Adequate Psychoanalytic Support for patients with narcissistic personality pathology and comorbid depression

This chapter is submitted for publication as:
Abstract

Short-term Psychoanalytic Supportive Psychotherapy (SPSP) is an evidence-based psychotherapy for depressed outpatients with Adequate Psychoanalytic Support (APS) as its core technique and assumed mechanism of change. This technique is an alliance fostering technique and therefore suitable for a broad range of severe personality disordered patients with comorbid depression. The technique of APS is illustrated using a clinical vignette of a depressed patient with severe narcissistic problems. APS with its focus on alliance building is particularly illustrative in patients with narcissistic problems because the relationship with the therapist, or anyone for that matter, is of major importance, at least on an unconscious level.
Introduction

Short-term Psychoanalytic Supportive Psychotherapy (SPSP) is a form of PDT with a proven evidence for depressive disorders (De Jonghe, 2005, 2014; Driessen et al., 2013). SPSP comprises 16 sessions within half a year (the first eight sessions weekly followed by eight sessions fortnightly). Its core technique is Adequate Psychoanalytic Support (APS). Recently, in this journal, De Jonghe et al. (2013) described the theoretic principles of SPSP. In this article, we illustrate the technique of APS in depression with comorbid narcissistic personality pathology using the clinical vignette of Peter to illustrate what APS is about in the consulting room. We demonstrate that APS is an alliance fostering technique and therefore suitable for severe personality pathology.

Adequate Psychoanalytic Support (APS)
APS is the adequate gratification of the patient's developmental needs that have been met inadequately in the first years of his life and that have therefore persisted into adulthood in their infantile forms, manifesting themselves in the primary aspects of the therapeutic relationship. It concerns all infantile wishes, desires and fears that manifest themselves in the relationship with the therapist through non-conscious behaviour and affects states that present themselves in the transference – counter transference dyad. We define support as adequate when the following 4 criteria are met: 1) the therapist explicitly has the intention to be supportive or emphatically validating (Lachmann, 2008; Schechter, 2007), 2) the patient is able to experience this validation affectively (Lachmann, 2008; Schechter, 2007), 3) the intended support fosters ego progression and counters regression (e.g. Dewald, 1994), 4) the experience of the support evokes a new experience of an external relationship that is dissonant to the usual and expected external-interpersonal relationships (e.g. Greenberg, 1986; Strachey, 1934).

Vignette of Peter
Peter is a 23-year-old young man who has been referred for depression and panic attacks. His main complaint is that he can't muster up the energy to do anything. He is afraid of being abandoned and he finds his perfectionism an increasing problem, because it starts to paralyze him. He's come to a halt with his studies because he can't finish anything or even get started because he is so strict about the results. He says that his existence depends on how he performs. The current period of depression with panic attacks started about eighteen months ago but has gradually got steadily worse. The panic attacks started a few weeks after his previous girlfriend broke up with him. When they faded into the background, the depressed, meaningless and empty feeling started.

Biographical details
Peter grew up in a family of four: he was the oldest of two; there was a sister who was 2 years younger. He has little contact with his sister. He describes his father (58) as someone who is very intelligent but slightly lacking in social skills. To Peter he was a man who is totally incapable of giving affection. He divorced his mother when Peter was 12. Since then, there has been virtually no contact. Peter is the one who gets in touch; father never takes the initiative. Mother (56) is described as a worrying type who looked to Peter a lot for consolation and clung to him after the divorce. Peter has some good friends.
Current social situation
Peter is currently living in student accommodation and he is not in a relationship. He studies biology and he is working on his master thesis, but is unable to finish it. He has been studying for 5 years now and he can't round things off. In addition, Peter does a lot of moonlighting as a waiter and so he spends hardly any time at home, but he has been off work a lot in recent weeks.

Psychodynamic diagnosis
According to DSM IV:
Peter was classified with depressive disorder, moderately severe and a personality disorder NOS with avoidant, borderline and narcissistic traits.

