PSYCHOANALYTIC PSYCHOLOGY, 1984, *1* (2) 99-112

The Psychoanalytic Treatment of Narcissism

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This paper discusses the need for change in emphasis from metapsychological debate to a sharp clinical focus on the complex nature of narcissistic pathology. Narcissism is viewed as a dimension of psychopathology found at all levels of psychic functioning, at the core of which are characteristic ego and superego deficits around self-cohesion, self-continuity, and self-esteem regulation. It is argued that, if the definition of conflict is not viewed too narrowly, traditional Freudian or ego-psychological techniques are applicable and that the treatment of narcissism does not require a new theory, separate from that of object relations. Clinical material is presented to illustrate that all psychological phenomena are over-determined and contain aspects of unresolved preoedipal and oedipal conflicts. There are critical selfhood aspects at each stage of development which must be understood and interpreted, in addition to the traditional structural conflicts. It is stressed that highly developed skills in listening and in interpreting are required in order to discern the narcissistic and object-relations aspects of the clinical material and that the countertransference around the analyst's own narcissism needs particular attention.

In the past 15 years there has been a vast outpouring of psychoanalytic literature on the subject of narcissism, paralleling the popular and sociological interest in the "me generation" and the intense quest for personal happiness and self-fulfillment, present in the 1960s and 70s. There have been major attempts at systematic metapsychological formulations of narcissistic pathology. However, such formulations, while conceptually illuminating, do not do justice to the complexity of actual clinical data and may even be a disservice in our work with such patients. In addition, these major explanatory attempts have frequently resulted in the establishment of warring factions and acrimonious debates.

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What has been particularly striking in reviewing the literature is the arcane and dichotomous nature of much of it. The more the debates intensify and the more positions become entrenched, the further removed we are from the clinical experience of the patient. In the game of fierce metapsychological tennis, the patient's experience often gets lost in the volley.

There seem to be five major issues around which the debates center. Although these questions are important to address, we must ask why we often seem to require absolute answers to them outside the context of the actual clinical experience with the patient. These issues are:

1. Do narcissism and object relations have separate existences and developments?
2. Does narcissism require a separate theory of clinical technique?
3. How do we conceptualize the nature of the early preverbal representational world?
4. Should aggression be viewed as instinctual or reactive to early narcissistic injury?
5. Is narcissism the result of pathological infantile organization or the result of interference with the normal unfolding and development of infantile narcissism?

We do indeed need to address these issues, as George Klein (1976) pointed out, as part of our dedication to the psychological understanding of man and, as teachers and supervisors, to transmit these understandings to others. However, the hardening of positions around these issues, outside of the clinical context, poses questions about the kinds of anxieties the treatment of narcissistic pathology creates for the analyst.

Much has been written about the trials of being outrageously idealized, devalued, raged at, and treated as an object. It seems likely that the intense need for theoretical certainty must involve some threat to the analyst's own narcissism. The patient with narcissistic pathology often represents a severe challenge to the analyst's competence and sense of efficacy. This challenge to the analyst's self-esteem seems to drive him into rigid intellectual defenses and an unrealistic need for certainty, removing him from the patient's experience and threatening to place the patient into a procrustean bed.

Narcissism is a dimension of psychopathology appearing at all psychological levels, including normalcy. While there may exist some patients who suffer only narcissistic pathology, it seems very unlikely. My experience leads me to believe that patients combine pathology having to do with the cohesion and continuity of the self with pathology more related to structural conflict, in varying degrees and configurations. That this is so implies that treatment of patients with substantial narcissistic pathology is highly demanding of the analyst. He must be a particularly keen listener and observer; his empathic

abilities must stretch to their limits in teasing out the narcissistic and the object-related aspects of the clinical phenomena; his tolerance for ambiguity, uncertainty, confusion, and for his own errors must be high; his talent at the psychoanalytic art of dosage, timing, and tact must pass a severe test. With such demands on the analyst, it is no wonder that he often prefers to enter the treatment room forearmed with a definite diagnostic and prescriptive formulation. This paper discusses some of the major theoretical issues in the treatment of narcissism, without attempting to settle for all time any of the major debates, and presents clinical material to illustrate important treatment considerations.

