her 20s, dating and quickly becoming sexually involved with different men. After becoming "born again" in her late 20s, Grace began to restrict her sexual behavior, and by the time she came to see me she had had no sexual contact with a man for over 12 years. Grace discussed her desire to marry, but also described a chronic and significant tendency toward indecision, fault-finding, and an overall dissatisfaction with the men she had dated, several of whom had expressed their interest in marrying her. It is important to note that despite her tendency to be both demanding of and depreciatory toward others, Grace was highly intelligent, quick witted, informed and opinionated about a broad range of current affairs and culture, and was attractive physically.

Grace was the second to youngest in a family of four. Her siblings were successful in their chosen professions and married with children. She described her mother as an angry, jealous, and defeated woman, expecting ever greater financial and social success from her husband, and being vocal about his inadequacy in these areas. Grace described being ambivalently close to her mother, valuing their "special" relationship, but also uncomfortable in her role as mother's confidante. She characterized her father as both a loving, sweet man who was available and kind to Grace, but also as a scoundrel, a weak man, unfaithful in his marriage, and inappropriately seductive with Grace in ways that made her increasingly uncomfortable as she grew into adolescence. Grace also characterized her father as bright yet unsuccessful in his work, functioning throughout his adult life at a level well below his capability. The environment in the home was described as serious and joyless, punctuated by episodes of out-of-control arguments between her parents, followed by retreat and terrifying silence.

In formulating a phenomenological and structural diagnosis, it was my impression that Grace's difficulties with mood, alcohol abuse, and impulse control were secondary to an underlying personality disorder. Evidence of significant identity pathology could be seen in the contradictory and rapidly shifting experiences of herself, from vulnerable and weak to hostile or strong, as well as instability in the area of self esteem, with Grace seeing herself as competent, capable, better than, and at other times ineffectual, diminished, less than. Identity pathology was also suggested by the unstable experience of those close to her (e.g., idealized to quickly devalued), and her difficulty investing herself in a personally satisfying, stable, and effective manner in work or recreation. Difficulties in interpersonal functioning, also pathognomic for personality disorders (APA, 2013), were significant, including somewhat volatile, off-and-on relationships with friends; a superficial, self-serving, need-fulfilling mode of relating to her friends; and feelings of anger and abandonment when friends failed to meet her idealized expectations. Further elaboration of these impressions through the intensity of Grace's feelings of envy, feelings of entitlement to special treatment and consideration from friends on account of her emotional needs, and the bitterness and rage that followed the disappointment of these expectations, all suggested that a primary Axis II diagnosis of narcissistic personality disorder was warranted.

Grace's difficulty tolerating anxiety and any negative emotional state or self-experience, along with bouts of impulsive coping to manage the same, pointed to significant comorbid borderline features. The absence of frank sociopathy, the evidence of some concern over her behavior and its impact on important people in her life, and her capacity, albeit limited, for object relatedness, suggested that her aggression was modulated to some extent by genuine concern for herself and others, thus making her a potentially good candidate for TFP, provided that mutually agreeable parameters to limit self-destructive behaviors that might compromise the ability to work in an exploratory frame could be established, i.e., a viable treatment contract. Grace's alcohol abuse and destructive impulses were of great concern in establishing a viable treatment frame, as was her insistence that these issues were irrelevant to her therapy. At an impasse so early, in the pretreatment phase in fact, and facing the prospect that I would not agree to work with her, Grace begrudgingly discussed the circumstances surrounding her suicide gesture, and we were able to establish an agreement about how she would manage her safety, including urges to hurt herself, as they arose in the treatment (for a detailed account of procedures in TFP for contracting around patient safety, see Yeomans, Clarkin, & Kernberg, 2015). Similarly, Grace agreed to limit her alcohol consumption, to discuss with me her struggle to do so, and, should those efforts fail, to attend Alcoholics Anonymous meetings as an adjunct to the therapy. After discussing with Grace the nature of the treatment I was proposing, that is, its exploratory nature, designed to help her understand factors outside of her awareness that were influencing her current yet longstanding difficulties, we began twice-weekly TFP.

The initial treatment process was characterized by Grace's exclusive focus on the contingencies of her life (e.g., her feelings about Brian, how to get motivated to prepare for an upcoming professional meeting), her inability to manage the same, and her expectation that I would help her in some concrete manner. The initial transference was dominated by her anger that I, like a broken ATM, was not dispensing the advice, guidance, or insight she demanded; even worse, she felt exploited, being denied by me the service for which she had dearly paid. "It's been 10 minutes and you haven't said anything; that's 50 dollars out the window!"

I struggled in these early sessions to find a reflective space for myself to try and understand and help Grace, but found myself feeling pressured and overwhelmed by her demands and anger. My interventions were regularly met with a contemptuous dismissal, and any silence on my part, no matter how brief, left Grace feeling deprived and enraged. A typical example is reconstructed below. Grace had begun the session discussing her disappointments in Brian, his lack of style, his tendency to be more withdrawn in large social gatherings, and the general lack of excitement that he

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conveys. I had suggested that these are also the same qualities in him that she is drawn to, that his stability in turn allows her to feel secure and comfortable with him.

Grace: Well that may be, but the other night, at Jane's party, he just sat there. I mean, we danced, and drank a bit, but like, come on, get up, look alive! It makes me feel like he's not the right person for me. I didn't have fun being with him, and we just argued the whole way home.

Therapist: He didn't look alive, or he was not helping *you* to feel alive?

Grace: Him, me, what does is matter?! I'm telling you, it just doesn't feel good, to see him just standing there.

Therapist: You seem frustrated, impatient, dissatisfied with me all of a sudden.

Grace: Yes . . . I come in, tell you I'm upset, angry, frustrated with my friends, complain about Brian. . . . I'm just not sure how this is supposed to be helping me, I just do not get anything from you. It's my time, it's my money, and it's expensive.

Therapist: (Somewhat exasperated) Look, clearly there is no magic wand I can wave to have these difficulties that have taken a long time in the making, resolve themselves for you . . . and that realization seems very disappointing, even infuriating to you, seeing the limits of what I can and cannot do.

Grace: *Limits?* You're not doing anything! You sit, you listen, you . . . I do not even really know what you do, and I leave with the same problems I came in with!

