CHAPTER 7

TFP-N Early Phases

In this chapter, we describe the early stages in TFP-N that are designed to address the multifaceted nature of narcissistic disorder. Because TFP-N emphasizes the individual's identification with both the self and object poles of the mental representations that comprise the internal world (that is, the grandiose self/devalued other; vulnerable self/idealized other), it is uniquely suited for narcissistic individuals with different phenotypic presentations, fluctuating mental states, and diverse contradictory or compartmentalized patterns. As described in Chapter 4, in TFP-N we first focus on the various manifestations of the grandiose self as they emerge in the patient–therapist interaction, as a route to identifying the specific internalized object relational dyads that comprise the grandiose self. Although we identify grandiosity as a core trait of narcissistic patients from early on, whether expressed overtly in socially dominant, arrogant attitudes and behaviors, or covertly in the form of preoccupation with convictions about greatness expressed in grandiose beliefs, cognitions, and fantasies, we do not necessarily confront grandiosity per se in the early stages of therapy. Rather, we focus on identifying the contradictory aspects of the grandiose self, such as the entitled and exploitative attitudes and behaviors that coexist with intolerable states of vulnerability, emptiness, inadequacy, and shame, as they are evoked in the moment-to-moment interaction with and experience of the therapist. We also focus on the costs and benefits of grandiosity, including the sense of specialness and uniqueness it confers, and the admiration or even adulation it may evoke in the interests of defining the grandiose presentation of the self-concept, a fundamental feature of pathological narcissism and NPD more clearly. There is also a sense of being left behind in developmental tasks because of a lack of investment in relationships, or in more mature

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patients, the often subtle sense of futility, inauthenticity or meaninglessness despite considerable satisfaction in professional achievements or social endeavors. This is because the grandiose self is organized around external admiration and not an internalized world of deep and meaningful relationships, so that the individual may have the sense that nothing memorable or sustaining has happened and may wake up in midlife with "a desperate sense of years lost" (Kernberg, 2008b, p. 301). In the early stages, it is most important to understand and empathize with how the grandiose self defends against the underlying anxieties about dependency, relying on others, fears of humiliation, and exposure that may be evoked in the therapeutic situation.

Initially, it is particularly important for the therapist to contain the projection of the narcissistic person's intolerable devalued, vulnerable aspects of self as a first step to interpreting their defensive functions. Interpreting in the projection involves clarifying the patient's experience of the therapist, or others in the moment, without challenging it or suggesting it has anything to do with the patient's motives or internal world. This allows the therapist to gauge which aspects of his or her experience the narcissistic person can own and which he or she must disown to avoid intolerable pain and anxiety, fostering the capacity to reflect on why this is the case. Holding or containing the projections while gradually introducing an alternative perspective lessens their toxicity and allows them to be reassimilated and understood. Only gradually, as the patient can tolerate it, do we introduce alternative perspectives that foster a more integrated sense of self and others. Thus, with narcissistic patients in the early stages of treatment and beyond we continually balance containment and interpretation. This is done initially through interpreting in the projection, which is designed to bypass the patient's sense of vulnerability, thereby avoiding the provocation of shame or humiliation that those with pathological narcissism often experience.

The importance of interpretation and containment in the treatment of narcissistic disorder is consistent with other, quite divergent theoretical perspectives, although the balance between the two techniques may vary according to the theoretical orientation of the clinician. Joseph (1959), from the neo-Kleinian perspective, talks about the necessity of the therapist containing the projection of "dependent and needy," as well as the "envious and hating" (p. 216) parts of the patient's self. Britton (2003), following Bion (1962, 1994), emphasizes the central role of the therapist in the "transformation of experience through the process of containment" (p. 21).

Those working from within the relational/interpersonal school advocate a shifting empathy–anxiety balance in the therapist's technique,

adjusted to what the narcissistic individual can tolerate at different stages of the therapy. Bromberg (1983) writes, "Interpretive work of a certain kind must be attempted right from the beginning if 'empathy' is to have any meaning beyond a quasi-artificial technical maneuver" (p. 378). Mitchell (1986) also describes work with narcissistic patients as a balancing act between accepting and clarifying the nature and function of the patient's grandiose illusions while interpreting how they are linked to atavistic object ties and have functioned as routes to preserve them.

Although much has been written about both the pitfalls and necessity of interpretation with patients who are narcissistically disturbed, there have been few attempts to delineate the specific steps in the interpretive process that might enable the working clinician to use an interpretive psychodynamic approach successfully with narcissistic patients. In the following section, we outline the object relations–based interpretive process in TFP-N, as it has been adapted for the treatment of patients with pathological narcissism. Although each patient–therapist dyad has its own unique treatment trajectory, we found that the guidelines delineated below have been helpful in engaging patients with narcissistic disorder and in working productively in the transference to explore the difficulties that bring them to therapy, as well as in expanding their capacity to work through these difficulties. We describe these as 'phases' of intervention but would like to emphasize that the therapist will repeat cycles of these phases numerous times in the course of each therapy.

More specifically, we focus on:

Interpreting in the projection (phase 1). The first phase of TFP-N involves clarifying and containing the dominant affects or lack of them that color the experience of the therapist and others in the moment. Containment often occurs through holding the projection about the therapist and others—that is, focusing on the patient's immediate experience without challenging it or linking it to the patient's history or aspects of the internal world.

Defining the dominant internalized object relation (phase 2). Phase 2 involves identifying the ideal self and object representations that defensively exaggerate and preserve the individual's grandiose self-concept. We also identify the vulnerable or intolerable aspects of self that are often defensively and rigidly projected onto devalued others with the goal of helping the patient to recognize his or her identification with both aspects of the object relation. Identifying the costs and benefits of a grandiose self-concept is often a crucial step in identifying the dominant object relation.

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Working with role reversals (phase 3). The dominant object relation is repeatedly activated with role reversals, wherein the patient may alternately enact the self-concept and project the concept of the object onto the therapist, or other; or alternatively identifies with the internalized object and treats the therapist as though he or she were the self, often without awareness.

Identifying object relational dyads with opposing affective valence that defend against each other (phase 4). For example, for many narcissistic patients the experience of a superior, omnipotent self in relation to a devalued other for whom one has contempt may defend against the experience of a gratified, dependent self in relation to a responsive, caring other for whom one feels love and gratitude. This positive dyad must be defended against because the narcissistic patient's internal experience prohibits or bars any trust/belief in it. The emergence of dyads with such a positive affective valence reflects the emergence of deeper layers of the object relational world beyond the superior/devalued dyads that comprise the grandiose self and hearken its dissolution. This paves the way for the emergence of a more varied, complex, and nuanced experience of self and others reflected in the multifaceted transferences that develop in the later stages of therapy.

Interpreting the unconscious conflicts, wishes, fantasies, and motivations underlying the grandiose self, along with their connection to past relationships and experiences (phase 5). It is through interpretation of the unconscious conflicts, wishes, and fantasies, and the split-off object relational dyads in which they are embedded, as they are lived out in the transference, that the patients eventually come to tolerate an *integrated representation*, one that is no longer as threatening to them, and thus does not require the splitting-based defenses that drive so much of the phenomenology of pathological narcissism and NPD (Caligor et al., 2009; Diamond & Hersh, 2020; Kernberg et al., 2008; Yeomans & Diamond, 2010).

Shifts in the patient's representational world evolve through a process whereby the therapist tolerates and contains the projections of needy, dependent, despised, hateful, sad, and envious feelings through the process of projective identification. Interpreting such dreaded aspects of the self, as they are experienced in the transference, leads to their modulation and integration, and ultimately the internalization of the therapist as an object capable of understanding, reflecting on, and integrating multiple contradictory aspects of the self and others (Bion, 1959; Britton, 2004b; Loewald, 1960; Blatt & Behrends, 1987; Kernberg, 2015).

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In this chapter, we focus on the first three phases of our object relations interpretive approach with illustrative case examples. Chapter 8 focuses on phases 4 and 5.

What Makes Interpretations Effective?

Crucial in each phase of the interpretive process is recognizing, empathizing with, and containing the anxieties around dependency, fear of exposure, vulnerability, or aggression emanating from self or others that may have catalyzed the development of pathological narcissism to begin with. The organization around a grandiose self in many cases is predicated on the denial and omnipotent control, not only of others but also especially in more disturbed narcissistic individuals, of aspects of internal and external reality. Therefore, interpretations at any stage of the process must be delivered with tact, empathy, and meticulous attention to the patient's response. Interpretations convey not only the therapist's understanding, observations, and hypotheses about the split-off or unconscious aspects of the patient but also the therapist's entire emotional attitude toward the patient (Rycroft, 1956; Kernberg, 2014, 2015). Because narcissistic patients may experience interpretations as critical judgments, interpretations are most successful if they function to help the patient to . . .

