BORDERLINE CONDITIONS and PATHOLOGICAL NARCISSISM

Otto F. Kernberg, M.D.

JASON ARONSON, INC.
NEW YORK

Eighth Printing, June 1980

ISBN: 0-87668-205-0

Library of Congress Catalog Number: 75-5616

Manufactured in the United States of America

Eight
The Treatment of the Narcissistic Personality

In this chapter I shall discuss the etiology, diagnosis, prognosis, and some factors in the treatment of patients with narcissistic personality structure. I do not expect to treat the subject exhaustively, but I hope to shed new light on certain areas. This paper deals mainly with the clinical problem of narcissism, and such metapsychological considerations as will be presented shortly have to do only with the etiology of pathological narcissism. The broader issue of the theory of narcissism in psychoanalysis is examined in Chapter 10.

I suggested in Chapter 1 that narcissistic as a descriptive term has been both abused and overused, but that there does exist a group of patients in whom the main problem appears to be the disturbance of their self-regard in connection with specific disturbances in their object relationships, and whom we might consider almost a pure culture of pathological development of narcissism. It is for these patients that I would reserve the term narcissistic personalities. On the surface, these patients may not present seriously disturbed behavior; some of them may function socially very well, and they usually have much better impulse control than the infantile personality.

These patients present an unusual degree of self-reference in their interactions with other people, a great need to be loved and admired by others, and a curious apparent contradiction between a very inflated concept of themselves and an inordinate need for tribute from others. Their emotional life is shallow. They experience little empathy for the feelings of others, they

obtain very little enjoyment from life other than from the tributes they receive from others or from their own grandiose fantasies, and they feel restless and bored when external glitter wears off and no new sources feed their self-regard. They envy others, tend to idealize some people from whom they expect narcissistic supplies and to depreciate and treat with contempt those from whom they do not expect anything (often their former idols). In general, their relationships with other people are clearly exploitative and sometimes parasitic. It is as if they feel they have the right to control and possess others and to exploit them without guilt feelings—and, behind a surface which very often is charming and engaging, one senses coldness and ruthlessness. Very often such patients are considered to be dependent because they need so much tribute and adoration from others, but on a deeper level they are completely unable really to depend on anybody because of their deep distrust and depreciation of others.

Analytic exploration very often demonstrates that their haughty, grandiose, and controlling behavior is a defense against paranoid traits related to the projection of oral rage, which is central in their psychopathology. On the surface these patients appear to present a remarkable lack of object relationships; on a deeper level, their interactions reflect very intense, primitive, internalized object relationships of a frightening kind and an incapacity to depend on internalized good objects. The antisocial personality may be considered a subgroup of the narcissistic personality. Antisocial personality structures present the same general constellation of traits that I have just mentioned, in combination with additional severe superego pathology.

The main characteristics of these narcissistic personalities are grandiosity, extreme self-centeredness, and a remarkable absence of interest in and empathy for others in spite of the fact that they are so very eager to obtain admiration and approval from other people. These patients experience a remarkably intense envy of other people who seem to have things they do not have or who simply seem to enjoy their lives. These patients not only lack emotional depth and fail to understand complex emotions in other people, but their own feelings lack differentiation, with quick flare-ups and subsequent dispersal of emotion. They are especially deficient in genuine feelings of sadness and mournful longing; their incapacity for experiencing depressive reactions is a basic feature of their personalities. When abandoned or disappointed by other people they may show what on the surface looks like depression, but which on further examination emerges as anger and resentment, loaded with revengeful wishes, rather than real sadness for the loss of a person whom they appreciated.

Some patients with narcissistic personalities present strong conscious feelings of insecurity and inferiority. At times, such feelings of inferiority and insecurity may alternate with feelings of greatness and omnipotent fantasies (10). At other times, and only after some period of analysis, do unconscious fantasies of omnipotence and narcissistic grandiosity come to the surface. The presence of extreme contradictions in their self concept is often the first clinical evidence of the severe pathology in the ego and superego of these patients, hidden underneath a surface of smooth and effective social functioning.

The defensive organization of these patients is quite similar to that of the borderline personality organization in general. They present a predominance of primitive defensive mechanisms such as splitting, denial, projective identification, omnipotence, and primitive idealization. They also show the intense, primitive quality of oral-aggressive conflicts characteristic of borderline patients. What distinguishes many of the patients with narcissistic personalities from the usual borderline patient is their relatively good social functioning, their better impulse control, and what may be described as a "pseudosublimatory" potential, namely, the capacity for active, consistent work in some areas which permits them partially to fulfill their ambitions of greatness and of obtaining admiration from others. Highly intelligent patients with this personality structure may appear as quite creative in their fields: narcissistic personalities can often be found as leaders in industrial organizations or academic institutions; they may also be outstanding performers in some artistic domain. Careful observation, however, of their productivity over a long period

of time will give evidence of superficiality and flightiness in their work, of a lack of depth which eventually reveals the emptiness behind the glitter. Quite frequently these are the "promising" geniuses who then surprise other people by the banality of their development. They also are able to exert self-control in anxiety-producing situations, which may at first appear as good anxiety tolerance; however, analytic exploration shows that their anxiety tolerance is obtained at the cost of increasing their narcissistic fantasies and of withdrawing into "splendid isolation." This tolerance of anxiety does not reflect an authentic capacity for coming to terms with a disturbing reality.

In short, the surface functioning of the narcissistic personality is much better than that of the average borderline patient: therefore, their capacity for regression—even to the level of psychotic functioning when undergoing psychoanalysis—may come as a real surprise to the analyst.

ETIOLOGICAL AND DYNAMIC FEATURES

An early effort to classify the narcissistic character as one form of libidinal type (5) did not become generally accepted, for reasons mentioned by Fenichel (3). Van der Waals (19) has clarified the issue of "pathological narcissism" by pointing out that severe narcissism does not reflect simply a fixation in early narcissistic stages of development and a simple lack of the normal course of development toward object love, but that it is characterized by the simultaneous development of pathological forms of self-love and of pathological forms of object love. According to van der Waals, normal narcissism develops simultaneously with normal object relationships, and pathological narcissism with pathological object relationships. He has also pointed out that progress in the understanding of pathological narcissism has been hampered by the fact that in psychoanalytic literature the clinical problems of narcissism are intermingled with the issue of narcissism as a meta-psychological problem.

Jacobson (6) has clarified the relationship between psychotic regression on the one hand and defensive refusion of

early self and object representations on the other. According to Jacobson, in the earliest stages of an individual's development, when self and object images are differentiated from each other and thus contribute to the development of reality testing and of ego boundaries, extremely severe frustrations in relationships with significant early objects may bring about a dangerous refusion of self and object images, a mechanism which allows the individual to escape the conflict between the need for the external object and the dread of it. Under these circumstances, a blurring of ego boundaries, the loss of reality testing, in short, psychotic regression, may occur. Such a development does not take place in the case of narcissistic personalities, whose ego boundaries are stable and whose reality testing is preserved. A. Reich (10) has suggested that in narcissistic personalities a regressive fusion takes place between a primitive ego ideal and the self.

