

Narcissism in Two Forms: Implications for the Practicing Psychoanalyst

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There has been a great deal of controversy expressed in the recent psychoanalytic literature as to the etiology and treatment of patients with narcissistic personality disorders. The most intense disagreement has been centered around the largely contradictory theories of Heinz Kohut and Otto Kernberg. The clinically important distinctions between these two theories are outlined in this article. They include the differential importance each theory places on aggression in the etiology of narcissism and resistance in the treatment of narcissistic patients. A basic difference between these theories is the model they adopt for the understanding of the development of narcissistic pathology generally; with Kohut advocating a developmental arrest point of view, and Kernberg advancing a theory more consistent with classical psychoanalysis, that of an instinctual or structural conflict.

This article contends that the understanding of the narcissistic patient can be greatly aided by recognizing that each of these theories correctly assesses and treats a specific form of narcissistic pathology. Clinical data from the psychoanalytic treatments of two narcissistic patients are presented. As is indicated by this clinical material, cues that the practicing psychoanalyst can employ in making the important distinction between the two forms of narcissism are offered. They include (a) the patient's response to the analyst's empathic interventions, and (b) the analyst's countertransference in relation to being an "audience" to the narcissistic patient. It is also suggested that there is a difference between patients with these two forms of narcissism in the way they convey aggressive material in the treatment situation.

There has been a great deal of debate concerning the etiology and treatment of the narcissistic personality disorder (Kernberg, 1974, 1975, 1976; Kohut,

1971, 1977, 1979, 1984; Kohut & Wolf, 1978; Masterson, 1981; Mendelschn & Silverman, in press; Rothstein, 1979, 1980). More important for this article, there has been a great deal of confusion in the field generally and particularly among psychoanalysts in training as to the most efficacious way to treat the narcissistic patient. Much of this confusion has centered around an attempt to reconcile two widely diverse approaches to this type of patient, that of Heinz Kohut and Otto Kernberg.

It is my contention that much of the confusion is due to the fact that these two widely contradictory theories correctly assess and treat two very different types of patients, both of whom have been correctly diagnosed as being narcissistic. Grasping this point and learning how to make the differential assessment as to which type of patient one is working with is crucial to theoretical understanding and clinical success.

This article outlines these contradictory theories, describes the types of narcissistic patients that each refer to, and offers clinical data that will elucidate these points.

TWO THEORIES OF NARCISSISM

There are three major points upon which there is clinically important debate between the proponents of Kohut's and Kernberg's theories of narcissism. These theories diverge in their view of aggression in the narcissistic patient, the role and view of resistance and most important, the basic model for understanding the etiology of the disorder (i.e., as to whether narcissism is a result of a developmental arrest or an instinctual conflict). (For a discussion of this latter issue, see Freyburg, 1984; Greenberg & Mitchell, 1983; Lachmann & Stolorow, 1976; Stolorow & Lachmann, 1978, 1980.)

Kohut conceptualized the etiology of narcissism as a result of a developmental arrest; that is, a mismatch of the child's normal narcissistic needs and the environment's ability to adequately respond to them (Kohut, 1977; Kohut & Wolf, 1978). In the case of the adult narcissistic patient, he or she experienced a maturationally determined need to be mirrored by and to idealize the parental figures during the pre-oedipal phase of development. This childhood need was not adequately responded to, thus causing that child, now an adult, to search in all relationships for what was experienced as missing. This etiological model of narcissism therefore can be understood as an arrest from childhood that pervades adulthood and is clinically evident at the time of the beginning of analysis. It is the analytic task, according to Kohut and his proponents, to begin where the patient's self ceased to develop (i.e., to provide an analytic environment in which the patient will be facilitated in experiencing anew his or her narcissistic needs and have them responded to in such a way as to allow the patient to develop a more cohesive self-system).