While Freud (1914) considered pathological narcissism to be fixation at or regression to the libidinal cathexis of the self, he was acutely aware that "self regard has a very intimate connection with the narcissistic libido" (p. 98). Annie Reich (1953) made a major contribution to the understanding of narcissism in her paper on the use of the aggrandized phallus to compensate for the trauma of imagined castration and resulting sense of defect in women. Prior to the recent surge of interest in narcissistic phenomena, many others such as Fairbairn (1941), Guntrip (1969), Laing (1960), Sullivan (1953), and Winnicott (1960) contributed much to the appreciation of the selfhood aspects of experience. Kohut's and Kernberg's prolific contributions brought wide attention to the use of grandiose fantasies as a way of repairing narcissistic injuries and solidifying the self-representation. However, use of clinical data from different patient populations and important differences in the use of similar nomenclatures have resulted in considerable confusion about the comparability of their contributions.

To do justice to the clinical data it is essential to define narcissism as a dimension of psychopathology, not as a discrete diagnostic category possessing exclusivity and specificity. The analytic understanding of narcissism pervades all our psychoanalytic work and cuts across all diagnostic categories. The task of the analyst is to assess the extent of the vulnerability of the self-representation, the degree of structural deficiency, and the susceptibility to decompensation. It is important to bear in mind that there is humiliation and injury to the developing sense of self in each psychosexual stage. Determining the point in development of unresolved conflicts will neither fully explain the nature of the pathology, nor convey the quality of the present day object relations of the patient. For this reason, it is essential to understand the prominent role of narcissistic issues in each stage and its consequence to the development of the emerging self.

What is self-pathology? Basically, it refers to the vulnerability of the fantasy of the self known as the self-representation. It involves difficulties in maintaining the cohesiveness, sense of continuity, and positive affective estimation of the self (Stolorow & Lachmann, 1980). Where such pathology is prominent, there are frequently feelings of emptiness, lack of initiative

and/or hyperexcitability, sexual problems, gender confusion, difficulties in tension regulation, and extreme sensitivity and vulnerability to the reactions of others. Other people are depended upon for confirmation and to maintain positive self-regard. The narcissistic patient characteristically relates to others as selfobjects who exist principally to serve some purpose of the self, either to reflect its grandiosity, provide some ego function, or supply some quality needed for the self's perfection. The use of others as selfobjects is manifested in the analysis in what Kohut (1977) has termed the mirror transference, in which the analyst is used to validate and reflect back the worth of the patient and is not seen as a separate person. The narcissistic patient both devalues and idealizes the analyst and, characteristically, after some initial uncovering work, exhibits grandiosity and omnipotence.

Hypochrondriasis, self-aggression, and eating disorders are common. There is vacillation in self-esteem based on minor external provocations. Panic attacks, feelings of desperate loneliness, and feelings of depersonalization are frequent. In some patients this is a chronic state of being; in others these feelings may follow upon experiences of humiliation, disappointment, failure, and rejection.

It should be stressed that the symptom picture cannot be taken at face value, as many of the symptoms mentioned may be related more to structural conflict, particularly castration anxiety which may be enormously disorganizing. Patients' descriptions of their psychological state must be carefully explored, as well as the quality of their object relations and the transference phenomena.

What does seem to be widely acknowledged about the problems of the narcissistic personality is that their origins predate the oedipal complex. There is, however, major disagreement on whether narcissism is a separate line of development, apart from object relations. Kohut (1971) contends that self-pathology consists of split off or dissociated self and selfobject images which emerge spontaneously during analysis and which need to mature into healthy self regard and acceptance of others as separate.

There is a growing body of evidence, particularly the recent infancy research referred to later, that early traumatic experiences and/or failures of empathy and relatednesss lead to fixed narcissistic positions and defenses in which fantasies of perfection and omnipotence of the self or an ideal object are of central importance. Kohut (1977) maintains a separate conceptualization of self-pathology, outside of conflict theory, and describes techniques of empathic mirroring to repair the structural deficiency in which the narcissistic configurations are mobilized to solidify the self.