> give voice to subtle personal experiences that the patient is struggling to articulate. For example, to state that the patient is being "resistant" in dealing with an issue is an interpretation from an external perspective. But to note how difficult it is for the patient to discuss a topic can capture the patient's feelings and struggles in a way that enables the patient to feel understood rather than being judged or criticized. (Blatt & Behrends, 1987, p. 287).

Interpretations, if accurate and well-timed—that is, offered on the cusp of the patient's evolving self-understanding—foster the patient's sense of making emotional contact with the therapist, who understands the patient's conflictual feelings, wishes, needs, and motivations as intelligible and coherent (Blatt & Behrends, 1987; Kernberg, 2015; Rycroft, 1956). We recognize that change does not take place only through an interpretative process (clarification, confrontation, and interpretation) but through the internalization of aspects of the therapeutic relationship. These include the therapist's interpretative function; concerned neutral stance, which involves empathy with myriad aspects of the patient's conflicts and object world; attunement to the patient's affective state; and

the capacity to hold in mind a view of the patient's current characteristics including non-narcissistic ones, and possibilities for growth and change beyond the narcissistic pathology. These all foster the patient's capacity to reflect on and integrate extreme, disparate, and split-off aspects of his or her experience.

Dealing with Narcissistic Resistances

Either because of constitutional factors or in response to early disappointments in significant others, many individuals with narcissistic pathology have withdrawn from the wear and tear of reciprocal relationships. They have retreated to an internal fortress, comprising combined ideal self and object images, that insulates them from genuine emotional investment and engagement with others, and the full experience of recognizing the loved and hated, gratifying and frustrating aspects of objects, both internal and external. As Joseph (1989, 2013) points out, as long as projections of aspects of the self are spread over a number of people, overwhelming affects and anxieties are avoided, and overt distress curtailed. However, in the intense dyadic arena of psychotherapy, particularly with treatments like TFP-N that focus on the transference, anxieties are likely to be activated around feelings of love and dependency, and envy and hatred that may have catalyzed the retreat to the illusory grandiose self to begin with. Not surprisingly, then, initially transference interpretations in particular are likely to be disparaged, ignored, denied, discounted, or appropriated. In the latter situation, the narcissistic individual may acknowledge the value of the therapist's observations but will immediately appropriate the interpretation as stemming from the self, saying things such as "Well, that makes sense but you're not telling me anything I didn't already know," or "What you just said indicates progress on our part, well maybe on your part, but I already knew that." In such situations, the therapist's contributions to understanding the problematic aspects of self and relationships may be valued and recognized, but they are almost immediately incorporated as aspects originating in the self. Such introjective mechanisms serve to reinstate the illusion of self-sufficiency, deny separateness between the self and other (Joseph, 1989), and short-circuit dependency.

Another form of incorporation of the therapist's interpretation involves "intellectual learning." This is the process by which the patient purports to learn from the therapist, recognizing and commenting on what he or she believes are the theories behind interpretations, or continually evaluating the therapist's contributions (that was good and insightful, or bad and unhelpful), but without any genuine reflection on the

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content or meaning of the interpretation or any acknowledgment of its resonance in the emotional life of the patient.[1] Narcissistic individuals' difficulty tolerating interpretations stems from their inability to accept evidence that anything good or valuable in the therapist is separate from them, which in turn protects them from seeing the therapist as a separate person. If they did, they would risk exposure of disowned aspects of the self and/or experience envy of the therapist's expertise and capacity to understand (Joseph, 1989; Kernberg, 2015). Thus, for individuals with narcissistic disorder, there is a fear of the independent, creative mind of the therapist, working to link aspects of the patient's experience that he or she is invested in keeping apart (Britton, 2004b).

Individuals with narcissistic disorder may present with a pressing need and desire to be understood, but they also may "appear to hate the very idea of being understood and in fact will try to disavow it and get rid of all meaningful contact" (Steiner, 2011, p. 372). Thus, the paradox of interpretive work with narcissistic patients is that they may have a hunger for the therapist to register, contain, mark, and understand their experience. Yet interpretations about the meaning of such experiences, and particularly interpretations that call attention to the transference or that challenge defensively held, or inflated (or deflated) self-representations, activate the individual's shame response, evoking overt hostility and contempt, and/or increased projective maneuvers. In addition, such interpretations may also activate fears of dependency and attachment. Consequently, the therapist's interpretive efforts are often met with knee-jerk rejection, arrogant dismissal, or retreats into pseudostupidity. Even when there is superficial or facile agreement with the therapist, or effusive praise for the therapist's acumen or intellect, the narcissistic individual often does nothing to advance the interpretation, thereby depreciating the content and the messenger.

These characteristic responses to interpretation may stem from the fact that for narcissistic patients, objects are kept "internally paralyzed," often in an immature ideal state, and if the therapist is felt to be too separate or too perceptive about the patient, it can precipitate antagonism or even destructive attacks (Feldman & Spillius, 2003, p. 561). The interpretive process in TFP-N is a stepwise process designed to bypass the activation of such formidable resistances, which lead to dropout,

[1]This risk is indirectly supported by Kanninen and colleagues' (2000) research showing that therapists tend to shift to cognitive interventions when working with patients with a dismissive internal working model of attachment. In addition, an fMRI study revealed the activation of a social aversion network and low levels of friendliness in the listener in response to a dismissing narrative (but not a secure or preoccupied narrative; Krause et al., 2016).

stalemates, or unproductive endless treatments. Identifying, addressing, and working with the self and object representations in which the conflicts and anxieties that the grandiose self defends against are embedded is the primary way of circumventing narcissistic resistances. It is an essential aspect of work with individuals with narcissistic disorder and constitutes a major aspect of TFP-N at every stage of the treatment process. Interpretation disrupts the narcissistic illusions of omnipotence and total self-sufficiency and helps the individual to understand how representations of actual, wished-for, feared gratifications, and/or frustrations with primary objects are encapsulated in such illusions. It is only by interpreting the latter as they are reexperienced in the transference that the narcissistic structure can successfully be addressed so that the patient can experience the self and therapist as separate beings increasingly free of distortion by narcissistic needs and projections.

For example, a patient whose self-concept as superior and invincible was melded with an idealized concept of his mother as beautiful and invulnerable saw any expression of need or dependency on the therapist as weak and deplorable. The patient imagined that the therapist would experience him as whining and complaining if he talked about what was on his mind, which limited his capacity to speak freely about the difficulties that brought him to therapy, including his dissatisfaction and sense of isolation in his current relationship, and his anxieties about performance at work. He could begin to experience genuine dependency on the therapist only after the ways in which his illusion of being perfectly self-sustaining and invincible was interpreted as it occurred in his retreat from emotional contact with the therapist in the moment-to-moment flow of the session. This illusion was tied up with his wishes to be like the mother he experienced as desirable but distant and this was being lived out in the relationship with the therapist. The patient's identification with such an emotionally unavailable and unattuned maternal figure, along with frustrated wishes for caregiving, rendered him emotionally unavailable in the transference (narcissistic transference).

Navigating through Resistance

How do we respond to patients who are internally highly reactive, and who tend to meet our interventions with challenging responses? What appear to be narcissistic resistances on the surface may often stem from identification with powerful, idealized, critical, or even punitive objects that have been merged with the individual's sense of self and with whom the individual remains internally bound up. Recognizing how interactions with the therapist might be shaped in part by object relational patterns comprised by the grandiose self is particularly difficult in the initial stages. Consequently, we have identified several strategies that

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have helped us to understand our patients' difficulties engaging collaboratively with our interpretative efforts, and to understand how these difficulties follow from an internal structure characterized by the pathological grandiose self. These strategies affect a good balance between the need to push forward with painful understanding and insight, necessary in the service of growth, and containment, a pulling back to help regulate the intensity of the patient's affect in the midst of this interpretive work.

Calling Attention

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, such as "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 process-level interventions mark recurring relational patterns, noting, for example, a patient's defensive shift away from affectively laden material, or noting that an exchange between the patient and therapist has become tense, hostile, or otherwise nonproductive, impeding more reflective communication. These interventions of calling attention to what is happening in the dyad also support the construction of a shared experience. 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.

Postponing Interpretation

Standard TFP technique encourages the tactful but prompt presentation to the patient of contradictions in his or her emergent narrative (i.e., confrontation or "bids for reflection"). With patients with narcissistic pathology, such an approach is 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." Kernberg (1975) suggested that our interpretive efforts may land more effectively when patients have "achieved some distance" from the immediacy of the patient–therapist exchange, and display their own "spontaneous curiosity" about the same.

