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INVITED COMMENTARY

Position Paper—Transference-Focused Psychotherapy (TFP) for Narcissistic Personality

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Abstract

Purpose of review The authors describe the application of a twice-weekly, exploratory psychotherapy, Transference-Focused Psychotherapy (TFP), to patients with Narcissistic Personality Disorder (NPD). The paper describes the pathology of object relations within which narcissistic pathology can be understood, and how TFP establishes a treatment framework to address narcissistic pathology. An outline of the assessment and treatment protocol is described along with a case example to illustrate the same.

Current findings The application of TFP to patients with NPD follows from recent research demonstrating the effectiveness of TFP for patients with BPD including some patients with comborbid NPD.

Summary Although empirical studies of the efficacy of TFP for NPD are lacking and warranted the authors suggest that, in the absence of any other empirically supported treatment for NPD, TFP may be applied to this challenging patient population.

Tom, a 42-year-old attorney with no prior history of mental health treatment, presented to my office after being passed over for partnership at his law firm. Divorced with two young daughters, Tom described a history of responding to emotional setbacks and stressors—his divorce, a less-than-expected bonus at his law firm, rejection by women—with superficial self-injury; he would burn himself on the thigh on rare occasions, resulting in minor scarring. In response to a recent setback, he burned himself more severely than usual, alarming himself to such an extent that he was prompted to seek treatment.

In our first meeting, he described intensely competitive feelings towards colleagues and friends, and a constant process in which he benchmarked himself in relation to others. He revealed that performance reviews at work referenced his tendency to take on too much work, refusing help, and bristling at the suggestion of collaboration. He had been told that he tends to over-step his place with clients and superiors and was alerted repeatedly to his carelessness. Commenting on this feedback, Tom stated that people played favorites, the claims were overblown, that others get away with far worse, and that the criticisms were the result of others' competitiveness and backstabbing. His personal assessment was that he was "head and shoulders" above his peers. At other moments, however, as if vacillating between two divergent experiences of himself, he also bemoaned how far behind others he was in terms of his career stature, financial position, and romantic life.

Tom's feelings about the women he dated were significantly colored by his sense of how *others* might view her looks, and what this would do to his place in the social standings. Tom's sensitivity to the experience of rejection, being overlooked, or to any feeling of being diminished was intense, involving a blanket devaluation of those whose adulation and attention he had just recently sought. Tom was intensely preoccupied with his appearance, working to build muscle, and cultivating his speech and his gait so as to convey a cool and superior demeanor that would convey to others his "alpha" status.

I found Tom's presentation off-putting at first: "I want some tips, strategies to help make me the "A" level performer I should be, in all areas of my life." In effect, he wanted me to help him *shore up* his grandiosity, to help his narcissistic defenses work better. The question in my mind, however, was whether I could help him see that these defenses, which he experienced as vital to his self-esteem and sense of self, were serving to protect him from feelings of weakness and inadequacy that he experienced as intolerable. Whereas he wished that such self-experiences should be *not-him*, I framed a goal for our work as that of perhaps helping him achieve a more balanced and realistic appraisal of himself overall, one in which he could build on the authentically positive aspects of his personality and capacities, while tolerating better what was imperfect, in need of work, and perhaps helping him to reconcile himself to his limitations.

Introduction

The case described, as we will come to see, is a fairly standard presentation of an individual with narcissistic personality disorder, functioning in the mid-range of what could be termed borderline personality organization (BPO), a syndrome characterized by a sense of identity based on sharp splits between various experiences of the self (in Tom's case, positive/grandiose, and negative/devalued self-representations), maintained by splitting-based defenses. Overall, Tom functioned fairly well, his narcissistic defenses by and large working to keep some external emotional stability and a relatively high level of functioning in his work and

relationships. But, the effectiveness of these defenses in keeping other feelings about himself, feelings related to his sense of vulnerability and insecurity, was being challenged, and those weaker affects and self-experiences were regularly breaking through the more grandiose, confident surface. Further, these defenses imposed a rigidity in his functioning, a fear of exposure, of taking risks, of freedom of thought and action, for fear of failing, and revealing vulnerability, that were limiting Tom's progress in work and relationships as he entered his forties.

