

14

TRANSFERENCE-FOCUSED PSYCHOTHERAPY FOR NARCISSISTIC PERSONALITY

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S. was a 23-year-old man who was referred to the lead author (BLS) for treatment pursuant to his withdrawing from his first year at a prestigious law school.¹ Overwhelmed by academic challenges that demanded great persistence, focus, and collaboration with peers, S. became severely depressed and withdrawn; disgusted with himself, he had feelings of inferiority and hopelessness and suicidal thoughts, all resulting in a late-semester withdrawal from school and an inpatient admission. S.'s inpatient treatment team noted his condescending attitude toward them and his fellow patients, his minimal engagement in the program, and his sarcastic, nonchalant attitude. Although he was aware that he was roundly disliked by the staff and fellow patients (a fact confirmed by the staff), he also stated that he felt chronically misunderstood, unappreciated, and neglected.

S. was pleased with his initial sessions; he experienced his therapist as earnest, knowledgeable, and forthright. Soon after the evaluation, however,

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¹The patient's identity has been disguised to maintain confidentiality.

S.'s complaints grew—about the therapist's techniques, the inefficiencies in billing and office security practices, and the therapist's attitude, which S. experienced as condescending. When asked about his increasingly cynical and critical attitude and his sense that most people had little to offer him, S. responded unguardedly. He discussed his awareness of the air of superiority he exudes, admitted that he had little patience for those whom he saw as being beneath him, and conveyed a sense of justification in his typically oppositional stance toward those superior to him, specifically when their requests of him were, in his view, short-sighted or otherwise not to his liking. Surprisingly, S. recognized the contradiction between his superior attitude and his current, seriously compromised life situation. S. could discuss with convincing depth his sense of fragility and proneness to humiliation, and he demonstrated some awareness of the defensive function of his arrogance and its self-defeating effects. Nevertheless, and despite genuinely viewing his demeanor and attitude as a character flaw, his conscious, predominant presentation and experience of self was one of brittle superiority.

In the initial sessions, the therapist suggested that S. seemed to hold two competing views of himself, each linked to a corresponding view of others: one in which he was superior, desirable, and competent, in relation to teachers, peers, and therapists who were naïve and weak, unjustifiably arrogant, with little to offer him; and a second view, in which he himself was the devalued, incompetent naïf, lacking in confidence or direction while posturing a snide rebellion against an authority unworthy of his respect. The therapist suggested that S.'s split sense of himself and experience of others is characteristic of individuals with a personality disorder, in his case, one marked by a particular difficulty associated with maladaptive self-esteem regulation (i.e., narcissistic personality disorder). His treatment recommendation was an exploratory psychodynamic psychotherapy called transference-focused psychotherapy (TFP).

INTRODUCTION

What follows are some preliminary considerations on the application of TFP (Caligor, Clarkin, & Kernberg, 2007; Clarkin, Yeomans, & Kernberg, 2006) for patients with narcissistic pathology. TFP is a twice-weekly psychodynamic treatment approach grounded in contemporary object relations theory; it posits that borderline pathology, including Axis II borderline personality disorder and other severe personality disorders, results from a fragmented sense of identity, one in which positive and negative representations of self and others are segmented in the mind for defensive purposes. The treatment approach combines elements of standard psychodynamic tech-

nique (e.g., attention to unconscious processes, a focus on transference, interpretation of conflict and defense), with a higher level of therapist activity, within a set of mutually agreed-upon behavioral parameters designed to set up a viable therapeutic framework that limits acting out and promotes the unfolding of the patient's full emotional experience and psychic life in the treatment setting. The ultimate goal of TFP is to promote the mental integration of the patient's extreme, unintegrated representations of self and others, and in doing so help the patient to more adaptively tolerate negative affects (e.g., aggression, anxiety, envy, guilt) and sustain meaningful engagements in interpersonal relationships and work.

Two well-controlled randomized clinical trials (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010) provided evidence that TFP is an effective treatment for patients with borderline personality disorder. Our collective clinical experience suggests that borderline and narcissistic personalities share core structural features (i.e., identity pathology, supported by the operation of "primitive" defensive strategies for managing intolerable self states and affects) and has led us to think that TFP would be effective in the treatment of narcissistic pathology. We discuss borderline personality organization (BPO), the syndrome characterized by identity pathology in combination with the predominance of primitive defensive strategies, and which, in our view, encompasses many of the personality disorders described on Axis II of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000); then we explore narcissistic personality disorder as a specific case of BPO. We then address the question of how TFP could be extended to work with narcissistic patients.