Difficulties in applying analytic technique to narcissistic pathology have been mistakenly taken as proof of the inadequacy of Freudian and ego-psychological theory. Many instances described to point up the inapplicability of Freudian theory appear on closer examination to reflect errors in tim-

ing, dosage, and tact. Interpretations which do not accurately capture the patient's meaning do not call for the replacement of classical theory, but illustrate its misuse. The point of view that narcissistic pathology is independent of conflict is based on an overly narrow definition of conflict. The therapeutic handling of grandiose fantasies or wishes for merger with an aggrandized omnipotent object is often a lengthy and arduous analytic task. It is not facilitated by accepting the patient's perception of himself at face value or by viewing his self fantasies as drive-related issues. It must be born in mind that where self-pathology is central, there is strong investment in the grandiose fantasies. Such fantasies clearly involve the wish for admiration from the analyst, but, as William Grossman (1980) pointed out, "they may also represent an appeal, a reproach, a gift, a revelation, and so on" (p. 13).

Kohut's formulation that early narcissistic structures characterize a decisive and universal stage in normal human development seems doubtful. Based on extensive observations and studies of normal young children (Freyberg, 1973), I feel strongly that adult narcissism bears little resemblance to that of young children who are surely grandiose, exhibitionistic, and omnipotent, but are warmer, more humorous and playful, quicker to forgive their disappointers, less primitively rageful and, most important, more responsive to genuine loving and caring. Kernberg (1974) has certainly made this point. It seems more likely that the pathological structures appear primarily in response to traumatic narcissistic injuries and/or defects in empathy and relatedness especially in the context of the separation-individuation process.

Unquestionably, Kohut has made a major contribution to psychoanalysis in demonstrating the narcissistic function of fantasies, images, self-representations, and transference phenomena which may, in the past, have been erroneously viewed only in their drive-related function. A significant error, however, seems to be his omission of early identifications in his conceptualization of narcissistic structures. Where narcissistic pathology is prominent, I have found primitive identifications with idealized body parts and fantasies of fusion with part objects to be prevalent psychological phenomena. Perhaps Kohut's grandiose self and idealized object are fantasies of fusion with and exhibition of idealized part objects. Identification with the penis (or wished-for penis) as an idealized selfobject would make the line between castration and annihilation of the self very thin.

What Kohut considers normal stages in arrested development, I believe, with Kernberg (1974), are better described as pathological condensations of the real self, grandiose self, and idealized object developed in the context of intense, predominantly pregenital, conflicts around love and aggression. Normal wishes for recognition and admiration are related to real needs, whereas the demands of pathological narcissism are excessive and unfillable. At least in good part, pathological narcissism is a consequence of the internal

destruction of supplies. No alleviation of the feeling of emptiness can be achieved without exploration and interpretation of their destruction. Of course, extreme tact must be used, as interpretations are often experienced as attack and may cause the patient to experience feelings of disintegration. The narcissistic patient needs to use the analyst for support, need satisfaction, and regulation of anxiety. He will react to interpretations as meeting or failing these needs. Interpretation of this use of the object will ultimately be of primary therapeutic importance.

What Kohut has sensitized us to is the need to explore the patient's self-representation carefully before interpretations are made. The patient equates being understood with having his perceptions validated. He fears devaluation by the analyst. Kohut, as well as Mahler (1968, 1971), helped us to understand that anger has an organizing (as well as a disorganizing) effect and serves some restorative functions. The interpretation of the use of the object or of hostility must follow a substantial period of acceptance during which the holding atmosphere has been solidly established. It is my experience that interpretations about anger are accepted most easily after the inevitable empathic failures of the analyst. These failures bring to mind the parental failures in empathy and the connection can be made explicit by the analyst. There is a ferocious quality to narcissistic rage, often straining the analytic process, which sometimes must simply be waited out.