The question of how to best treat such patients in psychotherapy, given the unique challenges posed by the nature of narcissistic pathology—the patient's grandiosity, need for admiration and adulation, sense of entitlement, sensitivity to rejection and perceived slights, and intense devaluation of those who do not accord them the respect, attention, and treatment they feel entitled to—has posed a challenge to therapists since the earliest days of psychoanalysis [1–3] and continues to be a subject of great clinical interest [4–13]. The challenges are heightened by the narcissistic patient's struggle to enter into any relationship characterized by mutual dependency and reciprocity, or any relationship in which they must acknowledge a need for another. Their experience of need and dependency as humiliating is often associated with a tendency to retreat in various ways, denying any need for help, expressing shows of grandiosity and independence, and in some cases destroying the good received out of humiliation, shame [14, 15], or envy [16, 17], all of which contribute to the significant challenge of treating narcissistic patients. Their chronic devaluation of those who provoke their envy, including their therapists, can grind treatments to a halt, and the corresponding sense of hopelessness, rage, and ineffectiveness experienced at times by therapists can contribute to treatment stalemates, endless treatments, or giving up on treatment entirely.

Given that we now live in an age characterized by a focus on the self as reflected in the popular press and social media [18, 19], it is not surprising that an increasing scholarly and clinical focus on narcissism and its pathological forms has emerged. Along with the ascendant focus on narcissism in the general public is the acknowledgement of higher rates of NPD among young adults reported in community studies [20], and in the general nonclinical population, especially the young (i.e., college students; [21]). Despite NPD's prevalence, with rates ranging from 1 to approximately 6% in studies of community samples [20, 22] and 2 to 17% in clinical samples, respectively [23–25], randomized intervention studies including only NPD do not exist. Furthermore, although there are chapters for each of five treatments for NPD in the Handbook of Narcissism and Narcissistic Personality Disorder [4], none have any empirical record of treatment efficacy, and studies assessing the outcome of specific psychotherapeutic or pharmacological interventions for NPD are rare and limited [26]. Given the high rates of comorbidity of NPD with other Axis II [20] and Axis I disorders [25, 27], the study of NPD in the context of studies of others personality disorders with which NPD co-occurs may become increasingly common (see for example research involving TFP for BPD with comorbid NPD; [12]).

Narcissism as a psychopathology of internalized object relations

Descriptively, narcissistic personality disorder, as described in the case of Tom previously, is characterized by an excessive and pervasive preoccupation with the self and its value, expressed through tendencies to ascribe all that is good, desirable, and valuable, to the self (i.e., the Pathological Grandiose Self), and the corresponding assignment, or projection, of parts of the self that are weak, vulnerable, or in any way compromised or undesirable, to others [8, 17, 28]. Although this preoccupation with the self and its value may be expressed through grandiosity, overt entitlement, arrogance, expressions of envy, and a hunger for admiration and praise, these descriptive features may also be hidden by defensive processes that result in a different surface presentation (e.g., depressive or masochistic), masking the "covert" narcissistic pathology [8, 29, 30, 31]. The grandiose self is thus conceptualized as compensatory, as a structure superimposed upon the divided sense of self described in the general case

of borderline personality organization, providing a semblance of integration with various degrees of effectiveness.

The defensive processes used to support the split by which the self is identified along the pole of grandiosity and others are repositories for anything devalued, less desirable, weakened, fragile, etc., include the following: "idealization/devaluation", mechanisms of intimidation through the threat of the NPD patient's hostility (i.e., "omnipotent control"), "externalization" of responsibility for all that is not ideal, and "primitive denial" (of all that is not ideal in the self). Through "projective identification", patients ascribe negative qualities to others, qualities that they themselves are identified with or enact at other times, also figures prominently in the defensive palette of narcissistic patients.

Treatment: transference-focused psychotherapy (TFP) and narcissistic personality disorder

Transference-focused psychotherapy (TFP; [32•, 33•]) is a twice-weekly, psychoanalytically informed treatment that combines structure and limit setting with an exploratory psychoanalytic approach to help address the underlying, or "structural" personality features that drive the surface expression of narcissistic pathology. TFP has been studied empirically and shown to be effective in treating patients with borderline personality disorder (BPD; [34, 35]). Borderline patients share many of the same underlying features of patients with NPD, which has made us consider the extension of TFP to the treatment of narcissism [33•, 36, 37].

The treatment begins with a detailed evaluation of the patient's symptoms, adaptive coping capacities and defensive style, interpersonal relationships, and life situation. The assessment of the descriptive and structural features of NPD as described previously is also essential in developing the NPD diagnosis and determination of acuity. Differential diagnosis of mood disorders can be particularly challenging. In the case of Tom, for example, his expression of low mood and self-injury must be differentiated from the more chronic states of depression, not characteristic of Tom, and the determination that these symptoms were more consistent with the experience of narcissistic deflation, the sudden collapse of his narcissistic defenses in response to an acute setback. In such cases, the decreases in mood last, typically, only until a new source of narcissistic supply, or the promise thereof, emerges.

