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Contrasting Viewpoints Regarding the Nature and Psychoanalytic Treatment of Narcissistic Personalities: A Preliminary Communication

Otto F. Kernberg, M.D. ⓘ

DESPITE THE EVOLVING AGREEMENT concerning the descriptive clinical characteristics of the narcissistic personality, widely divergent views have developed regarding its underlying metapsychological assumptions and its optimal technical approach within a psychoanalytic modality of treatment. Kohut's approach to these latter is very different from the one I outlined in an earlier paper (1970), one which is closely related to the views of Jacobson (1964), Mahler (1968), Riviere (1936), Rosenfeld (1964), and van der Waals (1965). Insofar as I have already described the clinical characteristics of narcissistic personalities (1970) and I see no major disagreements between Kohut's view and that of the other author's mentioned and myself, I shall not review them here. Instead, I shall focus on areas of agreement and disagreement regarding the metapsychological assumptions and treatment.

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CONTRASTING VIEWPOINTS REGARDING THE NATURE AND PSYCHOANALYTIC TREATMENT OF NARCISSISTIC PERSONALITIES: A PRELIMINARY COMMUNICATION

OTTO F. KERNBERG, M.D.

DESPITE THE EVOLVING AGREEMENT concerning the descriptive clinical characteristics of the narcissistic personality, widely divergent views have developed regarding its underlying metapsychological assumptions and its optimal technical approach within a psychoanalytic modality of treatment. Kohut's approach to these latter is very different from the one I outlined in an earlier paper (1970), one which is closely related to the views of Jacobson (1964), Mahler (1968), Riviere (1936), Rosenfeld (1964), and van der Waals (1965). Insofar as I have already described the clinical characteristics of narcissistic personalities (1970) and I see no major disagreements between Kohut's view and that of the other author's mentioned and myself, I shall not review them here. Instead, I shall focus on areas of agreement and disagreement regarding the metapsychological assumptions and treatment.

The Relationship of Narcissistic Personality to Borderline Conditions and the Psychoses

Kohut differentiates the narcissistic personality disorders from the psychoses and borderline states (1971, p. 18). In my view, the de-

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College of Physicians and Surgeons, Columbia University, New York City.

fensive organization of narcissistic personalities is strikingly similar to that of borderline personality organization in general, and differs from it only in a particular way.

The similarity in the defensive organization of narcissistic personalities and borderline conditions is in the predominance of mechanisms of splitting or primitive dissociation as reflected in the presence of mutually dissociated or split-off ego states: haughty grandiosity, shyness, and feeling of inferiority may coexist clinically without affecting each other. These splitting operations are maintained and reinforced by primitive forms of projection (particularly projective identification), primitive and pathological idealization, omnipotent control, and narcissistic withdrawal and devaluation. In general and from a dynamic viewpoint, pathological condensation of genital and pregenital needs under the overriding influence of pregenital (especially oral) aggression is characteristic of narcissistic personalities as well as of borderline personality organization.

The difference between narcissistic personality structure and borderline personality organization centers on the specific presence in the former of an integrated, although highly pathological grandiose self, which reflects a pathological condensation of some aspects of the real self (i.e., the "specialness" of the child that was reinforced by early experience), the ideal self (i.e., the fantasies and self-images of power, wealth, and beauty that compensated the small child for the experience of severe oral frustration, rage, and envy), and the ideal object (i.e., the fantasy of an ever-giving, ever-loving, and accepting mother, in contrast to their experience in reality—a replacement of the devaluated real parental object). I am adopting here the term "grandiose self," suggested by Kohut, because I think it better expresses the clinical implications of what I referred to earlier as the pathological self structure, or what Rosenfeld (1964) called the "omnipotent mad" self. The integration of this pathological grandiose self compensates for the lack of integration of the normal self-concept, characteristic of borderline personality organization: it explains the paradox of relative good ego functioning and surface adaptation in the presence of a predominance of splitting mechanisms, a related constellation of primitive defenses, and the lack of integration of object representations. There is general agreement about the clinical characteristics of this grandiose

self. Kohut and I disagree, however, about the origin of this grandiose self and whether it reflects the fixation of an archaic "normal" primitive self (Kohut's view) or a pathological structure, clearly different from normal infantile narcissism (my view).