Another point Kohut emphasized that has far-reaching clinical significance involves his view of aggression in the narcissistic patient. From this point of view, aggression is not a drive but is a reactive phenomenon. Kohut (1984) described two types of aggression he had observed: (a) aggression in response to a person who blocks the child's or patient's attainment of a desired goal, and (b) aggression in response to a person who threatens the child's or patient's sense of self. It is only the latter type of aggression that leads to narcissistic pathology (p. 138). This is a quite different conception of aggression when comparing it to a theory that sees the narcissistic aggression as "bedrock" and instinctual.

The third clinically significant point to be made concerning Kohut's view of narcissism relates to the issue of resistance in the analysis. It is argued that seeing resistance as a central focus evolves from a worldview that is not as relevant to human beings in the present era (Kohut, 1984). He stated that, whereas the person in Freud's time and particularly Freud himself saw the major human issue as knowing or not knowing; that is, conscious or unconscious, the contemporary human being is more concerned with issues of being (i.e., with the perpetuation and cohesion of the self). Resistance as a central focus belongs more to the former era's concern than the latter.

This does not mean that Kohut denied the existence of resistance. Kohut believed that resistance does occur in the treatment of the narcissistic personality but that the understanding of this phenomenon is quite different from that advocated by analysts with a more classical perspective. Whereas classical analysis (Greenson, 1967) described the omnipresence of, and need to, interpret resistance, Kohut (1984) emphasized the reactive and adaptive function of this phenomenon.

In the properly conducted analysis, the analyst takes note of the analysand's retreat (resistance), searches for any mistakes he might have made, nondefensively acknowledges them after he recognizes them, often with the help of the analysand, and then gives the analysand a noncensorious interpretation of the dynamics of his retreat. (p. 67)

In this way, resistance phenomena are seen as specific reaction to an empathic failure on the part of the analyst.

The adaptive function of resistance is central in Kohut's later writings (see especially Kohut, 1984, chapter 7). As opposed to a more classical point of view that conceptualizes resistance as a force opposing health, Kohut saw resistance as a healthy phenomenon. "My personal preference is to speak about the defensiveness of patients and to think of their defensive attitudes as adaptive and psychologically valuable and not of their resistances" (p. 114). This attitude is reflected in the paper in which he described his work with Mr. Z., a patient Kohut treated in two phases, first when Kohut still considered

himself a classical analyst and formulated material in conformity with this theory, and then after a 4-year break in the analysis when Kohut had developed his theories of self-psychology (Kohut, 1979). In the first analysis, Kohut formulated the case primarily in terms of resistance, particularly the patient's narcissistic demands as a resistance to the oedipal issues. In the second analysis, the narcissism was understood as an adaptive way of attempting to prevent fragmentation of the self-system.

Kernberg's views differ widely from those just outlined. His theory is one which is more consistent with the premises of classical analysis. In classical analytic ideology, pathology is conceptualized as resulting from an unconscious instinctual or structural conflict (i.e., a conflict between the drives and the defenses in the topographical model and between id, ego, and superego in the structural model). (See Arlow, 1963; Eissler, 1953; Freud, 1923; Greenson, 1967.) Classical analysis developed this theory on the basis of clinical experience with neurosis. In neurosis, the patient is subject to an instinctual or structural conflict centered around the oedipal phase. It is the analytic task to interpret the instinctual conflict in relation to the oedipal material so to change the structural balance of the mind (i.e., the relative strength of id, ego, and superego). (See Arlow, 1963; Freud 1923.) The analytic task is to enable the patient to make the unconscious conscious, or, as Freud (1933) stated, "Where id was, there ego shall be" (p. 80). Kernberg's theory of narcissism is consistent with this view of psychopathology with one major exception. In Kernberg's view (see especially Kernberg, 1975), narcissism is a result of an instinctual or structural conflict but in the case of narcissism, the conflict is not centered around the oedipal complex but rather around issues that predate the oedipal (i.e., oral rage). It is this instinctual or structural conflict which is the underlying motivation of the patient. It is against these drives that the patient erects robust characterological defenses (i.e., his or her narcissistic personality disorder). The analytic task, consistent with rules of classical psychoanalytic technique, is to confront and interpret the defenses so that the original instinctual pathology can be exposed and addressed.