I propose that a process of refusion of the internalized self and object images does occur in the narcissistic personality at a level of development at which ego boundaries have already become stable. At this point, there is a fusion of ideal self, ideal object, and actual self images as a defense against an intolerable reality in the interpersonal realm, with a concomitant devaluation and destruction of object images as well as of external objects. In their fantasies, these patients identify themselves with their own ideal self images in order to deny normal dependency on external objects and on the internalized representations of the external objects. It is as if they were saying, "I do not need to fear that I will be rejected for not living up to the ideal of myself which alone makes it possible for me to be loved by the ideal person I imagine would love me. That ideal person and my ideal image of that person and my real self are all one, and better than the ideal person whom I wanted to love me, so that I do not need anybody else any more." In other words, the normal tension between actual self on the one hand, and ideal self and ideal object on the other, is eliminated by the building up of an inflated self concept within which the actual self and the ideal self and ideal object are confused. At the same time, the remnants of the unacceptable self images are repressed and projected onto external objects, which are

devaluated. This process is in marked contrast to the normal differentiation between ideal self images on the one hand and ideal object images on the other, both of which represent the internalized demands of objects as well as gratification from these objects if the demands are met. The normal superego integrates ideal self images and ideal object images; the tension between actual self images and such integrated ideal ones becomes tension between the ego and superego. In patients presenting pathological narcissism, however, the pathological fusion between ideal self, ideal object, and actual self images prevents such integration of the superego, because the process of idealization is highly unrealistic, preventing the condensation of such idealized images with actual parental demands and with the aggressively determined superego forerunners. Also, actual self images, a part of the ego structure, are now pathologically condensed with forerunners of the superego, and, therefore, they interfere with the normal differentiation of the superego and ego. Although some superego components are internalized, such as prohibitive parental demands, they preserve a distorted, primitive, aggressive quality because they are not integrated with the loving aspects of the superego which are normally drawn from the ideal self and object images and are missing in these patients (15). Because there is so little integration with other superego forerunners, the generally aggressive and primitive kind of superego is easily reprojected in the form of paranoid projections. I want to stress that the primitive and aggressive nature of their superego ultimately derives from the intense oral-aggressive quality of their fixations. Narcissistic patients characteristically adapt themselves to the moral demands of their environment because they are afraid of the attacks to which they would be subjected if they do not conform, and because this submission seems to be the price they have to pay for glory and admiration; however, one frequently finds that patients of this kind, who have never shown evidence of antisocial activity, think of themselves as "crooks" and as capable of antisocial behavior "if they could get away with it." Needless to say, they also experience other people as basically dishonest and unreliable, or only reliable because of external pressures. This concept of themselves and others, of

course, becomes very important in the transference.

One result of the defensive fusion of ideal self, ideal object, and actual self images is the devaluation and destruction not only of external objects but also of internalized object images. Actually, this process never goes so far that there are no internal representations of external objects: it would probably be impossible to live under such conditions. To want to be admired and loved by others requires that others should appear at least somewhat "alive," internally as well as externally. The remnants of the internalized object representations acquire the characteristics of real, but rather lifeless, shadowy people. This experience of other people, especially those who are not idealized, as lifeless shadows or marionettes, is quite prevalent in the patients I am considering. Idealized people, on whom these patients seem to "depend," regularly turn out to be projections of their own aggrandized self concepts. Idealized representatives of the self, the "shadows" of others, and—as we shall see—dreaded enemies, are all that seem to exist in the inner world of these patients. A narcissistic patient experiences his relationships with other people as being purely exploitative, as if he were "squeezing a lemon and then dropping the remains." People may appear to him either to have some potential food inside, which the patient has to extract, or to be already emptied and therefore valueless. In addition, these shadowy external objects sometimes suddenly seem to be invested with high and dangerous powers, as the patient projects onto others the primitive characteristics of his own superego and of his own exploitative nature. His attitude towards others is either deprecatory—he has extracted all he needs and tosses them aside—or fearful—others may attack, exploit, and force him to submit to them. At the very bottom of this dichotomy lies a still deeper image of the relationship with external objects, precisely the one against which the patient has erected all these other pathological structures. It is the image of a hungry, enraged, empty self, full of impotent anger at being frustrated, and fearful of a world which seems as hateful and revengeful as the patient himself.

This, the deepest level of the self concept of narcissistic patients, can be perceived only late in the course of their

psychoanalytic treatment, except in the case of narcissistic patients with overt borderline features who show it quite early. British psychoanalysts who have analyzed patients with this character structure have reported the central importance of such basic dread of attack and destruction. In less disorganized patients, that is, narcissistic personalities with relatively stronger egos, one eventually encounters in the transference paranoid developments, with feelings of emptiness, rage, and fear of being attacked. On an even less regressed level, the available remnants of such self images reveal a picture of a worthless, poverty-stricken, empty person who feels always left "outside," devoured by envy of those who have food, happiness, and fame. Often the surface remnant of this line of primitive self images is undistinguishable from the shadowy remnants of devaluated object images. This devaluated concept of the self can be seen especially in narcissistic patients who divide the world into famous, rich, and great people on the one hand, and the despicable, worthless, "mediocrity" on the other. Such patients are afraid of not belonging to the company of the great, rich, and powerful, and of belonging instead to the "mediocre," by which they mean worthless and despicable rather than "average" in the ordinary sense of the term. One patient, after years of analytic treatment, began to yearn to become "average," meaning he wanted to be able to enjoy being an ordinary person, without an overriding necessity to feel great and important in order to cancel feelings of worthlessness and devaluation.

What brings about the crucial pathological fusion of ideal self, ideal object, and actual self images? These patients present a pathologically augmented development of oral aggression and it is hard to evaluate to what extent this development represents a constitutionally determined strong aggressive drive, a constitutionally determined lack of anxiety tolerance in regard to aggressive impulses, or severe frustration in their first years of life.

Chronically cold parental figures with covert but intense aggression are a very frequent feature of the background of these patients. A composite picture of a number of cases that I have been able to examine or to treat shows consistently a

parental figure, usually the mother or a mother surrogate, who functions well on the surface in a superficially well-organized home, but with a degree of callousness, indifference, and nonverbalized, spiteful aggression. When intense oral frustration, resentment, and aggression have developed in the child within such an environment, the first condition is laid for his need to defend against extreme envy and hatred. In addition, these patients present some quite specific features which distinguish them from other borderline patients. Their histories reveal that each patient possessed some inherent quality which could have objectively aroused the envy or admiration of others. For example, unusual physical attractiveness or some special talent became a refuge against the basic feelings of being unloved and of being the objects of revengeful hatred. Sometimes it was rather the cold hostile mother's narcissistic use of the child which made him "special," set him off on the road in a search for compensatory admiration and greatness, and fostered the characterological defense of spiteful devaluation of others. For example, two patients were used by their mothers as a kind of "object of art," being dressed up and exposed to public admiration in an almost grotesque way, so that fantasies of power and greatness linked with exhibitionistic trends became central in their compensatory efforts against oral rage and envy. These patients often occupy a pivotal point in their family structure, such as being the only child, or the only "brilliant" child, or the one who is supposed to fulfill the family aspirations; a good number of them have a history of having played the role of "genius" in their family during childhood.

I am not sure whether these observations explain the entire story. Once, however, the kind of mechanism mentioned—defensive fusion of ideal self, ideal object, and self images—comes into operation, it is extremely effective in perpetuating a vicious circle of self-admiration, depreciation of others, and elimination of all actual dependency. The greatest fear of these patients is to be dependent on anybody else, because to depend means to hate, envy, and expose themselves to the danger of being exploited, mistreated, and frustrated. In the course of treatment, their main defenses are erected against the

possibility of depending on the analyst, and the development of a situation in which they do feel dependent immediately brings back the basic threatening situation of early childhood (12).

