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EXPERIENCE OF SELF AND OTHER: NARCISSISTIC VULNERABILITIES

Clinically, we observe that patients whose self-esteem is especially brittle require certain considerations in formulating a treatment plan (e.g., Gold & Stricker, 2011). We refer to such patients as *narcissistically vulnerable*, but we are not using the term *narcissistic* pejoratively or as an equivalent to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) category of Narcissistic Personality Disorder. In contemporary psychoanalysis, as informed by self psychology (Kohut, 1977, 1984) and relational theory (e.g., Mitchell, 1986), narcissism is appreciated as a normal part of being human, and healthy self-love has its own developmental course intertwined with that of developing love for others. Regulating self-love and self-worth—that is, self-esteem—through life's inevitable failures, successes, losses, accomplishments, disapproval, and praise is a universal challenge requiring multiple adjustments, calibrations, and stabilizations daily. Some people, however, because of developmental setbacks and insufficiencies, struggle significantly with restoring a realistic, positive, and integrated sense of themselves through the upturns and downturns of fortune and misfortune.

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Such individuals are vulnerable to rapid, unanticipated, and painful stabs of hurt, criticism, shame, and humiliation and consequently must construct multiple self-protections against such injuries or risk devastating feelings of fragmentation and abyss. Such experiences occur along a continuum of severity.

It is the vulnerabilities to sudden intense injuries and the harsh, unrealistic, or rigid self-protections against being injured that disrupt relationships and rupture alliance. Such vulnerabilities and self-protections inhibit genuine openness. They deter taking in another person unguardedly. They impede spontaneous learning. For such reasons, mapping a patient's narcissistic vulnerabilities, the contexts in which he is most vulnerable, the self-protections he has put in place, and his areas of true strength from which sturdier self-worth can be fashioned are vital to protecting a therapeutic alliance and repairing its ruptures. This is true whether a cognitive-behavioral therapist is considering a psychoeducational intervention, a psychodynamic therapist is considering an interpretive intervention, or an educator is considering a classroom intervention. We now walk through specific data in the Rorschach, Thematic Apperception Test (TAT; Murray, 1943), Wechsler tests, and patient–examiner relationship that help us map our patient's narcissistic vulnerabilities.

NARCISSISTIC VULNERABILITIES: WHERE TO LOOK ON THE RORSCHACH

In this section, we examine Rorschach scores from within and outside the CS that bear upon assessment of narcissistic vulnerability. After discussing single indicators, we provide a clinical case example that synthesizes the treatment implications derived from multiple Rorschach variables.

Rorschach and Narcissistic Vulnerability: Comprehensive System Scores

In this section, we present Comprehensive System (CS) scores that bear on assessment of narcissistic vulnerability including reflections (*Fr + rF*), vista (*V*), morbid (*MOR*), and personal (*PER*) responses.

Reflections (Fr + rF)

We examined relational aspects of *reflections*[1] *of human movement* responses and the corresponding implications for therapeutic alliance in

[1]Reflections contribute to the CS's Egocentricity Index [3*r* + (2)/R], which has been considered another "measure of psychological self-focusing or self-concern" (Exner, 1986, p. 396). In a recent meta-analysis, the Egocentricity Index garnered little empirical support for its validity (Mihura et al., 2013). In light of both Mihura et al.'s (2013) finding and our own mixed clinical experience with this index, we forego its discussion here.

Chapter 6. Here, we discuss how reflection responses in general illuminate qualities of self-maturation and correspondingly carry implications for self-esteem regulation vulnerabilities and protections.

Reflections are empirically as well as clinically and conceptually established as associated with a patient's self-absorption and grandiosity (Mihura, Meyer, Dumitrascu, & Bombel, 2013; Weiner, 1998). Weiner (1998) captured one clinical translation of the empirical findings when he described the presence of reflections in a record as follows:

> associated with marked tendencies to overvalue personal worth and for individuals to become preoccupied with their own needs at the expense of other's . . . . With few exceptions, people with $Fr + rF > 0$ in their records are self-centered individuals who have an inflated sense of their importance and exalted estimate of their attributes. They tend to be selfish, self-serving arrogant persons who assign higher priority to their needs and interests than to those of others and are rarely drawn to acts of helpfulness and generosity that entail self-sacrifice. They approach life situations with an air of superiority and a sense of entitlement, and whatever they want to have should be theirs for the asking and whatever they wish to enjoy should be placed at their disposal. (pp. 152–153)

Weiner's (1998) emphasis is on the relationally off-putting qualities of someone driven to grandiosity. In this chapter, we emphasize the underlying insufficiencies necessitating the self-absorption and grandiosity. We do so because without awareness of the need behind our patient's off-putting behavior, we as therapists can be too easily put off and consequently unable to reach in and repair what is driving our patient's problems. What in such patients appears to be "inflated" self-esteem is usually its opposite—fragility of self-maturation in which there lacks reliable ways to resiliently recoalesce following circumstances that generate self-doubt, loss, and powerlessness. Appreciating that our patient's "self-serving . . . arrogant . . . air of superiority . . . [and] sense of entitlement" betray vulnerabilities within him increases our empathy, which is essential for our positively allying with him and creating treatment planning formulations that hold enough complexity to stand a chance of leading to different outcomes than he has tasted in other relationships (Elliott, Bohart, Watson, & Greenberg, 2011).

When our patient gives a reflection response, therefore, we are aware that he may impress others as self-absorbed or grandiose, and we consequently are interested in looking further for data that locate the vulnerabilities in self-maturation that have led him there. One of several places to look is the content associated with his reflection responses. For example, mull over the

contrasting nuances of vulnerabilities and protections contained in the following responses, each a reflection response given to Card VI:

- "A powerful battleship . . . you can see its reflection in the water." [*W Fro Sc AgC*]
- "It's a battleship . . . being hit by a torpedo . . . all of it is reflected in the water." [*W Fr.mpo Sc AgC MOR*]
- "A lush landscape, thick, like with vines in the front, bushes behind, then more forest behind that, going all the way back . . . all reflecting in the water here." [*W FV.Fro Ls*]

"Powerful battleship," "battleship being hit by a torpedo," and "lush landscape . . . thick . . . with vines" are three different self-experiences in which self-absorption (*Fr*) is occurring. The first emphasizes power, impenetrability, and implied domination in the face of battle. The second emphasizes failed protections, acute damage, penetrability, and helplessness against a sneak attack. The third emphasizes isolation in a 360-degree cocoon of nature in which the thickness extends forever and is described as rich but is potentially concealing and entrapping as well. The three patients' differences in self-experiences suggest correspondingly nuanced differences in treatment implications—despite their commonality of having *Fr*.