THE SYNDROME: BORDERLINE PERSONALITY ORGANIZATION

As experiences of the self in relation to others unfold in early childhood, they are structured by the mind into representations, conceived as cognitive/affective structures that serve as lenses through which the self, interpersonal exchanges, and life are subsequently perceived and experienced. Rewarding/gratifying and frustrating/negative experiences with caretakers are internalized, grouped together in the mind, and form the bedrock for the internal world of self and object representations. The first stage of organization of these dyads, before the integration that comes with healthy psychological development, is into two sets of dyads, one characterized by totally negative affects and representations (the *persecutory* dyad) and the other by a set of ideal affects and representations (the *idealized* dyad). Some of the persecutory self-object dyads frequently encountered in our work with borderline patients include a *deprived child* in relation to an *absent, neglectful, or withholding parent*;

or a *threatened, weak, vigilant victim* in relation to a *sadistic, persecutory, or mercurial parent*. A generalized example of such a dyad in a narcissistic patient might involve a *grandiose, fully independent self*, in relation to an *ineffectual, depreciated, dependent other*. An example of an idealized dyad might be that of a *dependent, yet perfectly nurtured self* linked with longing to an *admiring, caring, and loving parent*.

The internal array of these self–object dyads (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. Healthy identity is characterized by a sense of self that is stable, differentiated, integrated, and flexible. In contrast, identity pathology corresponds to a subjective sense of self and others that is (a) unstable (i.e., rapidly and unpredictably shifting); (b) poorly differentiated (i.e., the descriptions of self and other are impoverished or caricatured, idealized, or devalued); (c) unintegrated, meaning that positively and negatively imbued qualities of self and other are defensively segregated; and (d) inflexible, meaning that the individual cannot shift from the dominant, more ego-syntonic self- and object representations (even if these are negatively valenced), to dyads or representations that are defended against, because these are too painful or uncomfortable to experience.

Identity pathology is maintained by the operation of *primitive defenses*, also referred to as *splitting-based defenses*, including projection and projective identification, omnipotent control, externalization, and idealization/devaluation. All of these defenses function, at various levels of awareness, at times to ward off the persecutory dyad and at other times to ward off the threatening aspects of the idealized dyad (because of the anxieties associated with holding onto a very stimulating and positively valenced but also tenuous and brittle relationship). Essentially, the function of these defenses is to keep the camps of negative and positive affect separate insofar as their integration would pose a threat to the patient’s psychic equilibrium (i.e., a fear that the aggression associated with the negative affect would destroy the brittle segments of positive affect; Kernberg, 1984; Kernberg & Caligor, 2005; Klein, 1946).

The treatment process in TFP involves using the affect in a session to track the emergence of self and object dyads in the treatment relationship; specifically, which are most prominent, and how the roles in the dyad are alternately enacted or projected onto the therapist in the moment-to-moment process. As one example of a negatively valenced, surface dyad, the narcissistic patient often protests against therapeutic interventions that he or she experiences as reflecting an arrogant, depreciatory, or authoritarian attitude, suggesting that in the moment the patient is the helpless victim of a critical attack or that the therapist is exploiting the patient’s weak position to