This kind of person's incapacity to depend on another person is a very crucial characteristic. These patients often admire some hero or outstanding individual and establish with such a person what on the surface looks like a dependent relationship, yet they really experience themselves as part of that outstanding person; it regularly emerges in treatment that the admired individual is merely an extension of themselves. If the person rejects them, they experience immediate hatred and fear, and react by devaluating the former idol. If their admired person disappears or is "dethroned," they immediately drop him. In short, there is no real involvement with the admired person and a simple narcissistic use is made of him. When narcissistic personalities are themselves in a position of objective importance—for example, heading a political institution or a social group—they love to surround themselves with admirers in whom they are interested as long as the admiration is new. Once they feel they have extracted all the admiration they need, they perceive their admirers as "shadows" once more and mercilessly exploit and mistreat them. At the same time, these patients are extremely offended when one of their "slaves" wants to free himself. In the analytic situation this relationship is constantly re-enacted. These patients at times idealize the analyst and are convinced that he is the greatest analyst on earth. At the same time, on a deeper level, they experience themselves as the only patient of the analyst; I have found the literal fantasy in several patients that, when they are not in session, their analyst disappears or dies or is no longer "brilliant." Typically, over weekends and during vacations, these patients completely forget the analyst and do not permit themselves the mourning reactions that separations from the analyst induce in the usual psychoneurotic case. In short, the idealized analyst is only an extension of themselves, or they are extensions of the idealized analyst; it is the same situation in either case. There exists the danger of looking upon these patients as very dependent because of the satisfaction they obtain from such "closeness." It comes as a surprise to some

therapists that patients who seemed happy to come to their sessions over many years with unending expressions of praise and admiration for their therapist are all of a sudden willing and able to drop the relationship for the slightest reason or frustration.

These patients' feelings of emptiness and boredom are intimately related to their stunted ego development, which in turn is connected with their inability to experience depression. Many authors have pointed out that the capacity for tolerating depression, linked to the capacity for mourning over a lost good object or a lost ideal image of oneself, is an important prerequisite for emotional development and especially for the broadening and deepening of feelings. In addition, the devaluation of objects and object images on the part of patients with pathological narcissism creates a constant emptiness in their social life and reinforces their internal experience of emptiness. They need to devaluate whatever they receive in order to prevent themselves from experiencing envy. This is the tragedy of these patients: that they need so much from others while being unable to acknowledge what they are receiving because it would stir up envy; in consequence, they always wind up empty. One patient fell in love with a woman whom he considered very beautiful, gifted, warm, in short, completely satisfying. He had a brief period of awareness of how much he hated her for being so perfect, just before she responded to him and decided to marry him. After their marriage he felt bored with her and became completely indifferent toward her. During his psychoanalysis he came to understand how he treated his analyst in a similar way: he depreciated everything he was receiving from his analyst in order to prevent his envy and hatred from coming to the surface. After that, the patient gradually developed strong suspiciousness and hatred toward his wife for having all that he felt he did not have, and he was also afraid that she would abandon him and leave him with even less. At the same time, however, he was able for the first time to become aware of and to be moved by her expressions of love and tenderness. His awareness of his aggressive disqualification of her and his analyst, and his increasing ability to tolerate his hatred without having to defend against it by destroying his

awareness of other people made both his wife and his analyst "come alive" as real people with independent existences, and eventually permitted him to experience not only hatred but also love toward them.

DIFFERENTIAL DIAGNOSIS

The descriptive features of narcissistic personalities usually permit their differentiation from other forms of character pathology in which narcissistic character defenses are present. All character defenses have, among other functions, a narcissistic one: they protect self-esteem. In addition, there are patients with all kinds of character pathology who present marked character defenses especially erected to protect or enhance self-esteem. These latter cases have "narcissistic character defenses" in an essentially non-narcissistic personality structure, which has to be differentiated, therefore, from the narcissistic personality in the narrow sense used in this paper. Thus, for example, the stubbornness or oppositionalism of obsessive personalities often has a strong narcissistic quality; however, there is much more stability and depth in the interpersonal relationships of obsessive personalities than in those of narcissistic personalities, in spite of the fact that both may appear superficially as quite "cold." Also, the value systems of narcissistic personalities are generally corruptible, in contrast to the rigid morality of the obsessive personality.

The differential diagnosis in distinction to hysterical character structure is also not too difficult. An exaggeration of narcissistic traits, especially those linked with exhibitionistic trends, is quite prevalent in hysterical personalities; however, the need to be admired, to be the center of attention of the hysterical personality—usually a narcissistic reaction formation against penis envy—goes together with a capacity for deep and lasting relationships with others. Women with narcissistic personalities may appear as quite "hysterical" on the surface, with their extreme coquettishness and exhibitionism, but the cold, shrewdly calculating quality of their seductiveness is in marked contrast to the much warmer, emotionally involved quality of hysterical pseudo-hypersexuality.

A. Reich (9), further analyzing narcissistic types of object choice made by women as presented in Freud's classical paper on narcissism (4), described two types of object choice in women which, broadly speaking, correspond to the differentiation between narcissistic defenses in hysterical women on the one hand and the narcissistic personality as described in this paper on the other. A. Reich's first type is the woman who develops extreme submissiveness toward men who represent her own, infantile, grandiose ego ideal; such a woman appears to wish to fuse with idealized men, overcoming in this way her experience of herself as a castrated being. These women are able to establish meaningful object relationships with men, and their fusion with and idealization of men are based on at least some realistic and discriminating evaluation of the objects. The second type of woman which A. Reich describes corresponds to the "as if" type of personality; such a woman establishes transitory pseudoinfatuations with men, infatuations which represent a more primitive, narcissistic fusion with easily devaluated and poorly differentiated objects. This latter form of object choice reflects, A. Reich says, a more severe degree of pathology and lack of differentiation of the ego ideal, which goes hand in hand with an insufficiently developed superego and with a "predominance of aggression against the objects on whom the ego ideal is built" (9).

From a diagnostic and prognostic viewpoint, it is very important for the analyst to observe what kind of new transference developments appear when narcissistic transference resistances are interpreted. A good diagnostic study involving structural considerations should make it possible to differentiate between narcissistic personalities and other character structures with narcissistic features. The effects of consistent interpretation of narcissistic transference resistances should clarify the diagnosis in cases in which doubts about the character structure still remain. For example, an obsessive patient may start out in analysis with strong narcissistic defenses against oedipal fears or against sadomasochistic dispositions; a hysterical woman may develop initially strong narcissistic defenses against oedipal involvement and especially against penis envy. In all these cases the

analysis of such narcissistic character defenses soon opens the road to the underlying transference dispositions, with intense and highly differentiated transference involvements, in contrast to the process in the case of patients with narcissistic personalities. In the latter, narcissistic defenses do not change into other transference paradigms, but remain stubbornly linked to primitive, oral-aggressive drive derivatives and related primitive defense operations. Here the characteristics of the transference involvement oscillate between narcissistic grandiosity and aloofness on the one hand, and primitive, predominantly paranoid trends on the other. The patient's complete incapacity, maintained over many months and years of analytic work, to experience the analyst as an independent object is characteristic of narcissistic personalities, and is in sharp contrast to the transference involvements in other forms of character pathology where the transference may shift to reveal different, highly specific conflicts of varying psychosexual stages of development and with a highly differentiated awareness by the patient of the analyst as an independent object.