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 or her curiosity about the divergent ways he or she experiences the self and others. With this "postponing" strategy we can momentarily disarm the typical defensive posture of dismissal and devaluation or idealization long enough to capture some reflective space in the patient's mind, so that the work of clarifying the internal object world and how it plays out in work and relationships, and in the transference, can be more effectively examined. among narcissistic patients whose defensive barrier is stronger, where primitive defenses work more effectively to avoid any sense of fragility or weakness (Rosenfeld's [1987] "thick-skinned" patients), such a strategy may not be so effective, and a more direct interpretative approach is called for. In contrast, with "thin-skinned" narcissistic patients, whose defensive barrier is less robust, the oscillation or cycling between the poles of the patient's sense of self—strong and self-sufficient versus fragile and helpless—will invariably occur without our active interpretive effort but simply as a function of the patient's response to challenges in his or her daily living.

Spontaneity and Humor

The nonformulaic, spontaneous use of language that emerges in the treatment context can be used to address negative qualities in the self usually managed through denial or projection, thus facilitating a link between these tendencies and various object relations, and their oscillation in and outside of the transference. The introduction and mindful use of "play," as well as humor and creativity between patient and therapist, can help the patient observe and take ownership of, for example, his or her aggressive and dependent selves, bringing closer to his or her self-experience that is often projected outward, and with a diminished sense of its danger and toxicity (Coen, 2003, 2005).

A young man with a particularly voracious need for recognition, validation, and acceptance would invariably, at moments of great anger or frustration with the therapist, remind the therapist of how much money he had earned from the patient over the course of the several years of treatment. The patient's need to distance himself from his use of others for narcissistic supply was facilitated by his projection of his greed, manifested by his sense of being exploited. The patient would

gleefully intone "cher-ching" (the sound of a cash register) at moments when his vulnerability and dependency upon the therapist would dissolve in a regression to a psychopathic transference in which everyone is out to get what he or she can from another (Kernberg, 1992). The therapist began using the expression, "cher-ching," such that it eventually became part of the common language in the treatment, shorthand for the emergence of a particular object relations dyad, along with an understanding, born out of the interpretive work of its defensive functions.

Such an approach does not suppress the negative transference, but rather can allow its expression to be tolerated in a workable form in the moment. Furthermore, the therapist's ability to "play" with such language in an interpretive and challenging context conveys implicitly that the therapist can survive the patient's attacks, in fact using them to facilitate integration and sublimation of the same (i.e., engaging the patient's destructiveness in the service of growth; Coen, 2003). Furthermore, 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.

In TFP-N, then, our primary technique for dealing with narcissistic resistances is to identify such surface behaviors and attitudes as they emerge in the interactions with the therapist and then to translate them into specific object relational patterns that comprise the grandiose self. The rest of this chapter and the next focus on the application of the interpretive process with illustrative case examples to demonstrate the various phases already delineated in Chapter 4.

Phases 1 and 2: Clarifying and Containing the Immediate Affective Experience and Defining the Dominant Object Relations Activated in the Moment

The first step in the interpretive process is defining the immediate affective experience of self in interaction with the other as a first step toward defining the dominant object relation activated in the moment. As the therapist listens to the content and structure of the patient's discourse, including the patient's thoughts and feelings about the therapist and others, he or she begins to formulate the dominant representations of self in

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relation to others that are being evoked. When the therapist has a clear picture of such a self–object dyad, he or she names the actors in the most prominent object relation(s) along with the linking affects, and assesses the patient's reactions. The dominant affects in the session (or lack of them) are often the conduit to the most salient object relational dyad operative at that moment. Hence, the first step is to clarify and name the affect or lack of it. With narcissistic patients, the dominant dyad is often more evident in how the patient is interacting with the therapist, with the affect tone of the words used, rather than the verbal content of the material the patient is reporting. Is the patient treating the therapist as a passive audience to the patient's productions, as a mirror to affirm the patient's sense of specialness, as a virtuoso who can magically solve the patient's difficulties, as a service provider to do the patient's bidding or solve immediate problems, or as a psychic twin who is perceived as more similar to the patient than he or she actually is? Is the dominant affect one of dismissing devaluation, unrealistic idealization, or total negation of the therapist's presence and contributions in the session? All of these stances provide clues to the nature of the patient's object relational world.

For many individuals with pathological narcissism across the spectrum, the initial object relational dyad that emerges is that of the grandiose self and ideal object, constituted by projecting the ideal self onto the other much like a shadow, not quite separate from the self. The individual may appear to be hermetically sealed in such an ideal self–ideal object configuration, like Narcissus entranced by the image of the perfect other, and impervious to the reality of others beyond their ability to echo or reflect ideal aspects of the self. Initially, this ideal self–ideal other dyad renders others, including the therapist, as shadowy and unreal. The patient may perceive the therapist, like many other objects in the patient's life, as there to bolster and support the individual's exaggerated sense of self-importance, to confirm that he or she is at the center of the patient's grandiose narrative, the hero or heroine of the story so to speak, or to function as an ideal superior figure who counters the patient's sense of inferiority and affirms his or her covert grandiose fantasies. But it is important to note that as in the case of Narcissus, this quest for the perfect mirroring other is a chimeral one that is fraught with misrecognition of the true nature of self and other. The optimal stance for the therapist at this point is not necessarily to mirror grandiosity but to maintain a spirit of curiosity and reflectiveness as the grandiose narrative unfolds, clarifying what function this serves for the patient, and how it protects but limits the experience of self and others so that the costs and consequences of the grandiose self-functioning come increasingly into focus. These may include broken ties with partners, coworkers, friends,

or children; or shallow relationships that become less sustaining as the individual matures; an inner sense of hollowness or futility; and sometimes a lack of pleasure in the larger realm of culture, art, or spirituality since all that is ideal is centered in the self and its own gratifications. The therapist also notes any contradictory aspects of experience or shifts of mental states outside the grandiose narrative (e.g., experiences of doubt, vulnerability, confusion).

In those with thick-skinned narcissistic organization, the grandiose narrative often involves a valorization of accomplishments, successes, and talents. The suffering that brought them to therapy is initially obscured in an effort to procure admiration and adulation from the therapist to maintain the self-equilibrium. In the case of those with a more vulnerable or thin-skinned narcissism, the initial narrative may involve adulation and admiration of others, including the therapist, with the presentation of self as denigrated, weak, damaged, or vulnerable. The focus may be on experiences of deprivation and maltreatment that center around the specialness, uniqueness of the patient's suffering, and/or the patient's self-loathing and sense of futility to effect any change (Cooper, 1998). The therapist is enlisted to bear witness to such rigid and fixed narratives that center on defeat and helplessness, but not to explore. Attempts to understand, clarify, or explore the meanings and functions of the unrelenting focus on suffering may be experienced as an attack. In such cases, where grandiosity is expressed covertly as fixed, immutable disparagement of self, the therapist who often initially empathizes or is deeply moved by the patient's suffering may feel increasingly constricted in his or her capacity to interpret, explore, or even think about the intrapsychic or interpersonal dimensions of the patient's self-critical attitudes since they are often readily projected onto the therapist (Symington, 1993).

Inherent in either position is the negation of the therapist as a real, separate, valued person, but many patients with narcissistic pathology across the spectrum have no conscious awareness of the superior self–devalued other or devalued self–superior other internal representations that underlie their initial stance of nonrelatedness. Kernberg (1975) refers to these transferences as self–self transferences since there is no specific object relation involved, but only the projection of aspects of the self (idealized or devalued) onto the other, who is then seen as an amalgam of aspects of the grandiose self. In sum, the narcissistic organization may initially configure the specific object relational dyads taking shape in the transference, interfering with the patient's ability to see the therapist as a separate person or to invest in the relationship with the therapist. In such cases, the absence of transference *is the transference*.

It is important for the therapist to keep in mind that the narcissistic individual is caught in the paradoxical situation where the illusions of omnipotence and self-sufficiency, and repudiation of dependence on the other, can only be sustained "when they are established not autonomously but interactively with the object" (Maldonado, 1999, p. 1132). As Money-Kyrle (1965) points out, "This form of projective identification by which one person manages to dispose of his inferior ego by putting it in someone else, and causing this other to actually feel inferior, can be brought about in ways so subtle that not even the aggressor, let alone his victim, is consciously aware of what is being done" (p. 149). For therapists who are sidelined or relegated to such a marginal role early in the therapy, it can be difficult to understand that this is the first step in the emergence of an interpersonal relationship in the therapeutic dyad. Thus, with patients with pathological narcissism across the spectrum, the therapist must tolerate a sense of being devalued in the patient's experience and resist the impulse to respond reactively. Accepting criticism and being devalued is an important therapeutic intervention. It is what the patient cannot do since he or she feels any imperfection is tantamount to collapse.