Upon completion of the evaluation and the discussion with the patient of his or her diagnosis, the therapist must initiate a discussion with the patient of the conditions under which each particular TFP treatment can succeed. The discussion of the "treatment contract" in TFP [32•, 38] is designed to establish a mutual understanding of the condition to be treated and to set realistic and mutually agreed upon parameters related to patient-specific behaviors that represent resistances to psychological exploration and pose a threat to the patient or therapist's safety, and to the conduct of TFP (e.g., severe substance abuse, self-injury/suicidality, eating disorder). In Tom's case, we discussed his tendency to burn himself, which posed a risk to his safety. Tom agreed to refrain from burning himself and to promptly discuss with me any incidents in which he felt urges to do so. For cases in which he felt he could not refrain, he agreed to call 911 or present to an ER. In cases where the patient is retreating from life activities, which was not Tom's situation, the contracting process also involves an agreement concerning the patient's engagement in some structured activity

(a job, educational or training program) while he or she is in treatment, in order that the treatment itself not support secondary gain of the illness in the form of a passive, defensive retreat from life.

Once the treatment contract is in place, the treatment process of TFP proceeds according to two long-standing principles of analytic technique. The first is the instruction to the patient to speak about whatever comes to mind, without editing or censoring, or attention to what may be deemed socially appropriate, related to the issues that brought them to treatment. We encourage patients to share dreams, fantasies, experiences in their daily lives, and reactions to the therapist and treatment process. The second principle encourages the therapist to work from surface to depth [32•, 39]; that is, to start with what is more observable and closer to awareness before interpreting deeply unconscious motivations or "genetic" hypotheses relating symptoms to the patient's past, which easily become intellectualized and may serve to move the patient away from important experiences in the here and now.

As the therapist gently challenges narcissistic defenses as they manifest in the treatment relationship (i.e., the concept of *resistance* to exploration/reflection), it becomes possible to jointly observe and explore the various manifestations of the idealized/devalued self and internal object relations that appear. The overarching objective in TFP is to help patients become more mindful of the various self and object representations that constitute their internal life, and how these representations guide their perceptions and get expressed, maladaptively, in the course of their daily lives. Throughout the treatment process, the therapist listens for evidence of particular self and object representations as expressed through three channels: (a) the patient's verbal communication (the content); (b) the patient's nonverbal communication, including facial expressions, gestures, and the feeling created in the session; and (c) the emotional reactions evoked by the patient in the therapist (the countertransference). At times, it is difficult to discern a given self or object representation: is the patient being arrogant, showing off, playing for admiration or attention; am I seeing a vulnerable self being expressed, a coy self, meek self, or is there an anxiety or paranoia being expressed? A third, central principle in TFP involves the therapist's tracking the "dominant affect" at any given moment in the session. As illustrated in Fig. 1, it is the therapist's job to use the dominant affect to diagnose the particular self state that is active at a given moment in the patient, and how that self state is linked, *through an affect*, to a particular representation of the therapist. An envious self, linked through contempt, to a devalued other, might be one example of a negatively valenced, or "persecutory dyad" (Fig. 1).

In TFP, we also help patient understand the ways in which these self-object dyads tend to *oscillate* (reverse roles) over time; the same patient who defensively derides someone of whom they are unconsciously envious, at other moments may see himself as the devalued one, less accomplished or attractive, and linked through the affect of shame, to a superior other (Fig. 2). It is crucial to emphasize that narcissistic patients are identified with *both* the superior and the inferior poles, aggressor and the victim, although each identification is experienced at different times and at various levels of conscious awareness.