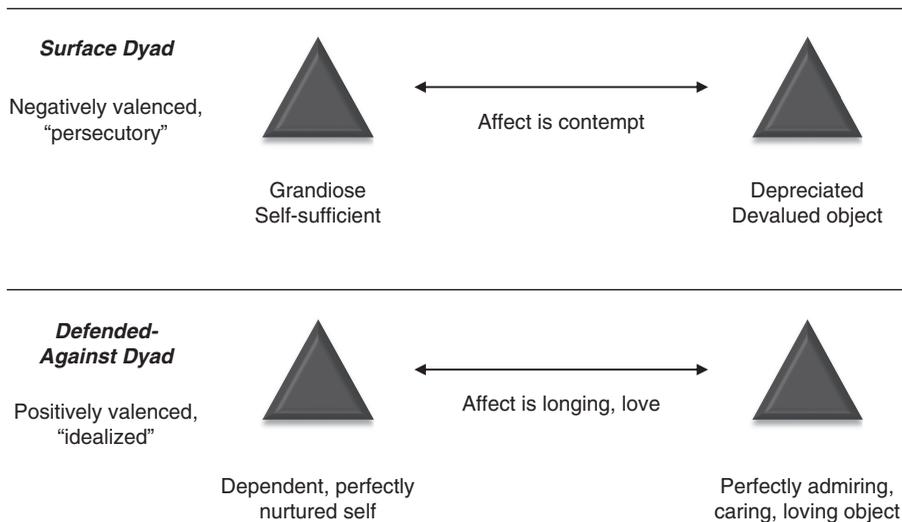


Figure 14.1. A pictorial representation of object-relations dyad interactions. The figure depicts one object-relation dyad defending against a deeper dyad.

demonstrate his or her own superiority. Invariably, however, the roles in this dyad alternate, so that the therapist experiences the patient as dismissing or ridiculing the therapist and his efforts (see Figure 14.1 for a graphic illustration of this dynamic). It is crucial to emphasize that one of the distinguishing features of BPO is that upon internalizing these dyads (in this example, a specific instance of a persecutory dyad), the patient becomes identified with both roles, with both the aggressor and the victim, although each identification is experienced at different times and the identification with the aggressor is often enacted without awareness or justified as "self defense."

In tracking these linked self- and object-representational dyads as they emerge in the treatment process, the therapist must also be mindful of the *layering* of dyads, that is, which dyad on the surface defends against another at greater depth. An example of such layering would be the manner in which the dyad of the negatively valenced, fully independent, grandiose self in relation to a depreciated, dependent object defends against a deeper, positively valenced, idealized dyad, that of a dependent and perfectly nurtured self, linked with longing to an admiring, caring, and loving parent.² (See Figure 14.1 for a graphic illustration of the layering of dyads.) Said differently, it is our experience that whereas the fears, negative expectancies, and aggression

²Note that we do not presume that these dyads are historically accurate; rather, they reflect internal representations of earlier experiences, now reworked in terms of the individual's present motivations, wishes, and defenses.

often dominate the transference, these negatively valenced affects and experiences often protect patients from painful longings for a positively tinged, gratifying relationship that holds the promise, unrealistically, of nurturance, support, and love devoid of any conflict and frustration. 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.³ At the same time, however, the idealized dyad is generally less consciously accessible to the narcissistic patient, even transiently, because of the intolerable feelings of envy that would be provoked by an object that the patient might need or depend on.

PATHOLOGICAL NARCISSISM AND BORDERLINE PERSONALITY ORGANIZATION

Our understanding of narcissistic personality disorder is as a specific subtype of BPO, a specific configuration of self- and object representations characterized by the pathological grandiose self (Kernberg, 1984), in which the self becomes the repository for all that is good, combining realistic representations of the self, idealized representations of the self (what one wishes one would be, or that which significant others wish one to be, *becomes* the self representation), and idealized representations of the others (as though they were one's own). Starting early in childhood, this defensive maneuver is thought to protect the nascent self, developing under conditions characterized by an excess of frustration, painful neglect, abuse, and/or trauma, often in combination with temperamental factors that compromise the child's emergent coping and affect regulation skills. The pathological grandiose self is thus compensatory in that it can be thought of as a structure superimposed upon the divided sense of self described in the general case of BPO, providing a semblance of integration by warding off any experience of the self that is negatively valenced, including feelings of inferiority, incompetence, vulnerability, aggression, and envy, all of which are ascribed to others, individuals, groups, institutions, and the therapist.

Like the more general case of BPO, the fragmented identity of the narcissistic patient is supported by primitive defenses. Kernberg, drawing on Rosenfeld (1964, 1971) and Klein (1946), suggested that the patient's fantasy

³In contrast to persecutory dyads, which are generally quite visible in borderline and narcissistic patients, idealized dyads are often hidden from view, with patients tending to deny the need for a longed-for relationship experience because that experience regularly fails to live up to its idealized form, thus corrupting the idealized vision with even deeper feelings of pain and disappointment.

of omnipotence serves to eliminate the experience of frustration and pain, that of a humiliating sense of need or dependency, and related feelings of envy. (Of whom would an omnipotent, grandiose self be envious?) When enacted interpersonally, the narcissistic patient unconsciously seeks to omnipotently control others, as if to guarantee the admiration, validation, or accommodation from others that he requires. The patient's sense of omnipotence is threatened, and the prospect of actualizing some limitation or failure becomes more real, when he comes into increased contact with the demands posed in his work situation or relationships. It is for this reason that many narcissistic patients functioning in the BPO range have difficulties in work and relationships, often responding to the reasonable demands of the same with an indignant withdrawal from real-life commitments.