From a structural viewpoint, the main difference between narcissistic personalities and other forms of character pathology is the different nature and functioning of the ego ideal. Normally, idealized images of the parental figures and idealized self images are first condensed into the ego ideal (6), which then is further modified by the integration and incorporation of more realistically perceived parental demands, of the sadistic forerunners of the superego, and of the more advanced aspects of the prohibitive superego. Such a "toned down," less grandiose, and more attainable ego ideal permits one the normal narcissistic gratification of living up to the internalized ideal parental images, and this gratification in turn reinforces self-esteem, one's confidence in one's own goodness and one's trust in gratifying object relationships. In character pathology other than the narcissistic personality, the excessive development of narcissistic character defenses results from an exacerbation of the early infantile ego ideal as a defense against fear and guilt over multiple conflicts. Thus, for example, in the case of many female patients with hysterical personality, the need to live up to internal fantasies of being beautiful and powerful may be a protection against feelings of inferiority which in turn stem from penis envy and castration anxiety. Again, in obsessive personalities, living up to primitive ideals of perfection and cleanliness may be a most effective protection against anal-sadistic guilt and conflicts. In all these cases, the exacerbation of or fixation at the infantile ego ideal is not accompanied by a primitive fusion of the self concept with such an ego ideal, nor by a concomitant devaluation of object representations and external objects. But in narcissistic personalities, such a primitive fusion of the self with the ego ideal, and concomitant processes of devaluation of external objects and object images, do take place in order to protect the self against primitive oral conflicts and frustration. The fixations at the level of normal infantile narcissism, which are pathological in any case, have to be differentiated from the more severe, particular distortion of all internalized object relations that take place in the narcissistic personality.

The following two cases illustrate the presence of narcissistic character defenses in nonnarcissistic personalities. The first, a female patient with hysterical personality structure, had a strong, although deeply repressed, conviction that underneath what she considered her ugly, distasteful body and genitals, there was the body and the genitals of a unique, extremely beautiful woman toward whom men would feel impelled to pay homage. At that deeper level, she fantasied herself as the most attractive woman on earth, a "mother-queen-goddess" who would achieve a perfect relationship with an ideal, great "father-husband-son." In the transference, she was willing to give her love to the analyst-father if he in return would comply with that perfect image which she had of herself by admiring her and never questioning her perfection and integrity. The patient experienced the analyst's interpretations as threatening to that image of herself, a severe attack on her self-esteem, and a shattering criticism which induced quite intense depression. When her haughty, derogatory attitude toward the analyst, a part of her narcissistic self-aggrandizement, was pointed out to her, she became angry and depressed, and at that point experienced the analyst as a

narcissistic, self-involved, grandiose father image. Her reaction represented part of the way she had actually experienced her father in her childhood at the height of her oedipal development. Disappointed at what she perceived as the analyst-father's "attacks" on her, she then felt lost and rejected by this idealized father, and defeated in her fantasies by other, idealized women-mothers in the competition for the father. Thus, she developed a full-fledged oedipal transference. This transference emerged after the undoing of her narcissistic character defenses, which in turn had stemmed from penis envy. At no point did she completely devaluate the transference object, or oscillate between primitive, orally determined paranoid transference distortions on the one hand, and narcissistic withdrawal into a more primitive self-idealization on the other. Since these latter elements were lacking, we may conclude that her narcissistic transference resistances did not reflect a narcissistic personality structure.

The second illustration of a narcissistic character defense was provided by a male patient with an obsessive personality structure. He was quite derogatory toward the analyst, reveled in his own interpretations of his material, and saw the analyst mainly as a background figure whose function was to applaud and admire these interpretations and insights. When this attitude was systematically examined, however, and the patient was consistently confronted with this defensive pattern, a new, deeper transference pattern evolved. In this new facet of the transference, the patient saw the analyst as a cold, indifferent, unloving mother image, and experienced feelings of sadness and loneliness, representing an early longing for his idealized mother. In this second illustration, too, when the narcissistic character defenses broke down, other transference patterns emerged in which the patient maintained a differentiated object relationship, neither devaluating the object nor taking flight into an idealized self image. In summary, both of these cases developed new, differentiated transference relationships after the narcissistic character defenses had been dissolved, whereas the narcissistic patient cannot acknowledge the analyst as an independent object and continuously and stubbornly regards him as a simple extension of the patient's own self concept,

although the regression within this same transference paradigm may fluctuate.

CONSIDERATIONS IN REGARD TO TECHNIQUE

Many experienced clinicians consider these narcissistic personalities as unlikely candidates for analysis, but at the same time as hopeless candidates for any method of treatment other than psychoanalysis. Against this extremely guarded prognosis, Stone (16) expresses a somewhat more optimistic viewpoint about the analyzability of these patients. E. Ticho (18), recognizing both the problems and the challenges of these cases, has proposed that narcissistic personalities constitute a "heroic indication for psychoanalysis." In my opinion, the fact that some of these patients not only improve with psychoanalytic treatment, but improve dramatically, shows that efforts to study the technical and prognostic features of these cases more thoroughly are well warranted.

Jones (7) published a paper on pathological narcissistic character traits as early as 1913. In 1919, Abraham (1) wrote the first paper on the transference resistances of these patients, in which he warned the therapist about the dangerous effects of narcissistic character defenses on the psychoanalytic process. He pointed to the necessity for consistent interpretation of these patients' tendencies to look down on the analyst and to use him as an audience for their own independent "analytic" work. Riviere (11), in her classic paper on the negative therapeutic reaction, describes patients who have to defeat the psychoanalytic process: they cannot tolerate the notion of improvement, because improvement would mean acknowledgment of help received from somebody else. She states that these patients cannot tolerate receiving something good from the analyst because of the intolerable guilt over their own basic aggression. Rosenfeld (12) has stressed how basic the intolerance of dependency is on the part of patients with narcissistic personality structure. Kohut (8) has illustrated how a patient with this personality structure could not tolerate the analyst's being a different, independent person. These papers all

emphasize the severity of the transference resistances of narcissistic patients.

I should like to illustrate this problem of transference resistance with a case history. A patient with narcissistic character structure spent hour after hour over many months of treatment telling me how monotonous and boring analysis had become, that in his associations the same contents kept coming up again and again, and that treatment was definitely a hopeless enterprise. At the same time, he felt rather good in his life outside the analytic hours, with some relief from his feelings of insufficiency and insecurity, but he was unable to understand why this had happened. I pointed out to him that, implicit in his description of his psychoanalysis, was a description of me as the provider of useless and silly treatment. The patient denied this at first, stressing that it was only his problem, not mine, that analysis could not work. I then pointed out to him that, at the beginning of his treatment, he had considerably envied my other patients, who had already received so much more from me than he had, and that it was strange now that he should feel no envy at all of the other patients, especially in view of his statement that it was his problem only that he could not benefit from analysis. I also pointed out to him that his previous, strong envy of me had completely disappeared, for reasons which had remained obscure to him. At this point the patient became aware that he really thought that it was entirely my fault that his analysis was, according to him, a failure. He now felt surprised that he was so satisfied to continue his treatment while considering me so inefficient. I pointed out to him how much satisfaction it gave him for me to be a failure while he was a success in his life. I also pointed out that it was as if I had become the worthless self of him, while he had taken over the admired self of me. At that point he became very anxious and developed the fear that I hated him and that I would take revenge. Fantasies came up in which he thought that I was telling his superiors and the police about activities of which he was very much ashamed. I pointed out to him that his fear of attack from me was one reason which prevented him from really considering himself in analysis and that he reassured himself that he was not really a patient by asserting that

nothing was going on in the sessions. At that point the patient experienced feelings of admiration toward me because I had not become confused and discouraged by his constant repetition that analysis was a failure. At the next moment, however, he thought that I was very clever, and that I knew how to use "typical analytic tricks" to keep "one up" over patients. He then thought that he himself would try to use a similar technique with people who might try to depreciate him. I then pointed out that as soon as he received a "good" interpretation, and found himself helped, he also felt guilty over his attacks on me, and then again envious of my "goodness." Therefore, he had to "steal" my interpretations for his own use with others, devaluating me in the process, in order to avoid acknowledging that I had anything good left as well as to avoid the obligation of feeling grateful. The patient became quite anxious for a moment and then went completely "blank." He came in the next session with a bland denial of the emotional relevance of what had developed in the session before, and once again the same cycle started all over, with repetitive declarations of his boredom and the ineffectiveness of analysis.