If we were to generate treatment implications from the three *Fr* responses, restricting our database to a single test response (a learning exercise only, *not* a recommendation for clinical practice), we would alert the therapist of our first patient that when her patient's read of a situation is adversarial ("battle"; *AgC*), the patient buttresses himself inside power and domination and plows through interpersonal waters with intentional impenetrability ("powerful battleship"; *Fr*). When we review the full configuration of the "battleship" response, we are able to add that her patient's stance is a stable one that functions smoothly for him (*FQo*, no cognitive special scores). Consequently, given the fluent operation of her patient's battleship stance, we would advise the therapist that when she experiences her patient plowing over and being impenetrable to her remarks, she is unlikely to get very far if she defensively enters into her patient's paradigm of deflecting attack through her own shows of power. We advise this occur because her patient functions smoothly in his stance, he is probably far more practiced at it than she, and nothing new will happen between them that has not already happened a thousand times before in her patient's interpersonal life. Instead, the therapist stands a better chance of entering new interpersonal waters with her patient if she remembers that his battleship stance is a signal that he somehow felt a challenge or threat in the air and thus needed to self-arm ("battle"). At such moments, the therapist might do well to discern what pricked the patient's threat sensors; to silently review his stated goals for seeking treatment; to support and ally with her

patient's strength, competence, perseverance, and investment in self (which is assumed to include raw materials from which his battleship approach originally was constructed); and, from such foundation, to refresh the moment's focus on his original goals and their shared contract to work *together* toward his goals. In such ways, over time, the therapist might help mature her patient's *Fr* moments into Ms and build accumulated experiences with such safe Ms in the therapy relationship. Perhaps then the patient's battleship will become less necessary or at least less dominating and self-absorbed.

With the second patient ("being hit by a torpedo"), the self-absorption (*Fr*) emerges in a context of acuteness and helplessness (*mp*) in the face of damage (*MOR*) because of failed barriers and sneak attack ("torpedo"). We alert the second therapist to her patient's vulnerability to feeling easily penetrated by remarks that he did not see coming. When the second patient shifts into self-absorption, it may be a signal that he suddenly felt wounded and is reverberating inside his absorption with self-amplifying feelings of damage (*MOR*). This therapist might do well to remember that openness and vulnerability in her patient are not necessarily invitations for empathy but rather are signals of exposure and need for repair of self-coherence and felt sturdiness. The specifics of the second patient's vulnerabilities steer the specifics of his repair process. Restoring stability and efficacy (to counteract the *m* and *p,* respectively) is the priority. With *transparency and respect* (the opposite of a "torpedo"), the therapist reconstitutes trust, delicately retraces her interpersonal steps to discern her implements of unexpected wounding (words? looks? tone?), and equally delicately (if the patient's trust and felt efficacy have been adequately restored) examines the particularities of the patient's vulnerable spots that her wounding breached.

The therapist of the third patient ("lush landscape") might experience subtler expressions of self-absorption from her patient than the first two therapists experienced with theirs. Overt battles and strident recoils from injury would be less likely. Instead, her patient might immerse himself in rich introspection that appears collaborative, but after a while, the therapist might notice feeling emotionally isolated as if subtly left out or ignored (the interpersonal complement to another's self-absorption). The therapist might notice a self-critical, ruminative quality to the patient's self-absorption as well (the *FV;* see the section "Shading Vista (*FV, VF, V*)" later in this chapter). We alert this therapist that her patient's inner experiences of shame may stimulate his retreat into self-absorption (notice that his response verbalization elaborates the *FV* and *then* adds the *Fr*). At such times, the therapist can empathize with her patient that interpersonal withdrawal likely provides a certain peace (*Ls*) and concealment ("thick"), which in balanced doses creates healthy respite, but that habitual withdrawal exacts costs of isolation and endless entanglement in his self-critical darkness ("going all the way back"). Consequently, a critical

treatment focus will be to develop alternative means by which her patient can metabolize his private experiences of shame. This patient always may possess the sensitivities that create shading responses, but ideally, with psychotherapy, his *Fr* would drop out, his landscapes would incorporate people, and his *FV* might be exchanged for *FT*.

Were we to narrowly conclude from the *Fr* > 0 in these three responses merely that all three patients were interpersonally self-absorbed, arrogant, and entitled, we effectively would end the search for what makes each one suffer and thus shrink the hope for empathic clinical intervention as well.[2] Instead, we expand our consideration to details of content, form quality, form dominance, special scores, sequential placement, nature and range of self-other paradigms, and data from other tests to pinpoint the unique humanity in each patient that correspondingly helps us direct each therapist uniquely. We are interested in *when* the patient is self-absorbed, in *what ways* his self-absorption is expressed, *why* he needs to be self-absorbed (what is the absorption solving), and whether he has other solutions or whether the self-absorption is pervasive. In short, we are filling in the map of our patient's maturation of self—the suppleness and depth of his sense of personal worth, the places where his self-worth is vulnerable, and how he reregulates in the face of his vulnerabilities. Such a map guides his therapist in the avoidance and repair of alliance ruptures.

Shading Vista (FV, VF, V)

As described in Chapter 5, *V*s use the blot's shading to denote perspective—either depth or distance. *V*s reflect a perceptual sensitivity to deep nuances of dark tonalities combined with a cognitive proclivity toward both seeing into and stepping back. As such, vista has been associated conceptually and empirically with introspection (sensitivity to nuances, capacity for perspective) that is negatively tinged (dark tonalities). In their meta-analysis of CS variables, Mihura et al. (2013) found that *V* responses correlate with criteria measuring "emotionally negative self-evaluation" (p. 571). Exner (1986) stated, "When V is present, it signals the presence of discomfort, and possibly even pain, that is being produced by a kind of ruminative self-inspection, which is focused on *perceived* negative features of the self" (p. 342). Weiner (1998) added that

> V > 0 is typically associated with self-critical attitudes that become increasingly negative as V grows larger. The more V in a record, the more

[2]Doing so also would be taking Weiner (1998) out of context and misunderstanding his interpretive approach.

> likely it is that subjects' attitudes toward some aspects [of] themselves or their actions have progressed from displeasure and dissatisfaction to disgust and loathing. (p. 157)

We wonder whether such intense focus on negative aspects of the self reflects inner raw places of shame (Morrison, 1987, 1989).

Vista and reflections can be considered together. When the self-absorbed leanings of $Fr+rF>0$ combine with the self-critical leanings of $V>0$, our patient's self-recrimination is locked into an echo chamber of self-involvement. There are multiple underlying sources for such a state. For example, self-absorbed self-attack may be the outcome of damaged self-development in which one rages relentlessly at oneself for failing to be perfect (Blatt, 1995; Freud, 1917/1963c). Sometimes ruminative, self-absorbed self-attack reflects a neurologically based inability to shift mental sets. Sometimes relentless, self-absorbed self-attack reflects memories and internalizations from complex relational trauma. Any of these possibilities can occur in combination. In addition, Weiner (1998) cited research about $V>0$ with $Fr+rF>0$ occurring in psychopathic criminals who are "upset with themselves for having been caught, convicted, and imprisoned for their offense" (pp. 157–158). He elaborated on self-criticism that is more defensive and reactive (self-serving) than relationally regretful. Knowing which of such possibilities fits our patient requires reviewing all test data for converging patterns of support for and refutation of alternative hypotheses. The particulars of treatment implications vary according to which underlying disruption (see Chapters 8 and 9) is gleaned from such an examination.