In contrast to typical cases of borderline personality disorder, which are characterized by extreme and unpredictable shifts in the self- and object representations activated in a given moment, the narcissistic dyad is often particularly stable and, for periods of time, inflexible. The artificially stable pathological grandiose self is kept firmly in place through the use of primitive defenses, such as omnipotent control, which involves the use of aggression, the threat of aggression, and the induction of a "walking on eggshells" feeling in the therapist and others. Such control facilitates an avoidance of any sense of inferiority, injuries to self-esteem, or anything that would suggest to the patient something lacking in the self and residing in others, something the patient might need to depend on or might envy. Unconscious as well as conscious feelings of envy may lead to the impulse to destroy the good aspects and experience of others, particularly those qualities admired in the other but that one does not possess (Kernberg, 1984; Rosenfeld, 1964). Pathological envy is a dominant experience and ever-present threat for narcissistic patients, one that is frequently warded off in the clinical process through the patient's grandiosity and devaluation of others, including the therapist. Idealization allows the patient to feel admired by those surrounding him, individuals and institutions worthy of his company and communion. Paradoxically, however, the patient needs to devalue those same individuals in order to stave off the awareness of any humiliating deficiency in the grandiose self, as well as feelings of envy. The episodes of rage characteristic of many narcissistic personalities (Kernberg, 2003; Kohut, 1972) reflect threats to or breakdowns in the pathological grandiose self, incited by situations in which the patient is forced to confront some aspect of reality that challenges the splitting off of negative self representations or that does not suit the patient's narcissistic needs at the moment (to have their brilliance reflected and admired by a brilliant object/therapist, or to be perfectly understood). When operating effectively (from the patient's perspective), this defensive style complicates the treatment process by contributing to a strong subjective sense of superiority and

self-sufficiency, eliminating the feelings of humiliation that accompany the narcissistic patient's need to depend on anyone other than the self, including the therapist.

TREATMENT

The work of TFP with narcissistic patients is complicated by the tenacity of their defensive processes, the degree of underlying aggression, the enactment and enabling of patients' entitlement and grandiosity in their lives outside the treatment, and by their heightened sensitivity to envy, with its associated affects of humiliation, shame, and inferiority.⁴ Nevertheless, if the therapist works with the patient to construct a mutually acceptable treatment frame, the containing and interpretive process can be used to slow down the interactions (and the projective processes) enough 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 recognize and integrate in order to move toward a sense of self in which positive and negative, aggressive and libidinal, hateful and loving affects are increasingly integrated (i.e., a "whole-object" position).

Evaluation and Anamnesis

The treatment always begins with a careful evaluation designed to determine whether the patient is operating in the borderline or higher levels of personality organization, and to derive his or her phenomenological diagnosis (for a more in-depth view of our assessment procedure, please consult our writings on the "structural interview" [Kernberg, 1984] and the Structured Interview of Personality Organization [Stern et al., 2010]). In addition to assessing the patient's representations of self and other, the quality of the patient's internalized values system (e.g., the presence thereof, capacity for guilt and remorse, presence of antisocial tendencies) and aggression (self- and other-directed, including self-injury/suicidality) are carefully assessed insofar as they are essential for determining the severity of the patient's pathology within the borderline personality organization spectrum and have prognostic implications.

The narcissistic structure and the operation of primitive defenses often make it very difficult to obtain a clear picture of the patient's self and object

⁴The underlying aggression may be more defensive in higher level and more primary in patients with low-level narcissistic personality disorder.

representations and of the quality of his or her engagement with external reality (work, recreation, romantic and sexual relations). One can often begin to formulate a diagnosis as one notices descriptions of self and others that are overly idealized or depreciatory, lacking depth and differentiation, or largely self-referential. It is also during the evaluation period that for the first time the therapist may sense being under the hostile, omnipotent control of someone who is threatened by close contact with an independent other (such as the therapist); in the patient's view, an uncontrolled therapist might enact the aggressive affects that the patient is denying and projecting. Conversely, the therapist may experience feelings of self-doubt and even humiliation when the patient systematically dismisses or evaluates his or her attempts to elicit history; these early countertransference responses can signal the operation of projective identification (Feldman, 2009; Kernberg, 1984), a primitive defensive procedure by which the patient reduces anxiety by unconsciously using the therapist as a repository of negative self representations and feelings that cannot be tolerated internally. In such circumstances, the countertransference can provide important clues about the dreaded and devalued aspects of self against which the pathological grandiose self defends.