There are narcissistic personalities who, in spite of a clearly narcissistic personality structure, function on what I have called an overt borderline level; that is, they present the nonspecific manifestations of ego weakness characteristic of borderline personality organization (severe lack of anxiety tolerance, generalized lack of impulse control, striking absence of sublimatory channeling, strongly predominant primary-process thinking on psychological tests), and they are prone to the development of transference psychosis. In such patients, the pathological narcissistic structure does not provide sufficient integration for a more effective social functioning, and they usually present a contraindication for analysis, even the modified psychoanalytic procedure that I recommend for most patients with borderline personality organization. A supportive psychotherapeutic approach may be the treatment of choice for these cases.

Repetitive chronic activation of intensive rage reactions linked with ruthless demandingness and depreciatory attacks on the therapist—"narcissistic rage"—is characteristic of narcissistic patients functioning on an overt borderline level. One also finds intense outbursts of rage in the usual borderline patient as part of alternating activation of "all good" and "all bad" internalized object relations in the transference. The relentless nature of this rage, however, the depreciatory quality that seems to contaminate the entire relationship with the therapist, and what evolves as a complete devaluation and deterioration of all the potentially good aspects of the relationship for extended periods of time so that the very continuity of treatment is threatened, are characteristics of narcissistic patients functioning on a borderline level.

The Relationship of Normal to Pathological Narcissism

Kohut (1971) thinks that narcissistic personalities "remained fixated on archaic grandiose self-configurations and/or on archaic, overestimated, narcissistically cathected objects" (p. 3). In his diagram (p. 9), he clearly established a continuity of pathological and nor-

mal narcissism, in the context of which the grandiose self represents an archaic form of what, normally and in the course of treatment, may become the normal self. It seems to me that his analysis focuses almost exclusively on the vicissitudes of development of libidinal cathexes, so that his analysis of pathological narcissism is essentially unrelated to any examination of the vicissitudes of aggression. I think that one cannot divorce the study of normal and pathological narcissism from the vicissitudes of both libidinal and aggressive drive derivatives, or from the development of structural derivatives of internalized object relations (Kernberg, 1971, 1972).

The narcissistic resistances of patients with narcissistic personalities reflect a pathological narcissism that is different from the ordinary adult narcissism and also from fixation at or regression to normal infantile narcissism. The implication is that narcissistic resistances developing in the course of interpretation of character defenses in patients other than narcissistic personalities are of a different nature, require a different technique, and have a different prognostic implication from such resistances in patients presenting pathological narcissism.

Pathological narcissism can be understood only in terms of the combined analysis of the vicissitudes of libidinal and aggressive drive derivatives. Pathological narcissism does not simply reflect libidinal investment in the self in contrast to libidinal investment in objects, but libidinal investment in a pathological self-structure. This structure has defensive functions against the underlying investment in both libidinally determined and aggressively determined primitive self and object images in the context of intense, predominantly pregenital, conflicts around both love and aggression.

The structural characteristics of narcissistic personalities cannot be understood simply in terms of fixation at an early level of development or lack of development of certain intrapsychic structures, but as a consequence of the development of pathological (in contrast to normal) differentiation and integration of ego and superego structures deriving from pathological (in contrast to normal) object relationships.

When one compares such patients with normal small children, it becomes apparent that grandiose fantasies of small children, their angry efforts to control mother and be the center of attention, have a more realistic quality by far than do those of narcissistic per-

sonalities. A two-and-a-half-year-old child's capacity to maintain a libidinal investment to mother during temporary separations is in striking contrast to the narcissistic patient's incapacity to depend upon the analyst and other people beyond immediate need gratification. Normal infantile narcissism is expressed by the child's demandingness related to real needs, while the demandingness of pathological narcissism is excessive, cannot be fulfilled, and is secondary to a process of internal destruction of the supplies received. The coldness and aloofness of patients with pathological narcissism —when their capacity for social charm is not put into action—the tendency to disregard others except in temporary idealization of potential sources of narcissistic supply, and the prevalence of contempt and devaluation in most of their relationships are in marked contrast to the warm quality of the small child's self-centeredness. Pursuing this observation into the historical analysis of narcissistic patients, one finds from the age of two to three years an impressive lack of the normal warmth and engagement with others and an easily activated destructiveness and ruthlessness, which is abnormal.