We also help patients to identify the ways in which one set of dyads with a negative valence (one being contemptuous of another, with possible role reversals, as in Figs. 1 and 2), defends the patient against other wished-for, or "idealized" dyads, perhaps a self longing to be recognized and appreciated by a

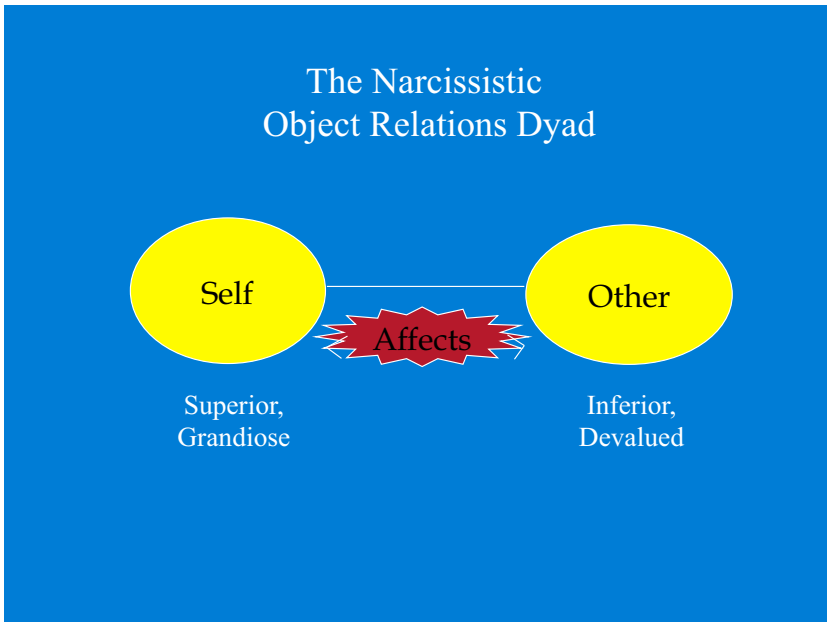

Fig. 1. The narcissistic object relations dyad.

highly valued, fully accepting and validating other (Fig. 3). Interpretation of the "layering of dyads" helps patients become aware that feared relationships often screen other dyads that are poignantly sought after, and that in some ways explain the need for what feel like painful and unproductive protective maneuvers (devaluation, externalization) that are characteristic of the persecutory dyad.

This, in short, is the work of TFP; helping patients to identify the various self and object dyads that dominate their internal life and which get expressed, in

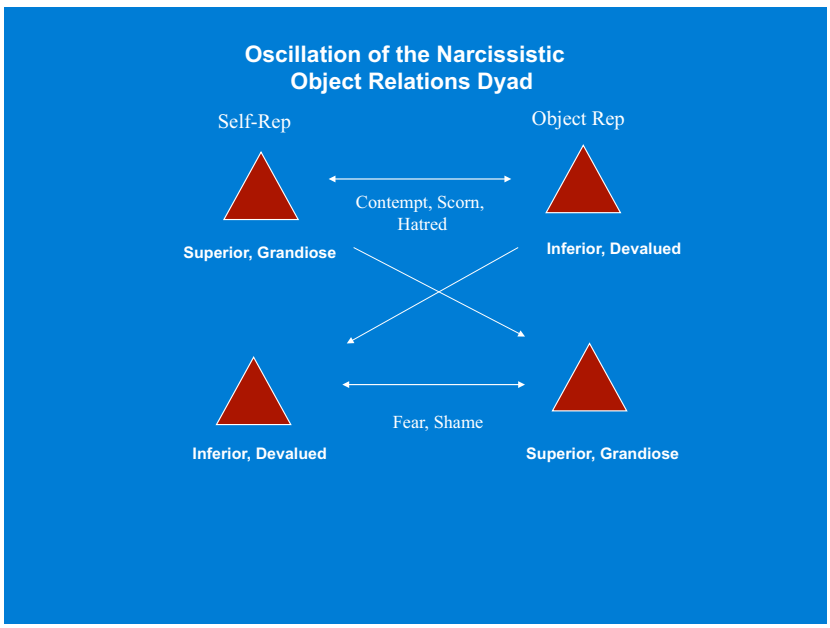

Fig. 2. Oscillation of the narcissistic object relations dyad.