The Treatment Contract and Setting the Frame

Subsequent to the evaluation, the therapist and the patient must determine the conditions under which TFP with this particular patient can succeed. The discussion of the "treatment contract" includes elements characteristic of all TFP treatments, such as session length and frequency, management of fees and absences from the treatment, and guidelines for free association (i.e., discussing what comes to mind without editing or censoring). Discussion of the treatment contract also includes individual elements designed (a) to address and limit patient-specific behaviors that have the potential to disrupt the treatment frame (e.g., recommendations of adjunctive treatment for eating disorders or alcoholism); and (b) to create safe conditions for both patient and therapist by establishing parameters for the management of acting out and suicidality. TFP is also premised on the notion that the patient's life activities are integral to the treatment process. Effective treatment requires that patients be productively engaged in some structured activity while they are in treatment (a job or an educational or training program) and that the treatment itself does not support secondary gain of the illness. 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, collaboration, and empathy; the struggles over ambition and striving; and the related impulse, under stress, to retreat. As might be expected, patients with significant narcissistic pathology

often experience this process as a coerced submission to authority, a relinquishment of cherished autonomy and control. It is nevertheless essential that patients, buffered by the containing and explanatory function of the treatment, confront the world from which they have psychically, and in the case of patient S., actually withdrawn. S.'s ready agreement to find a full-time job prior to returning to school, and to continue sessions upon his subsequent return to school, was prognostically positive. It demonstrated a willingness to compromise some of his autonomy in the service of growth and a developing ego strength that allowed him to confront his limitations and frailties while persisting in his work.

Treatment Process

After mutually acceptable treatment conditions have been established, the treatment proceeds, with the first phase generally focusing on the containment of suicidal and self-destructive behaviors through the patient's testing of the treatment contract. Issues related to fees and attendance and breaches in agreed-upon treatment parameters (e.g., those related to substance abuse or parasuicidality) are discussed. These behaviors, which tend to diminish over the first few months of treatment, are understood in the transference because they reflect the patient's self and object world as enacted in the treatment process with the therapist. Our efforts in this early stage involve clarifying the emergence of the actors, roles, or part-self and part-objects involved in the patient-therapist interaction (e.g., roles of dominance-submission, superior-inferior).

Transferences

There are several typical transferences that tend to develop in the treatment of narcissistic personalities, each derivative of the self-structure described earlier, and each with origins in the patient's earliest object relations. It is not unusual for psychodynamic clinicians to experience narcissistic patients as failing to develop any transference at all. Therapists may get the sense that they do not exist, or, to the extent that they do, it is only as impersonal "ATM therapists," valued to the extent that they dispense support, guidance, and interpretations on demand, and dismissed or devalued to the extent that they (properly) focus on the patient's internal world (self and object representations) rather than on solving the problems of the day.

Therapists frequently experience a transference in which a grandiose, omnipotent self stands in relation to an object (therapist) as passive audience. Patients relentlessly strive to be in charge of their narratives, whether or not these narratives correspond to objective reality, while at the same time complaining that the therapist, who struggles against the powerful influence of patients' omnipotent control, is passive or otherwise unhelpful. The ther-

apist's efforts to exert influence are dismissed or ignored, experienced as a threat, promising either intolerable envy of whatever good the therapist might possess or disappointment or rage at the therapist's reasonable limitations.