In the context of devaluation and attack, what is important at this early stage of therapy is to bring to light and build on nascent capacities for dependency, love, and object investment along with realistic aspects of the self-representation that may be evoked by the therapeutic situation. These often coexist with the grandiose self in varying degrees depending on the level of pathology (as discussed in Chapter 2). Examples of such nascent desire for help would be regular attendance in therapy and flashes of appreciation at the verbal or nonverbal level in response to the therapist's interventions, even if they are later negated. Nondefensive moments of eye contact between patient and therapist may also coexist with the climate of devaluation. Examples of the nascent capacity for investment in others would be devotion to a child, even if the child is seen primarily in the light of the patient's needs and projections, or dedication to caring for an impaired parent or spouse. Any traces of the capacity for love along with a realistic desire to be helped by the therapist may form the bedrock of a working alliance and a positive transference (Ronningstam, 2012). This allows for the analysis of the grandiose self, forming a bulwark for both therapist and patient to withstand and explore the defensive aspects of the contempt and devaluation toward others. Eventually they will explore its roots in early frustrations, disappointments, and traumas with early attachment figures, the full dimensions of which are usually opaque in the initial phases of therapy.

With clarification and confrontation of this initial dyad, more specific scenarios emerge, including the idealized grandiose self in relation

to a devalued therapist, or conversely, the superior therapist in relation to a devalued, inadequate patient. In either case, what we are seeing is an implicit object relation, rather than a fully developed object relation, representing an internalization of a relationship with a significant other. The most typical dyad is the grandiose self related to a depreciated object with the latter corresponding to the patient's own projected, depreciated self that cannot be tolerated or integrated. Indeed, with some patients this dyad emerges initially, and of course there are echoes of it in the patient's inclusion of the therapist in the circle of the ideal that deprives the therapist of any autonomy or individuality, annexing him or her to the position of mirror or observer.

Even when the devalued self-representation predominates, as in the case with those with vulnerable or thin-skinned narcissistic presentation, the good qualities of the other are often quickly appropriated to the self (Joseph, 1989, 2013). In fact, thin-skinned individuals entering therapy may resuscitate latent grandiose fantasies and wishes to be admired as the pinnacle of interpersonal relating, even though these fantasies may have been dormant prior to the beginning of therapy (Mitchell, 1986). This tendency toward rapid-fire appropriation of the valuable and ideal aspects of the other, rather than enhancing object relations, in fact denudes and depletes them. It interferes with the internalization of any aspects of the object that are not refracted through the prism of the grandiose self and immediately assimilated to it. Thus, the split, polarized primitive transferences of those with narcissistic disorder do not readily evolve in TFP-N as they do with patients with BPD.

At the most severe pole of the narcissistic spectrum, and particularly with those individuals who are organized at the lower borderline level, patients are likely to experience the therapist as voyeuristic or exploitative. In cases of malignant narcissism, the therapist may be seen as a dangerous or persecutory figure who must be defeated or destroyed (paranoid transference). Whatever the level of organization, these initial object relational scenarios are particularly tenacious and may predominate for long periods of time.

The tendency toward immediate appropriation of the positive aspects of the therapist, along with the tenacity of the projection of negative aspects of self, may prolong the patient's state of nonrelatedness to the therapist in the initial stages of treatment. Such projections inevitably create anxieties about the object, which show up initially in the denial of the therapist's importance, leading the therapist to feel ineffective or bored at best, or at worst, angry or frustrated and despairing. This is juxtaposed with relentless attempts to induce in the therapist feeling states that are intolerable to the patient's self. Alternatively, the patient may experience the therapist within the orbit of the grandiose

self, as omnipotent and omniscient, negating any attempts by the therapist to explore how clinging to such an ideal image serves the defensive function of not engaging more fully with others in external reality. In either case, in patients for whom the grandiose self-structure protects against intolerable anxieties around dependency or inadequacy, containment of these anxieties is essential to anchor the person to therapy. Such containment involves the therapist initially holding what is intolerable or unknowable to the patient, representing and reflecting on it in his or her own mind, and translating it into "a message that is digestible to the patient" (Busch, 2013, p. 116). In so doing, the therapist creates an atmosphere of safety in the treatment.

In these early stages of the interpretive process, containing and holding the projection should not be confused with direct mirroring of the patient's affect (Kohut, 1971). Rather, affective containment involves not only the process of accepting and tolerating the responses that the patient attempts to elicit in the therapist through projection but also the process by which, in a trial identification, the therapist actually tries on the complementary role in which the patient has cast him or her. This can provide a clue to the role in which the patient has cast the *self*, and to the dominant object relation being activated in the moment (Sandler, 1976). In so doing, the therapist embodies the role without enacting it, thus preserving the capacity to reflect on the object relation the patient is living out with the therapist and inviting the patient to do the same. Thus, although the therapist lends him- or herself to such trial identifications, he or she also functions as "an excluded third" who reflects on how the patient's different self-states linked to different object relational dyads operate in relation to each other and structure the patient's reality.

In the interpretative process outlined above, it is essential that the therapist pay close attention to the elemental aspects of good interpretation, such as timing, tact, clarity, relevance, and succinctness that most psychodynamic clinicians are well versed in (Busch, 2013; Yeomans et al., 2015). Optimally, interpretations emerge organically from the ongoing clinical process and engagement of the patient and therapist in the mutual exploration of the patient's internal world and external reality. In addition, however, it is essential, as Feldman (2007) points out, to maintain a balance between the conviction with which therapists formulate interpretations of their patients' communications, and a state of doubt that prevents interpretations from becoming "overvalued ideas, as opposed to a useful way of organizing and integrating their observations for the time being" (p. 374).

The ongoing dialectic between doubt and conviction in Feldman's (2007) view reflects the therapist's capacity to experience what is going

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on in the sessions, while at the same time actively formulating an understanding of the patient's communications, including the communications expressed through projection into the therapist. If the therapist becomes fixed on a particular interpretation or fact, he or she may miss the ongoing flux, movement, and flow; this may include shifts in the introjective and projective processes between patient and therapist, and the glimmers of both positive and negative aspects of representations of self and object as they emerge. The therapist's flexibility and openness to such minute relational shifts in the session, including shifts in the way the patient is representing the therapist, counters the inflexibility of the patient's grandiose self-organization. Interpreting with an optimal balance of doubt and conviction—a balance that may shift depending on the nature of the patient's material, stage of therapy, and the state of the transference and countertransference—helps the patient to recognize that interpretations are hypotheses that may be confirmed or disconfirmed only through further collaborative work. The therapist's capacity to remain open and receptive to the panoply of feelings and the mental representations to which they are linked—both negative and positive—sets the groundwork for the dissolution of the compensatory grandiose self into its component aspects of idealized and devalued self and object representations. These may emerge in fleeting, inchoate ways as therapy progresses.

Identifying the panoply of mental representations that underlie the grandiose self is gradual and problematic because the defensive organization around an inflated sense of self-importance leaves little room for exploring alternative realities about the self (e.g., vulnerability, self-depreciation, humiliation, dependency, or envy). As a result, clarification of the patient's experience of self and other in the moment, the first stage of the interpretive process in TFP-N, is also more difficult because the affects of humiliation, envy, fear, and dread, particularly of imperfection and dependency that devolve from the grandiose self, are defended against.

With narcissistic individuals in the early stages of TFP-N, we focus to a greater extent on the patient's immediate experience of the therapist, encouraging him or her to put the immediate, concrete affective experience of the other into words. We do this without suggesting that it has anything to do with the maladaptive, distorted object relational dyads that structure the patient's interpersonal experience, nor do we make any linkages between this experience and the patient's history or conflicts (Steiner, 1994; Caligor et al., 2009; Diamond, Yeomans, et al., 2011; Diamond & Hirsch, 2020). We move only gradually—as the patient can tolerate them—into interpretations that link the patient's experience of

the self to mental representations that encapsulate unconscious conflicts, impulses, and motivations. Observing the part of the patient's internal world that is disavowed and deposited in the other, including the therapist, is less threatening to the patient's rigid and fragile defensive system (depending on the level of organization).

For example, a successful entrepreneur with a history of rejection from an emotionally abusive and relentlessly critical father entered treatment when a business he had backed financially collapsed, leaving him facing a potential bankruptcy. Initially, he belittled the therapist for his inability to adequately understand the intricacies of this catastrophic financial situation. The therapist did not immediately link this demeaning attitude to an object relational dyad of rejecting, critical other and an unworthy self but instead observed how disappointing it must be to have a therapist who might not fully comprehend the financial complexities of the situation, and thus might not be able to understand his emotional devastation. Such interpretations are designed to provide cognitive containment of concretely experienced affect states or to identify what is the dominant overriding representation in the patient's mind. This approach of interpreting in the projection is consistent with what Steiner (1994) calls "therapist-centered" interpretation, but it focuses not only on projection of aspects of self onto the therapist but also onto others, along with the defensive maneuvers, fantasies, and affects involved. Interpreting in the projection is designed to bypass, at least at the outset, intolerable feelings and self-states, such as the patient's sense of weakness, inadequacy, and confusion. Clarifying and accepting for the moment the patient's experience of the other, including the therapist (i.e., the object representation), without calling attention to the way it may be defensively distorted, helps the patient to feel understood and contained. In contrast, *patient*-centered interpretations focus on clarifying and exploring the patient's feelings, thoughts, and behaviors along with the motives and anxieties behind them.