Notice how a score configuration (vista and reflection) becomes an orienting point (negative introspection and self-absorption) that stimulates hypotheses about the underlying disruptions creating such vulnerabilities. In turn, those hypotheses are validated, refuted, and particularized by examining the array of data in which the score-pair occurs. In this way, a psychodynamic approach to testing develops high-definition, individually tailored treatment suggestions that lie beyond the reach of computer-generated data analyses.

Morbid Content (MOR)

Exner (1986) described *MOR* responses as spotlighting self-images with "more negative, and possibly damaged features than is commonplace" and "an orientation toward the self . . . marked by considerable pessimism" (p. 397). When we are following leads on hidden vulnerabilities in our patient's self-maturation, we view *MOR* responses that evoke themes of damage, injury, and incompleteness as locating where and how our patient feels inadequate and possibly why. We use configurational and minisequential analyses (see Chapter 5) to elaborate the details of context, efficacy, and recovery surrounding our patient's experiences of inner damage.

Personal Responses (PER)

Justifying one's response with "past experience or prior knowledge" emanates from anxiety about the adequacy of that response (Weiner, 1998, p. 219). Weiner (1998) differentiated among three kinds of *PER* responses: self-justifying, self-aggrandizing, and self-revealing. The first two allow insight into self-maturation vulnerabilities.[3] Weiner explained the first two in this way:

> *Self-justifying Personals* consist of straightforward and unelaborated statements of resemblance between a blot or blot detail and something the subject has seen elsewhere. Common examples . . . [include] a bat that "looks just like the ones I've seen"; cartoon figures that "I see on the television"; and organs of the body that "are like the pictures I've seen in an anatomy book" . . . .
>
> *Self-aggrandizing Personals* go beyond mere mention of prior knowledge or experience that justify a percept to elaborate in proud fashion how much the subject knows or has done. In this type of Personal . . . a totem pole on Card VI becomes "the kind of native symbol I remember from my travels to the South Seas"; Card IX "reminds me of the impressionist paintings I've seen in the Louvre"; and a jet airplane on Card II evokes the comment, "I used to fly one of the those suckers, and I know all about them." (p. 220, italics added)

In both self-justifying and self-aggrandizing *PER*s, patients are managing unstable and fragilely maintained self-worth and coherence. Such patients likely carry doubts about their own value, importance, and meaning, sometimes behind which lie deeper fears about insignificance and subjectively felt invisibility or nonexistence.

In the self-justifying *PER*, a patient defends the legitimacy of his percept as if to say, "I really do have reason to see things as I do. . . . I am here; I exist; I have legitimacy." The quality of his *PER* telegraphs his anticipation that he will be judged as lacking, strange, or not credible. The quality of his *PER* also conveys an alert sensitivity to the examiner's reaction and a need for her approval. This combination of tentative self-legitimacy with alertness to others' reactions overlaps with some of the sensitivities Gabbard (1989) and Akhtar (2000) described, respectively, in their "hypervigilant" or "shy" narcissistic patients.

In the self-aggrandizing *PER*, a patient shores up a deeply hidden insecurity about his importance by promoting his specialness. His *PER* communicates, "I see the things I do because I am uniquely talented and experienced, and

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[3]In contrast, Weiner (1998) indicated that the third type of *PER*, Self-revealing *PER*s, are more relationship-seeking than expressions of felt inadequacy. Self-revealing Personals

> have a flavor more of sharing information than of showing off . . . [Such *PER*s] often indicate an effort . . . to reach out to the examiner, as if to say, "I want you to know more about me as a person." (pp. 220–221)

For example, "It looks like a church, like the one my family went to when I was little."

nothing and no one can question my importance and my existence." The quality of his *PER* insists on being better than, knowing more than, and being admired by the other. The quality of his *PER* also dissolves the importance of the other by ignoring her or pushing the envelope of disregard for her feelings. Such qualities overlap with those Gabbard (1989) described in his discussion of patients with the "oblivious" type of narcissism.

Rorschach and Narcissistic Vulnerability: Non-CS Scores

In this section, we discuss non-CS scores that aid in the assessment of narcissistic vulnerability. We discuss *shading as form* and other content categories.

Shading as Form [F(c) determinant]

In Chapter 5, we defined the Rapaport-derived *F(c)* score in terms of use of shading to carve out the location of a response. An example of an *F(c)* response is "faces" in "the heavily shaded upper half of Card IV, both 'faces' looking away from the midline" (Rapaport, Gill, & Schafer, 1968, p. 396). (In the CS, this uncommon location is scored *Dd*99). An *F(c) tend* (tendency) is noted when an important *feature* of a larger response is carved out of variations in the shading inside the response, such as the eye on the animal face, D3, on Card VII (Rapaport et al., 1968).

Lerner (1998) elaborated a clinical perspective on the *F(c)*:

> The variations in shading are subtle; therefore, to achieve such a response one must seek out, discover, and attune to finer nuances, as well as feel one's way into something that is not readily apparent. To do this requires perceptual sensitivity in addition to searching, articulating, and penetrating type of activity. Individuals with this type of sensitivity—who have their antennae out, if you will–tend to present as hypervigilant, thin-skinned, and excessively vulnerable . . . . (p. 419)

We fine-tune Lerner's (1998) observations by appreciating the differences between people with innate perceptual sensitivities and people with psychologically motivated needs to search their environment in a hypervigilant manner. A person with *innate perceptual sensitivities* simply sees into the interior of things without effort. Intricate observations are naturally visible. On the other hand, a person with *psychologically motivated needs* to search his environment does indeed "seek out" details with his "antennae out" as Lerner (p. 419) described. When a child with innate sensitivities is attuned to and has his perceptions affirmed, he develops confidence in his apprehension of nuances. When, instead, sensitivities are missed, ignored, or defensively maligned—or when trauma dysregulates and stimulates the development of perceptual hypervigilance—the development of self is damaged accordingly

and this is when we see what Lerner aptly described as "hypervigilant, thin-skinned, and excessively vulnerable" (p. 419; see also Peebles, 1986b).

An *F(c)* response in and of itself, therefore, is not a marker for pathology or disordered self-development. We look configurationally and sequentially, to determine how much our patient's perceptual seeing-into is a gift that opens potential for artistry, perspicacity, and empathy, and how much the gift has been hijacked as a survival tool for anticipating potential assaults. In the former situation, what could feel to others like "searching . . . penetrating" perceptual behavior actually reflects simple, effortless awareness in which insights are visible naturally. An example of such embedded perceptual strengths comes from Card VII where the *F(c)* is in *Dd99*, carved-out, light gray shapes at very bottom of the card, on either side of the center:

> Two lovers, walking hand in hand on the beach (INQ) Their heads, shoulders, here's where they're kind of holding hands [center, tiny] or arm in arm. (beach?) See how it spreads out on the bottom, lighter like sand, and you can see the lovers from a distance (distance?) They look smaller, like there's lots of beach ahead of them. [*Dd+ Ma.FY.FDu* (*F(c)*) *2 H, Ls COP;* notice that the 'perceptual seeing into' is associated with creative synthesis (*DQ+*, blend), an *FQu* that is readily discerned when pointed out, affect is contained (*FY*), perspective taking (*FD*), and benevolent human interaction (*Ma, COP*)]