Making use of the operationalization according to PDM (Task Force, 2006), Peter could be classified as a narcissistic personality disorder, depressed/depleted type. The following psychodynamic characteristics of his self, his relational functioning and affect regulation could be recognized clinically in the initial intake and from the first sessions of SPSP. SPSP does not require a full examination of the personality at the start as its technique is tailored to the individual patient and his ego capacities. His view of himself is negative, meaningless and hollow unless others confirm his value. He has an incoherent damaged self that lacks vitality, a false self with clownish behavior that serves to protect his fragile true self. He projects this negative self-image on others, especially authority figures. Peter uses others as self- or mirror objects, not able to empathize with their needs and feelings. Instead suffocating them with his need to be mirrored and validated. Object relational functioning: Peter is very quick to put people down if they don't immediately impress or validate him. On the other hand, he can be very impressed by others and then he has a strong tendency to feel worthless and weak. Many work related contacts and friendships have ended in conflicts as a result. Peter’s affect regulation fails at times and he quickly shifts to shame, self-contempt or contempt on others, depression or hypomanic mood states. Defense mechanisms are projection, projective identification, idealization and devaluation. In structural terms, his fragile sense of self coincides almost entirely with his ego ideal (Freud, 1914), in which the fantasized ideal situation was something that must be urgently actualized (Lachmann, 2008). Peter’s perception of reality is generally accurate but can fail under pressure and be distorted in intimate contacts. His ego strength and resilience is meager resulting in panic attacks and severe mood swings due to life circumstances.

Session 1
T: Welcome, Peter. This is the first session of SPSP. We will be talking about your depression and its background. So we will not only talk about symptoms, but also about your situation in life and in particular your relationships with other people and what you think and feel about yourself. This all of course related to your current depression with the aim to understand it better and to reduce your symptoms.
P: [looks at the therapist with an expression of wide-eyed surprise] I'm not at all convinced that therapy that is so short can help me. That's just treating the symptoms. I've already had treatment like that and it was no use to me at all. I have to dig deeper: that's where my problem is. Anyway, I know you have to stick with the protocol: that's what you get paid for so I don't blame you personally.
T: Would you rather have a longer lasting treatment? One with an open end?
P: Yes that’s what I am telling you but you don’t seem to understand that!
T: So you don’t agree with this treatment?
P: No but that’s pretty standard in my life ...
T: Let’s see where we can get during the next 16 sessions. We usually manage to make enough progress but if you’ve not improved enough after 16 sessions, I’m not just going to shut the door on you. Tell me, when did you get so depressed?
P: I don’t want to just graduate. My thesis has to be absolutely fantastic and I hope my supervisors will think I’m fantastic too and talk about it with one another. But that puts so much pressure on me that I never actually get round to doing anything. I’ve always felt that I need to perform to earn attention and love.

Reflection on criterion 1: counter transference and APS
The therapist felt overwhelmed by Peter’s devaluation of the treatment and the transitional space (Winnicott, 1958) between the two of them was attacked. She managed to use these typical counter-transference feelings (Gabbard, 1998) to understand some of what Peter was unconsciously communicating about his rigid and restricted inner world with almost no symbolic space to enjoy growing, playing or seeking (Lachmann, 2008; Waska, 2012). These counter transference feelings however are a risk for the therapist as it impedes to meet the first criterion of APS (i.e. the therapist intends to be supportive). Therefore it is important to be aware of it. According to the supportive attitude, at this point, the therapist did not confront Peter with the underlying psychodynamics of his devaluation, possibly narcissistic rage, the projection of his own vulnerability (Kernberg, 1998; 1984), or with his reluctance to engage in therapy and feeling dependent. Instead, she managed the devaluing transference (Misch, 2000) by accepting and containing the projection of the unbearable despair, anxiety of being abandoned even before it started and his fragile sense of self. This helps her to emphatically validate his affects (Lachmann, 2008), explore his disappointment in the treatment plan and explain to him that she would not turn him down when treatment was not helping and start exploring together where his mood swings come from and how they can be understood.