Interpreting in the Projection

Once the patient's immediate experience of the therapist has been defined through clarification and confrontation, we work on interpreting in the projection with the understanding that projection and projective identification are always dyadic experiences that may catalyze shifts in both the patient's and therapist's experience. In other words, the therapist may experience the self in accord with the disowned pole of the object relation. This identification and its containment help the therapist to identify the dominant object relational dyad in his or her mind, as a

prelude to interpreting it. Even after a dominant object relational dyad has been recognized, it is more difficult for individuals with narcissistic disorder to recognize their identification with the defended-against pole of the dyad than is the case with other personality disorders.

Thus, the goal is to put the emphasis on defining the patient's immediate affective experience of the therapist, using his or her own experience of the patient as a guide, as a way of mobilizing, observing, and discussing the dominant object relations as they take shape in the transference. This is in contrast to interpreting a dominant object relation right off the bat before the patient has a full affective experience of it, or capacity to tolerate his or her identification with both aspects of the dyad. For those across the spectrum of narcissistic pathology, such an affective experience is truncated, since affect is inherently object seeking (Fairbairn, 1952; Kernberg, 2015)—that is, it involves acknowledging not only the need and desire for something in relation to the other but also the other as an autonomous being separate from the self. Hence, defining the patient's dominant affective experience of the therapist (or absence of it) is the first step toward activating and defining the total object relation activated in the transference. The latter is more effective once there is a reciprocal interchange of self and object representations in the transference. This may proceed more slowly with more rigidly organized, aloof narcissistic individuals who refuse to project or experience aspects of their internal world, beyond a grandiose sense of superiority and/or the unilateral devaluation in relation to the therapist out of fears of dependency and/or exposure.

The focus on the patient's experience of the other, including the therapist, temporarily bypasses the provocation of the narcissistic patient's shame, humiliation, or rage, since it is more tolerable for him or her to see flaws in the other than it is in the self. For example, a patient who had seemed to be progressing in treatment flew into a rage at the therapist and threatened to quit therapy because she felt that in the previous session the therapist had missed a cue about how she was feeling rejected by her boyfriend. She had actually only made passing reference at the end of the session about how her boyfriend had not returned her call, focusing primarily on how perfect the relationship was for her. In such a situation, interpreting in the projection initially would involve a statement of how difficult it must be to have a therapist who did not understand the painful experience of rejection that she had had difficulty conveying; only later would the therapist explore the patient's motivations for withholding information (e.g., fear of exposure, envy of the therapist) that might have been humiliating to reveal (patient-centered interpretation).

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Insofar as the narcissistic patient is intolerant of perceiving flaws in the self, one aspect of technique is to focus more on negative feelings, such as humiliation, weakness, or shame *as they are projected onto the other or the therapist*, or on positive idealizing experiences of the other, including the therapist. Interpreting in the projection is particularly important with narcissistic patients who cannot tolerate seeing imperfections in the self but may be able to observe them in the therapist and thus can reflect on what it is to have limitations. An implicit function of interpreting in the projection is thus to communicate that a person (the therapist) can be imperfect and still continue to exist and function without the total collapse the narcissistic patient imagines is the alternative to perfection. At the same time, the therapist must convey to the patient the firm conviction that he or she has the skills and knowledge to help the patient to safely explore his or her experience, even dreaded and disowned aspects, and to work through the difficulties that brought the patient to therapy. Negative projections are contained but not accepted as an objective reality.

The capacity to work with such projections with tact and authenticity requires that the therapist tolerate the ferocity and toxicity of the patient's intolerable feelings and self states without returning them to the patient prematurely (Steiner, 2003; Joseph, 1989, 2013). This requires that the therapist has done the work of taking in and bearing "the truth of what he or she has become in the patient's psychic reality" (Steyn, 2013, p. 1094). Of course, this necessitates that the therapist contain the feelings that are evoked in him or her, as opposed to discharging them in interpretations that might be premature (Steiner, 2006). Rather, the therapist contains and processes the experience of the patient's projections in the interests of ultimately using these as building blocks for interpretations not only of the process by which the patient projects affects and representations onto the therapist but also his or her identification with these projected aspects (projective identification).

In sum, the goals in the initial phases of treatment are (1) to identify affect while containing it; (2) to identify the constellation of feelings and representations that have been activated through everyday experiences, including the experience in the session with the therapist *as a first, more palatable conduit into the internal object world of the individual, in particular, the idealized and devalued representations that comprise the grandiose self*; and (3) to help the patient to tolerate imperfection by seeing the dreaded aspects of his or her self and internal objects as they are projected onto the other or therapist, who first contains them and then, through his or her interpretive activity, helps the patient to explore, understand, reflect on them, and ultimately reintegrate them as an aspect of the self.

Case Example: Early Phases of Interpretation in TFP-N for NPD

The treatment of Mark, a relatively high-functioning narcissistic individual (discussed in Chapters 1 and 2), illustrates the early phases of interpretation in TFP-N. Mark, an accomplished architectural engineer and a partner in a leading international firm, entered therapy because of symptoms of anxiety and depression. These symptoms were related to conflicts with his long-term relationship partner. He had been with his girlfriend on and off for the past 10 years, 5 of which they had lived together. They were both in their mid-30s, and she was pressuring him to commit to having a child with her while she was still able to do so, or to go their separate ways. He had broken up with her several times to pursue other relationships, only to return to her when it looked like he might permanently lose her to someone else. Although she was an extremely accomplished interior decorator whose work had been featured in major magazines, he worried that interior decorating was an inferior occupation and that his associates might judge her as not worthy of him. Initial assessment also revealed that there were unsatisfactory and even punishing aspects of the relationship. Although his girlfriend professed to adore him, she made him feel inadequate for not making more money, constantly comparing him to the more affluent partners of her friends, and expecting him to provide a lifestyle comparable to her privileged upbringing. Although he often rejected her sexually, he also wondered whether his sexual performance was adequate since although she desired him, she also made denigrating remarks about their sex life. Relationships with significant others who create exacting standards and inordinate demands to which the individual submits masochistically often go hand in hand with exploitation and entitlement in those with narcissistic pathology. The sensitivity to critical others, even if devalued, often derives from identification with idealized and persecutory internal objects that make impossible demands on the self.

Mark had not been able to resolve his conflict about the relationship in several former treatments and began dealing with his ambivalence by secretly seeking Internet liaisons. An accomplished architectural engineer who had been promoted to partner at an unusually young age, he was coasting on his past accomplishments at work, and was brought up short when he was told that his compensation would be cut unless he developed new business for the firm. This was expected of him as a partner and was necessary in a recession. A previous CBT treatment had helped Mark with his performance anxiety at work, but not with his relationship issues. He had been able to advance in his career, but the underlying narcissistic structure had not been resolved. This was evident

in his torturous self-doubt that was obscured by his grandiose sense of superiority, by his tendency to find gratification in ideal fantasy objects, and the harsh critical elements of his internal world that were not in sync with realistic self-appraisal. Mark also displayed a pattern of experiencing interest and excitement in superficial contacts but then anxiety when he began to enter into deeper, more complex reality-based relationships.

Before starting the current TFP-N treatment, Mark had consulted with several well-known clinicians but found none suitable. They were described in derogatory terms: They did not understand him, they were of no help to him, or they simply reflected what he told them. In the initial consultations, the therapist suggested that a narcissistic disorder—which involved, among other characteristics, a chronic pattern of fluctuation between overestimation of his capacities and collapse into states of self-doubt and paralysis—seemed to underlie his difficulties with work and relationships.

Mark accepted the diagnostic feedback and in fact said that none of the therapists he had consulted had understood the nature of his difficulties in those terms. In the initial stages, there were flashes of the ideal self–ideal other dyad, although these were also shorn of any genuine sense of relatedness or dependency, and often quickly devolved into their opposite sense of devaluation. For example, in the initial sessions, Mark balked at certain parameters of the treatment contract, including the therapist's insistence that most sessions take place in person and in her office rather than on the phone, which he felt was unreasonable given his complex travel schedule. The therapist called attention to the implicit devaluation in this stance along with the ways this might function to keep her at a distance, putting a "screen" between them, as well as enabling him to remain in control by relegating the therapist to the role of spectator. She explained the necessity for in-person sessions, as well as other parameters of therapy by describing the contract as a foundation for the therapy, just as an engineer would require a solid foundation when building a bridge or other structure, using a metaphor related to his profession that she thought might bring the point home. His initial response was a scornful repudiation of any analogy between her work and his. He finally agreed to these and other conditions of the contract only after he looked the therapist up on the Internet and found that she had written a book on sexuality in the era of the Internet that he believed made her uniquely suited to treat him, in the same breath dismissing this as a "pop psychology topic." This statement epitomized the striking mélange of idealization and devaluation that characterized the initial treatment phases.