In contrast, in psychologically driven hypervigilance, watchful attentiveness to details may be used for piercing belittlement of others, to guard against danger, or for exquisite discernment of just how to mold oneself to become what another wants . . . all of which reflect efforts to protect and keep intact an inadequately developed (and therefore inadequately protected, inadequately regulated, and unstably valued) sense of self (Gabbard, 1989; Lerner, 1998; Winnicott, 1965). Consider this response to Card IV, illustrating how perceptual sensitivity can be "hijacked as a survival tool for anticipating potential assaults":

> A giant –p– with x-ray vision. You can see his eyes [points to two dark *F(c)* spots in center at top under *Dd30*] almost cross-eyed like he's concentrating energy. And there is his x-ray vision coming out. [points to center dark trail or path, the dark enlarging center of *D5*] (Giant?) Big, and high up, like he's looming. (X-ray?) Like his eyes are penetrating right through you—it's like the ink and the darkness, and the way it pushes down, the perspective makes it look like it's going into something. Looks mean, like he's trying to control you. [*W+ Ma.ma.FD.C'F–* (*F(c) tend, Fs*) *(H), Xy P AG confab;* notice that the "perceptual seeing into" involves effort at synthesis (*DQ+*, blend), but what is pulled together entails distorted perception (*FQ–* that is a spoiled *FQo* and *P*), loss of

distance ("right though *you* . . . trying to control *you*"), and reasoning imbued with over-embellished fantasy (*confab)*, all marked by dangerous relational content.]

Other Content

There are certain contents, not captured by the CS categories, that alert us to a potential precarious and vulnerable sense of self and other content that alerts us to potential efforts to manage and protect against such an experience. Responses in the former category are those referencing fragility, delicacy, shakiness, and precarious balance. Responses in the latter category are those connoting inflated estimations or idealizations, such as references to royalty, beauty, intelligence, deities, exotic animals or places, fancy jewelry, clothing, or other amenities (Cooper & Arnow, 1986; Schafer, 1954). A single such response in either category simply denotes shades of color in our patient's personality. Several such responses, with recurring indicators of devaluing and idealization, are concerning.

Case Examples of Rorschach Assessment of Narcissistic Vulnerability

In the first of our two examples, we turn to a response to Card VI from an intellectually gifted young man who recently had been hospitalized following a psychotic break. It is one of four reflection responses in his protocol of $R = 38$.

> A castle . . . the water is a reflection . . . it [castle] is falling apart . . . water's eroding it away. [*W*+ *Fr.ma*– *Ay, Na MOR*]

Here, we see content combining importance and protection (castle), in configuration with the structural markers of *W*+, *Fr, MOR, m,* and *FQ*–, and in an overall context of $Fr + rF = 4$. This evocative response enables us to appreciate, among other things, the current state of the patient's sense of self. A castle—a grand residence reflecting dominion, privilege, and resources and typically a sturdily built fortress of protection against enemies—is in precarious condition. The castle is "falling apart"; it is being eroded away by external forces of nature. The patient's thematic content converges with his pessimistic experience of himself (*MOR*), his subjective feeling of acuteness and helplessness (*m*), and his actual slippage in cognitive-perceptual functioning (*FQ*–). The presence and quantity of his *Fr*s converge with "castle" and *W*+ to signal self-absorption (*Fr*) with an inflated ("castle") and striving (*W*+) sense of self. Simultaneously, his *Fr* converges with "falling apart" and *FQ*–, *MOR, m* to signal the young man's reverberating absorption (*Fr*) with a subjective experience of previous specialness and unassailability ("castle") that is now helpless (*m*) to an externally instigated ("water's eroding") process of

acute (*m*) deterioration (*FQ–, MOR*). The examiner wrote in the test report that "this young man is suffering the painful deterioration of something that has been grand to him, namely his mind."

For our second Rorschach example of detailing narcissistic vulnerabilities, we return to Betsy (Bram, 2010), to whom we referred in Chapters 4 and 6. Betsy is the angry, depressed 14-year-old who suffered physical complaints rather than feeling emotions and who had been unable to establish a therapeutic alliance and stay in treatment. Her complete Rorschach data are contained in Appendixes 4.1, 4.2, and 4.3, but we will highlight several Rorschach structural variables and contents to examine as we consider whether vulnerabilities in the development of Betsy's ability to regulate her self-esteem have contributed to her difficulties to establish a trusting alliance with a therapist. Key scores in her $R = 15$ protocol include $MOR = 7$ and $Fr + rF = 2$. Betsy's *MOR* contents included "something with its head chopped off," "chicken without a head, "killed animal," "bobcat without a tail looking at its reflection," "sad person in an odd outfit," "dead bird," and "wingless chicken." Her two reflection responses were:

> I-1. A dragon about to take off. Not a very happy dragon. It's rather angry. (INQ) Wings are here. Bumps are where the eyes are. Feet right here. And that's just a shadow. Doesn't look happy because the eyes are bunched together. The rest of it is shadow or reflection. (Reflection?) Sort of a reflection. (Shadow?) Because it's black.
>
> [W+ *Fr.FC'.FMau (A), Hx 4.0 AG, AgC, fab-confab*]
>
> VIII-12. [sideways >] It's obviously some kind of animal. I'd say a bobcat, because it doesn't have a tail. It's out on rocks in the middle of a lake. It's obviously curious about the water. Because it's leaning against a stump in an effort to see it. (INQ) Okay. Animals right here. Stump. And its head is down, so it looks like he's trying to look at something. And rocks. (Rocks?) I dk. Just seems to me what he'd be standing on. (Water?) Some sort of animal leaning over something. Looks like it would be a reflection and it looks like it could be in the water. [Patient hides her face.]
>
> [*W+ FMa.Fr+ C avoid [for water] A, Na P 4.5 MOR, fab-confab*]

It is noteworthy that two of Betsy's 15 responses (13%) are reflection responses. If we were to adopt a strictly empirical approach to the Rorschach and consider Betsy to have a narcissistic personality in the *DSM* sense based on $Fr + rF = 2$, we would not have learned who Betsy is or have offered her therapist much clinical direction. The label *narcissistic* gives us a hint of a person's interpersonal impact, but it says nothing about her being wounded, how she is wounded, how she self-protects, why she chooses that means of protection, how able she is to reflect on her style, and how uncomfortable

she is with her choices. It is the answers to such questions, not the label, that offer a therapist a way to proceed therapeutically, particularly when developing and sustaining an alliance.