P: [...] Everything is okay when I’m with friends but I get paralyzed again the next day, when the pressure’s on again. I was at a party recently.
T: That sounds tough. The pressure is high, never a break. Even so, you generally seem to manage fine in your contacts with others. Is that right?
P: Yes, I always feel better with other people than when I’m alone in my room brooding. I spend too much time in bed and I’m getting more and more out of shape. I’m not doing any sports at all any more, haven’t got the energy. I am ashamed of myself, look at how I have become.
T: Maybe that would be a good place to start. A bit of structure, a bit of a plan and deciding on what time to get up? Getting back to sports again: what do you enjoy?
P: I like running. I’m actually quite good at it, but I’m certainly not as fit as I used to be. I can’t keep up with my best friend, so I don’t do it anymore because I feel so ashamed.
T: How long do you like to run for?
P: Usually about 10 km. But I can’t manage a decent time any more.
T: You like doing it?
P: Yes, I love it!
T: And you feel good then?
P: Yes, I feel great.
T: I can see you do, you’re enjoying yourself just thinking about it. Maybe you should try a short run this weekend?
P: I will, I think.

**Reflection on criterion 2: the patient experiences support**

Peter’s narcissistic, rigid way of forcing himself into good performing is becoming more visible and affectively experienced as suffocating by the therapist. The interventions focussed on Peter’s fragile good feelings when he vividly talks about how he loves running. The shame he talks about is detected and understood by the therapist but she noticed that his fragmentation-prone sense of self needs to be strengthened first before feelings of shame can be talked about and explored. She serves as an auxiliary ego by containing his shame and vulnerable sense of self (Dewald, 1994) and at the same time encourages him to take some small steps on the way to growth and enjoyment. Whether Peter experiences a new relationship as opposed to his expectation of the other person as not interested or too self absorbed, is unclear at this point but is may be a good starting point for transforming his view of the world and of what he may expect from others in an intimate encounter (Lachmann, 2008).

**Session 3**

T: How has your mood been in the last week?
P: Nothing has changed. I still feel the same. And I don't think this therapy is going to help either. And I don't think that you can understand or help me.
T: It must be scary to think you're not making any progress. Can you tell me about your doubts and fears?
P: I'm not sure whether this form of therapy is working for me. It probably works for some people, but my problems are much more profound. I'm sure you mean well and it's nothing personal, but I can manage the day-to-day things fine myself.
T: You don’t think it's a good idea to start off with day-to-day things and you don't feel I understand you?
P: No, I want to dig deeper, that’s where the roots are, that’s where we have to go. Maybe it would be better to get another therapist? Someone who knows where things are coming from.
T: Do you feel scared, anxious it may never get better?
P: Yes. I just want to get rid of that horrible feeling and I just can’t do it.
T: Well, I can certainly relate to that and also to the idea that it takes too long before you see things getting better. Have things been bad all week?
P: No, not all week. Things were okay during the weekend; I took things a bit easy, went for a run twice and went out one night. I actually felt quite good at the weekend. But on Monday I had an argument with Tim and Marc. They just don't understand me. They are even more stupid than I am. I wanted a good conversation but then they started messing around and flirting with girls and I just didn't want to descend to that level.
T: So tell me about Monday, what happened exactly?
Peter said that he often spent Monday nights with Tim and Marc and it gradually became clear that he always wanted to show off. But that he actually always felt very lonely after a night like this.

T: Do Tim and Marc know that you often feel shitty and depressed?
P: No, and they don’t ask me about it either. It’s like they’re not interested in me at all.
T: How do you feel when you say this?
P: Lonely and depressed.
T: It sounds sad ...
P: Yes, but that’s never really how I feel about it.
T: Would you feel a bit less lonely if you were to tell them something about how bad you have been feeling recently?
P: Maybe, but they don’t bring up the subject.
T: Do you ask them sometimes how they are doing?
P: Mm, I don’t know, not very often, I don’t think.
T: Any idea why none of you do that?
P: No, that’s just the way it is. I always do it like this. With everyone actually.
T: But you often feel lonely and sad afterwards.
P: Yes, I do, and I always think that they think I’m a jerk-off.
T: That’s sad ...
P: I thought you’d think I was a jerk-off as well.
T: Thought? You don’t think so anymore?
P: I am not sure anymore, in the very beginning I was sure.