When the therapist steps out of the role of being the passive audience, what is often revealed, through affects related to contempt and rage, is the dyad of a grandiose, omnipotent self in relation to the depreciated, devalued object (therapist). The emergence of this underlying dyad, which is typical of patients with narcissistic personality disorder and borderline organization, may be staved off for a time by techniques that reflect, validate, or empathize with the patient's productions. Yet, in our experience, this underlying dyad will emerge and must be addressed within the transference in order for the pathological grandiose self to be analyzed. The manifestation of this dyad in the transference can take several forms. At times we observe the devaluation of the therapist through passive acceptance or a thinly veiled pseudo-idealization of the therapist's communications ("Oh, that is such a brilliant idea"; "I'm so lucky to have you"). The limitations of this superficial gratitude are revealed as the therapist's communications are in turn forgotten ("What did we talk about last time?"), ignored, or as patients repeatedly fail to use them to deepen their understanding or to link them meaningfully to their difficulties ("hmmm, how interesting . . . anyway."). In other expressions of this same transference, our efforts are met with an overtly contemptuous response, with an outright hostile, knee-jerk rejection of whatever is offered, without any apparent reflection. We understand such immediate, dismissing reactions to our interventions in several ways. The rapid consumption and concurrent surface dismissal allow patients (a) to eliminate any awareness of something good existing outside of themselves that they did not possess, thus preventing them from experiencing envy; (b) to eliminate any sense of unfulfilled need within herself, which would provoke feelings of helplessness and dependency (Rosenfeld, 1964); and (c) to stave off potential feelings of humiliation associated with having been made aware of a deficiency in the self or the feeling of having submitted to an authority (Steiner, 2006). Other explanations for the rejection of the therapist's interpretive efforts involve the patient's experience of another's viewpoint and mind as overwhelming and annihilating, replicating earlier experiences of the self being used for the parents' narcissistic aims (Britton, 2004).

In patients with more intense aggression and a less well-developed and internalized system of moral values, one may see the transference of a grandiose, omnipotent self in relation to a projected exploitive, envious object (therapist), or at lower levels on the same spectrum, a persecutory, dangerous object (therapist). In such cases, the therapist is experienced as exploitive, interested in the patient for money or wisdom, or as enhancing himself or herself through the glow of the patient's special talent and ability. We understand this as a

defense against the patient's insecurities and sense of emptiness, resulting in a need to greedily take in whatever resources on the outside might supplement or complete the sense of perfection strived for in the self. Episodic reversions to a paranoid stance in turn stave off the patient's sense of emptiness and inadequacy while at the same time protecting his or her fragile self-esteem from painful feelings of envy. Finally, in the syndrome of malignant narcissism, characterized by more pervasive and significant paranoid, aggressive, and antisocial tendencies, the therapist is experienced as dangerous, an object that needs to be neutralized and defeated (Kernberg, 1984). In such cases, the only gratification derived by the patient may be in the defeat of the therapist and of all goodness in the external world, represented to the patient as a grandiose triumph over external persecutory, exploitive forces. The danger of negative therapeutic reactions resulting from this transference, including the potential triumph through self-destructiveness and destructiveness over the therapist (who at times inevitably comes to represent all external sources of neglect and mistreatment), or over the perceived strength of persecutory objects, is severe, and such cases must be treated with the utmost caution.

Countertransference Management

The countertransferences that develop in treatments with narcissistic patients tend to be intense and unstable, to develop rapidly, and to be confusing to the therapist. Countertransference pressures are intimately related to the topic of technical neutrality in that they often involve intolerable feelings of anger, self-doubt, and even humiliation in the therapist—the very feelings that the patient is warding off through projection—that may lead to enactments. As such, these intense countertransferences can disrupt our ability to reflect upon and understand a patient's inner world and to effectively communicate with the patient. The capacity to recognize, tolerate, and process such countertransference feelings is an essential aspect of the treatment process. Bion's notion of containment (Bion, 1967; Ogden, 2004), in which the inexpressible, inchoate, projected elements of the patient's experience are "contained" in the mental and emotional experience of the therapist in the service of ultimately being returned in more organized, elaborated, and tolerable form to the patient, is central to the intersection of countertransference management and the interpretation process in TFP (Caligor, Diamond, Yeomans, & Kernberg, 2009).

At times, therapists experience feelings of boredom with narcissistic patients. This countertransference may signal the operation of the patient's omnipotent control, with the threat of the combination of the patient's rage and narcissistic vulnerability working to render the therapist powerless to introduce anything other than weak, validating responses. This is particularly problematic under conditions in which the patient accepts no outside influ-