To understand Betsy more fully, therefore, we look at the context of her reflection responses—their configuration, sequence, and place in her overall testing record. Betsy is self-absorbed (*Fr* + *rF* = 2) and angry (*AG*, *Ag*C; "dragon . . . rather angry"; "bobcat") with a large persona to boot ("dragon"). We saw evidence of that provocative combination in the referral information and her behavior in the testing when she sat in the examiner's chair and offered mocking responses to the Wechsler items (see Bram, 2010). Betsy's self-absorption and anger interfere with her establishing a collaborative alliance. But it is only by knowing *why* Betsy *needs* to be self-absorbed and angry, however, that we can open paths for developing connection and collaboration with her. Betsy's self-absorption (*Frs*) is colored with unhappiness and pessimism about herself (*FC'; MOR;* "not very happy"; *MOR* = 7). She is developmentally poised for growth ("about to take off," "obviously curious . . . trying to look"), but sadness and aloneness haunt her movement and come through in her verbal and behavioral embellishments (*FC'*; "just a shadow"; "out on rocks in the middle of a lake"; hiding her face). Thus, although Betsy puts forth an angry, provocative persona ("dragon"; "bobcat"; patient–examiner behavior) and pushes others away with her self-absorption (*Fr*), underneath she actually is struggling with pervasive feelings of inadequacy and incompleteness (*MOR* = 7/15 responses; multiple animals lacking body parts; *(2)* = 0 [Exner, 1986]). Therefore, concluding that Betsy is "narcissistic" and subsequently conceptualizing her as someone who is full of herself or has inflated self-esteem would lead a treater away from Betsy's core. Betsy is more accurately and empathically understood as struggling desperately against underlying vulnerability and inadequacy of self-development both of which are darkening her natural curiosity and efforts to blossom ("take off"). Such a nuanced understanding of Betsy's narcissistic vulnerability was one critical factor in enabling her therapist to form an alliance with her that made it possible for a meaningful and effective psychotherapy process to take hold (Bram, 2010).

NARCISSISTIC VULNERABILITIES: WHERE TO LOOK ON THE TAT

We are alerted to struggles regulating self-esteem when TAT stories contain (a) premises and themes involving criticism, inadequacy, fragility, rejection, misattunement, and misunderstanding; (b) emotions of shame,

humiliation, hurt, contempt envy, or anger and revenge; or (c) premises and themes involving high ambition, glorification, idealization, extraordinary beauty, extraordinary intelligence, specialness, superiority, or entitlement. TAT narratives provide outlines of the conditions under which a person's self-esteem is most likely to be dysregulated. Such self-esteem dysregulation can be relationally or achievement driven (Blatt, 2004, 2008).

Let us turn to TAT data from the evaluation of Barry, a graduate student in his late 20s who had struggled with long-standing social anxiety and avoidance and who increasingly was depressed and isolated. Barry was previously in an insight-oriented psychoanalytic psychotherapy, which he thought had helped him understand himself "a bit better," but he did not feel that the understanding had translated into much improvement in his social life. He ended that therapy suddenly and unilaterally because he "just didn't like going anymore." Barry could not quite say why exactly he did not like going. Two years later, Barry consulted a psychiatrist. The psychiatrist requested testing for Barry before referring him to another therapy because the psychiatrist wanted to learn what needed to be known to help Barry tackle his symptoms more satisfyingly and avert another premature and confusing flight from treatment. Here are Barry's stories to Cards 1 and 3BM, each followed by a list of implicit premises conveyed within his narrative:

> Card 1: He's looking at his violin. Looks sad and, like, kinda hurt. (Led up?) Just had a violin lesson. The teacher came to the house for a lesson. The kid had been practicing really hard and was proud to show her what he could do. He did okay at first but messed up some parts. His teacher told him what he was doing wrong, mean about it. (Thinking?) "I suck at this. This is pointless. I'll never be really good." (Next?) He wants to quit, but his parents tell him to stick with it. Then the same thing happens the next week and the next week after that. Eventually, he can't take it anymore, does quit, and never plays music again. (What do you mean, "it"?) All the criticism.

Implicit Premises:

- People give their best effort yet the outcome is hurt and failure.
- Efforts and abilities are not seen, valued, and appreciated.
- Feelings of self-worth easily shatter.
- People have high ambitions ("be really good").
- Helpers and authorities focus on what is wrong.
- External criticism is unrelenting.
- External criticism is personalized and reshaped internally into harsh self-attack.
- Leaving is the only solution to the hurt from relentless criticism.

Card 3BM: The guy is pretty upset and crying. He just found out he didn't get into the good college he wanted . . . rejection letter. (Thinking?) "I'm a failure. I let everyone down." Wondering "How am I gonna face my friends?" (Next?) Goes up to his room, locks his door, and cries for hours. Parents keep knocking on his door. Doesn't want to talk to anyone.

Implicit Premises:

- Ambitions ("good college") are not realized.
- Failure to achieve or be recognized is experienced as rejection and is crushing.
- Failure feels like public humiliation and shame (fear of facing friends).
- Withdrawal and isolation are the solutions to rejection, failure, and shame.

Themes around trying, failing, feeling shamed, and fleeing repeat in Barry's two stories. Because of this repetition, we infer that these themes are telling us something about Barry. We hypothesize that Barry anticipates that his hard work toward high goals will fail to satisfy important others who will not recognize and validate his effort but instead will criticize and reject. We hypothesize that Barry experiences such criticism as hurtful. He internalizes it as severe self-attack and subsequently feels humiliated and ashamed by his felt failure. We hypothesize that the only solution he has developed to such pain is to leave suddenly or to withdraw into isolation. Each of these hypotheses bear on Barry's abrupt leave-taking of his psychotherapy as well as on his suffering around social anxiety, avoidance, and isolation that initially brought him to treatment.

One of several methods of exploring the validity of our hypotheses is to elicit Barry's reactions to them, which is what the examiner did as part of her post-TAT inquiry. The examiner recapped the repeating themes in the two stories and asked Barry to what extent such themes might relate to Barry's psychotherapy experience. Barry pondered and affirmed that the stories' themes described how he often felt in life. He then thought about his psychotherapy experience in particular and recounted his commitment to the process, his regular attendance, his carefulness about being on time, the fact that he paid his bill promptly, and his efforts to "free-associate" and bring in dreams. With bitterness, however, he went on to describe his therapist as critical and condescending and as actually hurting Barry multiple times as, for instance, when he labeled Barry's worries as "neurotic." Barry said that he often felt worse after sessions and began to conclude that his therapist did not like him. Barry then paused and conceded that he probably did quit the treatment because he was tired of being "unappreciated" and criticized.

Barry's two TAT stories contained references to criticism, inadequacy, rejection, and misattunement, with accompanying emotions of shame, humiliation, hurt, and anger. Consequently, we weigh the possibility that Barry wrestles with a weakness in his self-development; namely, a core vulnerability in his ability to restore self-worth in the face of setbacks. Barry's narratives convey a need for others to actively validate his efforts at mastery and a sensitivity to deep injury when they do not.[4] In the absence of positive feedback, Barry is vulnerable to feeling shame and rejection so unbearable that eventually he leaves the situation entirely. Boding well for treatment is the fact that the strivings depicted in Barry's narratives ("be really good"; "get into the good college") are realistic (reasonable, attainable) rather than unrealistic (inflated, grandiose).[5] Additionally, in his TAT stories and their inquiry, Barry manifests two significant psychological strengths: his openness and his ability to reflect. For example, his stories and inquiry responses are expressive, not guarded; his narratives and inquiry behavior depict sensitivity but not defensive denial; and he willingly engages with reflection during the post-TAT inquiry. Barry's abilities to engage with authenticity and openness and to reflect on his responses present significant assets that, if engaged (and explicitly noticed and appreciated; see the next paragraph), could help offset the challenge to psychotherapy posed by Barry's painful vulnerability in self-esteem regulation.