Reflection on criterion 3: ego progression
Peter’s attacks on the treatment and the therapist professional abilities continued. She could empathize though with his anxious feeling of never getting better, of being in this state forever. Kohut (1978) pointed at the restoring function of the narcissistic destructive impulse to prevent the fragile self from disintegration. She therefore contained his rage, did not confront him with it but instead helped him find out that things were not only bad all week. She noticed his feelings of profound loneliness and sadness that seems to be only partly conscious at this point when he tells her that his friends are not interested in him and that he is not able to make real contact with them. He never feels sad about it; he is just scared that people find him a jerk-off. She was cautious not to confront him with his lack of empathy with the inner lives of his friends but instead understood his mirror needs and asked about why they don’t show interest in each other. Because of his lack of empathy towards others, he doesn’t feel the support of others and more importantly, he doesn’t ask for any affiliation himself. Here, the auxiliary ego function (Dewald, 1994) of the therapist is to explore how he could affiliate more with Tim and Marc by exploring their way of communication towards each other. He then starts to wonder about his lack of intimacy with his friends. This can be seen as a first developmental step of ego growth: he was beginning to sense something about a lack of mutual empathy in his relationship with Marc en Tim and also with his therapist. Furthermore, this gave way to reflect upon him and wondering whether the therapist sees him as a jerk.
Session 5

*P:* Things went better last week until about half an hour ago, when I suddenly remembered in the shower that I had an appointment with you. Then I started feeling down again. I don't know, I just did.

*T:* What do you think that could mean?

*P:* I don't know, I still have to tell you so much, there's still so much you don't know about me but I don't know where to start. And now there's been this argument with Janice [sighs and looks slightly desperate].

*T:* Janice?

*P:* Yes, I sometimes fool around with her, but that's not going well at all either. It's all so hopeless.

*T:* [silent]

*P:* I'm so tired; I'd just like to go to sleep. This really isn't helping at all. I still feel as depressed as I did a month ago.

*T:* You actually felt quite good all week, but when you were in the shower this morning and started thinking about therapy, you got tired and down. Now we're talking about Janice and the same thing is happening. Do you think those two things are linked in any way? Coming here and talking about Janice?

*P:* Mm, I just don't feel like telling you everything.

*T:* Do you feel you have to?

*P:* Yes, I have to tell you everything, don't I?

*T:* Maybe you don’t want to tell me everything about you and Janice? After all, you don’t know me that well yet.

*P:* No, I really don't want to tell you all the details. I don't know whether it's really necessary but I just have a feeling that I have to do it.

*T:* You're so focused on how you have to behave and how you should perform, even here with me.

*P:* I do that all the time, with everybody, it doesn't matter whom. Always [sighs and looks relieved].

*T:* You look relieved?

*P:* Yes I am I guess [sit up straight and looks at the therapist with a livelier expression].

**Reflection: on the experience of the therapeutic alliance**

The therapist explored in detail why Peter felt bad in the shower. This way, she implicitly makes a connection between an affect state and feelings about external relationships. Initially, it was not clear to her what was going on, but she sensed he was communicating something vital about the therapeutic relationship. By exploring, they found out that Peter saw treatment as another arena in where he had to perform at the cost of his own wishes and needs and he himself made the historical link: “I'm always focused on how to be the best, better than all the others. But that's because people need me to: my mother, my girlfriends and my father. It's always about being the best. Otherwise you're a nothing, a waste”. This gave way to the clarification of the connection between an interpersonal pattern and his depression: “This is a pattern right? Always trying so hard to be the best in everything you do en with everyone you are, at school, with your friends. It’s a heavy burden on your shoulders. Do you think this burden could be related to you being depressed?”

Indisputably, transference traces were at the fore. One way of exploring them would be to bring the destructiveness of his behavior towards the surface. Of understanding his
reluctance to come to therapy as a destructive withdrawal from treatment and of obstructing an evolving intimate new relationship he so non-consciously longs for. Lachmann (2008) describes the use of leading edge interventions as opposed to trailing edge interventions. The former recognizes and validates self-defeating behaviors in the service of attempting to achieve self-cohesion and protect the almost fragmenting self. As the therapeutic relationship developed, the therapist could experience more of Peter’s attempts to protect his sense of self against the intrusions and desperate needs of others. She understood this as an autonomous striving for regaining more care and comfort for him and hence validated it.