ence yet is engaging in parasuicidal or otherwise self-destructive behaviors. The therapist's feelings of irritation with the patient are often associated with a patient's brittle idealizing stance, with its strong undercurrent of devaluation. A therapist's feelings of hopelessness are not only a logical outcome of the relentless depreciation experienced in some treatment processes, but can also be thought of as the result of a complementary countertransference (Racker, 1957), in which the hopeless and defeated representations of the patient's self are projected, induced in, and experienced by the therapist, whereas the patient, ensconced in the pathological grandiose self, acts as though he or she has no problems whatsoever. For the therapist, fear of patients and for his or her own physical and legal safety can at times represent a realistic attunement to a patient's rageful expressions of envy and wishes for revenge. Fear of one's own rage toward the patient, in response to accusations of greed, ignorance, neglect, or aggression; the patient's effort to enact boundary violations; or the rejection by the patient of therapeutic efforts, are prominent countertransference reactions that the therapist must recognize and address. The failure to tolerate and contain one's fear, resentment, or even rage toward a patient can have damaging or even disastrous consequences, resulting in the therapist's ignoring the extent of the patient's self- or other-directed aggression or contributing to boundary violations and other forms of acting out on the part of the therapist. The supportive and organizing function of peer consultation groups in addressing these powerful countertransference reactions cannot be overemphasized.

Interpretation

The core process of TFP takes place largely through one broad technical strategy, long viewed as central to the psychoanalytic process, but modified somewhat in the case of TFP, namely, interpretation. Interpretation in TFP (Caligor, Diamond, Yeomans, & Kernberg, 2009) involves repeatedly identifying the actors in the therapeutic dyad as they are experienced and shift across a session, tracking their emergence, projection, and oscillation in the moment-to-moment process, and eventually developing hypotheses about their defensive function. The goal of these efforts is to help the patient gain awareness of and tolerate the confusion in their inner world by examining how it unfolds in the transference.

Interpretation is conceived as a series of interventions that build on one another. In the language of traditional psychoanalysis, the cycle of interpretation consists of three elements: (a) requesting *clarification*, seeking information from patients regarding their subjective experience so as to clarify which dyads are being enacted on the surface in a given exchange; (b) *confrontation*, which is an attempt to invite the patient's collaborative reflection upon an apparent contradiction in the patient's communication (either a contradiction between

how the patient presents at different moments, or a discrepancy between the patient's words, or between the verbal report and the patient's affect and/or behavior); and (c) what is thought of as *interpretation* proper, a linking of the content of the clarification and/or confrontation to a hypothesis about the unconscious determinants of the patient's surface experience. (For a detailed depiction of the interpretive process in TFP, see Caligor et al., 2009.)

The guiding principle that helps to focus the therapist's attention when selecting the subject of an interpretation is that of affective dominance. What is affectively dominant at a given point in the session can be expressed through the content of the patient's communications, his or her behavior in the session, and, as is often the case with narcissistic patients, through the countertransference, the affect avoided by the patient and now displaced, resonating in the therapist. Interpretation ultimately helps patients integrate the present, conscious experience with that which has been split off, either projected onto others, dissociated from a different self experience, or repressed. Throughout the treatment process, the therapist works to intervene and interpret from a standpoint of "technical neutrality," that is, a concerned but objective observer of the patient and his difficulties, rather than one clearly identified with one side or the other of the patient's conflict. Rather than implying indifference to the patient's concerns, technical neutrality simply dictates that the therapist does not actively take sides in the patient's conflicts (i.e., those between opposing internal wishes, between internal wishes and external prohibitions, and between wishes and the constraints of external reality). The technically neutral stance thus allows for the therapist's empathy with each side of the patient's conflict, in service of understanding the patient's unconscious motivations and determinants and helping the patient become better able to understand and resolve internal conflicts.

The full cycle of interpretation can be illustrated in the case of S. Early clarifications focused on S.'s shifting experiences of the therapist in the developing transference. S.'s defensive response to inquiries about his failure to follow up on inquiries he made in search of summer employment prior to his academic withdrawal led to the suggestion that he was experiencing the therapist as a critical, demanding parent. In response to this clarification, S. noted how his experience of the therapist matched his typical experience of his father, whose demands for academic perfection were exceeded only by his exasperation at his son's torpor (in the father's view, S.'s actively wasting his intellectual gifts and talent). In summary, the earliest object-relation dyad to emerge in the treatment, a persecutory dyad, was of the therapist as a critical parent, linked by affects of fear and shame, to a depreciatory self-representation of S. as incompetent and ineffectual.