In Kernberg's view, aggression is not merely reactive but the original reason for the narcissistic pathology. It is the patient's inability to manage his or her aggression that causes the patient to develop the narcissistic defenses. In this view, this patient is seen as having a great quantity of the aggressive drive. It is not clear from Kernberg's writings how he understands the preponderance of aggression in these patients. He seems to waver on the question as to whether the great quantity of aggression in these patients is due to constitutional factors (i.e., the patient is born with a higher drive quantity or is a result of a particularly frustrating environment). (For a discussion of this issue, see Klein & Tribich, 1981.)

Kernberg conceptualized the treatment of the narcissistic patient in a different way than was outlined in the discussion of Kohut. It is Kernberg's view

that the treatment should focus, particularly in the beginning phases, primarily on the analysis of the narcissistic resistances. It is only by confronting and interpreting these resistances, particularly the transference resistances, that one can expose and work with what is truly underneath the defenses (i.e., the oral rage that created the pathology). Kernberg felt that only by means of this approach can an analyst have an impact on the core structural conflict that is the etiological basis for the development of the pathological narcissistic personality. He characterized Kohut's treatment as superficial because it merely ameliorates the defenses, particularly grandiosity (Kernberg, 1975, especially chapter 9). It does not change the personality or effect the underlying pathological structures.

Two cases are presented now to illustrate the clinical distinctions between those narcissistic patients whose pathology is most adequately conceptualized in terms consistent with Kohut, versus those whose pathology is more adequately explained by Kernberg's theory.

THE CASE OF JOHN¹

John came into therapy when he was 30 years old. The patient was unmarried and employed as a piano tuner, a job he felt was demeaning given his compositional talents in the field of classical music. Two months before seeking treatment, a close friend of 12 years died of bone cancer. Although the patient experienced only the most minimal signs of mourning, he stated that due to this experience he began questioning the meaning of life generally and his own life-style specifically. In line with this, John complained that since his friend's death, he had become aware that most of his relationships generally and his relationships with women particularly, were characterized by extreme superficiality. With women, John's relationships were exclusively one-night stands, although he expressed a strong motivation to take himself and his life more seriously, a wish to settle down, and a need to make a more conscientious pursuit of career objectives.

During the initial interview, no overt symptomatology was detected. The patient's phenomenological experience was marked, not by anxiety and its manifestations, but by intense loneliness. He stated that he had two goals for the treatment: (a) to develop an increased capacity for deeper and more satisfying relationships; and (b) to get rid of his imperfections so he could truly be, in his words, "unblemished."

John was the fourth of six children (second son) born to third-generation Irish Catholic parents living in New York City. From entries in John's baby book, which he brought into the treatment sessions, and from reports of

¹This patient was in treatment with the author.

older siblings, his life at home was rather peaceful and emotionally rich during his first 18 months, at which time his sister was born. Entries in the baby book as well as John's earliest memories indicate that he began to have some significant difficulties during this period. According to his mother, John needed constant attention and was intensely jealous of his younger sibling. John's first memory is of hiding under the dining room table for what seemed to him for hours while he waited for someone to notice that he was missing. This early memory was reported with a great deal of emotion.

John's earliest memories of his parents were marked by intense idealization. John described his mother, at this point in his life, in exclusively physical terms as the most beautiful woman he knew. His father is described as a large, healthy man with a booming voice and an infectious laugh. "When I was 5 and 6, my mother used to read to me and the others. It was beautiful. My father used to put me on his knee and let me listen to opera with him on Sunday afternoons. He was so much fun and so strong."

Both of John's parents were heavy drinkers throughout his childhood. However, when John was 8 years old, their drinking became excessive. John recalls that his parents would leave home for long periods of time and return in a drunken state, demanding that the children carry them upstairs to bed. When John was 11 years old, his father's drinking advanced to such an extent that he was unemployable. The patient's most painful memory was returning from school with a number of friends and meeting his father on the street, shabbily dressed, drunk, and demanding that his son give him money for another drink.