Once therapy began, Mark filled the sessions with torturous ruminations about his relationship, which took the form of a litany of faults

that he found intolerable in his girlfriend. He talked about how it was unimaginable to him to have a child who would bind him to her further. He focused on his longings for an ideal partner, whose current form took the shape of a woman he had met on the Internet. Initially he attempted to direct the sessions, often beginning with a list of topics to discuss, organizing the communications to present a ready-made product to the therapist in lieu of free associations that could be productively explored. Attempts by the therapist to clarify or expand the range of the discussion were routinely blocked by statements like "We will get to that later, but didn't I just tell you that I wanted to focus on [X] topic?" Or in response to the therapist's observations, he would say, "That makes sense now, but I'll forget it as soon as I leave here because I never remember or think about anything my therapists say. . . . When I leave the session, it is as though it never happened." He also expressed feelings of futility and hopelessness that he would ever be able to truly fall and remain in love, and compared himself to peers who were in committed relationships and who were starting families. The therapist observed in the early sessions that just as Mark had not been able to commit to a relationship, it had been difficult to commit to the treatment contract that stipulated roles and responsibilities for both patient and therapist. She also observed that now that therapy had begun, it seemed that there was only space for one person in the room. He readily replied that he had not learned anything from any of his previous treaters that he did not already know and expected that it would be the same in the current therapy.

Initially Mark filled the sessions with material about immediate crises at work or in the relationship, sometimes wanting solutions to immediate problems, focusing on whether he should leave his girlfriend or not. The therapist reminded him that the goal of his therapy was exploration of his characteristic patterns that were contributing to his paralysis and dissatisfaction in his work and relational life, rather than providing solutions to immediate problems. He responded either by devaluing the therapist's contributions or by affirming them in a superficial fashion without much elaboration, reflection, or expansion. He evaluated sessions as to whether they had an optimal balance among "exploration, listening, and interpretation," which he had learned from previous treatments and from reading about psychodynamic techniques. Such aspects of discourse, although indicative of narcissistic resistances, may in fact also represent the first glimmer of making sustained contact with the therapist as a real, if devalued, object. The therapist observed that while this constant evaluation of the therapist's contributions kept him in control of the session and affirmed his sense of superiority, it also kept him from getting the help he needed. This brought the costs and consequences of his grandiosity into the transference.

The focus in the initial sessions was on helping Mark to articulate his own experience of the therapist that in the first months took the form of seeing her as an ideal therapist who might help him finally fall and remain in love since she had written about sexuality and attachment in the era of the Internet. The therapist attempted to clarify why he had been unable to leave his current relationship. She suggested that his girlfriend provided something he needed, and wondered what it was? He talked about how her adoration made him feel secure, but that she also made him feel inadequate for not making more money, constantly comparing him to the more affluent partners of her friends. Thus, through clarification, more vulnerable aspects of the self emerged.

Although, at times, Mark saw the therapist as an idealized figure who might solve his dilemma, more often, he saw her as flawed, inadequate, and unhelpful, and himself as the expert. His own sense of fallibility was intolerable, and his immediate need was that these negative aspects of self be contained by the therapist and understood in its projected state. In the initial stages of treatment, this stance that therapy is useless and all is futile, is often an indication of the depth of the patient's withdrawal from more authentic relatedness. Although in most cases, it might represent the concrete manifestation of the superior self–devalued other dyad in the transference, it also provides a window into the patient's painful feelings of emotional isolation.

Even though the devalued other also represents an aspect of the grandiose self that must be split off, it can be worked with productively because it involves an acknowledgment, if only through projection, of something beyond the ideal. However, with Mark, as with many narcissistic patients, initial attempts to call attention to his belittling, critical attitude were often deflected or ignored. An example of such an intervention might be: "I wonder if you are aware of the belittling tone of voice in which you made that comment. I have noticed that this tone escalates when certain issues come up here [giving examples from previous sessions]. Perhaps you are trying to put me at a distance in order to ward off exploration of the painful issues and anxieties that brought you to therapy." Such attempts to interpret the defensive manifestations of the ideal grandiose self–devalued other dyad in the transference by observing how it protected Mark from delving deeper into the conflicts that brought him to therapy received superficial acknowledgment. It was only after an interpretation by the therapist evoked a constellation of intense feelings that he could experience his identification with both sides of the ideal–devalued dyad, as the following clinical material shows.

In the third month of therapy, in a session in which Mark obsessed about his conflict between his girlfriend and his Internet partners, the

therapist observed that the choice seemed to be not between two sexual relationships but between investing in an actual relationship versus remaining sequestered in his fantasy world of Internet relationships where he could control and watch anonymous individuals play out his scenarios of dominance and submission. Mark arrived 10 minutes early for the next session and knocked insistently on the door 5 minutes before his session was scheduled to begin. When the therapist opened the door for him at the appointed time, he presented with rigid body posture and a tortured expression, stating immediately that he was thinking of leaving treatment.

MARK: I don't know why I came this morning. I am feeling very adversarial, and this feeling has grown—not diminished.

THERAPIST: It seemed very important for you to come in and tell me how adversarial you are because you came 5 minutes early. So perhaps you have some positive feelings as well, although you are considering leaving therapy.

MARK: Well, I did feel that we made some progress last week when you said to me that I am having trouble having a real relationship versus investing in a fantasy world; that the real conflict was not between my girlfriend and the women I meet on the Internet dating site, but between investing in an actual relationship versus remaining sequestered in a fantasy world. That was progress on our part, well maybe on your part—but I already knew that. And you misunderstood something crucial in the last session—I was talking about my girlfriend, and you failed to pick up on my statement about how she is feeling increasingly hopeless about our relationship and is not encouraging toward me this week. When we talked about my repairing the relationship with her it was totally wrong—rather than encourage me, she mocks me. And you were disturbingly incorrect when you asked about repairing our relationship; how could you not see that she has pushed me away? But then I guess I couldn't really tell you what was going on. This week she even talked about a separation.

THERAPIST: It sounds like I really disappointed you because I didn't understand intuitively that she was pushing you away even though you were having trouble telling me this directly. Maybe it's difficult to speak freely here when you feel like you are being put down or rejected.

MARK: Well, last week you ended the session just as I was in the midst of talking about this. In fact, you cut me off, and I am not one to be cut off.

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THERAPIST: It sounds like you are experiencing me as a woman who will cut off and push you away like your girlfriend, and who will fail to care for you and meet your needs. That makes you fearful of speaking freely here and makes you want to leave therapy.

[The interpretation centers on the patient's experience of the therapist, interpreting in the projection, instead of the therapist observing that Mark is the one who cuts off by threatening to leave therapy and refusing to commit to his girlfriend.]

MARK: Yes, my girlfriend has been pulling away. She is away visiting her family and very monosyllabic on the phone with me. She said she doesn't know if she wants to go on with the relationship. I keep coming back to your comment about my fantasy life and how it sustains me, and how after a while I withdraw from all relationships.

THERAPIST: Perhaps that is happening here as well, because you started out saying we had made some progress, but then backtracked and said it was only I who had made progress, or that you knew this all along about yourself anyway, as though it was not something that had come out of our work together.

MARK: Well, she [the girlfriend] treats me like I'm a pathetic creature; she is not empathic to me anymore. She ridicules me for my paralysis and inability to stop going on the Internet. I don't respect her, but I'm not sure I can live without her.

THERAPIST: It's possible that you did tell me about this and I missed it, but it's also possible that you were so upset by her withdrawal that you couldn't tell me directly what was happening. Today I think you were experiencing me that way as well—from the start you saw me as someone who couldn't understand and empathize, who would judge you harshly. It must be difficult to have a therapist who doesn't understand your anguish. But maybe it's also threatening to have a therapist who understands you. I'm thinking about your appreciation of my comment in the last session.

MARK: *(After a few moments of silence)* I . . . I'm very anxious today because I have to do a presentation for a new office complex in Asia, and I am very worried that they won't like it and will think I'm incompetent. I wanted to talk about that but then I couldn't. [*Manifestation of identification with the devalued object pole of the dominant object relational dyad*.]

THERAPIST: I guess you were worried about telling me this for fear that I wouldn't understand how fearful you can be, particularly when you feel inadequate, or that I would judge you as you judge yourself for having these feelings.