At times it is difficult to imagine how frequent and how repetitive such interactions are, extending as they do over two or three years of analysis; this resistance to treatment illustrates the intensity of the narcissistic patient's need to deny any dependent relationship. It is obvious that consistent examination of the negative transference is even more crucial in these patients than in others undergoing psychoanalysis. These narcissistic patients persistently seek to devaluate the analytic process, to deny the reality of their own emotional life, and to confirm the fantasy that the analyst is not a person independent from themselves. A recent motion picture by Ingmar Bergman, *Persona*, illustrates the breakdown of an immature but basically decent young woman, a nurse, charged with the care of a psychologically severely ill woman presenting what we would describe as a typical narcissistic personality. In the face of the cold, unscrupulous exploitation to which the young nurse is subjected, she gradually breaks down. She cannot face the fact that the other sick woman returns only hatred for love and is completely unable to acknowledge any loving or human feeling

expressed toward her. The sick woman seems to be able to live only if and when she can destroy what is valuable in other persons, although in the process she ends up destroying herself as a human being. In a dramatic development, the nurse develops an intense hatred for the sick woman and mistreats her cruelly at one point. It is as if all the hatred within the sick woman had been transferred into the helping one, destroying the helping person from the inside.

This screen play reproduces in essence the transference-countertransference situations that develop in the treatment of severely narcissistic patients. All the patients' efforts seem to go into defeating the analyst, into making analysis a meaningless game, into systematically destroying whatever they experience as good and valuable in the analyst. After many months and years of being treated as an "appendix" of the patient (a process which may be subtle enough to remain unnoticed for a long time) the analyst may begin to feel really "worthless" in his work with such a case. All his comments and interventions seem to dissolve into meaninglessness, and whatever sympathetic feeling he had for the patient is systematically destroyed by the latter. Following an unsuccessful, long treatment, a defensive devaluation of the patient on the analyst's part may occur, reinforcing the patient's feeling that his analyst is becoming one of those dangerous objects from whom he had attempted to escape; or some minor frustration of the patient may grow into a general awareness on the patient's part that he is no longer in control of the analyst. Interruption of treatment may occur at this point; the patient escapes from a hated, frustrating transference object, which he eventually reduces to a "shadow" once more, and the analyst's countertransference may reflect a corresponding feeling of "emptiness," as if the patient had never existed.

There are several technical implications of the above considerations. First, the analyst must continuously focus on the particular quality of the transference in these cases and consistently counteract the patient's efforts toward omnipotent control and devaluation. Then the analyst also has to watch carefully for his long-term countertransference developments. He should bring the countertransference into the analytic

process, not by revealing to the patient what his own reaction is, but by consistently recognizing in the countertransference the hidden intention of the patient's behavior. For example, when the patient systematically rejects all the analyst's interpretations over a long period of time, the analyst may recognize his own resultant feelings of impotence and point out to the patient that he is treating the analyst as if he wished to make him feel defeated and impotent. Or, when antisocial behavior in the patient makes the analyst, rather than the patient, worry about the consequences, the analyst may point out that the patient seems to try to let the analyst feel the concern over his behavior because the patient himself cannot tolerate such a feeling. Because these patients treat the analyst as extensions of themselves, or vice versa, the analyst's emotional experience reflects more closely than usual what the patient is struggling with internally, and thus the use of countertransference reactions is particularly revealing in treatment.

One technical problem which is especially difficult for the therapist to handle is the occurrence of sudden "switches" in the emotional attitude of the patient. Especially following moments of understanding or relief, the patient tends to drop an entire subject matter rather than to be obliged either to feel grateful to the analyst for his help, or to be motivated to deepen his understanding of that particular issue. The tendency to devaluate the analyst operates here, together with an effort to rob the analyst of his interpretation; one has to be very attentive to this sudden "disappearance" of what only minutes ago, or a session ago, appeared as an important problem.

One final word about technique. One should probably not treat many of these patients at the same time, because they put a great stress and many demands on the analyst. In addition, it may help to keep in mind that these patients require the longest psychoanalytic treatments in order to break through the pathological character structure activated in the transference.

In the past some clinicians felt that these patients did not develop a transference, and that they always kept a "narcissistic noninvolvement" toward the analyst which prevented analytic work. Actually, these patients develop a very intensive transference that I have described above; what appears as

distance and uninvolvement on the surface is underneath an active process of devaluation, depreciation, and spoiling. The undoing of this transference resistance typically brings about intense paranoid developments, suspiciousness, hatred, and envy. Eventually, after many months and sometimes years of treatment, guilt and depression may appear in the patient; awareness of his aggression toward the analyst may develop into guilt over it, and more human concern for the analyst as a person in combination with a heightened tolerance of guilt and depression in general. This is a crucial moment in the treatment of these patients and represents an essential prognostic factor at the same time. Those patients who have at least some tolerance for guilt and depression when the treatment starts do better than those who cannot tolerate these feelings at all. This observation leads us into our next topic: the general issue of prognosis in the psychoanalysis of these patients.

PROGNOSTIC CONSIDERATIONS

The overall prognosis for narcissistic personalities is guarded. The rigidity and smoothness in functioning of this character structure are great obstacles to analytic progress. From the viewpoint of the patient's pathology, the advantage of a complete characterological "isolation" from any meaningful interpersonal relationship is hard to give up. These patients are able internally to withdraw from social life as effectively as the most severe schizoid character. And yet, they usually seem to be in the center of things, efficiently extracting "narcissistic supplies" while subtly protecting themselves from the painful experience of more meaningful emotional interactions.

I suggested in Chapter 3 that narcissistic personalities, in spite of the fact that their defensive organization is, broadly speaking, similar to that of the borderline personality, benefit very little from expressive, psychoanalytically oriented treatment approaches geared to that category of patients, and that psychoanalysis is the treatment of choice for narcissistic personalities. Some of these patients not only tolerate the analytic situation without excessive regression but are so extremely resistant to any effort to mobilize their rigid

pathological character defenses in the transference that they remain untouched by analysis. In patients with narcissistic personalities and overt borderline characteristics (multiple symptomatology, severe nonspecific manifestations of ego weakness, regression to primary process thinking) psychoanalysis is contraindicated. These patients usually cannot tolerate the severe regression and reactivation of very early pathogenic conflicts in the transference, necessary to their analytic treatment, without psychotic decompensation. A more supportive treatment approach seems best for this group. In regard to those narcissistic patients who seem capable of undergoing psychoanalysis, I have found the following prognostic considerations useful in individual cases.