In the transference, one principal function of the narcissistic resistances of narcissistic personalities is to deny the existence of the analyst as an independent, autonomous human being, without a simultaneous fusion in the transference such as can be observed with more regressed patients. It is as if the analyst were tolerated in a type of "satellite existence," with frequent role reversals in the relationship between patient and analyst and without any basic change in the total transference constellation over many months and years. The grandiose self permits the patient to deny his dependence on the analyst. Regularly, however, when this defensive constellation has been worked through, it turns out that this denial of dependence on the analyst does not represent an absence of internalized object relations or an absence of the capacity to invest in objects, but a rigid defense against more primitive pathological object relations centered around narcissistic rage and envy, fear and guilt because of this rage, and yet a desperate longing for a loving relationship that will not be destroyed by hatred. This defensive constellation is very different from the activation of narcissistic defenses in other types of character pathology.

The narcissistic personalities' curiosity about the analyst's life

in areas other than those related to his immediate needs is often absent for many months or years. The simultaneous presence of what on the surface seems "normal," although infantile, idealization and of complete obliviousness toward the analyst on the part of these patients alerts us to the differences in idealization that exist under normal and pathological circumstances. The absence of the capacity to depend on the part of narcissistic personalities, in contrast to the clinging dependence and persistent capacity for a broad spectrum of object relations in borderline patients, contributes fundamentally to the differential diagnosis of narcissistic personalities functioning on an overt borderline level and usual borderline patients.

In Kohut's thinking, narcissistic personalities suffer from a lack of optimal internalization of the archaic rudimentary self-object—the idealized parent imago (1971, pp. 37–47). He stresses that the small child's idealizations belong genetically and dynamically in a narcissistic context: this proposition makes sense in the context of Kohut's view that it is the quality of the libidinal cathexes and not the target of the instinctual investment that determines whether an internalization is basically narcissistic or object-oriented. Because of traumatic loss of the idealized object, or a traumatic disappointment in it, optimal internalization does not take place, and Kohut suggests that the idealizing transference of narcissistic personalities corresponds to a fixation at an archaic level of normal development.

In my view, the idealizing transference reflects a pathological type of idealization and corresponds to the massive activation of the grandiose self in the transference. What Kohut calls the mirror transference, reflecting the activation of the grandiose self, and what he calls idealizing transference, correspond in my thinking to the alternative activation of components belonging essentially to a condensed pathological self. As I mentioned earlier, this pathological self stems from the fusion of some aspects of the real self, the ideal self, and the ideal object—a condensation that is pathological and does not simply represent fixation at an early stage of development.

In my view, the early idealization of the analyst in the transference does not constitute a paradigm essentially different from the projection of the grandiose self onto him, and frequently contains many elements of the characteristics of the grandiose self. In addition, in the early stages of the analysis, idealization of the

analyst serves to re-create the patient's usual incorporative relationships with potential sources of gratification. The idealization of such sources represent the gratifying fantasies that other people, in this case the analyst, still have something valuable that the patient has not yet incorporated and that he needs to—and will—make his. The early idealization is also a defense against the dangerous premature emergence of intense envy, and against the processes of devaluation of the analyst. Devaluation of the analyst may protect the patient against envy, but it may also destroy the hope for receiving something new and good; on a deeper level, it may reconfirm his fear of not ever being able to establish a mutually loving and gratifying relationship.

The sudden shifts from periods in which the analyst is seen as a perfect, godlike creature, into a complete devaluation of the analyst and self-idealization of the patient, only to revert once more to the apparent idealization of the analyst and to the patient's experiencing himself as part of the analyst, indicate the intimate connections of the components of the over-all condensed structure—the grandiose self—that characterizes narcissistic resistances. The analysis of all these components of this pathological structure reveals its defensive functions against the emergence of direct oral rage and envy, against paranoid fears related to projection of sadistic trends onto the analyst (representing a primitive, hated, and sadistically perceived mother image), and against basic feelings of terrifying empty loneliness, hunger for love, and guilt over the aggression directed against the frustrating parental images.

Psychoanalytic Technique and Narcissistic Transference

Kohut's over-all strategy of technique aims at permitting the establishment of a full narcissistic transference, especially the unfolding of the mirror transference reflecting the activation of the grandiose self. He implies that this transference development completes a normal process that has been arrested, namely, the internalization of the ideal self-object into the superego and the related growth from primitive into mature narcissism. Kohut suggests that "during those phases of the analysis of narcissistic character disturbance when an idealizing transference begins to germinate, there is only one correct analytic attitude: to accept the admiration" (1971, p. 264). The analyst, Kohut says,

> interprets the patient's resistances against the revelation of his grandiosity; and he demonstrates to the patient not only that his grandiosity and exhibitionism once played a phase-appropriate role but that they must now be allowed access to consciousness. For a long period of the analysis, however, it is almost always deleterious for the analyst to emphasize the irrationality of the patient's grandiose fantasies or to stress that it is realistically necessary that he curb his exhibitionistic demands. The realistic integration of the patient's infantile grandiosity and exhibitionism will in fact take place quietly and spontaneously (though very slowly) if the patient is able, with the aid of the analyst's empathic understanding for the mirror transference, to maintain the mobilization of the grandiose self and to expose his ego to its demands [1971, p. 272].