In the feedback to the psychiatrist, the examiner highlighted the importance when working with Barry of careful attunement to, and validation and repair of, empathic ruptures (Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011). The examiner emphasized that Barry easily experiences interventions as hierarchical, critical, and thus hurtful, and therefore strengthening the platform of mutuality and respect between them would be a critical focus of the work. For example, inquiring about how Barry heard something the therapist just said when Barry falls silent would be one means of building on Barry's capacity for reflection and engaging him respectfully as a mutual partner in deciphering communications. A simultaneously crucial therapy focus would be cultivating Barry's ability to reliably restore self-worth in the face of normal setbacks and scant encouragement. Steadily recognizing Barry's strengths, growth, and commitment would be a cornerstone of such work. Another cornerstone would be developing Barry's ability to use his hurt as a signal to slow down his experience, to expand his means of interpersonally reading situations,[6]

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[4]Such need and sensitivity is consistent with Gabbard's (1989) "hypervigilant" narcissism (self-development vulnerability).

[5]Had Barry specified "become a world famous violinist" on Card I or "Harvard" as the college on Card 3BM, then we would look for other test indicators of his setting up *un*realistic, unobtainable (grandiose) goals for himself, the discovery of which would lead to additional, slightly different treatment suggestions.

[6]Cognitive techniques might help him evaluate his expectations about others' criticism (e.g., recognizing and remedying "thinking errors," such as mind reading, catastrophizing, and all-or-none thinking).

to check out his perceptions, and to use his ability to engage authentically as a stepping stone toward expressing his disappointment rather than withdrawing. Such developing capacities might breathe oxygen into Barry's world of suffocating social anxiety and constriction and allow him solutions beyond depression-inducing social isolation and leave-taking. In sum, the examiner explained that recognizing Barry's narcissistic vulnerability was a crucial piece in maintaining an alliance, sustaining Barry's participation, and providing a focus for the therapeutic work and the amelioration of Barry's symptoms.

NARCISSISTIC VULNERABILITIES: WHERE TO LOOK ON THE WECHSLER TESTS

Weaknesses in self-development are evidenced on the Wechsler tests in the patient's attitude toward his performance and in the content of his responses.[7] We discuss attitude toward performance first and proceed to response content.

Attitude Toward Performance on the Wechsler Tests

Failure and not knowing are inevitable on the Wechsler tests because there *are* right and wrong answers and questioning continues until a ceiling of multiple failures is reached. Consequently, we are able to sample directly the patient's capacity for, and style of, recovery from performance pressures and failure. When paying attention to issues of self-development, we monitor our patient's attitude toward himself and his performance and the impact of his self-stabilization and self-restoration strategies on his performance. For example, we listen for self-encouraging and self-denigrating utterances and gestures. We attend to the patient's *accuracy of appraisal* of performance, *flexibility* (range of approaches depending on fluctuations in the patient's performance), *reasoning* (blaming, justification vs. deduction, analysis), their *locus of responsibility* (external locus [tests, examiner, parents, school] vs. internal focus [self]), and their *tone* (compassion vs. harshness). We attend to the salutary or corrosive impact of such strategies on our patient's subsequent test performance—that is, does our patient subsequently persist, do better, give up, or lose focus? The patterns we discern across the Wechsler subtests and items form a window into the suppleness versus fragility of our patient's sense of self and reveal which behaviors are perpetuating each.

[7]The patient's experience of the examiner during the Wechsler tests is also relevant and will be taken up in the section "Narcissistic Vulnerabilities: Where to Look in the Patient–Examiner Relationship."

To illustrate, we turn to the testing of a graduate student, Dan, who sought help in understanding his profound sense of paralysis in his efforts to complete his dissertation. Dan's intellectual capacity was excellent (Full-Scale IQ = 140, Verbal Comprehension Index = 140, Very Superior, above the 99th percentile). He had a few relative weaknesses in attentional and organizational capacities that played a minor role in his difficulty completing tasks. Central to his stuckness, however, were his feelings and perceptions about himself. These crippling feelings and perceptions were evident throughout Dan's Wechsler administration. Here, we examine one sample: his attitude toward his performance on the Arithmetic subtest.

Unknown to Dan, he scored in the Superior range on Arithmetic (scaled score = 14). While answering the Arithmetic items, he intermittently made comments such as, "I'm no good at this," "I can't do these in my head," "I know I'm taking too long," and "Remember, I didn't take my Ritalin today." He made such comments *after correct responses*, demonstrating inaccurate self-appraisal. And he made such comments *prior to incorrect ones*, raising the question of whether his negative self-appraisals undermined his subsequent performance. Following the subtest, Dan explained to the examiner, "I know I'm not doing well enough and not reflecting my true ability. I'm a grad student and supposed to be an adult, but I feel like a child."

For Dan, being timed and the prospect of being wrong exposed disabling insecurity and self-doubt. His internal sense of not measuring up impaired his ability to accurately appraise his performance. His inaccurate, negative self-evaluations possibly contributed to his failures. Dan experienced the Arithmetic subtest and much of the Wechsler test as deflating. He described it repeatedly as an opportunity to show his "true ability," and which, instead left him feeling small, inferior, inadequate, helpless, and ashamed ("like a child").

We make the representational inference that Dan's difficulty regulating his self-worth under conditions of timed, exposed performance (Arithmetic) easily could show up in similar situations of timed (deadlines), exposed performance (completing his dissertation) with similar manifestations and consequences. Under such conditions of timed performance, Dan's self-appraisals tend to be *inaccurate*, his self-appraisals tend toward rigid and repetitive (do not change with changes in his performance), he more often blames rather than problem-solves, he locates the problem in himself, and his tone is harsh and unrelenting. In short, performance pressure destabilizes Dan's self-esteem, and his attempts to recover not only are insufficient but also impair his performance.

To help Dan with completing his dissertation and tackling life beyond, the examiner suggested that treatment concentrate on repairing Dan's weaknesses in self-development. In particular, his underlying assumptions about

personal inadequacy and his wobbly strategies for restoring a sense of competence in the face of challenges. There were roles for exploratory, relational, and cognitive–behavioral techniques in such a process. The examiner alerted the therapist and Dan to the likelihood that the very problems Dan would be working on in therapy would likely show up in the therapy relationship. Such moments would provide Dan with an opportunity to put into practice the understanding and tools he was acquiring in therapy. For example, Dan might be fearful of sharing his reflections, ideas, and struggles for fear of being "wrong." He might experience the therapist's offering a different perspective as criticism or an indicator of failure. At such moments, the therapist could help Dan slow his reactivity, untangle how he arrived at his conclusions, and consider alternative explanations. In instances in which the therapist unwittingly contributed to Dan's feeling foolish, it would be important for the therapist to acknowledge this fact, apologize, and repair the relational rupture.