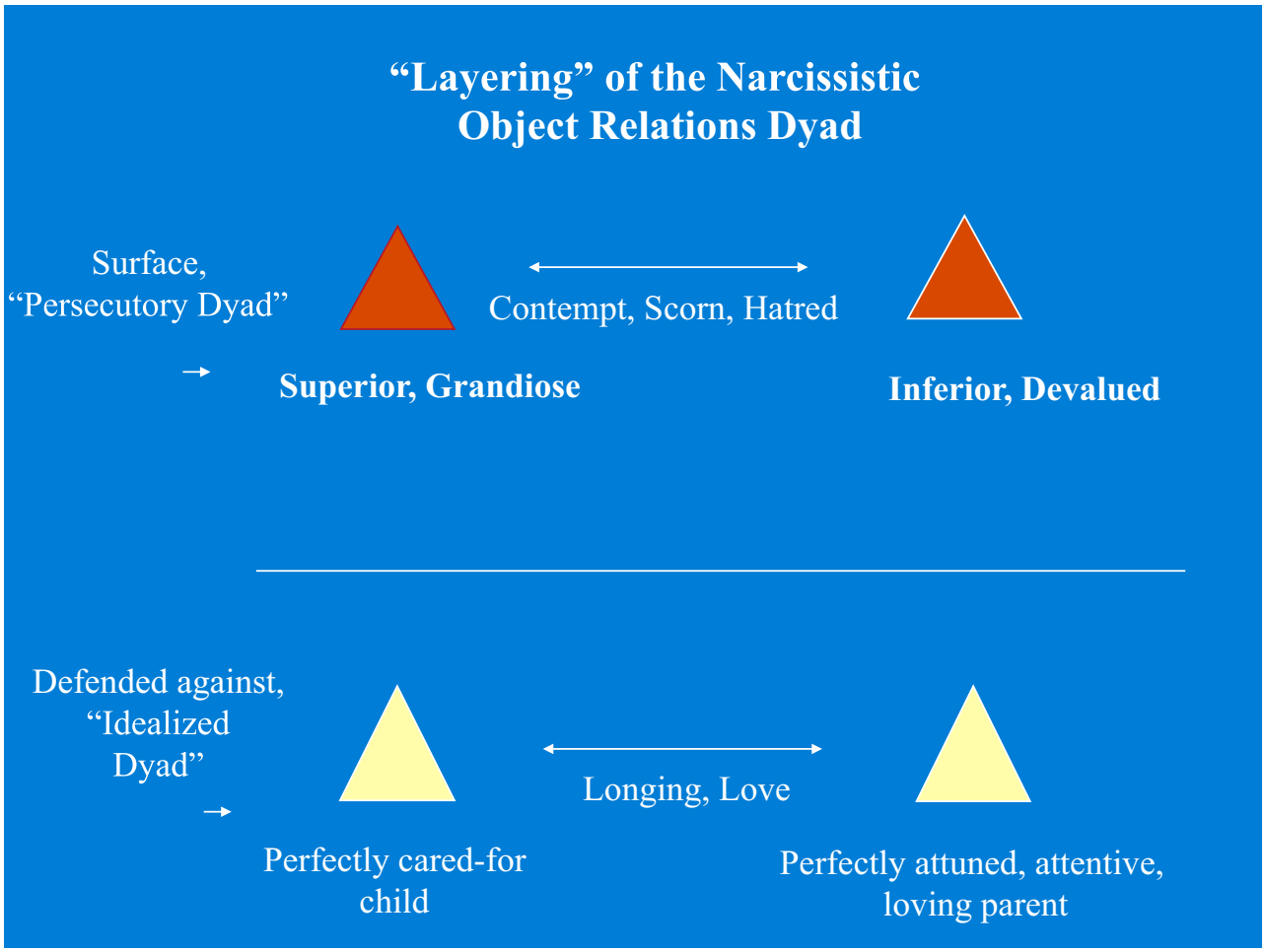

Fig. 3. "Layering" of the narcissistic object relations dyad.

highly split, segmented ways, in their lived reality. It is the rigidity with which devalued self-representations are managed, the interpersonal mechanisms through which these representations are ascribed to others, that cause much of the narcissistic patient's interpersonal strife and which ultimately result in a sense of emptiness and incompleteness in the self. Helping patients tolerate what is not ideal in the self without collapsing, hopefully being able to use their contact with what had been projected in service of realistically strengthening the self, is ultimately the goal of TFP.

The interpretive process

The key technical strategy through which TFP operates is the interpretive process [32•, 40]. We think of three stages of interpretation, which unfold throughout a given session or over the course of several sessions. "Clarification" is the process of inquiry, by which the therapist *seeks clarification* as to the patient's fullest understanding of what he is discussing, his current self state, the dominant affect, and potentially his experience of the therapist at that moment. "Confrontation" involves the gentle presentation of