The difficulties of the narcissistic patient may be best understood as an inadequately resolved individuation, having to do with the mother's failure of support and empathy in the face of the child's ambivalence, curiosity, and assertiveness. The self, after all, is the name given to one's experience of one's self, as distinct from others. The rapprochement subphase, as described and set forth by Mahler (1968, 1971), is a critical juncture during which language and motor ability are rapidly advancing. During that phase the child attempts to individuate and, if the mother responds with less availability, he will cling and behave regressively. He needs her empathy and relatedness to grow and he will forego his separateness to ensure self-esteem supplies from her. He merges with her to regain his narcissistic equilibrium. This sets the paradigm for regressive boundary blurring at times of narcissistic injury. With threat of withdrawal, such a child is unable to establish self-esteem independently. He remains vulnerable to identity confusion. At the time of rapprochement there are already significant identifications with mother and a vacillation of the child between merger and separation. If the child's efforts at individuation cause the loss of mother's relatedness and admiration, the child reacts with fear and rage. Persistent early rage can lead to fragmentation and to identification with part objects which may be idealized and used for self-restitution. Merger with mother becomes a method of dealing with rage and anxiety which the child learns he cannot master independently. The untamed pregenital rage can become pathologically condensed with genital aims, so

that there is confusion of sexual and aggressive impulses, as described by Kernberg (1975). Lack of empathy and acceptance of the child in his bid for a separate sense of self will color all future psychosexual stages, each of which contain its own potential for defeat, shame, and humiliation. It seems likely that the traumatic nature and potential for disorganization of the self-representation involved in the mastering of the oedipal conflict is vastly underestimated by those who attribute the etiology of self-pathology solely to the preoedipal period.

We do have some reliable evidence, independent of patient report, on the etiology of self-pathology. For example, recent infant research provides striking evidence of "early infant-mother interaction of a dynamic and continuous nature in which complex patterned interrelationships change over time in response to interactional events" (Sander, 1980, p. 186). In a series of video tapings, Gaensbauer illustrated as reported by Sander (1980), in five different infants, "varying patterns of affective behaviors which were related to marked variations in the caretaking environment" (p. 186). In addition, there is a growing body of literature on the effects of the Nazi Holocaust and other massive human disasters on the parenting abilities of the survivors. For the most part, it suggests that parental impediments in emotional relatedness and in acceptance of the child's autonomy portend difficulties in the development of self-cohesion in the offspring. (Barocas & Barocas, 1973; Freyberg, 1980; Krystal & Niederland, 1968; Sigal, Silver, Rakoff, & Ellin, 1973; Trossman, 1968).

Apparently, the etiology of self-pathology has much to do with the quality of the early mother-child interaction. Familiarity with infant research films makes it difficult to imagine a developing self conceptualized separately from the dyadic relationship. Whether, in regard to an individual patient, we speak of some pathology of the self, or in another we find the self pathology more central, with an impoverishment of object ties, has to do with variation of other developmental factors in the individual child, as well as with the fact that the separation-individuation conflict is critically reworked in adolescence.

If one does not adopt an overly narrow view of conflict, the technical distinction between compensatory structures (Kohut, 1977) and defenses is a matter of the analyst's empathic skill. As in the case of structural conflict, the analyst begins the treatment with a period of acceptance of the patient's narcissistic defenses: arrogance, disdain, devaluation, disregard, or self-preoccupation. During this time the analyst can assess the nature and function of these defenses, that is, whether they serve to ward off self-disintegration or anxieties around strong libidinal and aggressive impulses, and develop some sense of the nature of the transference. Where the narcissistic issues are central, the analyst must prepare for a lengthy empathic period. It is essential during the period of acceptance for the analyst to learn

how the patient uses objects, fantasies, images, behaviors, or transference manifestations to maintain his or her self-esteem, and to avoid premature interpretation of these psychological phenomena. The analyst must assess: how fragile is the sense of self; what devices restore the patient's equilibrium; how poor is his or her tension regulation; how much the patient needs external validation to feel cohesive; the severity of trauma required to induce disintegration. It is particularly important, because of the vulnerability of the sense of self of these patients to avoid misinterpreting the need for narcissistic objects as libidinal strivings and/or defensive regressions from oedipal issues until such time as there is much greater self-cohesion.

As in the analysis of more neurotic patients, the analyst must employ classical psychoanalytic technique and allow the transference phenomena to develop spontaneously. In the case of the narcissistic patient, these phenomena are grandiosity, exhibitionism, idealization, and use of the object for affirmation, self-esteem regulation, self-cohesion, and tension reduction. The analyst must concentrate his interpretations on the narcissistic function of certain resistances and defenses until such time as more self-cohesion develops, thus allowing the patient to tolerate interpretations of libidinal and/or aggressive object-related impulses. Narcissistic issues will never disappear, and that aspect of psychological phenomena must always be considered as possibly requiring subsequent interpretative attention. The analyst must also be carefully attuned to the possibility that obvious, manifest narcissistic phenomena will be used to conceal or defend against the emergence of a transference neurosis.