We have follow-up treatment information for Dan. As it turned out, recurringly, Dan did indeed experience the therapist (and others) as if they were judging him critically. Dan began to recognize that such moments of felt criticism echoed remembered moments with his mother and that he had internalized the harsh aspects of his mother in the form of his own relentlessly self-critical voice. Relational rupture-repair work (Safran & Muran, 2000), therefore, proved central not only to building an alliance but also to Dan's core work of repairing developmental vulnerabilities in his experience of self.

Response Content on the Wechsler Tests

We look for indicators of self-vulnerability in thematic content: criticism, fragility, painful rejection, humiliation, shame, and envy. We look also for indicators of self-protection efforts: preoccupations with beauty, intelligence, power, admiration, or specialness. We track content and unusual verbalizations, embellishments, intrusions, and unexpected failures that suggest instability of self-worth. A patient can express such concerns on any Wechsler item but a few items tend to elicit them:

- Wechsler Adult Intelligence Scale (WAIS–IV; Wechsler, 2008) Similarities: items 9 and 12
- WAIS–IV Picture Completion: item 3
- WAIS–III (Wechsler, 1997) Picture Arrangement (stories with shame or embarrassment): items 7, 9, and 10
- Wechsler Intelligence Scale for Children (WISC–IV; Wechsler, 2003) Similarities: items 11, 13, and 16

Consider the following Wechsler responses from Jason, a young man who had been suffering for years with undiagnosed symptoms of depression,

obsessive–compulsive disorder, and body dysmorphic disorder, but who had been terrified and avoidant of telling anyone about his struggles and had been reluctant to follow through with a psychotherapy referral:

> Similarities item 12: They both symbolize something more complex, like in an artistic way, and they're *both trying to be beautiful* [emphasis added]. (Which is your answer?) Both are supposed to be simple but *more beautiful* [emphasis added], so I suppose the latter one. (0 points)
>
> Comprehension item 12: Sometimes they perform a necessary function in the environment, and if there's *something beautiful* [emphasis added], it shouldn't be terminated. (Which is your answer?) Mostly the second one. (0 points)

Jason—who was bright and verbally adept (FSIQ = 131, Verbal Comprehension Index = 125)—unpredictably failed two Wechsler items (while passing subsequent more difficult items) because personal preoccupations with beauty spoiled what otherwise would have been full-credit responses. The examiner raised this anomaly with Jason during the testing feedback and wondered aloud whether Jason struggled with concerns about appearances. With intense shame, Jason acknowledged longstanding efforts to put on his "good face" to his friends and family and to appear happier and better functioning than he really is. He admitted to efforts to hide his internal struggles and his experience of himself as terribly flawed (including beginning to share his body dysmorphia). The examiner empathized and puzzled with him about what it would be like then to share himself with a therapist, given the importance he placed on maintaining appearances. Together, they discussed how difficult Jason felt it would be—given his profound shame—simply to show up for appointments, much less to speak frankly about what he was feeling and what was really going on.

This discussion created an experience for Jason, one that gave Jason (and his prospective therapist) important information—namely, that when someone listened to him with sensitivity to his shame, empathy for all that he lost from hiding, respect for his strengths, and an attitude of compassionate interest, he was able to share painfully private information about himself and end up feeling understood rather than humiliated. When Jason did begin therapy, the themes of shame, appearances, and the courage it took simply to be there remained front and center, alongside his therapist's sensitivity, empathy, respect, and compassionate interest. In this way, Wechsler response content opened a door to collaborative alliance-building and treatment focus during the initial phase of Jason's psychotherapy.

A second illustration of the contribution that Wechsler response content makes to detecting narcissistic vulnerabilities comes from the evaluation

of Sarah, a 13-year-old who was experiencing considerable strain getting along with peers, teachers, and her psychiatrist. Here are four of her responses to the WISC–IV Similarities subtest:

> Item 2: Liquids. *I'm really smart* [emphasis added] with this solid, liquid, and gas stuff.
> Item 3: They're both food. And *I like them both* [emphasis added].
> Item 11: *People admire them* [emphasis added].
> Item 14: *Beautiful* [emphasis added] land forms.

When the examiner prepared an inference map (see Chapter 10) before writing his report, one of his headings was labeled "Experience of Self." Under that heading, he listed the four Similarities responses described previously. He also listed Sarah's self-disparaging comments (e.g., "I'm no good") made when she encountered challenging items on Block Design and Comprehension. He listed Rorschach data: *Fr* = 1; content (castle, mirror, and swan); and *MOR*s (animals with damaged or missing parts). The examiner synthesized the information from this data-grouping to construct a picture of the weaknesses in Sarah's self-coherence and her efforts to compensate for those weaknesses. He conceptualized an adolescent who, despite her self-involvement and embeddedness in her own point of view (*Fr* = 1; "I like them"), is struggling with feelings of being damaged ("I'm no good"; *MOR*s). To offset her feelings of damage, she longs to be recognized as special ("I'm really smart"; castle, swan) and has a high need to be mirrored, admired, and validated (*Fr* = 1; "people admire them," "beautiful"; castle, mirror, swan). Sarah's efforts to obtain the appreciation she seeks, however, can carry a self-aggrandizing quality ("I'm really smart"; castle) that is apt to put off her peers and others.

The examiner's synthesis helped Sarah's psychiatrist, parents, and teachers to understand and maintain empathy for the underlying vulnerabilities driving this adolescent's provocative behavior, which in turn helped them provide the realistic appreciation and affirmations Sarah needed to build a valued self-grounded in reality. Subsequently, Sarah's psychiatrist shared that the test findings helped him better appreciate just how hard it was for Sarah to be in his office having to answer questions about things that were "wrong" about her. He consequently shifted his focus in sessions from inquiring about her "problems" to inquiring about her interests and accomplishments. He discovered that such a shift enabled her to then tolerate discussion of her troubles without feeling "picked on" by him. The examiner's synthesis also led him to a recommendation for a social skills group (aimed at helping Sarah to listen, take perspective, understand the impact of her behavior on others) as an adjunct to the individual psychotherapy process.

Narcissistic Vulnerabilities: Where to Look in the Patient–Examiner Relationship

Narcissistic vulnerability is picked up in the patient–examiner relationship through attunement to the relationship templates that arise in the testing situation. It is helpful to be open to the question, "The patient is experiencing me (the examiner) 'as if' . . . ?" To organize relational information as *data,* it is necessary for the examiner to learn (through supervision and personal therapy) his own interpersonal templates, his "stimulus value" (what reactions he tends to elicit in others normatively), and his personal map of reactivity and perceptual distortion. As Peebles (2012) explicated, "If we know our internal maps adequately, we not only are better positioned to register nuances about our patient but also can respond without alarm and with therapeutic openness when our patients inquire about *our* [emphasis in original] reactions" (p. 95). Confident knowledge of our own interior interpersonal patterns allows us to account (however imperfectly) for our role in the patient–examiner dynamics so that we can discern our patient's contribution more clearly.