Session 6
T: How was your mood last week?
P: It is slowly getting better; I think we’re getting somewhere. Yesterday I really had to go and see my mother. I woke up and I didn’t feel like it at all. I pictured her face: so happy to see me; it’s very endearing, but irritating. So I thought I’d go for a run first and then see how things went. Then I met Gabe and we went for a cup of coffee. Then we stayed for beers and I ended up not going to see her. I called her to say I wasn’t coming and she was sad, I could tell.
T: How did you feel about making a decision just for you?
P: I didn’t really feel guilty. It felt good actually. We’re doing well together, you and me. By the way, do you run? I was talking to Gabe about you and he asked what you were like.
T: You’re happy about what we’re doing here?
P: Yes, and things were more fun with Janice this week, there was less competition, we were just being kind to one another.
T: It looks as though you’re starting to be less harsh on yourself. As if things are more in line with your own desires. Do you think that has impact on you feel?
P: Yes, it does, I feel a lot better. So we’ve done a good job together, haven’t we?

Reflection: on addressing the narcissistic self in the context of the therapeutic alliance
Peter starts to feel more autonomous and strives for more care and libinal fulfilling of his own needs. He is able to enjoy a nice meeting with his friend without feeling the obligation of visiting his self-absorbed mother. Hence liveliness, playfulness and more freedom come with it. Mirror transference wishes in the form of a twin ship transference are emerging (Kohut, 1978). His parents were not able to meet his archaic narcissistic needs. He also was not able to idealise either his mother or his father (Kohut, 1978). There was an inability of both to meet him in his inner world and mirror his affects, strivings and autonomous desires so that he did not have a clue about himself besides clowning and making them all feel better (Winnicott, 1958). In line with Kohut (1978), the therapist serves as a self-object without confronting or interpreting the functions she serves. She understands his need for sameness in this struggle to find cohesiveness and reflects his genuine feeling of working together towards a sensible goal by simply asking whether he feels happy about the work they are doing together. He confirms this, says he feels better and rephrases the good works they have been doing. This way, the therapeutic alliance is firmly co-created by both therapist and patient (Lachmann, 2008).

Session 7
T: How was your mood last week?
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P: I have been sad and panicking, all week...
T: I am sorry about that, why was that do you think?
P: How would I know? I just didn't have the feeling at all that I could do my tricks; I just couldn't do anything at all! I felt so stupid. I just wanted to stay in bed.
T: That must have been a really tough week, feeling like this. What do you mean when you say you couldn't do your tricks?
P: I couldn't show off. I had an appointment with my thesis supervisor and I just froze. I ran into a few friends and I couldn't think of anything funny to say. I felt completely stuck.
T: You always have to perform haven't you? The pressure is so high. You can't just be with someone and see what happens?
P: No, I'm afraid people will think I'm stupid or boring, an empty nothing ...
T: You feel this enormous pressure on you whenever you're around people. And when the clown fails, you feel bad, miserable and ashamed. You just want to disappear, because you feel so hollow and you end up feeling depressed.
P: Yes, that's how it feels all the time.
T: How do you feel now?
P: I feel I'm stupid, weak, boring, ugly, a failure ...
P: It makes me sad... [silent]
T: Can you tell me about what's going on inside you now?
P: Sad [cries quietly], I really feel so bad. I'd like to just disappear, just get away.
T: It must be awful to feel this bad about you yourself. Even though you're a good student, you have Janice and nice friends, you do all you can to help out your mom and stay in touch with your dad, that's still how you feel about yourself.
P: Yes I'm really scared. Scared I'll always be on my own, that nobody wants me [cries].
T: [silent]
T: How does it feel like when you cry for a bit like that?
P: Feels pretty okay actually, I never do that really, it's a bit of a relief.
T: Taking the time together here for your sadness and fear feels as a relief.
T: [After a brief silence] how do you feel about us not meeting next week?
P: Not good. That works out really badly now, that protocol of yours.
T: You're sad and angry you can't come next week, just when you're feeling so sad now?
P: Well, is there any point? Nothing will change anyway.
T: No, there won't be any changes to our schedule but I think it's important for you to share with me how you feel about it.
P: I guess so...