Therapist: It sounds as though you feel, with Brian, and right now with me, that if I, or he, leave you with some difficult, painful thoughts or feelings about yourself that are unresolved, with you having, and having to *think* about feelings that are still difficult or uncomfortable, that I've given you absolutely nothing.

Grace: Wow. So that's it?? I'm sure there is more. There has to be more.

Therapist: So I'll say again: If I cannot make all the difficult feeling and experiences of yourself go away, as happens when I ask you to *think* with me about them, then I'm useless, or worse, potentially helpful, but keeping the help intentionally from you.

(Long silence)

Grace: Ok, so what I supposed to *do*??!!!

In this segment, I am working to help Grace better understand her reactions, first to Brian, and then to myself. Initially, I urge her to explore her experience of him as not sufficiently active and alive, pointing to a conflict in her about Brian's more introverted qualities. At this point, I'm focusing on her contemptuous affect toward him, and her experience of him, broadly speaking, as devalued. I also plant the possibility that she is wishing for him to be more active, so that she can feel more vibrant, and to overcome her own sense of herself as insecure, feeble, listless. This intervention, an attempt to work on the process of projective identification, can also be seen as working on Grace's identification with both poles of the persecutory dyad, essentially asking her to reflect on "Who is it, you or he, who is listless and dull?" It is after this comment that she becomes angry with me, contemptuous of what I have to offer, and devaluing of me and my efforts. Here, we move into the transference, and I urge her to reflect on how angry and disappointed in me she became when I was not dispensing insights and guidance as skillfully or helpfully as she liked, on her wish for an omniscient and always validating therapist, one who would perfectly intuit her needs, and intervenes in such a way as to eliminate any emotional discomfort she might have. Sharing this interpretation, which could be seen in the language of TFP as an example of naming the actors in the idealized dyad, resulted in a further devolution of the affective tone of the session, with Grace experiencing me, who moments ago was the embodiment of the unrealistically hoped-for answer to her problems, as thoroughly unhelpful and withholding.

The segment ends with Grace saying "Ok, so what I supposed to *do*??!!!" During the ensuing minute, I attempted to reflect on her response, tolerating my confusion and using Grace's and my own affect to identify which self representation and experience of me had become activated in the process. As the session came to an end just seconds later, with me still attempting to process the preceding sequence, Grace exploded: "So that's it? Nothing else to say? You know you make about five dollars a minute!" With this remark, Grace flung open my door, slamming it with shocking force into an adjacent file cabinet, knocking some of my materials to the floor.

Upon her return later that week, Grace made no mention of the incident, speaking calmly about a work dilemma she had negotiated in between the sessions.

Therapist: It's been several minutes at this point, and you've not brought up how our last session ended.

Grace: What?

Therapist: (Lightly) You really do not remember? You were enraged with me, you stormed out, slamming my door, knocking things to the ground . . . it was quite a scene.

Grace: Well that's a bit of an exaggeration, and if I knocked anything over, that was purely accidental.

Therapist: But you were angry . . . very angry with me.

Grace: I keep telling you, this treatment is not working for me. If this is all you have to give me, I do not see how things are going to change. . . . I think I have a right to be kind of pissed off (Pause). Look, I know there is no magic pill you can give me.

Therapist: Yet you seem very angry with me at moments where I do not provide one, and where I ask you to look at *you*.

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Grace: Well of course . . . it feels like shit to have to look at *me*. Of course, I'm gonna fight against doing that. I want to feel different and I'm afraid we just go in circles and I'm going to feel like this forever. And you, well, you'll get paid either way . . .

Therapist: I suppose, sure. . . . But to make sure I understand, it sounds like you see me as, at best, well intentioned, benign, but ineffective, and at worst, as exploitive, greedy, and not really caring whether what I do is helpful or not.

Grace: No, I do not think you're exploiting me. . . . I'm not sure how much you really care though at the end of the day.

Therapist: Ok, but then let's try and understand more your reaction to me when you feel I'm not helping you . . . what you think is going at those moments? (Pause)

Grace: At those moments . . . I do not know. I just feel bad. It feels like there is nothing good in me, about me, or my life, and that it's just going to continue to be that way. And you go off and get to sit in your nice office, and go to your nice home, your family . . . And I really *need* something to change in my life, and all you do is sit there and think!

Therapist: So one thing I'm hearing clearly is that you feel bad about yourself in general when I ask you to focus on *you*, your difficult feelings and behaviors. But that you also feel badly in relation to what you imagine my life to be. It feels very humiliating, pegging yourself against your vision of my life.

Grace: Yes, it feels like shit.

Therapist: And I sense that at those moments you'd do just about anything to reverse that painful situation; it seems like one of the ways you do that is to dismiss that which I do have to offer you. If what I'm offering is so worthless, well, it narrows that gap between us. . . . I cannot be that successful, or feel very good about myself if I'm that unhelpful.

Grace: I'll have to think about that. I do not know.

Therapist: It also seems, at those moments, that my job in your mind, like Brian's, is to do *anything* to make those bad feelings of inferiority, of your own inadequacy, go away. *That* would be giving you something.

Grace: Yes . . . but I do know, truly, that that is not so realistic.

Therapist: Well that may be, but what I'm struggling with is the fact that the moments where I most feel I can be helpful, the ones in which I try to help you understand what goes on inside of *you*, are the ones you're most desperate to get away from. You feel humiliated, deprived, and you get demanding. You see me as taking from you, but what you want, it seems, is to grab anything from me: "Give me something! Give me what you have, to make these feelings go away, to reset my feeling strong and good." When I ask you, instead, to *think* with me about what you're going through, it feels as though I'm leaving you with nothing, humiliated and empty, while I get to go on to my nice life . . . and it feels like a cruel attack, and even moves into a feeling of my taking advantage of you.

Grace: I can see that. I'm not sure what to do with that . . . but it makes sense.

This sequence of interpretive efforts could be thought of, in the language of TFP, as first a confrontation, that is, between Grace's behavior in the recent session and her calm, dismissive attitude toward it in the current moment, followed by a series of clarifications around the dominant affect of anger and hostility toward for me, to try to narrow in on the specific self and object representations that Grace was experiencing in relation to me, that is, as not giving her enough/depriving, superior (and therefore an object of envy), and perhaps as a tantalizing and even sadistically teasing object (Fairbairn, 1952).