While I would certainly agree that it is important to permit a full development of the transference rather than to prematurely interpret it, and that the analyst needs to avoid—as in all analytic cases—any moralistic attitude regarding the inappropriate nature of the patient's grandiosity, Kohut's approach may unwittingly foster an interference with the full development in the transference of the negative transference aspects, may maintain the patient's unconscious fear of his envy and rage, and thus hinder the working through of the pathological grandiose self. Kohut implies that the mirror transferences, which reflect the activation of the grandiose self, must be tolerated to permit its full development because otherwise the narcissistic grandiosity may be driven underground. It seems to me that systematic analysis of the positive and negative aspects of the patient's grandiosity from an essentially neutral position better achieves the goal of full activation of the narcissistic transference. I agree with Kohut that the psychoanalytic treatment of narcissistic personalities does center on the activation of the grandiose self and that the patients need help to achieve full awareness of it in a neutral analytic situation; but I think that to focus exclusively upon narcissistic resistances from the viewpoint of libidinal conflicts, with an almost total disregard for the vicissitudes of aggression in these cases, interferes with a systematic interpretation of the defensive functions of the grandiose self. In my view, both the primitive idealization and the omnipotent control of the analyst need to be interpreted systematically; the patient needs to become aware, obviously in a noncritical atmosphere, of his need to devaluate and

depreciate the analyst as an independent object, and thus protect himself from the reactivation of underlying oral rage and envy and the related fear of retaliation from the analyst.

In the course of this work, what regularly emerges is that, underlying the patient's consciously remembered or rediscovered "disappointments" of his parents, are devaluations of parental images and real parental figures that the patient carried out in the past in order to avoid underlying conflicts with them. The patient's disappointments in the analyst reveal not only fantasied—or real—frustrations in the transference: they also reveal dramatically the total devaluation of the transference object for the slightest reason and, thus, the intense, overwhelming nature of the aggression against the object. Direct rage because of frustrations is an infinitely more normal, although exaggerated, type of response. In addition, the implication of "either you are as I want you, or you cease to exist" is also the acting out of unconscious need for omnipotent control of the object, and reflects defenses against aggression. "Disappointment reactions" in these cases reflect conflicts about aggression as well as libidinal strivings and, more immediately, a protection against general activation of oral-aggressive conflicts. The narcissistic transference, in other words, first activates past defenses against deeper relationships with the parents, and only then the real past relationships with them.

The analyst needs to focus on both the positive and negative transference; focusing on such remnants as exist of a capacity for love and object investment, and for realistic appreciation of the analyst's efforts, prevents an almost exclusive focus on the latent negative transference, which can be misinterpreted by the patient as the psychoanalyst's conviction that the patient is "all bad." The analyst certainly needs to avoid educational pressures or a moralistic stance, and I think the best way to achieve this is to analyze the motives that determine narcissistic defenses, including the activation of the grandiose self. One prominent reason why these patients cannot tolerate facing their feelings of hatred and envy is because they think such feelings would destroy the analyst, destroy their hope for a good relationship with him, and crush their hope of being helped. At a deeper level, these patients fear that their aggression will not only destroy the potentially loving and giving object, but also their own capacity to give and receive love. At the same

time, to neglect interpreting the negative aspects of the transference may heighten the patient's fear of his own aggression and destructiveness and intensify the need for activation of the narcissistic resistances. In short, the optimal technique for resolution of the narcissistic resistances is to systematically interpret both the positive and negative transference aspects.

The realistic wish to maintain a good relationship with the analyst and to be helped by him is the patient's starting point, one might say, for the recuperation of normal infantile and mature dependence and self-evaluation. Insofar as narcissistic resistances against full awareness of the patient's underlying rage and contempt are also at the service of preserving the good relationship with the analyst, the interpretation of this double function of narcissistic resistance may greatly help the patient to be able to face his split-off contempt and envy. In short, noncritical interpretation of the negative aspects of the transference may help reduce the patient's fear of his own destructiveness and doubts about his goodness.