Reflection on criterion 4: experiencing a new interpersonal relationship
This extended example from session 7 shows the gradual process of Peter getting more in touch with experiences and feelings that stems form his true self. With it come feelings of grief, of being scared to lose the love of everyone when he gives up his clownish tricks. Note that he reports being sad and anxious but not depressed. The narcissistic shield is cracking, with feelings of shame, sadness and despair as a consequence. His original narcissistic defense against these affects is given up and the underlying anxiety is experienced fully as state of panic. The therapist explores the feelings that come to the surface when the clown is not doing its tricks, by containing his inner world full of sadness and fear. She is cautious not to side with either the harsh self-critical internalized interpersonal relationship or its massive ego ideal together with a new emerging sense of true self. She does not interpret
this object relational dyad (Waska, 2011) but tries to establish an optimal tension between
the old view of Peter on himself and the emerging fragile new way he is experiencing her
seeing him (Greenberg, 1986). Structural change can occur, albeit limited in short time
treatment, when his capacity to experience the therapist as a new object develops
(Greenberg, 1986) and the conviction of knowing for certain that others, including his
therapist, find him a jerk and a nothing, can be doubted. In developmental terms, through
the co-creation of the therapeutic relationship, the therapist’s affective responsivity
promotes Peter’s affect integration and consequently his sense of self can emerge
(Bruschweiler-Stern, et al., 2002; Stern et al., 1998).

Session 9
After 8 weeks in SPSP we switch from weekly sessions to fortnightly sessions. After this first
two-week gap between the sessions, Peter felt depressed and was angry at the therapist for
asking him stupid questions about how he felt. He talked about his parents' divorce and how
he felt he screwed up: “I couldn’t get them back together. I couldn’t let mom feel a bit
better”. The session ends with the therapist expressing the understanding of him feeling
down when he so often feels he has failed, that he’s no good for anything or anyone. He
always had to perform to get attention and to avoid being left alone: getting good grades for
your fathers’ love and being a clown to make mom feel better. It was never about him, what
he needed, how he felt inside. Peter responds with sadness and the expression of his feeling
of loneliness.

Reflection on addressing defense using APS
There had been a fortnight between the sessions and the therapist noticed in Peter partly
unconscious feelings of missing her tremendously and at the same time, angeriness with her
for not being there. However, the temporal displacement (Akhtar, 2009) towards his parents
prevents his conscious feelings towards the therapist to come to the surface. Now the
original primitive aggression towards his parents becomes visible in the transference. This is
not interpreted but the original emotion is validated in a supportive way. Note that only the
defense mechanisms that undermine the ego or form a threat to the therapeutic
relationship are discussed (Dewald, 1994, Misch, 2000). More neurotic defenses such as
displacement (Valliant, 1991) are supportively explored with the intention to allow the
patient to experience at least a certain aspect of the displaced feelings. The main
intervention here was an upward interpretation that enables the ego to integrate some
painful affects without putting pressure on the ego by increasing anxiety as a result of
interpreting downward (Langs, 1973). Peters’ constant strain on achieving and making
everyone feel better, his failing this tremendous task and his feelings of loneliness, sorrow
and ultimately depression as consequence, was understood in the context of his fear of
being left alone and not taken care of.

Session 11
Two weeks later, Peter was still very down and desperate. He felt weak and the therapist
gradually felt herself slipping into the same feeling. He seemed to be completely in despair
and the only way of getting out of his own stranglehold was a passive suicide wish that he
projected onto the therapist, suffocating her with it. She stressed the importance of routine,
exercise and interpersonal contact. But Peter looked at her disdainfully and said: “I really
don’t come here for instructions like this; I can think them up for myself”.

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T: Do you think there might be a link between your sadness in our last session and the desperation you feel now?
P: Don't know. I just feel the study pressure. It really has to get finished now and I'm never going to manage. I really have messed it up for good, I might as well just give up now.
T: Have you thought about our last session?
P: A bit, made me sad...
T: And you're still giving yourself hell, aren't you?
P: Yes, somebody has to, otherwise nothing will happen.
T: You have to get mad at yourself to get something done?
P: Well yes, ... apparently... [silent]
P: Can I come back next week instead of two weeks from now? Not that it's doing much for me, but leaving me alone when I'm like this feels just inhuman.
T: [hesitates] OK let's schedule an extra appointment for next week.