Although it was acted out through her devaluation and was far from her conscious awareness, I could, through the initial clarifications of her experience of me (mistreating and exploiting her), slowly move to frame this experience more fully as a projective process that could be interpreted in dyadic terms, that is, that of her greedy self, wanting to use anything I might have to offer in the moment, not to understand or grow, but to fill the void of her despair and emptiness, and to evade or reverse other negative experiences of the self (humiliated, inferior, needy, deprived, envious). At those moments, Grace's conscious experience is of me trying to take from her, without regard to her well being, to serve my own personal needs. Thus what began as a series of therapist-centered interpretations (see Steiner, 1993) evolved, to use the language now of TFP, into a broader description of how each of us was being experienced in the treatment process, and ultimately, to an interpretation of the oscillation of the persecutory dyad that led to her awareness of negative elements of herself that she traditionally dealt with through projection, that is, demanding, impatient, hungry parts of herself (Caligor et al., 2009; Yeomans, Clarkin, & Kernberg, 2015).

What was also addressed through this process, although less explicit than the reversal in the primary dyad discussed above, is the fuller interpretation of the "layering of dyads," specifically, Grace's wish for an idealized relationship in which she could turn to a perfectly attuned and attentive therapist for help in eliminating any negative, empty, devalued experience of herself, and how, in the expected failure of that idealized situation, it was hard for her to hold onto an image of me as helpful at all, experiencing me instead as persecutory and exploitive.

Grace's indignant and critical feelings toward a close childhood friend, Michelle, provided an opportunity to address other aspects of the developing transference. Michelle was never available when Grace reached out, making her wait for a return call, and regularly

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prioritized her husband, three small children, and job over Grace. Grace could hardly deny the congruence between her experience of Brian, Michelle, and myself, despite her insistence that my interest in any discussion of her experience of me was evidence of my own insecurity and self-centeredness. Closely following Grace's affect, however, I began to share the idea that her tone was not simply one of disappointment in Brian, Michelle, and myself, but more complex, involving aspects of which Grace seemed unaware, such as contempt, and a superior and critical attitude tinged with some pleasure, in highlighting our ineptitude, selfishness, and callousness. Although she disputed this observation—which stood in contrast to Grace's conscious experience of herself as the *recipient* of others' denigration and contempt—Grace became increasingly cognizant of this part of her attitude toward others. What also emerged alongside this observation was Grace's sense of never feeling satisfactory with herself, her feeling insufficiently accomplished, by her own standard, and in the eyes of others, in the domains for work and love. The foregoing lead to interpretations that Grace's chronic experience of others as deficient had something to do with a negative self-representation, that is, that the contempt by which she distanced herself from others protected her against a deficient experience of herself. We came to see how the dyad she was enacting in relation to others was constantly active within herself, at varying levels of awareness, with her as both the source of and object of the devaluation. In the language of TFP, this interpretation, of yet another dyad that emerged with prominence in the treatment process, represented the patient's alternating or oscillating identification with each pole of the persecutory dyad.

What follows is a reconstructed, and excerpted example of the full cycle of interpretation with Grace, one that unfolded in a distinctly nonlinear fashion over two sessions. Grace arrived to a session and began with a list of complaints: Brian had disappointed her again by giving her a bland, impersonal birthday gift; she drank too much last night, slept poorly, and was exhausted while up against a deadline; nothing is changing in her life; and treatment is not helping. As she went on, I felt increasingly exasperated and provoked. The last session had been a good one, ending with our having reached some understanding of how critical and demanding Grace can be and with her actually feeling some sense of concern and curiosity about these tendencies.

Therapist: So your sense is that the treatment is not helping, that I'm not helping. Yet something *has* been different here lately, there was a much more collaborative feeling between us in our last meeting. You seemed to experience me in a positive, helpful light; now that's totally gone, you feel unhelped, quite dismissive of me.

Grace: What do you want me to say? You ask me to say "whatever is on my mind" . . . well . . . *this* is what's on my mind.[2] I'm getting nowhere.

Therapist: Yes, I can see that is what you are feeling, but can I be curious about the shift in your feeling with me without your getting angry with me?

Grace: I do not know. That feeling from last session is gone, what can I say.

Therapist: I'm wondering if you can see that at the same time you're feeling unhelped, I'm suggesting that there might be something important to look at here, and you're dismissing that idea out of hand . . .

Grace: *You're* feeling dismissed? Ok, so we'll talk about what's on *your* mind apparently. . . . Because what's on my mind doesn't seem to count.

Therapist: Wow . . . I just do not know what to say; we were in such a different place last time we met, the contrast seems . . .

Grace: I feel like I'm doing this all wrong, like you're telling me I'm doing it all wrong, I can never get this right with you.

Therapist: Ok, so let's pause for a second. Something is going on between us here. . . . you're activated, and shutting down, and we are both feeling dismissed and unheard. Let's see if we can think together about how we got stuck in this place.

It was only after Grace expressed how critical I was being of her, of her sense of never being able to "get it right" with me, that I realized that I was caught up in some form of an enactment. Upon agreeing with Grace, stating what is obvious to both of us, that I was having a reaction to the way she began the session, the affective intensity and pacing of the interaction between us immediately shifted. I could perhaps have followed by interpreting this moment through the lens of projective identification, which it appeared to be: The urgency of her need to get well and progress, residing in me at that moment, leaving me exasperated by her rejection of our recent good work. Perhaps a more accurate and accessible interpretation might have focused on her sense of being dismissed by me, and how it ran parallel to my experience of Grace dismissing our recent productive work. Although likely accurate, and consistent with the strategy in TFP of interpreting reversals in the dominant dyad, my instinct was that either interpretation, in the midst of such an affectively charged interchange, would not have been appropriate (or simply was not possible for me to deliver tactfully from my own position of being affectively activated in that moment). As often happens in the treatment of narcissistic patients, our countertransference pressures are intense: Here, I felt dismissed, both in the acute, microcontext of our recent session, and in a chronic sense, having struggled with Grace for some time to further her reflective capacity.