MARK: Yes, that's it. I used to be paralyzed with anxiety in situations like this, and then if the client didn't like the model, I'd get depressed and withdraw or lash out. My former therapist helped me to control my performance anxiety and my anger, but I still fear that it will come back—this feeling of incompetence, this paralysis, and that I'll get angry and be humiliated.

THERAPIST: Maybe that accounts for why you were so insistent on having this session, knocking on my door 5 minutes early, because you needed to talk about these feelings, but then when you saw me, you feared that I would humiliate you as well. It is as though someone always has to humiliate or be humiliated. Today you fear that that someone will be you—it sounds like this fear comes up not just at work but with your colleagues and clients, your girlfriend, and with me as well. [*Defining the dominant object relation as it is emerging in the transference.*]

MARK: Yes, that sums it up. I think I can face the presentation now. [*At the door he turns to say "thanks."*]

The foregoing session material illustrates the gradual process by which Mark came to recognize his identification with both sides of the dominant dyad as they emerged directly in the transference. For example, it is clear from the above session material that there is an evolving representation of the therapist as someone who could help him develop greater understanding of conflictual and confusing aspects of his experience (i.e., "we made some progress"). But no sooner had this positive representation of the therapist emerge, Mark immediately backtracked, insisting that he had known that all along. Thus, he attempted to reinstate his psychic equilibrium through devaluing the therapist and retreating into grandiosity ("I already knew that"). Here we see that the feelings of being helped by the therapist elicited feelings of humiliation and rage and activated narcissistic resistances that functioned to deny dependency on the therapist and eradicate her capacity to help him. This was evident in his scornful repudiation of the value of the insight and in his threats to quit. He dealt with these negative feelings by immediately appropriating her insights and disparaging her skills, focusing not on what she had observed correctly but on what she had missed. We see in this case example the complex projective and introjective mechanisms that shore up the grandiose self.

The above clinical material also illustrates the value of interpreting in the projection—that is, focusing on the patient's immediate experience of the therapist (in this case, the sense of the therapist as inadequate or "woefully incorrect") without immediately linking it to the part of

the patient he was projecting (the self as inadequate), or to the patient's current conflicts or history (Feldman, 2007; Steiner, 1994). Interpreting in the projection in this instance helped to contain the intolerable anxieties about exposure and dependency that were propelling Mark to leave therapy. Such interpretations can move the clinical process forward by helping the patient to reflect on the anxieties evoked by the therapist's understanding. We see in this session material the oscillation between a narcissistic refuge and emergence from it in the form of a realistic appreciation of the therapist's efforts to understand him. We also see a movement from hyperindependence to wanting to be understood in allowing himself to reveal defended-against aspects of his inner world (e.g., his fear of humiliation, his dread of dependency). This was because the therapist first contained his anger and anxiety through clarification of these affect states, and then through interpretation of the object relation taking shape in the (negative) transference the patient was helped to face and tolerate the split-off aspects of self.

However, it should be noted that the recognition of the therapist as a separate person with the capacity to understand aspects of Mark's experience was only momentary and then felt to be intolerable and quickly retracted. The foregoing case example highlights how interpreting in the projection may function as the first step in identifying feelings of weakness and inadequacy—the denied and projected pole of the object relational dyad. In the first part of the session, the therapist's provisional acceptance of the projection of Mark's devalued aspects of self allowed him to begin to reflect on and talk about how these were tied to painful anxieties, more specifically his own fear of humiliation lest the deficiencies of his designs be seen by his colleagues. The therapist then connected this with his fear of being judged by her.

Interpreting in the projection involves the therapist containing the full force of the intolerable anxieties or feelings that are being projected. It is important to remember that projective identification is at core a dyadic event. It may result initially from seismic disturbances in the patient but is also felt as aftershocks in the therapist who is the recipient of the projection (Feldman, 2007; Joseph, 1985). Initially the therapist was taken aback by Mark's assertions that he planned to leave therapy since he had expressed appreciation for their work in the previous session. She had a momentary experience of confusion and disappointment, but after reflecting on the process she was able to see that the intensity of his reaction and his threats to leave therapy might have been related to anxieties about feeling exposed by the therapist's interpretation. But at this stage, the interpretation, although it evoked strong feelings of anxiety and anger, helped the patient move toward a deepening of insight, but also to a deepening of the relationship with the therapist. Thus, this

interchange illustrates that holding or containment is a process that includes both cognitive and affective components in that it involves both concern for the patient and an openness to tolerate and explore intense and sometimes unknown or poorly understood affects as they emerge in the dyad.

The therapist's interpretation to the effect that Mark's major conflict was between investing in a real relationship or fantasized ones, had jolted him out of a long-standing retreat to fantasy where his sense of omnipotence was assured. The interpretation had breached his grandiose defenses and exposed his inability to tolerate real intimacy and the narcissistic nature of the transference—for example, using the therapist as a sounding board in ways that left little room for an appreciation of her interventions. Overwhelmed by anxiety that the therapist might have understood something about him of which he was unaware, Mark had arrived early for the session, and intruded on the therapist's space in order to regain his sense of omnipotent control. She reminded him of his recent positive statements about treatment at the end of the last session and wondered whether her interpretation had made him feel understood, but then exposed because it introduced something that he did not already know about himself, which he found destabilizing, if helpful. He concurred that it was unusual for him to acknowledge that he benefited from therapy and talked about how he had deliberately held the therapist at arm's length because he did not want to get close to her or be infantilized by her.

This case example illustrates how it is essential, as Kernberg (2014) has observed, for the therapist to sustain his or her emotional commitment to the patient in order to maintain his or her wish to help and understand in the face of the patient's expressions of arrogance and devaluation. Such resiliency and steadfastness on the part of the therapist protects the therapist from "falling into the trap of reactive devaluation of the patient in response to his or her contempt" (Kernberg, 2018, p. 190). It also models for the narcissistic individual that negative experiences and limitations can be tolerated and explored in the interests of further understanding.

Indeed, once the therapist recognized the feelings of humiliation, fears of dependency, and loss of control behind Mark's threats to quit, she could contain the countertransference feelings of being disappointed and devalued, recognizing them in part as reverberations of what the patient was experiencing. She was then able to translate her own countertransference reactions and metabolize them into insight into and understanding of the patient's experience. This allowed the work to proceed with further revelations, elaboration, and reflection on his part on how his own concepts of self and others might be structuring his experience

of the therapist and others. In addition, the therapist's acknowledging that her lack of attention to his fear that his girlfriend might actually end their relationship devolved from her own less than perfect ability to understand his communications, which modeled the capacity for reflective activity and tolerance for imperfection or fallibility without masochistic self-flagellation or sadistic retaliation. The latter, in turn, helped Mark to reveal and reflect on his own anxieties about imperfection as they were activated by his upcoming presentation to a major client.

It should be noted that in this session there were indications of role reversals in the patient's focus on the therapist cutting him off, even while he himself was enacting this by threatening to leave therapy, and hence cutting off the therapist. In each phase of the interpretive process, we see emerging evidence of the next phase that will then be more fully elaborated as the therapy advances. We see examples in the clinical material above of the early phases of the interpretive process in TFP-N: defining the dominant object relations, identifying with both poles of the dyad, and the emergence of role reversals in the transference. This session material also provides an illustration of the ways that an accurate characterization of the dominant object relationship may lead to an intensification of the pattern in the transference, with an interchange of roles.

Phase 3: Working with Role Reversals

In TFP-N, the therapist initially identifies the predominant object relational dyads of the idealized self–devalued other or idealized other–ideal self that comprise the grandiose self-structure and then works with how the individual oscillates in identifying with both self and object poles so that he or she may alternately enact one role, while projecting the other in role reversals as they occur in the transference (Yeomans et al., 2015). This process entails bringing the patient's attention to how aspects of self-experience that are systematically projected into the therapist or others in the moment may then be enacted by the patient, often without awareness. Due to the rigidity of the narcissistic organization and the individual's difficulty with acknowledging and identifying with negative aspects of the self, the recognition of role reversals may be protracted (Diamond & Hersh, 2020; Yeomans et al., 2015).

By repeatedly calling attention to how the patient's negative experience of the therapist may represent in part an aspect of self, the therapist models for the patient how to step back and reflect on identification with both poles of an object relational dyad as they unfold over time. Such an observing stance introduces what Kernberg (2014) and others

have identified as a third term or triangular process into the therapeutic mix, in that it invites patients to transcend their immediate experience of the moment and to reflect on how their identifications may shift according to fluctuations in their relationships with others (the therapist) and to fluctuating states of mind. In terms of psychological structure, it is the beginning of building a foundation from which the patient can contextualize—can observe and assess—the immediate experience of the moment. As patients form links with aspects of experience that have been spilt off, dissociated, or enacted, they can begin to recognize that their behavior may actually stem in part from a representation of a mental model or working model of relationships in their minds that contribute to shaping their experience of the current interpersonal interaction (Caligor et al., 2009; Diamond, Yeomans, et al., 2011; Kernberg et al., 2008; Yeomans et al., 2015). Through focusing on role reversals, the initial rigid ideal/devalued configuration is gradually translated into a specific object relation; a model of self in relation to others; and the fears, conflicts, and affects that infuse them.