Prognosis of Narcissism, Treated and Untreated

Secondary gain of illness, such as life circumstances' granting unusual narcissistic gratification to a patient with a socially effective narcissistic personality structure, may be a major obstacle to the resolution of narcissistic resistances. This is also the case when there is secondary gain of analytic treatment itself, such as with psychoanalytic candidates in training with narcissistic personality. Another major prognostic factor is the extent to which negative therapeutic reactions develop. This type of negative therapeutic reaction is typically linked with particularly severe repressed or dissociated conflicts around envy, rather than with superego factors; this reaction is more severe than that seen in depressive-masochistic patients with a sadistic although integrated superego. Cases with relatively good quality superego functioning, reflected by the capacity for real investment in values transcending narcissistic interests, have a good prognostic implication, in contrast to cases in which there are subtle types of manipulative and antisocial behavior, even in the absence of major antisocial features (which would make the prognosis very bad indeed). In simple terms, honesty in their daily life

is a favorable prognostic indicator for the analysis of narcissistic personalities.

While Kohut does not, so far as I can tell, refer specifically to prognostic differences in his approach to narcissistic personalities' functioning on various levels of ego and superego integration, he conveys a generally optimistic outlook. In my view, and on the basis of Kohut's published writing, his approach leads to a higher level functioning and better adaptation of the grandiose self without a basic resolution of what I consider the pathological structure of the grandiose self. This may well be why, in Kohut's findings, there is no direct specific relationship between the changes in the patient's narcissism and the patient's object relations. It seems to me that the effect of his approach, if not his intentions and technique, have re-educative elements in them that foster a more adaptive use of the patient's grandiosity.

I strongly agree with Kohut's conviction that narcissistic personality disorders should be treated by psychoanalysis whenever possible. Even in cases that are functioning quite successfully, except for some relatively minor symptoms, and where the combination of intelligence, talents, luck, and success provide sufficient gratifications to compensate for the underlying emptiness and boredom, one should keep in mind the devastating effects of unresolved pathological narcissism during the second half of life. We need to consider that throughout an ordinary life span, most narcissistic gratifications occur in adolescence and early adulthood. Even when a string of narcissistic triumphs and gratifications are achieved throughout most of adulthood, the individual must eventually face the basic conflicts that come with aging, chronic illness, physical and mental limitations, and, above all, separations, loss, and loneliness. Therefore, we must conclude that the eventual confrontation between the grandiose self and the frail, limited, and transitory nature of human life is unavoidable.

It is dramatic how intense the denial of this long-range reality can be in the case of narcissistic personalities who, under the influence of the pathological grandiose self are unconsciously (and sometimes consciously) convinced of their eternal youth, beauty, power, wealth, and the unending availability of supplies of confirmation, admiration, and security. For them, to accept the breakdown of the

illusion of grandiosity means to accept the dangerous lingering awareness of the depreciated self—the hungry, empty, lonely primitive self surrounded by a world of dangerous, sadistically frustrating, and revengeful objects.

The normal reaction to loss, abandonment, and failure is the reactivation of internalized sources of love and self-esteem, which are intimately linked with internalized object relations and reflect the protective function of what has been called "good internal objects." Regression in the service of the ego often takes the form of regression to such reactivated internalized object relations of a protective kind—a regression which in turn strengthens and broadens the patient's capacity for meaningful relations with others and with humanity and value systems at large. The capacity to work through mourning processes; the capacity for being in love; the capacity to feel empathy and deep gratification in identifying with loved people and values; the sense of transcendence with nature, of continuity within the historical process and of oneness with a social or cultural group—all are intimately linked to the normal activation of internalized object relationships at the time of loss, failure, and loneliness.

This is in striking contrast to the vicious circle triggered off by narcissistic loss in the case of narcissistic personalities, where defensive devaluation, primitive envy, and panic because of the reactivated sense of impoverishment further complicate narcissistic loss and failure. This becomes particularly evident in the narcissistic patient's incapacity to come to terms with old age. Therefore, and in spite of the limited number of patients we are able to help and the very extensive analyses required in these cases, it seems worthwhile to invest much effort in the treatment of what so often looks deceptively like an almost "normal" subject.

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47 Walworth Avenue
Scarsdale
New York 10583