Recognizing the point at which one's countertransference moves into enactment provides us the opportunity to reorient the

[2] Although patients often feel criticized by such interpretations—"you told me to 'speak about whatever comes to mind'"—this vignette provides an illustration of how what may appear to be "free association," in TFP, is often used by the patient as an opportunity to depict his or her situation as confirming the dominant object relation, here with Grace as the unfairly treated victim of an insufficiently helpful therapist. In this example, the "free" association is brought for defensive purposes, to distance Grace from her rejecting and demanding tendencies, her greed, and to deny what may be good and helpful in others, indeed, most recently between us, and in doing so to reinstate her dominant sense of grievance, of having been wronged by the world.

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interchange, and ourselves, to a technically neutral stance, from which we are neither siding with, nor enacting one or another side, of the patient's conflicts. Rather than implying indifference or disengagement, a technically neutral stance allows us the space to reflect, internally, on our experience of the patient, and our countertransference in the moment. In this example, the therapist did not become clear as to his countertransference until the patient pointed out what she experienced as his hostile, dismissive attitude. After Grace pointed out that she was not feeling heard, that she was feeling dismissed, the dominant object relation started to clarify in the therapist's mind, that is, that in Grace's experience, I was enacting a dismissing role, one quite possibly that had a particular resonance for myself, and which clearly was part of the array of internal objects from which I could draw based on my own personal experience. At the same time, a tendency to be coolly dismissive was central to Grace's difficulties, with this experience of herself often split off, expressed without conscious awareness through her behavior, and experienced consciously as emanating from others. In TFP, we attempt to use the countertransference as an opportunity to reflect upon different aspects of the patient (and clearly the therapist as well) that are being enacted, between patient and therapist, linked by a particular affect in the moment, while remaining aware that both roles, both poles or parts of the dyad, represent aspects of the patient.

In our now calmer, more reflective state, I encouraged Grace to think about her experience of feeling dismissed, by myself, and others.

Therapist: (From above) . . . Let's see if we can think together about how we got stuck in this place.

Grace: I do not know. (Pause). You just seemed so impatient and annoyed with me, I do not get this therapy, what you want me to be doing, and I never seem to be getting it right.

Therapist: Well, you did hear me expressing some exasperation perhaps, with the sense that we had lost something that had gone well between us. Those moments have been hard to hold on to. But you saw me as angry and critical, yes?

Grace: Yes, but I do not know; maybe you were not feeling that.

Therapist: That's interesting because it reminds me of something else from our last session; do you recall our discussion of the fee for the missed appointment?

Grace: Yeah . . . but how is that related. That was *last* session.

Therapist: How inept I can be, you telling me how backward my policy is, why do not I hire an assistant to help me sort out these administrative things. That lead to other complaints about my approach—I need to direct you more, ask more questions, while also projecting more authority.

Grace: Yeah, I get it . . . so?

Therapist: In these interactions one of us is experienced as critical, and the other being criticized and on the defensive. I was reminded of that as you were speaking just now, experiencing me as the angry, impatient critic, and last time I felt that from you, like I was an employee getting a finger-wagging, bad review from his boss.

Grace: Are you serious??!! That is so unfair, I raise one issue with you last time, and you make me out to be some raving lunatic who can never be satisfied. Well, I guess *you* can be the critic but I cannot say a word!

Therapist: Hold on a second here . . . what just happened? Something I said really touched a nerve.

Grace: Yeah, you basically told me that I'm intolerant, that I get bossy and controlling whenever I do not have it just my way, and that's really hurtful. It's unfair and not an accurate image of me.

Therapist: Well I do not know. Perhaps I'm being still critical, unfair. And perhaps I'm pointing out something I'm quite sure we've seen before, with Brian, and last session with me. But from the looks of it my comment still is touching a nerve.

Grace: I felt like you were mocking me. (Pause). My mother would always mock me: "yes, your highness." Anything she didn't like, things I needed that were too much for her. I'm sorry that being a fucking parent is so burdensome to you. Uh . . . it comes with the territory . . .

Therapist: I'm not sure I follow.

Grace: She used to say that I'd boss her around, tell her what to do. Sure, I can be opinionated, and my friends will sometimes tell me that I'm very definitive, brusque, and do not have a lot of patience for their complaints. But with my mom, she responded to things I needed as if it was a major imposition . . . every anxiety, every request . . . and I was an anxious kid. What I needed was a big burden to her.

Therapist: So I'm wondering if this sense, of your needs as a burden, and my critical sense of impatience—which you felt from me today, and I felt from you last session—had something to do with how our session started. You felt dismissed by me, that I was unreceptive to hearing about what has been bothering you the past few days, critical, impatient.

Grace: (Pause) Maybe . . . (Pause). Yes, I definitely felt you to be impatient.

Therapist: But that was also not the main feeling you had last session, am I right? You were frustrated with *me* about my personal style in the treatment, my policies, but in talking that through you became reflective about how critical you can be; you felt

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concerned about yourself and experienced me a with you, as helpful, yes?

Grace: Yes

Therapist: But the experience of me can change very quickly.

Grace: Yes

Therapist: What's going on now?

Grace: I'm feeling a bit hopeless. I'm kind of feeling that I'm never going to be able to be in a relationship. It just feels like too much work, with Brian.

Therapist: And with us too. I made a comment about something going on between *us*, you've dropped it.

Grace: I just do not know what else to say.

Therapist: So what I'm thinking about is our work, and how hard it is to hold onto to me as someone helpful, and *with* you, trying to help you sort through these issues you struggle with. Your sense of disappointment, your *anticipation* of being disappointed—that I'll come to see your turning to me for help as burdensome, and dismiss what you need of me. You're vigilant for that happening, watching for me criticizing and dismissing . . . and if I'm not listening perfectly, hearing you right where you are, or say something that's not totally in line with what you're thinking about in that moment, it's felt as though I'm totally against you, harshly critical and intolerant. All this tension around needing me, needing something from me, holding onto something good with me, is very hard. And then we end up reverting to this situation in which one of us is feeling dismissed or criticized by the other.