Case Example: Role Reversals

Over time, Mark's narrative of exalted professional success and attractiveness to women was punctuated with moments of insecurity and torturous self-doubt, but it was difficult for him to recognize how these were being lived out in the transference relationship. The latter only came clearly into focus around a crisis about paying the therapy bill, which Mark had let go for several months. He began the session by talking about his distress that his girlfriend was threatening to end the relationship after discovering his Internet activities. Quite quickly he shifted gears and said in a somewhat cavalier tone that he recollected he had ended the last session with his promising to pay the bill. He said that he had tried to reach his insurance company to find out why they were not paying but had been put on hold and then hung up because he had a pressing meeting. The therapist wondered, given how desperate he was about his work and relational life, why he was jeopardizing his therapy by not paying the bill for several months. When she called attention to the somewhat dismissive attitude and tone of voice that Mark used in responding to her inquiries about the bill, he stated, "Now over 10 minutes of the session have gone by and you are imposing your agenda on me . . . you're like a mother telling me what I have to do. You're not my mother, but like a mother." The therapist observed, "It sounds as though you are experiencing me as a demanding but neglectful maternal figure who imposes her agenda and never has your needs in mind, and yourself as an angry, resentful child who has to do her bidding (paying the bill)

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in order to win attention or affection but who, instead, resentfully withholds payment in order to remain in control." He replied, "No, I experience you as a mother type, not my mother." He clarified this statement by saying that he expected special treatment from the therapist, who he believed should treat him pro bono—something he knew his own mother who "taxed every gift at every gate" would never do. The therapist proposed that, without any awareness, he might be the one who was imposing his agenda—to attend therapy without paying—and thus be enacting a reversal of the relationship. While Mark viewed the therapist as powerful and controlling, and himself as vulnerable, simultaneously, the therapist saw in this exchange the emergence of dependent wishes and the hope and desire for a perfectly gratifying object, who would see him pro bono. Each phase of the interpretive process leads to the emergence of saplings of what will ensue and be worked on in the next phase.

This led to an exploration of Mark's identification with a controlling and withholding maternal figure who was being projected onto the therapist. The therapist pointed out that by not paying the bill he was attempting to control the therapist, to act in a way that turned the tables of power and control, and thereby avoid any sense of dependency or need. She observed that he talked about driving away significant others, but perhaps it was also her that he feared driving away with his demands for special treatment. Paying the bill meant acknowledging his need for and dependence on the therapist, as well as the limitations of what she could offer him. He stated that he saw therapy as a lab experiment to try to have a different kind of relationship, but said, "I always ask for too much and wind up with nothing." Now he feared that he might have driven away his girlfriend with his demands for total devotion in the context of his not making an enduring commitment to her, and also feared he may have alienated the therapist by not paying the bill. Mark ended the session by asking the therapist, "How much do I owe you?"

In a subsequent session, Mark interrupted the session abruptly twice by taking work-related phone calls or writing texts that he claimed were urgent. The therapist interpreted these behaviors as devaluing of the therapy but also as another manifestation of his wish that she be an indulgent maternal figure who tolerates behaviors that bend the therapy frame. Mark responded that he knew that his actions were a "misjudgment and not good." The therapist stated that by interrupting the sessions by taking phone calls and not paying the bill, perhaps he wanted to let her know what it felt like to feel demeaned and controlled, feelings that he had acknowledged were evoked by having to pay the bill, and otherwise observe the therapeutic frame. Mark observed that he demeaned the therapist as a "leitmotif." He said that he wanted the therapist to indulge him and make him feel special to counter his self-disgust. He

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said, "I have self-disgust all the way through; I am self-judging all the way through. Part of my self-disgust is I can't be proud of my girlfriend. When we are alone I value the time together and appreciate her insights about people and we talk about art and architecture, but then when we are with others, I worry that she is second rate—that she is not brilliant enough, or beautiful enough, and I feel humiliated. I acquiesce to keep myself in this debased state, where I can't be with her or without her."

The therapist interpreted these statements and recent actions in sessions as revealing two dominant representations of the self: (1) the entitled, all-powerful self who engages in treatment-disrupting behavior with impunity linked to an indulgent maternal figure with contempt as the linking affect; and (2) the devalued, dreaded image of the self as one who cannot measure up linked to a controlling, rejecting maternal figure, with anger and fear as the linking affect. In his actions—not paying the bill, interrupting the sessions—Mark alternately enacted and projected both representations of self and others, oscillating between the two, sometimes projecting one aspect onto the therapist and at the other time experiencing it himself.

These examples illustrate how when working with role reversals in the transference, an apt interpretation may first *intensify* the dynamic between patient and therapist, resulting in a rapid interchange of aspects of self and object poles of the dyad. In this case, devaluation of the therapist decreased over the next few sessions as the patient's awareness of it developed, leading to the emergence of more positive feelings of the sense of self as dependent and inadequate, longing for an all-giving, caring maternal figure—that had been previously defensively split off for fear of exposing his vulnerability. The capacity to hold in mind this defended-against dyad as it oscillated with the previously dominant grandiose self–devalued other dyad showed some partial integration in the internal world. This was reflected in the evolution in the transference from narcissistic and paranoid to a dependent transference. Here we also see the emergence of insight in which the patient shows some understanding that the object relational scenarios that were being lived out with the therapist in fact characterized Mark's other relationships as well.

Consistent interpretation of Mark's attempt to control the other he experienced as controlling and/or rejecting led to an awareness not only of the rejecting critical elements in himself but also the dependent longings, sense of weakness and humiliation, and associated fear and rage from which the grandiose self protected him. The recognition of his identification with both poles of the grandiose devalued dyad as it was being lived out with the therapist was the first step toward taking back the projection and experiencing the full weight of the anger, longing, and

fear of humiliation that led to the critical devaluation of others, including the therapist, clearing the way for a more positively valenced experience of the self in relation to the therapist and others to emerge. The product of work on role reversals is the recognition and tolerance for the contradictory positively (idealized) and negatively valanced (negative, judgmental) concepts of self and other at the same time, and the capacity to acknowledge that these are in part aspects of one's own mind as they emerge in the transference. Working with role reversals fosters recognition and reflection on the way that negative characteristics or modes of acting and being that the individual deplores in the therapist and others might actually represent aspects of the self and identification with negative aspects of internal objects. In so doing, this tempers the narcissistic person's grandiose sense of perfection and infallibility.

For those with narcissistic disorder, consistent work with role reversals in the transference leads to an expanded understanding of the underlying conflictual object relations with both an aggressive and libidinal, positive and negative cast that the grandiose self defends against. Work with role reversals in the transference enables the patient to understand *in vivo* how the narcissistic organization constricts his or her relations with others—that is, how it functions to camouflage and protect the individual from the full experience of longing for connection with wished-for others and abject feelings of dependency on all gratifying others (e.g., Mark's wish that the therapist treat him for free), as well as hateful feelings in relation to others experienced as fearsome or critical. In terms of the latter, one aspect of the grandiose self that was activated in the transference for Mark involved feelings of rage at a depriving, critical maternal figure that surfaced in frequent references to a TV series in which a therapist was both threatened and protected by her patient, a Mafia boss. The therapist understood, explored, and interpreted these paranoid aspects of the transference as indications of an investment in a sense of omnipotence and destructiveness, as well as a fear of merger with a maternal figure that would lead to annihilation of self. Such fantasies of harm and incorporation were also indicative of projective defenses that served to protect the self from persecutory, harmful internal objects.

Summary and Conclusion

The session material presented above shows that as the rigid, consciously held dyads of inferior/superior and idealized/devalued are explored through role reversals in the transference of other, positively and negatively toned object relational dyads that previously had been defensively

dissociated now begin to emerge. The rapid alternation of idealized and devalued representations of self and others evident in the session material presented above allows for reflection on and interpretation of the grandiose self into its component aspects that foreshadow its dissolution. At the same time, we see how the interpretive process in TFP-N is not primarily an intellectual endeavor but one that blends affect and cognition in ways that invite the patient into a new and richer mode of relating, and that puts the patient in deeper contact with a range of self and object representations beyond the sphere of the grandiose self.

In the following chapter, we present the latter phases of the interpretative process in TFP-N with case examples to illustrate how, with the resolution of the grandiose self, more complex, integrated object relations emerge, which in turn are reflected in more varied and advanced transferences.

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