Reflection on projective identification and APS

The transitional space (Winnicott, 1958) in the therapeutic dyad was attacked, very much like the first encounters between them. The therapist felt overwhelmed by Peter’s deep feelings of meaninglessness and identified with his unconscious passive suicidal wish. She evacuated these unbearable affects (Spillius & O'Shaughnessy, 2012; Waska, 2011) by acting out in two ways. First by stressing the importance of daily routine and interpersonal contacts. At that point, she was freeing herself from the suffocating parts inside her and was not actively be supportive. Likewise Peter did not feel supported or understood. Second by granting him an extra session. In doing so, she did the very things he is so familiar with and at the same time terrified of: not being understood, not being loved, not being able to cope, to be a looser and in desperate need of an extra session. As such the projective identification came to a full circle (Kernberg, 1998, 1984; Waska, 2011). Using the technique of APS, this projective circle is not interpreted unless it would form a threat to the therapeutic relationship. In this case, it turned out that Peter felt better the next week and that he opened up toward his professor in sharing his insecurity about his thesis. He went running and saw his friends. The therapist continued to help Peter make the link between what he had done himself: expressing his insecurity instead of clowning around and being harsh on himself on the one hand, and his improved mood on the other. She did mention briefly the issue of it being an additional session but because he was feeling better and there was no threat of an alliance rupture, the projective identification was not further explored or interpreted.

Final sessions

Peter continued to do well. The theme of the last sessions was his tendency to think in black and white terms and his high standards. He began to be more lively, less rigid and strict and the transitional space between the two of us could slowly be explored. Play entered our relationship as a consequence and there was room for a little joke now and then (Lachmann, 2008; Winnicott, 1958). He began to feel in though more profoundly with his own sense of self, his own wishes, dreams and wanting. In the meantime, he was studying again, finished his thesis and could feel proud of himself. His depression faded, as did the panic attacks. In the final two sessions, Peter was angry that treatment came to an end and projected the unbearable affects of pain and aggression onto the therapist. Although this was a familiar pattern by now it felt less massively split off and less destructive. He was integrating his affects slowly into his sense of self although the therapist never pointed this out. Regression
in the service of the ego (Kris, 1952) became visible when he expressed his feelings of aggression that treatment did come to its end and at the same time he was able to express his longing for love and care from me forever without losing his reality testing.

Discussion

We evaluate the four postulated criteria of Adequate Psychoanalytic Support and briefly discuss them in line with the vignette.

The therapist intends to emphatically validate
From the very start of treatment, although Peter behaved headstrong, the therapist could be empathic because behind his narcissistic shield, she saw a little boy wanting to receive affects of love, recognition and emotional care that he is not receiving in daily life nor seems to have experienced good enough in his younger years. This enabled the therapist to be real empathic despite all his actual devaluations and rage expressed in the therapeutic relationship. The exception was the session where she felt Peter’s suicidal wish and aggression strongly projected onto her. She lost her adequate supportive stance because this intervention was a regressive gift and a implicit message to him that indeed he needed extra help and was not capable of dealing with matters on his own. The therapist lost her containing function, felt his and her own rage and evacuated these feelings by acting out and reaction formation by agreeing on an extra session. The therapeutic relationship by now was strongly built, and although this was a technical flaw, it did not cause a rupture. As to date there is no empirical knowledge of what technique works for whom, there is some convergence in the literature to start with a self psychological approach involving emphatic validation and fostering the therapeutic alliance in narcissistic pathology (Gabbard, 1998). The supportive stance of the SPSP therapist is an alliance-fostering stance with the technique of APS and alliance building going hand in hand.

The patient affectively experiences the validation as such
In the beginning of treatment, Peter was not able to feel the therapists’ empathy. He entered treatment with an expectation of others as potentially critical, judgmental and dismissing. In addition, he had negative feelings of short-term treatment. In a review on clinical research related to treatment effects, Defife & Hilsenroth (2011) show the predictive value of real treatment - and role expectations on the alliance and treatment outcome. In the first session of SPSP, we explicitly discuss the treatment frame and goal and we come to a psychodynamic formulation of why this person, in these life circumstances and within the context of this specific life history, developed these depressed symptoms (Defife & Hilsenroth, 2011; Perry et al., 1987). This formulation is more or less explicitly shared with the patient depending on the anticipated supportive impact of it. In case of Peter, and with narcissistic patients in general, the risk of such an explicit formulation is that patients don’t feel understood and genuinely seen for who they are. That’s why the therapist focused on life circumstances and interpersonal patterns related to Peter’s depression as the treatment goal in the initial phase of treatment without explicitly pinpoint his damaged fragile self stemming from the lack of mirror objects in the past.