What we see in this segment is a series of comments that started with a focus on Grace's experience of being impatiently criticized by me. Our clarification of this object relational dyad, and the interpretation of its oscillation or reversal as it emerged in the transference, gradually led to the emergence of genetic material that was more deeply felt, and amenable to interpretations that linked past events with present internal experience, and memory with current dominant representations. In the ensuing months, Grace and I came to expand the final interpretation in the sequence above, an interpretation, in the language of TFP, of the "layering" of idealized and persecutory dyads. We came to understand the way in which our repetitive engagement in the negative surface dyad, in which one person was experienced as powerful, rejecting, critical, and superior, whereas the other felt demeaned, criticized, or dismissed, defended against the expression of a wished for, idealized dyad, namely that of an all-giving, never disappointing or frustrating object (therapist, parent) in relation to a needy, but admired and loved child. We came to realize that the experience of a persecutory relationship between us resulted from her experience of my failing her vision of myself as this idealized figure. We could also see how Grace anticipated and actively participated in the failure of this idealized situation, her tendency to provoke and spoil, and the notion that her critical and contemptuous tendencies not only reflected feelings about herself from which she needed distance, but served to enact and fulfill the negative expectations she had of her understandably imperfect objects. Said differently, I was also able to interpret to Grace the notion that one of the functions of our protracted engagement in the vicissitudes of the negative, surface dyad was to defend her against the intense anxieties associated with a desired loved object who has what to give, but who can also frustrate and disappoint.

In our joint interpretive work going forward, Grace and I repeatedly tracked her wish for a perfectly giving and available partner (boyfriend, therapist), her disappointment and rage when Brian or I inevitably failed her, along with her retreat to a persecutory dyad in which someone was reliably critical, and the other reliably disappointing. Interpretation of these dyads as they became manifest in the transference allowed Grace to become aware of an increasing mix of self representations; Grace could increasingly come to see herself as someone who was both angry and demanding, as someone whose indignation and denigration of others was gratifying, and constitutive, and as one who was at the same time desperately in need of reassurance in her goodness, in her capabilities, and in the hope that her destructiveness could be overcome. Interpretation along these lines also helped Grace became increasingly aware, in fleeting moments, of something positive that I might have to offer her. Grace became increasingly able to reflect on my thoughts in the session, appearing to genuinely consider and tolerate a point of view different from her own without becoming overwhelmed with feelings of humiliation, or, in its defensive expression, devaluation, or rage directed at me. With this progress, Grace, from within the experience of the persecutory sphere, vulnerability exposed and guard up, could increasingly tolerate and engage a therapist whom she came to experience as giving, attentive, and helpful, thus posing a challenge to her internal object-related expectations.

These changes in the treatment mirrored changes in Grace's life outside of treatment. Although Grace's abuse of alcohol as a retreat from painful affects was a significant concern at the outset of treatment, the initial treatment contract helped to limit the extent and severity of Grace's drinking, which never posed a threat to the treatment and was not a topic of significant concern. Over the course of our work Grace's social life appeared to broaden, and she seemed better able to tolerate contact with her friends without becoming overwhelmed by feelings of envy and rejection. Similarly, and perhaps most significantly, Grace was able to resolve her intense ambivalence about Brian, to increasingly value and appreciate his capacity for love and devotion without having them tainted by her previous exaggeration of his inadequacies or imperfections. She ultimately made a decision to get married. Although this decision required her to move to another city, and thus to terminate her treatment, I understood Grace's ability to commit to marriage as indicative of her increasing ability to sustain closer contact with others, especially Brian, without needing to flee from, or act out against the frustrations she concurrently experienced. In short, this treatment helped Grace to move from a retreat from close relations and defensive devaluation of others, into a position of greater and more tolerable engagement with herself, her therapist, and in her more important social and romantic relationships.

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Discussion

The case of Grace reflects several of the typical challenges presented by our more difficult narcissistic patients functioning in the borderline range during the initial phase of treatment. The treatment process frequently involves working through the patient's demanding and controlling tendencies related to obtaining various narcissistic supplies (for emotional support, practical guidance, admiration), impulsive coping when those supplies are not forthcoming, and tendencies toward envy-driven devaluation, all of which were in evidence in Grace's life and in the transference. These clinical features of narcissistic pathology place a tremendous countertransference burden on the therapist, one that requires constant attention and monitoring. In this connection, we have found that the insight and guidance of a peer-consultation group, one in which therapists can present material from their work involving patients like Grace, is essential in supporting their ability to maintain a reflective analytic stance over time, and to contain the inevitable pull toward enactment.

The remainder of the article will continue to use the case of Grace as a springboard for a discussion of several typical transference patterns that emerge in the treatment of narcissistic personalities. Although not exhaustive, the described transferences and their discussion will further illuminate the challenges of working with narcissistic patients, and lead into the subsequent discussion of the difficulties associated with the interpretive process with narcissistic patients, and adjustments in tact and timing in the practice of TFP that facilitate the same.

Narcissistic Transferences

There are several transferences that tend to develop in the treatment of narcissistic personalities, several of which emerged in my work with Grace, each derivative of the self-structure described above, and each with origins in the patient's earliest object relations. Typical of narcissistic personalities as they enter treatment is their resistance to the very notion and relevance of the internal, that is, of internal conflict, or of an internal, representational world. For many patients, the wish is for the treatment to focus on problems in the external world, on "reality," for example, whom to marry, what job to take, how to solve a particular problem—often despite having had multiple experiences in prior treatments of such efforts failing to resolve their difficulties, or to instill any greater confidence in the patient's decision-making capacities. From the patient's perspective, this is understandable; they are in distress, related to problems in their everyday lives, for which they need help. At the same time, our patients lack the understanding, which we attempt to impart over time through the treatment process, that their concerns about external reality are chronically conflictual because they reflect unresolved conflicts in the patient's internal world. These patients substitute an argument about morality, about what to do, or a bid for the therapist's agreement on a question of right or wrong, in place of a discussion of their psychic reality (Britton, 2004; Steiner, 2005).