contradictions, apparent to the therapist, to the patient for his or her examination. When tactfully presented—"you say that being rejected by her doesn't doesn't bother you, yet you were describing it to me and abruptly stopped speaking, and you seem to be fighting back tears; how might we understand that?"—such confrontations can provide a route into the object relations being expressed both on and beneath the surface, and serve, when all goes well, to soften the patient's defensive stance. In the case of Tom, confrontations similar to the one described previously, resulted in our ability to clarify his need to present a strong self image, resilient, desirable, in the face of rejections which rendered him small, longing, and vulnerable (oscillation in the persecutory dyad). The confrontations also led us to a more full interpretation of the relationship he had been longing for, one in which he could be perfectly open about himself, including his fragile and needy self, to someone who is perfectly accepting and admiring. We could discuss, in this third stage of the interpretive process, how his longing for such an "idealized" dyad feels so fraught for him, and how quickly, at the hint of rejection, of being overlooked, or of being seen by his partner as less desirable than some other man, lead him to experience the partner as an utterly rejecting, misleading, exploiting partner, one against whom his guard has to be maintained.

The interpretive process outlined previously involves the working through of various transferences typical of narcissistic patients, several of which may be operative over the course of the treatment depending on the acuity of any patient's given pathology. The basic paradigms include the psychopathic, paranoid, and depressive transferences [41], as well as narcissistic transferences [36, 37, 42], which have the unique characteristic of being operative within, and serving to screen, each of the other types of transference. Narcissistic transferences stem from the NPD patient's inability to depend on others and to establish relationships that are mutual and reciprocal, wherein the other is seen as truly independent and not an extension of the self and as a source of gratification of one's own needs at any given moment. The narcissistic transferences often involve a devaluing or dismissive stance towards the therapist, one that figures him as lacking anything of value to offer, and thus removes him as a potential source of envious feelings. Initial relationships with a narcissistic patient may convey the sense of a non-relationship, wherein the therapist is seen like one's radiology technician: providing a function, but interchangeable, anonymous, unseen. Similarly, the therapist may be treated as an audience, expected to admire, listen, and validate, but not to have anything to contribute. Interpretive efforts in TFP are offered, to the best of our ability, from a position we term "technical neutrality." Short of patently self-destructive behavior, we cannot know what challenges our patients should take up, what risks they should embrace or avoid, nor determine their most optimal life choices. Our interpretations, therefore, are observations we share as a concerned, neutral observer. We are clearly rooting for our patients, support that is manifest through our sustained attention, care, and efforts to be empathic towards all aspects of their personality. Our chief role, however, is to interpret our patient's conflicts, and point to aspects of their feelings about themselves and how they manage their life situation and relationships, of which they are unaware. We work to not take sides between their

competing interests, desires, urges, and inhibitions, but rather to help them think critically about what might motivate a given choice or reaction, and how it relates to their conflicts around grandiosity, self esteem, and the corresponding tendency to devalue.

Maintaining a stance of neutrality when interpreting a given transference is quite challenging, however, in the face of the powerful and at times overwhelming counter-transference reactions that frequently accompany the transferences described previously. The boredom experienced by a therapist rendered irrelevant and impersonal by a patient speaking as if to an admiring audience can lead to an enactment of that personae in the patient's internal world in the form of a chronic pattern of mutual disengagement. The rage, impotence, and sense of incompetence experienced by therapists in response to our patients withering contempt and devaluation, or their hostile expressions of envy, can, if not recognized and contained, lead to enactments (including interpretive enactments; [43]) and potential boundary violations. Discussing one's treatment of narcissistic patients with a peer supervision group should be considered a requirement of working with such patients, as our own shameful or otherwise uncomfortable reactions to our countertransference can easily lead us to dismiss or minimize our awareness of the same.

The following brief example of the interpretive process as it unfolded with Tom illustrates the confluence of TFP's model of analytic listening (i.e., following affect across the three channels of communication), defense analysis, and the interpretive process in TFP. Several months into treatment, Tom began a session telling me (BLS) how he had almost gotten caught by his girlfriend of almost one year, Sarah, in a lie related to his participation in an underground card game that he had begun to frequent. Tom had mentioned this to me off-handedly on several occasions, but in this instance, I noted his fear of getting caught by his girlfriend, and inquired as to why he felt such a strong need to keep it hidden. He responded that he felt that she would be overly judgmental of it … "It's not something that guys in our circle, or guys that she likes, do," referring to the illicit nature, financial risk, and hint of danger associated with the game. I also sensed in his response a bravado, showing *me* that he is comfortable with risk and posturing strength to me in the room. At this point, Tom fell silent, looking around in what seemed like an annoyed, impatient manner (Table 1).