As for the debate about whether aggression is best conceptualized as instinctual or as reactive to early narcissistic injury, I feel, with Kernberg (1975), that, clinically speaking, the issue is of little consequence to its resolution with the patient. What seems to be constitutionally based in all animals, including man, is the reaction of fear and aggression in the face of threat. Mankind reacts to peculiarly human sources of threat and with myriad variations in the ways he may express his aggressive response.

A clinical vignette is presented which may serve to illustrate etiological, as well as technical issues, and to convey some sense of the complexity of narcissistic phenomena. Feona was a 30-year-old physician who entered treatment because of her highly unsatisfactory relations with men. She desperately needed to be linked to a man in order to feel alive, safe, and worthwhile, and she experienced overwhelming feelings of disintegration and panic whenever a relationship with a man ended. In addition, she felt extreme anger at and envy of men particularly since her parents placed higher value on them than on women. She was unable to distinguish and label her affect states, instead feeling diffusely tense, panicky, and unhappy. She "walked through life in a fog," feeling nothing for others, and experiencing no distinct affects of any kind.

Feona's parents met in Auschwitz and married shortly after liberation. They were in poor health and meager financial circumstances when they emigrated to the United States. Feona was conceived before they found jobs, a place to live, or learned the English language. She was placed in a day care center at a very early age and remembers that all during childhood she would come home each day to an empty apartment after school. She recalls hearing her mother cry at night and staring into space as though no one was there. All of the parents' relatives had perished in the war and Feona felt she had to make up to them for their losses. Her parents insisted that she inhibit all anger and aggression toward them and a younger sister born 6 years later. In the family, there was enormous pressure to be happy, well, conforming, and successful. Feona remembers her parents, in an effort to inhibit her anger, aligning themselves with anyone with whom she had a disagreement. She felt very misunderstood and an object in their efforts to restore their place in the world.

About the time Feona began treatment, her parents were pressuring her to give up her career and get married. As this issue was explored and some attempt was made to elicit her feelings, Feona reported becoming dizzy and confused. She spoke frequently about the foggy feeling she experienced and her lack of connection to anyone or anything. She felt empty inside and terrifyingly alone. She was uncertain about what qualities she possessed unless others responded to her in one way or another. She lived in terror of being called ugly, fat, or stupid because that would make it so for her.

Treatment began by helping her to understand her feeling states and differentiating separate affects from the diffuse mass of inner turmoil. Over a year's time, she began to recognize feelings of anger, sadness, and fear, but was unable to express them in appropriate situations. The transference that developed was one in which the analyst was a selfobject who functioned to identify her feeling states and validate her experiences. Grandiosity was expressed in asking for frequent appointment changes and leaving messages on the analyst's answering machine without identifying herself. There were contemptuous comparisons of the analyst with her friend's therapist who provided specific advice. Her disappointment was accepted and acknowledged. This gradually allowed her to express her "annoyances" at the analyst somewhat more openly, although her fear of retaliation was omnipresent. After a long period of listening and acceptance, the need to be special was interpretively related to her underlying fears of emptiness.

As Feona was able to express more angry feelings, she reported frightening dreams of sadistic retaliation. Her enormous rage toward men and her terrible fear and envy of their power were explored. She recalled fantasies during adolescence about Nazis abusing women sexually which were at the same time arousing and horrifying. Men who were abusive, unreliable, and demeaning were enormously attractive to Feona. During intercourse with them

she had stimulating fantasies of them physically harming her. However, these fantasies served to keep her from relinguishing control and experiencing orgasm. In this material, we can clearly see the intense untamed pregenital rage and the amalgamation of it with libidinal and genital aims.

Exploration of difficulties with men gradually led to elucidation of a central concern: she felt profoundly defective, inadequate, unlovable, and in contant fear of disintegration. She had little sense of her own continuity over time. She felt she was an enormous disappointment to her parents who wanted a son and who did not admire her as she was.