We conceive of this resistance as the manifestation of the patient's defensive process operating between patient and therapist, and in its operation, constituting both a specific self-object dyad, and obscuring deeper layers of wished-for and feared experience of self in relation to others. As long as Grace struggled to get her therapist to act, to advise or guide, she could avoid thinking about her tumultuous emotional life, self experience, and relationships with others, including the therapist. The powerful conflicts within Grace became manifest at times as a power struggle between her and her therapist, as Grace insisted she was not being helped in a real sense with practical decisions requiring urgent attention, and with the therapist feeling that what he could offer in his role as a psychodynamic clinician was rejected. One function, albeit unconscious, of Grace's tendency to pose this series of insoluble problems was to reinforce a dominant experience of herself in relation to others: that of a needy, dependent self in relation to a cruel, withholding object world, and to stoke a sense of indignation, a sense of being owed reparation for past and present hurts and deprivations, while recreating the feelings of hurt and deprivation in the treatment situation itself. Furthermore, through the experience of the therapist failing her, Grace also gained access to a channel through which devalued, hated aspects of her self could be ascribed to the withholding, cruel, neglectful therapist, the "lavoratory" therapist (Rosenfeld, 1987), the container of negative, discarded self representations.

Related to Grace's focus on external contingencies, and reinforcing the same dominant persecutory experience in the transference, was Grace's early experience of the therapist as an impersonal interpretation machine, an "ATM-therapist" in which a purely economic exchange—I need, you give—defined the treatment relationship. This transference was related to a chronic sense of grievance over a level of sustenance and support experienced by her as denied or never available in sufficient measure, accompanied by the angry demand that such support be promptly provided. Grace's greed, her constant focus on what was available to be taken in from others was matched only by the consistency of the process by which it was spit out. Grace vacillated between knee-jerk rejection of her therapist's efforts and a momentary acceptance and superficial consideration of what was offered, either of which was typically followed by some declaration of the therapist's uselessness to her (e.g., "Ok, I get it; so now what?"). In other patients, this type of rejection can manifest as superficial agreement with the therapist, at times even praising the therapist's acumen or intellect, while doing nothing ultimately to advance the interpretation, silently, at times unconsciously, depreciating the content and the messenger. The rapid, superficial consumption and incorporation of the message, coupled with her concurrent surface dismissal of the messenger, allowed Grace to momentarily eliminate any sense of unfulfilled need within herself, and to eliminate any awareness of something good existing outside of herself that she did not possess, that is, to prevent her from experiencing feelings of envy, helplessness, and dependency in relation to the therapist (Klein, 1957; Rosenfeld, 1971; Steiner, 2008).

Grace's focus on external reality, her initial difficulty tolerating any unmet need in herself and the awareness of any limitation in her therapist, and her staunch antagonism posed a significant challenge to the therapist's analytic function early in the treatment, and to her ability to use the therapist to establish a secure, good, and helpful internal object. Attempting to work analytically with such patients, we are often left to wonder whether we can reach and help someone who can be so dismissive of us and our interventions, who is so preoccupied with being concretely gratified, and for whom a collaborative process appears to reconstitute a disappointing and abandoning object relationship. Although these countertransferences typically represent reactions to displaced,

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projected aspects of the patient's own experience, the question of how best to use this awareness to productively and tactfully engage our patients is addressed, along with some technical recommendations related to the same, below.

Understanding the Threat of Interpretive Creativity

Although it serves as the primary technical strategy in TFP, interpretive work constitutes a major threat to our narcissistic patients' protective armor. Our interpretations and other efforts to make meaningful contact with our patients frequently touch off intense feelings of rage and shame, and, under such conditions, can be experienced by our patients variously as an enactment by the therapist of a humiliation (Steiner, 2006), a reflection of the therapist's difficulty tolerating disturbing, anxiety-infused self states (Feldman, 2007), and/or a reflection of the analyst's own self-involved, narcissistic needs (Bromberg, 1983). All of the foregoing can result in a reinforcement of the patient's defensive stance, a confirmation in the patient's mind of the persecutory internal world view, with the self represented as a victim of the bad object's attack, and, ultimately, in projections of increased force and vigor.

Among the numerous explanations for the narcissistic patient's rejection of the therapist's interpretive efforts that have been offered in the literature, several that seem particularly relevant to the case of Grace and our discussion of NPD are reviewed below. The patient's experience of another's viewpoint, independence, and creative activity as overwhelming and/or annihilating has been described by Britton (2004). Similarly, the therapist's creative, linking function, as manifest through interpretive work, can provoke intolerable feelings of envy, leading to the destruction of anything new, not already possessed or understood by the patient, setting off a vicious cycle of deprivation, followed by demandingness and greed, and accompanied envious spoiling of what is offered (Feldman, 2009; Steiner, 2008).

Feldman (1993) also addresses the threat posed to narcissistic patients by the independent and creative interpretive efforts of the therapist, suggesting that patients are most comfortable when the therapist conforms to a role assigned him by the patient, a role congruent with the patient's internal object world and expectancies. This can involve either the therapist's validation and gratification of the wished-for, idealized therapist–patient dyad, or, the familiar, albeit negatively valenced role of a withholding, critical, rejecting, or otherwise disappointing object. The failure of the therapist to get caught up in the enactment of either of the assigned roles suggests the therapist operating independently of the patient's control. Interpretations emanating from the therapist's independent functioning can thus provoke intense anxiety in the patient, creating a situation in which the patient cannot locate himself in the familiar role either in identification with, or opposition to, his internal objects. Like Britton, Feldman (1993) also suggested that the analyst's independence evokes the patient's unconscious envy of the oedipal couple, whose creative, independent thought and communion, presumably, threatened the patient's need to communicate with a containing maternal object.

Steiner (2005) has similarly addressed the issue of the patient's refusal to engage with the independent, creative mind of another, and how this resistance reflects the threat posed by the other's independence to the patient's distorted, but fragile construction of reality and its protective function. Steiner suggested that the patient's wish for unity of thought between patient and therapist, for validation by the therapist of the patient's dominant self and object world view, would, in fantasy, allow the patient to avoid the reality of imperfect objects, and of the experience of feelings of deprivation, humiliation, badness, persecution, and guilt. The patient's insistence on the "moral" argument, on getting the therapist to focus and agree with how things should be, the way he should be treated by others, allows the patient to avoid realistic feelings of deprivation and frustration that must be mastered in service of emotional growth. Further, the insistence on such "moral" arguments allows the patient to defer the reclamation of projected self representations, that is, the patient's own role in the destruction of the real, imperfect but available relationship with the therapist and others, through his effort to control and force those others into conformity with the unrealistic, internal, idealized object. Interpretation of the foregoing poses a threat to the patient's wish to live in the perfectly moral world of idealized self and objects, and forces upon the patient the work associated with loss and mourning, the struggle to bear the guilt, anxiety, and disappointment that facing reality involves (Steiner, 2005).