In this exchange, we see resistance (s#1), and the enactment of the patient's defensive system, confronted or challenged by the therapist as it emerges in the process (s#3). What is revealed initial is a fairly typical paranoid transference, one of being judged or shamed by a critical, harsh, object (s#6–11). Initial confrontations of resistance always have a persecutory element, with the therapist figured as the critical judge from which the patient needs refuge. The effort must be made to thread the needle between a steadfast inquiry that challenges the patient's defensive avoidance of that which is conflictual, while doing so in the spirit of inquiry rather than taking a moralistic stance. Once the initial dyad is clarified, however, it paves the way for further elaboration, or clarification, of what the patient has been doing and how he has been experiencing himself, and ultimately for the interpretation of both poles of the dyad in the persecutory dyad, that follows (segment #13).

Table 1. Sample clinical process

		Process	Commentary
1	Th	We were talking about your card game and you went silent.	Therapist's challenge to Tom's *resistance* to free association, signaling a defensive process operating in the transference.
2	Pt	Nothing else to say really. Just a game, not sure what there is to say about it. Not sure why we're spending time on it when it's not that big a deal in my life.	
3	Th	You say it's not a big deal, yet you spent quite some time discussing the fear of her finding out about it, with me. And now you've gone silent, and dismissed me, as if there might be something about it you don't want *me* to find out.	"Confrontation"
4	Pt	It's none of her business, I have a right to keep certain things private, what … so I should just tell her everything?	
5	Th	Well I can't tell you what you should disclose or not to Sarah, but I am wondering about what seems like your wanting to shut down the discussion with me. I wonder if you feel criticized or judged by me for what you have disclosed or not.	Attempt to clarify the dominant self-experience at the moment.
6	Pt	Yeah, you seem all over me about this. Why would I want to tell her about the game? She doesn't need to know that … if we break up, that information would be out there; how is that good for me? This game is not a group of the most upstanding citizens of the world … I'm sure she'd have feelings about that.	
7	Th	But it also seems like you did not want to discuss it with me; I wonder if there is also a sense that I'd disapprove of your playing?	
8	Pt	Well, it's not going to happen much more. I've lost money and it's gotta stop. End of discussion.	Again, a defensive cut-off with the therapist, i.e., a resistance.
9	Th	You know that when you want to shut it down, it sort of screams for me to get more curious right?	A playful bid for his reflection, and a test of his defensive system, as if to say "can we look at this together?"
10	Pt	Yeah ….	Said with a sheepish smile that gives me the green light to pursue the issue further. Prognostically positive; his defenses yield to gentle confrontations, suggesting that he can tolerate some exposure of what is less than perfect in himself in service of growth.
11	Th	You're criticizing me for being too moralistic and prudish about honesty, and you're saying "can't *anything* stay private between me and Sarah?" You want to avoid the criticism you expect from her. Yet you're also shutting me down, making me wonder if you feel *I'll* be critical of you if you tell me what's really going on with the game.	
12	Pt		

Table 1. (Continued)

		Process	Commentary
		The other night I blew a lot of money. I had to go to the ATM three times, and lost, well, the equivalent of almost a week's pay. It's not good …. Like a joke of a stereotype: I got down, and I got angry, and in trying to win it back I lost more. Now I'm worse off than before.	
13	Th	You wanted to avoid telling me, to avoid exposing your feeling of shame around the game to me. You sense that I would see it as transparent, the appeal of the danger and risk, of the big win, along with the big uplift to your self esteem that would go with along with it. Keeping it to yourself here, you can retain that sense of strength, while I, the prudish, square doctor struggle to understand. You protect your feelings of shame, of being the small, struggling one.	Interpretation of the primary self-representation and the defense against the same, in the transference.
14	Pt	Yeah, sure. I get that. With all the financial stress, the idea of a big score does … well … did appeal to me. Now I just feel foolish…but more stuck. I feel behind where I should be, even more so now, and it feels like a struggle. Wouldn't you want to hide that too? No one wants to see that … not Sarah, not anyone.	