Our patient's struggles around maintaining and restoring self-worth show themselves relationally through his experiencing us as harshly critical, belittling, mean, impersonal, and shaming, or, conversely, as the exclusive holder of intelligence, worth, and competence in the dyad. Similar struggles around self-worth also manifest obliquely in *our* countertransference of feeling uncharacteristically denigrated, devalued, deskilled, demanded upon, and underappreciated, particularly when such feelings oscillate with our feeling excessively or uncomfortably idealized and flattered. Additionally, we may find ourselves feeling unexplainably guilty, protective, cruel, or mean about what we are subjecting our patient to in the testing process, particularly if our patient is having difficulty tolerating failure.[8] Or we may feel frightened of our injured patient's rage when he lashes out and try to sidestep it through conscious or unconscious alterations in our administration or scoring.[9] We track manifestations of all such feelings from their subtle twinges to their overt disruptions. We track their waxing and waning across time, tests, and

[8]One's reactions of feeling denigrated or unduly elevated are understood in their simplest form as what anyone would feel in response to a person who is belittling or idealizing. At times, however, our patient may not be blatantly derogatory and yet we find ourselves feeling deskilled or inept. The concept of projective identification is useful because it captures how a patient elicits in another through subtle, implicit, interpersonal pressures the feelings that he is unable to tolerate within himself (see Gabbard, 1995). Whichever way we conceptualize the experience theoretically, the data bit is the same: Our patient's struggle to restore and maintain an experience of himself as valuable and competent is so unstable that it seeps into the interpersonal field and shapes how others around him feel.

[9]Such alterations include uncharacteristic slip-ups, such as unintentionally omitting a Wechsler subtest or item or a particular Rorschach or TAT card, forgetting to inquire, and giving (or experiencing an internal pull to give) full credit when partial or no credit is earned.

item content. We are interested in patterns, including their repetition; their convergence with structural and content test data; and the conditions under which our patient feels inadequate, powerful, competent, exposed, defensive, or open.

An example of patient–examiner data that illuminated weaknesses in self-development comes from the evaluation of Anna, an accomplished professional woman in her mid-30s who had been encouraged by her family to seek therapy because she had been unable to sustain satisfying intimate relationships. After several failed attempts to connect with different therapists, Anna was referred for testing to help understand what was making it difficult for Anna to find a treatment match that worked.

During the Wechsler and Rorschach inquiries, friction arose between Anna and the examiner. The examiner used a routine query in Comprehension ("Tell me another reason . . . ") to ask Anna for a second response on a few items. Anna became hurt and irately challenged—"What was wrong with what I just said?" and "Why? Was my first answer not good enough?" When the examiner offered her an opportunity through query to improve from a 1- to a 2-point response, Anna snapped, "What more do you want? I know I was right . . . Wasn't I?" On the Rorschach, Anna was exasperated when asked to go through the cards a second time as part of the standard Inquiry. She complained, "Why do you have to ask me those questions about what makes it look like that? Can't you just see it?" As the testing proceeded, the examiner began doubting whether he knew what he was doing. He wondered whether he was making administrative mistakes in his decisions to inquire into certain responses and if his style of inquiry was heavy-handed or unconsciously humiliating. He began to dread the inquiries and made decisions to avoid some. It was only with later distance of time and space that he could reflect on his administration as having been ordinary. Anna, however, had experienced his ordinary inquiries as extraordinarily critical, hurtful, demanding, and skeptical of and assaultive to her ideas and point of view. The examiner marveled at the intricacy of projective identification, with Anna's insecurity, self-doubt, fear of being wrong, and harsh self-denigration having—through her interpersonal impact—become his own (see Gabbard, 1995).

The examiner found no test evidence for Anna's having disordered reasoning or delusional (paranoid) thinking. And although Anna's approach to emotional regulation fluctuated, it showed adequate capacity to delay and integrate feelings with thinking. The examiner believed, therefore, that Anna's unexpectedly strong negative reactions to inquiries emanated from points of brittleness in her self-esteem ("What was wrong with what I just said?"), which, in turn, was likely a significant factor in her struggles establishing trusting therapy relationships and intimate romantic partnerships. Given Anna's response to the examiner's efforts to clarify and help her elaborate

her test responses, it was easy to imagine Anna feeling hurt, criticized, and destabilized in response to a therapist's doing the same ("Tell me more about it" or "How did that make you feel?"), *particularly* around topics about which she felt insecure. On the testing, Anna's method of protecting her raw place of insecurity was to irritably attack and criticize the examiner ("What more do you want? I know I was right!" . . . "Can't you just see it?"), and it was likely she would do the same in similar kinds of moments with a therapist or a significant other. In fact, the examiner offered the insight in his report that Anna's going on the offensive might be thought of as a helpful signal that something in the interaction had just caused her to feel vulnerable, potentially inadequate, or ashamed.

Keys to bridging from test findings to interventions that would make a difference in Anna's therapy were, first, to search in the structural, content, and behavioral data for clues to conditions that allow Anna to let the smallest glimmers of closeness, reflection, and collaboration to occur and, second, to engage actively within the patient–examiner relationship to test out those conditions. Both steps were essential next steps because understanding Anna's vulnerability was insufficient for knowing how to reach her in the midst of it, and the referral questions were about how to reach her. One clue to being reached lay in Anna's own words during Comprehension. Part of her reprimand to the examiner was, "I know I was right . . . Wasn't I?" and "Was my first answer not good enough?" Anna's tone was adversarial, but Anna's words actually were requests for reassurance. A second clue lay within two of Anna's TAT stories. To Cards 10 and 18GF, she told similarly themed stories: An older mentor is providing counsel to a younger person who was angry and now has given up. The professor in Anna's Card 10 story expressed the theme's sentiment succinctly, "Don't waste your life being angry. *I* see who you are. Keep living up to that." The examiner listened to such data and untangled himself from being snagged inside Anna's relational paradigm of attacking person versus inept-feeling person. He regrounded himself inside his competence and approached Anna thoughtfully during the test feedback session. He offered Anna a "theory" that he'd "been thinking about." He said it was easy to see her anger, but he bet that what she had been feeling that fewer people see were her talent and her earnest wish to be something special. Anna's eyes teared up. The examiner did not push. Instead, he remembered her acute and accurate awareness of nuances (revealed by her Rorschach shading responses) and added slowly, "And I bet they don't realize how much it's hurt when you haven't felt seen for who you feel you are and could be."

The examiner's delicate handling of feeling pummeled; his integration of the patient–examiner material with TAT and Rorschach data; and his respectful, compassionate persistence in the relationship with Anna threaded

the needle and laid groundwork for new relational possibilities for Anna—possibilities sampled in the testing and built in the therapy.

This chapter concludes Part II of this volume, in which we have examined how to assess four psychological capacities essential to psychotherapy's alliance, focus, safety, and learning. These four capacities are reality testing and reasoning (Chapter 4), emotional regulation (Chapter 5), and experience of self and other (Chapters 6 and 7). This chapter zeroed in on a particular aspect of self-other experience—that of narcissistic vulnerability—elaborated because it has pivotal relevance to alliance development, ruptures, and repair. As we begin Part III, "Diagnostic Considerations," we will discuss and illustrate how test data help us establish which of the underlying developmental disruption models are relevant to understanding the source of the patient's symptoms and, thus, are important guides for focusing treatment.