As stronger anger at her parent's demands mounted, the patient displayed a remarkable symbiotic retreat in which the boundaries between her and her mother were significantly blurred. Her rage rendered her enormously anxious and guilt-ridden to the point of panic. She remarked that the anxiety "flooded her whole body leaving nothing else". Her own feelings were obliterated and she came to the decision that her mother was right in suggesting that Feona renounce her career. She would try to find someone to marry and settle down with. Maybe having a family of her own would make her happy. This identification with mother clearly reflected the unresolved attachment to the maternal figure and the instability of her individuation. There was lengthy exploration of her need to give up her sense of self and her own feelings to retain the desperately needed approval of significant others. Feona remarked that it had never occurred to her that she could be separate and have her own values, feelings, and wishes. To love and to be loved one had to be the same as the other. Her feelings were not real until discussed with her mother and now with the analyst. Her need for a selfobject to validate her experience, acknowledge her feelings, and regulate her self-esteem flowered in the transference and was slowly and gradually interpreted in terms of their compensatory purpose.

Grandiose phenomena appeared in which she confessed to feelings of being very brilliant; someone who would undoubtedly make medical history by discovering the cure for cancer. It frightened Feona to express this grandiosity because she believed others would hate her for her talents and would retaliate. She was morbidly afraid of others' jealousy. Her jealousy of her younger sister had been dealt with harshly by her parents. She was especially frightened by her father's temper and felt she had only her mother to turn to.

Empathic understanding and exploration of her grandiosity in terms of her childhood experiences of parental unrelatedness and nonacceptance resulted gradually in improved self-cohesion and awareness of her own feelings. She made more friends and dated men who treated her with respect. Her self-esteem, however, remained heavily dependent on how others reacted to her. Any slight or rejection resulted in binging on sweets, as well as feelings of being "back in the fog." She began to realize that the type of people she chose as friends revealed her need to idealize others and gain self-esteem by association with them. But secretly she felt superior to her friends and resentful of

her need for their approval. Her time spent courting friends left her no time to furnish her apartment, pay her bills, buy clothes, and so forth.

Exploration of her use of the transferential object to supply her self-cohesion and the connections of her problems with childhood disappointments continued to build ego strength. The self-representation, however, remained vulnerable to being out of control, helpless, or not getting her way. Exploration of her needing to be in control became pivotal in treatment. What emerged was Feona's conviction that she was entitled to special treatment and that others should be obliged to meet her needs. She was helped by gentle, tactful interpretations to see the subtle ways she manipulated others because she felt no one would willingly do things to please her. She responded to these interpretations with obvious gratification, remarking that it felt "strengthening" to be understood but not judged. Interpretations that control and manipulation seemed necessary because overt assertion and anger were not acceptable sustained her self-esteem.

Direct conflict with mother over her career, even after 3 years of analysis, still precipitated decompensation and significant boundary blurring. These decompensations brought about eating binges and intense sexual activity, both of which restored cohesion.

In the fourth year of treatment, Feona reported several dreams in which she possessed a penis, ushering in a period of intense exploration of phallic issues. The revelation evolved that she felt most nearly whole when she had intercourse and had a penis inside her. She felt in control of her life and worthwhile. The merger with the idealized phallus clearly provided more self-esteem and cohesion. After much analytic work on the narcissistic aspect, the more object-oriented phallic themes emerged: competition with and hatred of men, envy of their control over themselves and others; fear of the penis as a weapon of harm; and her wishes for men as protectors. However, the narcissistic disturbance was strongly disruptive in these object-oriented conflicts. Feelings of disintegration and panic accompanied hurts and failures in the phallic and oedipal arenas. The same psychological phenomena served at times to elevate self-esteem and consolidate the self-representation; at other times they also served to ward off competitive and oedipal strivings. The binging is a good example of these multiple purposes. The stuffing of the self with food was experienced as solidifying and consolidating at times of narcissistic vulnerability. Overeating was also utilized to gain weight and make herself feel unattractive to men, both in response to sexual fears and as a way of retreating from competitiveness with other woman, including the analyst. It was particularly crucial to understand at each juncture if the narcissistic issue was predominant or the phallic-oedipal issues, so that appropriate empathic or uncovering approaches would be employed.