A comment on alternate psychodynamic models

In addition to our contemporary object-relations-based approach to the treatment of NPD, there are two other prominent schools within psychoanalysis that have written extensively on their work with narcissistic patients. For self psychologists, following the work of Kohut [44, 45] and elaborated in various streams of contemporary psychoanalytic writing [7, 46–48], the understanding of NPD is grounded in a very different theoretical understanding of narcissistic pathology, from which follows a rather different treatment approach. Whereas TFP therapists tend to view NPD as a pathology of internal object relations, self psychologists view NPD as rooted in the individual's fixation at an early stage of development, one in which the developing child's need for parental mirroring and idealization of the parental figures is central [48]. Self-psychologists focus acutely on these early needs of the self, or "selfobject" needs, as they manifest in the expressed wishes vis-à-vis the therapist and others, with mirroring responses and a willingness to accept the patient's need for idealization of the therapist as a key therapeutic strategy. In contrast to our approach, self-psychologists view aggression as reactive to disappointments or frustrations in those same situations and approach them more from the standpoint of empathizing with the disappointed, wished-for situation. Casting this aspect of Kohutian technique in light of TFP, one might say that self psychologists focus on the idealized, wished-for relationship, without linking this to a reality that can never

realistically deliver, or how the wished-for relationship relates to aggressively tinged, feared but often induced, experiences of the self with others.

The relational school of psychoanalysis' work with NPD patients is perhaps most explicitly addressed in the work of Bromberg [49] and Mitchell [50, 51], who emphasize the tension, the "delicate balance" between empathically conveying that we hear and understand our patient's conscious experience and felt needs, and the therapist's questioning of that same experience, i.e., why it needs to be felt in that particular way, and why our narcissistic patients' needs to engage others in the particular, maladaptive ways they often do (e.g., as sources of admiration, as envious competitors, as deflating, competitive superiors). These relational writers [49–51] emphasize the need for patients to feel understood as a pre-condition for more elaborated interpretive work, while at the same time recognizing the risk of a passive, unquestioning acceptance of our patient's transferences as serving to consolidate long wished-for, idealized ways of relating to objects and their entitlement to the same. Indeed, the necessity of confronting the patient's maladaptive use of the therapist is seen as a central part of relational work with narcissistic patients, along with the recognition that some more challenging narcissistic patients who present resistances to being understood, who misuse or fail to be moved by our efforts to understand, need a further "push" [49], noting that those pushes never go smoothly, but if handled with tact, help to usher patients into a stance of emotional learning and growth.

Key differences between such an approach and TFP involve the specification and focus in TFP on the treatment contract in order to both contain and understand the transference-implications of the patient's acting out behaviors, and the elaboration in TFP of a specific model of pathology, along with a corresponding assessment and well-elaborated treatment protocol. Last, relational writers emphasize to a greater extent the co-construction of transferences, and the *therapist's* contribution to the transference-countertransference matrix, whereas in TFP, our view is that the predominant use of primitive defenses by narcissistic patients implies a consistent distortion of the experience of others driven primarily by the patient's need to project what is undesirable in the self, and to incorporate into the self all aspects of self and other that are deemed desirable.

Conclusion

Through the process of interpretation over the course of treatment, with patients working through their idiosyncratic enactment of the grandiose self through its expression with the therapist and others, splitting processes begin to break down. Over time, patients approach a more "whole object" or "depressive" position [52, 53], one in which they begin to recognize and tolerate the awareness that the person with whom he or she experiences powerful experiences of persecution, neglect, derision, or humiliation, is the same person towards who the patient is directing his or her longing and desire, for care, love, and admiration. Ultimately, patients can come to see the therapist as someone who is well intentioned, kind, and insightful, with real help to offer, despite being flawed, despite failing the standard set by the idealized self. This evolution, from a paranoid or split internal set of representations and experiences of

self and other, to a more "integrated" position, is the primary goal of TFP, what we call "structural change," transforming the borderline and narcissistic structure and the maladaptive defensive system upon which it was based.

Thus, TFP starts with a treatment arrangement or contract that establishes the optimal, safe conditions for an exploratory process, one in which the representations of self and other that constitute the grandiose self can emerge in the treatment, where their examination in the process becomes the instrument of therapeutic gain. In TFP, the analysis of the various self-object dyads that constitute the grandiose self over the course of the treatment ultimately helps to soften the narcissistic self structure, allowing for devalued aspects of the self, lost to the self through projection, to be reclaimed. Although painful, this process signals the start of the journey to repair, the move towards the more integrated state described previously. Although this state of experiencing the self and others no longer promises the comfort of idealization, of self and other, the patient can now begin to relinquish the futile search for perfection in self and others, as painful as this process can be, and take up the more fruitful and adaptive struggle of living with more realistic appraisals and expectations of the self and others.

Compliance with Ethical Standards

Conflict of Interest

Barry L. Stern declares that he has no conflict of interest.
Diana Diamond declares that he has no conflict of interest.
Frank Yeomans declares that he has no conflict of interest.

Human and Animal Rights and Informed Consent

This article does not contain any studies with human or animal subjects performed by any of the authors.

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