Although Peter was sceptical about the treatment, the therapist felt confident and verbalised this confidence in SPSP, which may be an essential element in the initial
encounter for the continuation of treatment (Hilsenroth & Cromer, 2007). In addition, she contained her aggression and insecurity in the counter transference and by doing so, implicitly, a new way of interpersonal relating could be experienced in the therapeutic relationship. A way of relating he did not expect or anticipated on. Likewise the therapist experienced a new playful way of relating to him in the therapeutic setting. There came more transitional and symbolic space (Winnicott, 1958) in the therapeutic dyad, because his mirror hunger faded (Kohut, 1978). There were several true moments of meeting (Stern et al., 1998) especially in the final sessions when they fooled around sometimes; making jokes and both surprised each other in this way of relating. Peter came more in touch with his genuine archaic needs and the little boy that was playing hide and seek behind his condescending presentation, dared to show his face more en en more often. At those moments the therapist felt pride, there is no way he could have missed that. This process was never explicitly verbalised but affectively felt and experienced.

**APS fosters ego growth and counters regression**

In terms of pathology of the self, Peter increasingly developed more autonomous strivings and could leave the clown more often in the dressing room. The therapist was less needed as a mirror object (Kohut, 1978) and he allowed her and him to be separate people in a close relationship. As a result he felt less despair and more vitality in important aspects of life. His ego ideal is less massive and suffocating, sublimation gives way to finish his thesis (Freud, 1914; Kernberg, 1998). He is now more capable of choosing a profession that will fit his needs and ambition and he enjoys the company of his friends more. His initial damaged sense of self is slowly on his way of transforming into a firmer self. Note that none of these things were verbalised but implicitly experienced in the therapeutic relationship. For example:

**P:** I have told my professor that I was really worried about the presentation and that I was afraid I would fail. He reassured me and said that my master thesis was already fine. That I shouldn’t worry about the presentation. I felt so relieved [..] I went running too. I got up on time every morning and I didn’t go to bed too late either. I saw Marc and Tim even though I didn’t really feel like it. But we had a good time.

**T:** You maintained your routine, saw your friends and you told your professor about your worries. That’s quite something. Did these things affect your mood do you think?

**P:** Definitely!

As we know from studies of The Boston Change Process Study Group that changes in mental structure can occur implicitly by moments of meeting in which the relationship as it is implicitly known by two people, has altered and thus changes mental states and behaviour. (Stern et al., 1998). The fact that the symptoms of depression and panic were fully in remission is another way of evaluating the ego as more resilient.

**APS evokes the experience of two (or more) dissonant external-interpersonal relationships**

The level of interventions was mostly on Peter’s external relationships explicitly and more implicitly, the therapist monitored constantly the echoes of them in the therapeutic relationship without exploring his feelings about the therapist in depth and without referring to transference traces. By engaging and co creating in a new accepting relationship in which Peter was allowed to feel, think and say anything that came to his mind, in where there was
genuine interest in his inner world, two external-interpersonal relationships simultaneously could emerge in the intersubjective therapeutic environment: an old harsh aggressive object relation that infiltrated in his id, ego, super ego and ego ideal, and a new benevolent one. Although in short term therapy, internalization of a new affectively laden external relationship (Kernberg, 1998, 1984) can only be partial, every part he identifies with, gives him better chances of meeting people with whom he can intimately relate. For he now for the first time in his life had a sense of what it is like to be real in a relationship and still be cared for without having to clown around. And while several aspects of his self-pathology remained untouched in this therapy, the growth that occurred hopefully continues and keeps changes his outer and inner world on the way.

In conclusion, APS offers a model to foster the alliance, making it suitable in the treatment of severe personality disordered patients, with for example narcissistic pathology that needs psychotherapy for a major depressive disorder.
References