Finally, the experience of shame (Broucek, 1982; Lansky, 2003; Morrison, 1989, 1999; Morrison & Stolorow, 1997), provoked in some patients by an overall stance of need, petitioning someone else presumably possessed of something helpful that the patient lacks, may contribute to the narcissistic patient's difficulty accepting and using the help they seek through the treatment. Shame involves the subject's experience of anything deficient or lacking in the self, associated with dawning awareness, or full-on experience of humiliation and like affects in the treatment process. Grace's preemptive attacks on me and others, her devaluation and its effect of spoiling the good she experienced in others, can indeed all be thought of as defenses against shame (Morrison, 1999).

In sum, when a dominant and cherished self-object configuration, however painful and maladaptive for the patient, is threatened, the patient feels under attack. The wished-for, good connection with an object that can receive projections, process and contain the same, can be threatened, significantly raising anxiety and shutting down the creative interplay between patient and therapist. At such moments, the patient's experience of a persecutory treatment relationship and process can become overwhelming. LaFarge (2000) has argued that the therapist's communications when the patient's mode of experience is characterized by the paranoid-schizoid position should focus on the containment of affect, rather than a more cognitively elaborated interpretation in the traditional sense. Indeed, at such moments, an overly strident interpretative stance may be experienced by the patient as either an enactment, one that has the effect of confirming the persecutory internal experience that the patient was attempting to manage through projection, or as evidence of the therapist's own disturbance, of the therapist being overwhelmed by anxiety or confusion that cannot be tolerated and must be pushed back into the patient (Feldman, 2007; Steiner, 2005).

Facilitating the Interpretive Process With Narcissistic Patients

Analysts have long recognized the need to modify "standard" analytic technique to meet the needs of narcissistic patients (e.g.,

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Bromberg, 1983; Coen, 2010; Mitchell, 1988). Following from the foregoing discussion of the difficulties in the interpretive process, we have identified several strategies in the literature and through our clinical work that, through a sharpening of our attention to issues of tact and timing, have enhanced our interpretive efforts in the practice of TFP. For example, a stance of clarifying and simply accepting for the moment our patient's experience of ourselves, that is, the object representation, without linking this experience to more sensitive self representations, or interpreting the oscillation in the dyad or the operation of the patient's projective defenses, represents a momentary joining of patient's defensive system in service of supporting a containment within the treatment dyad of intolerable self states usually managed through projective processes. Protracted attention to this side of the dyad, that is, *the patient's experience of the analyst*, is referred to by Steiner as an "analyst-centered" interpretation (1994), and may be important in the initial stages of TFP with narcissistic patients because it is more tolerable for them to focus on clarifying their experience of the other, even when that experience is disappointing or hostile, than it is to suggest that the disappointing object may be within. Analyst- or therapist-centered interpretations are designed to bypass, at least at the outset, the patient's self-experience of weakness, inadequacy, aggression, and/or confusion, thus hopefully avoiding the provocation of the patient's shame, humiliation, or rage. This might allow for a gentler confrontation of the patient's defensive processes, and a more tactful way of entering into contact with the unacceptable, projected parts of self.

An array of preinterpretive interventions, comments that summon a remnant of the patient's observing ego, can also be useful in the treatment process with narcissistic patients, momentarily offsetting the patient's typical intolerance for interpretation. "I have a feeling you may be inclined to reject what I have to say, but here goes . . ." Or, "I'm aware of something that I'd like to share with you, but I'm reminded of earlier instances where my doing so has resulted in you becoming very upset with me and what I have to say—what do you think of my sharing this idea with you now?" Such an approach represents a momentary, deliberate acceptance of, rather than interpretation of the patient's omnipotent control, and is designed to address it indirectly, and thus invite them to stay in a more reflective and open frame of mind, which may reduce the affective shock with which some narcissistic patients experience interpretations.

At times, simply drawing the patient's attention to a pattern in the process, for example, to the patient's knee-jerk rejection of the therapist's communications, can be helpful in raising the patient's curiosity about the process and in sustaining contact through difficult exchanges. "This seems to be one of those instances when it's difficult to hear me"; or, "I think it's happening again, where you move away"; or, "Oh, here we go again, I see we're arguing with one another—we are caught in it now; can we think for a minute together about what might be going on?" These interventions mark recurring patterns in the process, noting to the patient his defensive shift away from affectively laden material, or the engagement between patient and therapist in an unusually tense, hostile or otherwise nonproductive exchange that disrupts patient-therapist contact and is impeding more reflective communication. These interventions also support the construction of a shared experience, as opposed to interpreting the destruction of that shared experience by the patient. Although in the moment this does not interpret the defensive function of the destruction of meaning or contact, it helps get the patient–therapist dyad back on a reflective track in the moment, opening a possibility for mutual observation and understanding of something important taking place in the transference (A. R. Munich, personal communication, 2010).

Working with material that is outside the transference—"external material," which of course may be intimately linked to the transference—is often a first step in approaching transference interpretations. Doing so for more extended periods might allow narcissistic patients the safety of contemplating and elaborating an inner object world as it hovers in the session, but in much greater depth than they might, were they talking about the same material in the here-and-now treatment relationship. Although one risk of this strategy might be the deflection of the negative transference, an alternative view is that we are simply being mindful of when and how a certain transference should be broached, and trading off a discussion in the transference, for the potentially richer elaboration of the patient's internal world as it is discussed and worked with outside the treatment relationship.