As S. complained about the various critical authorities dictating his life to him, the therapist became increasingly aware of becoming alternately

annoyed with and disengaged from him. S. had several instances in which he was “confused” about logistical matters, citing a “miscommunication,” resulting in missed sessions and his failure to follow through in a timely manner with some of what he had agreed to in the treatment contract (his working to obtain a temporary job and to reinstate his academic status). S. became angry when the therapist suggested that these misunderstandings were all emotionally beneficial to him, allowing him to avoid situations that would provoke his anxiety or threaten his self-esteem. S. shared his sense that he should not have to follow up on policies with which he did not agree, that it was important to him to move at his own pace as opposed to the therapist’s, and that he was the expert on his emotional needs. At this point S.’s attention could be drawn to the oscillation in the dominant, surface dyad; it was now S. who was in the role of the critical parent, silently but actively undermining the authority of the therapist, which he viewed as wrongheaded and ineffectual. Through repeated observation of this pattern to S., in and beyond the particular treatment setting (recall that the hospital staff experienced him as imperious and depreciatory), both he and his therapist came to understand how the two sides of this dyad alternated in defending against one another: first, how his arrogant, critical attitude toward others (including the therapist) staved off feelings of his own inadequacy and smallness; and second, how his self-representation as weak and ineffective allowed him both an excuse to withdraw from challenges that could elevate him (albeit at the risk of humiliation and failure) and the diminished but secure position from which to enviously mock anyone actively working to succeed, including those attempting to help him.

On a more positive note, even at the earliest stages of S.’s therapy, the therapist had a palpable, although intermittent sense of a positive, warm working relationship. S. would speak freely, associating in rich images to his daily goings on, hopes, and pleasures, and providing a window into his internal world. The freedom of S.’s speech, and the disinhibition and suspension of vigilance which it implied, is typical of higher level narcissistic personalities and suggested that S. was not always threatened by the possibility of his mind happening upon unwanted or threatening self-representations, and likewise, that he did not always feel threatened by the therapist’s independent mind, the function of which he implicitly recognized as being to help him access and tolerate aspects of his experience that would otherwise be felt as overwhelmingly negative. This more benign, positive transference was associated with a dyad, warded off in much of S.’s life by the vicissitudes and behavioral consequences associated with his experiences of persecutory dyads, in which a dependent, satisfied, and curious child was linked by affects associated with respect and affection, to a loving, admiring, and nurturing parent. In this dyad, we see the counterweight to the narcissistic patient’s sense of omnipotence and self-sufficiency, the nascent ability to tolerate some

measure of healthy dependency. S. was indeed able to think of his tendency to become arrogant and contemptuous of others, while at other times demeaning himself, feeling inferior and weak, as a defensive position, protecting him against longings for reliable and consistent closeness, affection, and support that had historically proved fleeting.

Interpretation, the effort to observe with the patient the object-relations dyads operating on the surface and the way they defend against dissociated or projected experiences of the self and other, thus poses a major threat to the pathological grandiose self. Therapist efforts to breach the patient's protective armor can touch off a range of affects, including rage and shame, and is experienced frequently by patients as an intentional enactment by the therapist of a humiliation (Steiner, 2005), one that often results in projections of increased force and rigor. S. was unusual in his ability to tolerate the therapist's interpretation of his arrogance as a defense against a weak and devalued sense of self and to deepen through his associations the mutual understanding of this frequently projected part of himself. S. and the therapist were able to form, relatively quickly, a working alliance that could survive the onslaught of his pathological grandiose self, and in which S. could tolerate the therapist as a partner in what is usually a long and painful process of analyzing the pathological grandiose self. Analysis of the pathological grandiose self in the transference is essential to TFP and is considered to be the factor that allows for lasting, durable changes in the patient's personality, going above and beyond the more limited goal of shorter term relief of the narcissistic patient's symptoms of anxiety or depression. Patients at lower levels of BPO, whose use of aggression-fueled primitive defenses to keep the depreciated, devalued self more firmly projected onto the object world, require more protracted attention to periods of clarification. Steiner's (1994) notion of "therapist-centered" interpretations, in which the patient's experience of the therapist is clarified and simply accepted for the moment, 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, can be helpful. Such interventions may help the patient to feel understood and supports a containment in the treatment dyad of intolerable self states usually managed through projective processes. (For a more complete discussion of the interpretive process, see Caligor et al., 2009; Diamond, Yeomans, & Levy, 2011.)

SUMMARY

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 firsthand examination becomes a powerful therapeutic tool. Through the recognition of these part–self and part–object representations as they unfold in the treatment, and 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, and ambivalent representations of self and others. 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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