Another example of the multiple aspects of the same psychological phenomenon was the patient's intensive sexual activity. She craved the sensation of having a penis within her because it served to provide feelings of cohesion

and self-worth. She fantasized owning the penis and felt this won her the admiration she craved. This need for ownership of the phallus for narcissistic equilibrium persisted throughout most of the treatment. When sexual contact was unavailable or men broke appointments, Feona continued to fall into her foggy states and resorted to binging. The sex act, it was revealed, also gave Feona tremendous relief in that the man had an orgasm and she did not. She remained in control. After considerable interpretation in terms of narcissistic function, the analyst detected a glee in the patient's reports of not having an orgasm. She remarked that Feona seemed triumphal. Feona laughed anxiously and acknowledged her secret feeling that she had disarmed the man, made him soft, and rendered him weak and drained. Both the narcissistic needs and angry competitive impulses surrounding the phallus were acknowledged and it was the analyst's task to tease out and help the patient understand which aspects were predominant at different times. Often angry competitive feelings were warded off by obsessive compulsive defenses requiring the traditional interpretative approach.

The transference for over 4 years most resembled the selfobject transference in which the analyst was used to provide the self with cohesion, continuity, and positive affective estimation. There were grandiose configurations to be admired, as well as idealizations, devaluations, and rages at empathic failures. The fifth year brought the beginning of issues of jealousy and rivalry with women, first in relation to mother and sister and subsequently in the transference. Her idealizations of the analyst took on a new feel and were interpreted (as it turned out) correctly as a way of not dealing with her anger, jealousy, and rivalry with the analyst. She was able to express her feelings of superiority toward the analyst, especially when she imagined she was powerful and had a penis. She also expressed feelings of superiority in terms of professional status and attractiveness.

Her fear of losing the love of and attachment to the maternal figure was powerful and disorganizing. The lack of completion of the individuation process made the resolution of the competition with the mother especially traumatic. The strong early identification with mother's needs and affective states created extraordinary anxiety in the patient, often causing serious regressions and decompensations. During such regressions, uncovering work became secondary to interpretations about the difficulties in mastering and regulating her own emotional states.

Feona, now in the sixth year of treatment, has been increasingly able to tolerate uncovering work about her love for her father and her yearnings for his admiration and affection as a woman. There are still regressions to dependence on the analyst and significant others for self-validation when too much anxiety is aroused by uncovering work. This occurs less often now, is shorter in duration, and she seldom goes on eating binges. The indiscriminate sexual activity has ended and she is dating a few different men who treat her well.

Her difficulties in loving a man because of her need to relinquish the old tie to mother and give up the narcissistic selfobject role her mother provided has yet to be resolved. That the oedipal conflict is complicated in this way by central pathology of the self-representation will significantly lengthen the time needed for resolution.

Throughout Feona's treatment, it was critical to bear in mind that increased rage and consequent strengthening of the grandiose defenses could result from moving too quickly from an understanding to an interpretive approach. By accepting and stressing the narcissistic function of certain defenses, there developed a more cohesive sense of self, more solid self-esteem, and the ability to tolerate interpretations around object-related themes. It is clear that empathy aided self-cohesiveness, but interpreting and taming of rage were decisive in that consolidation. Narcissistic rage leads to disintegration of the self and to the destruction of self-esteem supplies so that the development of sublimatory channels for the expression of aggression is essential. The internalization of the object (analyst), no longer seen as selfobject, becomes a stabilizing structure in terms of ego functioning (self-cohesion and tension regulation) and in terms of superego functioning (self-esteem regulation).

This clinical vignette, I believe, illustrates that all psychological phenomena are over-determined and contain aspects of unresolved preoedipal and oedipal conflicts. Each psychological event expresses all the different layers of development, and varying interpretive approaches are different ways of describing and understanding the same event. We are always dealing with preoedipal and oedipal issues at each moment of treatment. It is our arduous task to decide which aspect of the psychological event upon which to focus. It would indeed be much easier to deal with either narcissistic or object-related issues with each patient, depending on his diagnostic label. Fortunately, or unfortunately, we must accept human complexity and the fact that human drives, needs, and affects link self and object inextricably from birth until death.

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