Although standard TFP technique encourages the tactful, but prompt presentation to the patient of contradictions in his emergent narrative, that is, confrontation, or "bids for reflection," these are often met with rageful, contemptuous, paranoid, or otherwise dismissing responses that shut down the opportunity for productive exploration. An alternative approach would involve more extended periods of clarification as we "lie in wait." Invariably, and specifically with narcissistic patients more prone to transient defeats, depressive affects, and narcissistic vulnerability, there are shifts away from the grandiosity to a self-state characterized by failure and self-loathing, as the patient's defensive processes break down, resulting in a momentary return of that which had been projected. These windows into our patient's vulnerability arise organically, without any active interpretive effort, and present valuable opportunities for us to support the patient's awareness of the otherwise dissociated self-representations and to begin to raise his curiosity about the divergent ways he experiences himself and others. By avoiding more direct confrontation and active interpretation, our objective in this strategy is to avoid active provocation of the typical defensive posture of dismissal and devaluation, hopefully allowing the patient to more comfortably elaborate his or her internal world through the material (see also Morrison & Stolorow, 1997, for an elaboration of a similar technical strategy, albeit not applied to the diagnosis and interpretation of role reversals in TFP). Lying in wait, as described above, is also consistent with the notion that interpretations with some narcissistic patients are tolerated more easily when the patient himself "displays some spontaneous curiosity about the nature of the interaction with the therapist, and has achieved some distance from it's immediacy" (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989).

In the case of Grace, the nonformulaic, spontaneous use of language that emerged in the treatment context, for example, the reclamation in the treatment of "her highness," a term that she and the therapist both could eventually use to address her imperiousness and entitlement, facilitated a link between this tendency, various object relations, and their oscillation in and outside the transference. The introduction and mindful use of "play" and creativity between patient and therapist can help the patient observe and take ownership of, for example, their aggressive and

dependent selves, bringing closer to their self experience that which they often project outward, and with a diminished sense of its danger and toxicity (Coen, 2002, 2005). Similarly, the therapist's occasional reference to "not earning my five dollars" came to signal an awareness of Grace's greedy self, her fear of the therapist being exploitive or withholding, and her underlying fear that he, like others before, would disappoint her, as a result of his own deficiencies or hers. Such an approach does not necessarily suppress the negative transference, but rather can allow its expression to be tolerated in a workable form in the moment. Further, using language that has evolved in the shared treatment context helps the patient draw upon the experience in the treatment of a successful and productive exploration of a specific dyad, as well as its oscillation and defensive function. Doing so facilitates the patient's ability to persist in working with the dyad in its current expression in the transference, with the attendant aggression and frustration, thus promoting a richer understanding of the material, and ultimately an integration of previously split-off affects, and experiences of self and object.

Conclusion

As we have seen, in TFP, as we analyze the different self and object dyads that comprise the grandiose self, we see a movement toward the dissolution of this structure, and a corresponding increased ability to tolerate and work with feelings and self experiences that had previously been managed through projection, for example, feelings related to vulnerability, dependency, longing, and hostility, as the patient begins to relinquish grandiose defenses. In the case of Grace, all of the complications with the interpretive process were abundant and clear. The therapist's efforts to interpret projective defenses, of Grace's own neediness and fragility and its manifest compensations, were summarily dismissed. At times the therapist's countertransference to Grace's devaluation lead him to become argumentative, enacting for the patient the experience of a harsh, critical, narcissistically preoccupied parent who could not contain and process for the patient the demanding expression of her needs, as well as her sense of deficiency.

It is our sense that the interpretive process, enhanced by the modifications to standard TFP technique elaborated above, contributed to Grace's more nuanced understanding and experience of self and other, to her ability to recognize that her imperious and dismissing self was part of a greater whole self, which also contained a vulnerable, weak self, and to recognize that the boyfriend who loved and was attentive to her, could also be the source at times of great frustration, anxiety, and disappointment. Likewise, Grace came to see her therapist as someone who possessed both limitations and strengths, and whose imperfect attention could be sufficient to help her. These more complex representations allowed her over time to make increasingly productive use of the treatment situation. Her subsequent relocation to another city led to the termination of treatment, but in the termination process, Grace showed an understanding and appreciation of both the aspects of the work that led to her ability to break through the isolation and paralysis she presented at the outset of treatment, and a recognition of the issues that needed further exploration and analysis.

As noted above, this article attempts to describe the theory and technique of TFP in the case of a fairly common presentation of narcissistic personality disorder, in the early stages of treatment. Our article focuses on the earlier stages of treatment because it is during the initial phases that the patient's aggression, impulse to act and react, along with the associated countertransference pressures, pose the greatest threat to our analytic function. Establishing a viable treatment contract, setting the tone and focus of the treatment, and establishing the treatment as an anchor in the patient's life are central early phase tasks, that are complicated significantly by the volatility typically associated with our work with narcissistic patients. As treatment progresses, as the concrete demands and struggles for control characteristic of the earliest sessions diminish and the patient settles into an exploratory process, the ideal representations that comprise the grandiose self become comingled with, and now shaped by emerging memories, associations, and transference experiences. In this way, the generic grandiose self–devalued object dyad typical of the earlier phases shifts as more nuanced, "component representations" emerge (Kernberg, 2014), adding the specific, personal stamp of the individual's object relational history to the patient's narrative and the transference. Work with patients in these later stages of treatment typically involves analysis of their expanding and deepening relationships with others, work related to the fears and anxieties they face as they increasingly undertake challenges, professional and interpersonal, and analysis of their feelings of dependency on the treatment and therapist.

In sum, TFP begins with the establishment of a treatment framework that optimally facilitates an exploratory process, one in which the representations of self and other that so powerfully shape the patient's life experiences come alive in the treatment relationship, wherein their first-hand examination becomes a powerful therapeutic tool. Through the recognition of these disparate and unintegrated representations as they unfold in the treatment, through the repeated interpretation of their meaning and defensive functions in the transference and in the patient's life outside of treatment, patients become more aware of motivations that were previously hidden, yet highly determinative of their subjective experience. Increasingly, patients can tolerate the negative self-experiences they had projected onto the outside world, while also tolerating more realistic, imperfect representations of self and others that ultimately may lead to potentially more satisfying and positive experiences of self and others in relationships. This process ideally allows patients an enhanced control over their emotions and a greater sense of freedom, choice, and pleasure in the totality of their lives.

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