1. Tolerance of Depression and Mourning

The prognosis improves for patients who preserve some capacity for depression or mourning, especially when their depressions contain elements of guilt feelings. For example, one narcissistic patient began his treatment by discussing his feelings of remorse over having gotten involved with a woman who had three small children and who was very much in love with him. The children also loved him and he suddenly found himself "surrounded" in an atmosphere of friendliness and love which prevented him from carrying out his usual behavior of "dropping out" after having "made" a woman. (The transference implications of these feelings were taken up only later in his treatment.) This patient was able to improve markedly over a period of several years of analysis.

Two incidents in the treatment of this patient illustrate his gradually increasing tolerance of guilt and depression. After the first year of treatment, and after the exploitative nature of his relationship to women had been explored, the patient impulsively married the same woman and interrupted treatment for several months; he later explained this action as caused by his fear of the analyst's interference with his decision to marry. The marriage represented at this point both a defense against deepening of his guilt feelings and an acting out of his guilt feelings. Two years later we examined an episode which had

repeated itself quite frequently. The patient's work led him to other cities where he would briefly become involved with women and then completely forget them the moment he left town. After two years of analysis, he had to visit one town, and he decided not to visit a girl there with whom he had been involved for many years. She still thought that he might eventually marry her, seemed always happy with his visits, and conveyed the impression to the patient that she could not get involved with any other man as long as he was still in her life. In the analysis, we had examined the exploitative nature of his relationship with her and his need to defend against guilt feelings in regard to this girl. After arriving in his hotel at that city, the patient thought with intense pain of the disappointment that she would experience after he left her once more. He also felt an intense sexual excitement pressuring him into seeing her. For hours these two feelings struggled in him and he finally had a crying spell with feelings of sadness and sorrow for both the girl and himself. He felt that to see her would only stir up again false hopes in her, and would be bad for her and for the better part of himself. He also was aware that his sexual excitement represented a wish to gratify her sexually and, thus, to allay his guilt feelings toward her, and was also an attempt to escape from his awareness of the entire problem. He finally decided not to see her, experiencing then an increase in his feelings of love and gratitude toward the girl, together with feelings of sadness and mourning, experiencing her as a good, lost object, and feeling that it was now too late to start a new life with her. I must stress that I at no point interfered with his wishes to see her; his not seeing her did not represent a submission to my will. After this episode the patient became much more tolerant of people who were incapable of action because of their strong feelings, people whom he had always depreciated in the past.

2. Secondary Gain of Analytic Treatment

Unfortunately, there are social and professional conditions which give a strong secondary gain to "learning" the method of analysis. The defensive operation of "robbing" the analyst of

what he has to give in order to defend oneself against the envy of the analyst and against the need to acknowledge dependency upon him is strongly reinforced under such "learning" conditions. One minister, who had been sent to analysis because of promiscuous sexual behavior, was very happy with the prospect of analytic treatment, which would give him advantages in the professional field of education in which he was involved. This felt advantage presented an insoluble resistance; the gratification of "learning" analysis compensated most effectively for the underlying depreciation of the analyst and for the patient's inability to accept himself as a patient. Candidates for psychoanalytic institutes should not present a narcissistic personality structure (13), but some applicants with such characteristics do manage to be accepted for psychoanalytic training, especially since the intellectually gifted kind of narcissistic personality may have a very promising aura of originality and intellectual curiosity (17). Such candidates remain in analysis in spite of the emotional emptiness that develops in their analyses, and they may even manage to complete their training with no appreciable change in their narcissistic features. What happens is that the ultimate gratification of becoming a psychoanalyst is sufficient to compensate for the envy and hatred of the "giving" analyst, and the candidate's inability to depend on the analyst and to establish a full-fledged transference neurosis on the level of his basic oral-aggressive conflicts remains unnoticed. Eventually, most candidates with narcissistic personality structures stop doing analytic treatment, even if they have graduated from institutes, because their lack of interest in and involvement with patients makes psychoanalysis a boring procedure to them.

3. Transference Potential for Guilt versus Transference Potential for Paranoid Rage

Riviere (11) stressed that these patients are incapable of tolerating a dependent relationship with the analyst because of deeply buried but ever-present feelings of unconscious guilt. In contrast, Rosenfeld (12) mentions the underlying paranoid disposition, and the strong oral-sadistic transference, behind

these patients' incapacity to tolerate dependency. There are narcissistic patients with each kind of underlying transference potential. Once the typical transference defenses of magical, narcissistic fusion with the analyst and devaluation of him as an independent person, together with the accompanying struggle against real dependency on the analyst, have been resolved, some patients develop intense paranoid reactions in the transference, while other patients seem able to experience at least some guilt and concern over what they are doing to the analyst. Even if their previous history has not given evidence of conscious guilt, this second type of patient (resembling the type described by Riviere) has a better prognosis than the type who experiences a pure paranoid reaction in the transference.

4. The Quality of the Sublimatory Potential

Patients who have been able to achieve some really creative development in a certain area of their life have a better prognosis than those who have no capacity in this regard. Sometimes it is difficult to evaluate this factor, but careful attention to the patient's interests and aspirations will provide this information. For example, one patient had vivid and chronic fantasies of accumulating a collection of antique art, and was very envious of people who possessed ceramics or other objects of this kind. He was, however, completely incapable of differentiating between anything of value and third-rate imitations, and unable or unwilling to inform himself meaningfully about issues of quality. In short, he only wanted to decorate his house the way the people who collected antiques and whom he envied decorated theirs. I must stress that collecting antiques was his main aspiration in regard to personal wealth and yet it was a superficial interest. Another patient was interested in existential philosophy, talked very much about it, and after months of treatment it turned out that he had read only a few books popularizing this particular philosophy. A third patient, although he had reached a high professional level requiring a great deal of reading and formal education, did not read anything other than what was required for his examinations, and, once graduated, was incapable of doing any

further reading. In this last case, once the problem of envy of what other people knew and could contribute was analyzed, he was able to read and learn from what he was reading, at the same time being able to learn from his own analysis.

In all the cases just mentioned, the patients had a low sublimatory potential in spite of the fact that superficially they exhibited a special talent or interest. The next few cases present a higher sublimatory potential, and a better prognostic outlook. The patient mentioned above, who impulsively married in the beginning stage of his analysis, was a merchant, interested in history. His interest seemed genuine and was a source of real pleasure for him; he had achieved real depth in that area and yet devaluated his own achievements, because of the unconscious fear that if he were triumphant in anything other people's envy would destroy it. Another patient was an amateur musician, and during the early stages of analysis frequently stated that when he played the piano, the only thing that was good about him came to the surface. Music was like an ideal though mysterious companion; the patient felt that whenever he deeply enjoyed listening or playing, some vaguely experienced trust or confidence in goodness was being reconfirmed.

5. The Degree and Quality of Superego Integration

I have already mentioned that superego integration in narcissistic personalities is poor. Their superegos mainly contain derivatives of primitive, aggressive, distorted parental images without the normal integration of aggressive forerunners with ideal self and ideal object images, and without the later phase of superego depersonification and abstraction. Some of these patients, however, do present a depersonified and abstracted superego in some areas. For example, they may be honest in money matters, in keeping promises, and in emotionally uninvolved daily interactions with others. They may experience shame, if not guilt, when they break minor conventions surrounding interpersonal relationships. These patients have a better prognosis than those in which there is very little of such "minor morality" left. Patients who lie to the analyst over a long period of time, as well as to other people, or

present other forms of antisocial behavior, have a bad prognosis. It almost goes without saying that the antisocial personality structure, which represents an extreme form of this lack of superego development, has the worst prognosis of all. There is nothing new in mentioning the absolutely hopeless prognosis for the analytic treatment of antisocial personalities, but I am stressing here the continuum between the narcissistic personality and the antisocial personality which I see as an extreme form of pathological narcissism with, among other features, a complete absence of an integrated superego. In contrast, those narcissistic personalities with obsessive features have a better prognosis. One has to be careful, though, in diagnosing obsessive characteristics in narcissistic patients, because they may convey a false impression of an obsessive person. This is especially true for narcissistic personalities who are highly intellectual and cultivated: the smooth and cold quality of their thinking processes and the absence of emotional reactions may be mistaken for obsessive traits. However, in the truly obsessive personality we find intense and deep emotional reactions at points of anxiety, and at points which represent displacements of their emotional conflicts. For example, obsessive personalities may feel strongly about social, cultural, and political issues, and they may develop a surprising understanding of emotional depth in others while being apparently so "cold" themselves. In contrast, narcissistic personalities show superficial emotions of a quick and transitory kind, against a background of emotional blandness and indifference.

6. Presence of Life Circumstances Granting Unusual Narcissistic Gratifications

One element in the patient's life circumstances that leads to a poor prognosis is the opportunity for the patient to act out his needs for power, social importance, and admiration. A power-oriented narcissistic patient may already have achieved such a position in his profession and social life that it may appear to him quite "normal" and, therefore, it is difficult to analyze this form of "chronic acting out." In the same way that the candidate

of a psychoanalytic institute may use his analysis as a ladder to professional status, a patient may use a pre-existing outlet for the gratification of his pathological narcissistic needs outside the analytic relationship and thereby compensate for frustration suffered in analysis, resulting in a therapeutic stalemate.

7. Impulse Control and Anxiety Tolerance

Narcissistic patients often have relatively good impulse control in all but a few areas which represent a compromise formation permitting the gratification of pathological narcissistic needs. For example, one patient had very good impulse control except for periods of homosexual acting out, in which he would pick up an occasional partner in such an impulsive way that he endangered his social position and risked conflict with the law. This patient used a homosexual experience to escape from the rage that any frustration from his girl friend brought about. If she appeared critical of him, he would leave in his car, pick up a man in a public rest room, have him perform fellatio on him, and then drop that man with a feeling of disgust and return home relieved. It gradually emerged that in the homosexual interaction he had the fantasy that the man who was sucking his penis needed him terribly and that the patient was the owner of all the love and fulfillment that was available in the interaction. He could give this love to the other man, thus proving to himself that he was the wealthy one. Later, after dropping his partner abruptly and depreciating him, he identified himself with the hostile and derogatory mother whom he had envied and hated and with the girl friend who represented his mother. By the whole action, he also took revenge on his girl friend-mother by reassuring himself that he did not need her sexually. In this example, what appeared on the surface to be a lack of impulse control was a specific defensive organization which could be understood and resolved analytically. The prognosis is better for these patients than for those who exhibit poor or nonexistent impulse control, who lose themselves in acting out, such as so-called "chaotic" personalities, or those who combine some form of sexual deviation with an impulse neurosis—alcoholism, drug addiction, etc. Prognosis is also guarded for

those patients in whom anxiety immediately brings about generalized acting out or intensification of other symptoms: in short, for those whose anxiety tolerance is very low.

8. Regression toward Primary-Process Thinking

I suggested above that the combination of overt borderline characteristics and narcissistic personality structure usually contraindicates psychoanalytic treatment. Some narcissistic patients may show little symptomatology, good impulse control, and not even too low an anxiety tolerance and, yet, primary process thinking is surprisingly near the surface. For example, one patient functioned quite well in his life, but he had developed over the years the pleasurable fantasy that there was something "Christlike" about him and he enjoyed speculating about the characteristics he shared with Christ. He correctly assessed these fantasies as unrealistic, but at the same time he felt they were very pleasurable. At the beginning of his treatment, the intensity of these fantasies increased to the point that he wondered whether perhaps he was not Christ after all; then he regressed acutely into a schizophrenic reaction, which probably would not have occurred at that point had he not been offered an expressive psychotherapy.

One other point in regard to the regressive potential of the patient; overt borderline features, especially a lack of impulse control, an inability to tolerate anxiety, and a tendency toward primary process thinking, contraindicate psychoanalysis in these cases even if they show the presence of guilt and a potential to experience depression, because in these cases the depression that develops during treatment may regress into a psychotic depression or serious suicidal attempts. Every narcissistic character who is to be successfully treated must undergo periods of severe depression and suicidal fantasies, and if he does not have sufficient ego strength to tolerate this development, his life is in serious danger. In those cases where the ego is weak, supportive psychotherapy is indicated. Among the patients studied in the Psychotherapy Research Project of The Menninger Foundation, those with severe narcissistic character structure combined with overt borderline functioning could be treated quite successfully with a purely supportive approach.

9. The Motivation for Treatment

The crucial test of the motivation of these patients comes only after a period of analysis. The usually acceptable motivations for treatment, such as the wish to get rid of symptoms, may prove quite spurious in patients with narcissistic personalities. They may really want to become "perfect," and may enter analysis with such expectations. The question of whether "perfection" will turn out to mean for them freedom from symptoms so that they can be superior to everybody else, or whether it will be exchanged for the wish to get rid of their crippled emotional lives is often difficult to answer at the initiation of treatment. In any case, the more a person wishes to overcome feelings of emptiness, difficulties in empathizing with others, and his internal coldness, the better the prognosis.

A CRUCIAL PERIOD IN THE TREATMENT

After the patient systematically works through the defensive organization of pathological narcissism, his primitive oral conflicts regularly come to the surface. His intense hatred and fear of the image of a dangerous, aggressive mother are projected onto the analyst as well as onto all other significant beings in his life. At some point, the patient has to become aware that this fear of attack from the mother represents a projection of his own aggression, linked to the rage caused by his frustration by mother. He also has to become aware that his ideal concept of himself is a fantasy construction which protects him from such dreaded relationships with all other people, and that this ideal self concept also contains a hopeless yearning and love for an ideal mother who would come to his rescue. The deep aspiration and love for such an ideal mother and the hatred for the distorted, dangerous mother have to meet at some point, in the transference, and the patient has to become aware that the feared and hated analyst-mother is really one with the admired, longed-for analyst-mother.

At this point, an extremely difficult emotional situation comes about for the patient: he must acknowledge the realistically good aspects of the analyst (mother) which he has previously denied and devaluated and bring upon himself a shattering feeling of guilt because of his previous aggression toward the analyst. The patient may feel despair because he has mistreated the analyst and all the significant persons in his life, and he may feel that he has actually destroyed those whom he could have loved and who might have loved him. Now he may have intense suicidal thoughts and intentions, but if he has been selected for analysis because of his good ego strength, he may work through this conflict without premature reassurance from his analyst. As the narcissistic patient works through this crucial period in the analysis, he comes to acknowledge the analyst as an independent being for whom he can feel love and gratitude. Simultaneously, the patient will begin to acknowledge the independent existence of other significant persons in his life. For the first time he may show an authentic curiosity about, interest in, and satisfaction with what goes on in other human beings. It is as if people were coming alive in the patient's external world as well as in his internal world of objects and self experience, his "representational world" (14). This stage in the analysis contrasts strikingly with the previous emptiness of the fantasy and emotional life of the patient.

Normal regression in the service of the ego involves one special dimension, namely, the reactivation of past internal object relationships as a source of internal support in times of crisis, of loss of external support, or of loneliness. Normally, the emotional wealth derived from past happy relationships with others not only permits the empathic enjoyment of the present happiness of others, but also is a source of internal consolation when reality threatens to bring about loss of self-esteem. Narcissistic patients are not able to resort in this way to their own past. If they are treated successfully, they come to realize a deeper and more meaningful life, and begin to draw from sources of strength and creativity in their newly developing world of internalized object relationships.

The following case history illustrates this crucial period of treatment in one particular patient. At one time, this patient

had become aware that he had always treated the analyst as a "mirror" of himself, and had built the analyst up as a kind of powerful slave, totally at the patient's service, something like the genie in the fairy tale of Aladdin's Lamp. He realized that, between the sessions, he had had the feeling that the analyst had disappeared into an only potential existence, as if the analyst were confined in a bottle that the patient could put away. At this point, for the first time after years of analysis, the patient exhibited curiosity about the life of the analyst and envy of the analyst's private life. He became aware of anger and regret at being separated from the analyst over the weekends, and also had feelings of gratitude because the analyst had been willing to "stick with him" in spite of his chronically derogatory behavior. This patient had always depreciated literature, especially poetry, and everything that did not deal with "strong, cold, useful facts."

Then one day he remembered a fairy tale that had impressed him in his early childhood but that he had completely forgotten since. It was the story of "The Nightingale" by Andersen (2) and the patient, an unimaginative person, spontaneously interpreted the story through associations and dreams over a period of several days. He understood that he himself was the Emperor of China in the story, because he was as deprecatory of everybody else as the Emperor. China itself, in that fairy tale, was like the fantasy world of the patient, because everybody was depreciating everybody else in it. The nightingale (the live, real one) was the only warm and loving creature in that world, but the Emperor was not able to love it. Although he enjoyed its song, he dropped it without remorse when the shiny, jewel-covered mechanical substitute was offered to him. The mechanical nightingale covered with jewels and gold represented the Emperor's (patient's) own mechanical lifeless self. When the Emperor became ill and longed for the nightingale's song in order to become well again, the mechanical bird broke down and was no longer available, because the Emperor himself, the patient felt, had destroyed everything surrounding him. One night, when the Emperor was about to die, all the good and bad deeds of his life came back to him and

made him suffer. The patient understood this to be an expression of the Emperor's final awareness of the bad sides of himself, and of his despair at ever undoing all the wrongs he had done. The patient felt very moved by the idea that the real-life nightingale came back at last, to sing by the dying Emperor's window and thus saved his life. The patient said, with deep feeling, that he now understood why, as a child, he had been moved to tears by this story and he cried at that point. The survival of the real, good nightingale in the story reaffirmed the patient's faith in the existence of a good being who was still available and had not been killed, in spite of all the Emperor's—and the patient's—greed and destructiveness. The Emperor was saved because he had kept inside of himself such a good and forgiving object. The nightingale also represented the good analyst who had not been killed by the patient's destructiveness.

This example illustrates not only the patient's understanding of a crucial problem in himself, but also his generally deepening awareness of emotional life; for the first time, he could accept a previously depreciated form of literature. To see a patient come alive during treatment, and begin to feel for the first time real concern for and interest in others as well as in an internal life of his own, is a gratifying experience for the analyst. It compensates for the many months and years of emptiness and meaninglessness with which these patients try to drown the analytic situation.

The prognostic considerations examined in this chapter illustrate the limitations and difficulties in the psychoanalytic treatment of patients with narcissistic personality structure. Even if we cannot successfully treat many of these patients, at least they permit us to better understand and resolve narcissistic defenses in patients with less intensive overall character pathology. I believe that careful selection of these cases may bring about more encouraging therapeutic results with those who initially are considered hopeless and are, therefore, not treated, or who are taken into analysis under the erroneous assumption that they fall into the category of the ordinary character neurosis and cause disappointment after many years of analytic work.

SUMMARY

A general hypothesis regarding the etiology of the narcissistic personality structure is proposed, involving the relationships between pathological narcissism and pathological object relationships. Technical problems in the psychoanalytic treatment of narcissistic personalities are examined—especially their typical transference resistances—and prognostic criteria are outlined.

BIBLIOGRAPHY

1. Abraham, K. A particular form of neurotic resistance against the psychoanalytic method (1919). *Selected Papers on Psycho-Analysis.* London: Hogarth Press, 1949, pp. 303-311.
2. Andersen, H. C. The nightingale. In: *Tales of Grimm and Andersen.* New York: Modern Library, 1952, pp. 714-721.
3. Fenichel, O. Typology. *The Psychoanalytic Theory of Neurosis.* New York: Norton, 1945, pp. 525-527.
4. Freud, S. On narcissism: an introduction (1914). *Standard Edition,* 14:67-102. London: Hogarth Press, 1957.
5. ———. Libidinal types (1931). *Standard Edition,* 21:215-220. London: Hogarth Press, 1961.
6. Jacobson, E. *The Self and the Object World.* New York: International Universities Press, 1964.
7. Jones, E. The God complex (1913). *Essays in Applied Psycho-Analysis,* 2:244-265. New York: International Universities Press, 1964.
8. Kohut, H. (1968). The psychoanalytic treatment of narcissistic personality disorders. *Psychoanal. Study Child,* 23, 86-113.
9. Reich, A. Narcissistic object choice in women. *J. Am. Psychoanal. Assoc.,* 1:22-44, 1953.
10. ———. Pathologic forms of self-esteem regulation. *Psychoanal. Study Child,* 15:215-232. New York: International Universities Press, 1960.
11. Riviere, J. A contribution to the analysis of the negative therapeutic reaction. *Int. J. Psycho-Anal.,* 17:304-320, 1936.
12. Rosenfeld, H. On the psychopathology of narcissism: a clinical approach. *Int. J. Psycho-Anal.,* 45:332-337, 1964.
13. Sachs, H. Observations of a training analyst. *Psychoanal. Quart.,* 16:157-168, 1947.
14. Sandler, J. & Rosenblatt, B. The concept of the representational world. *Psychoanal. Study Child,* 17:128-145. New York: International Universities Press, 1962.
15. Schafer, R. The loving and beloved superego in Freud's structural theory. *Psychoanal. Study . . . .* 15:163-188. New York: International Universities Press, 1960.
16. Stone, L. The widening scope of indications for psychoanalysis. *J. Am. Psychoanal. Assoc.,* 2:567-594, 1954.
17. Tartakoff, H. H. The normal personality in our culture and the Nobel prize complex. In: *Psychoanalysis—A General Psychology,* ed. R. M. Loewenstein, L. M.

Newman, M. Schur, & A. J. Solnit. New York: International Universities Press, 1966, pp. 222-252.

18. Ticho, E. Selection of patients for psychoanalysis or psychotherapy. Presented at the 20th Anniversary Meeting of the Menninger School of Psychiatry Alumni Association, Topeka, Kansas, May, 1966.
19. Van der Waals, H. G. Problems of narcissism. *Bull. Menninger Clin.*, 29:293-311, 1965.