When the patient was 16 years old, his mother fell asleep in an alcoholic stupor while smoking a cigarette and died 3 months later from the resulting burns. John's father died 2 years later from what seemed to be general physical decompensation connected with the cumulative effects of alcohol and the loss of his wife.

From approximately the age of 8 to their deaths, John stated that he saw his parents very negatively. "They were basically monsters. They weren't parents. They were hideous and grotesque. . . . I wanted them to be strong and beautiful like they were before but they weren't. . . . Why couldn't they have stayed the way I thought they should have been? They were poor excuses for people."

When John's father died, the patient was in his sophomore year of college and continued to perform adequately in his academic pursuits. It was during this time, that John experienced a number of transient homosexual relationships with his professors. He continued to have heterosexual relationships as well, most frequently, with women significantly older than he.

Upon graduation, John pursued a graduate degree in musical composition. The faculty asked him to leave after one year there, however, because of inferior academic performance.

At the time of the first interview, John had worked at a piano shop for a number of months. His social life consisted of frequenting different bars every evening in pursuit of sexual partners. He would often miss work and there was some evidence that his job was in jeopardy as well.

John's dreams were rich in detail and frequency. Two of his dreams are presented so as to offer a more complex clinical picture of his dynamics.

The following dream was reported in the third session:

I was shaving, looking in the mirror, when very suddenly my reflection in the mirror became rather distorted. My face began to look like this hideous woman's face. Really ugly. I looked around to see if a woman was standing behind me but she wasn't. When I looked back into the mirror, my face was back to normal. I woke up shaking.

John was able to associate this dream material with two major aspects of his personal life. He first described how the woman somewhat resembled his mother when she was made up to go out for the evening. "She looked rather hideous—kind of like a clown. You know how women look right after they put on their make-up." The second stream of associations spoke to John's need to see himself through other people's eyes. "I don't know who the hell I am so I look to other people to tell me. I am always looking into the mirror to see who I am—not how I look but who I am. Do you understand the difference?"

The second dream was reported approximately 18 months into the treatment.

I was in this strange land where everything was in these weird colors. All the other people were wandering about carrying little make-up mirrors. I was the only one in this land without his own one. People told me to seek out King Taboree and beg him for a mirror of my own. I think the dream ended when I got on my knees to beg for my own make-up mirror.

John saw his wish to get his own mirror as a wish to see himself without looking into other people's mirrors (i.e., to have a sense of self that stems from a more internal source rather than from other's views of him). He also saw this dream as speaking to his relationship with me. "You are the king. You have the mirrors. You have the ability to give me my own or deny it."

The third dream was reported in the final two weeks before termination of the treatment, approximately four and a half years after the initial session.

I was having an argument with some man. He said he wanted to pay me a certain amount of money and I thought that was too little. So we were arguing back and forth. He was making his points and I was making mine and all I can remember is that it basically stayed liked that until I woke up.

John's association to this dream material was in the context of the transference. "I was holding my own, not yielding, not running away, not pushing you around [with a big smile]. We were two equals and it felt invigorating."

These dreams reflected the different phases of the transference as described by Kohut and Wolf (1978). In the beginning phase, John demanded constant and unflawed mirroring. He needed the analyst to agree with his perceptions, to see his side of every issue, and to recognize his vulnerability and his right to do what he did. During the middle phase, coinciding with the second dream, John needed the analyst to be an ideal figure. It became less important for him to agree with the patient. Now it was crucial that the analyst's life be seen as perfect, his interventions perfect, and his attitudes correct. The analysis took on the flavor of a mentor relationship, that is, John was studying at the feet of the analyst-guru who possessed the answers to all matters. During the third phase, in the final 8 months of the treatment, John exhibited changes in the way he interacted in the sessions with the analyst; for example, the patient began to ask the analyst some tentatively expressed questions about his life (curiosity was seemingly absent before this phase), treated the analyst with less deference, and began to report dreams in which John was depicted as a strong and integrated man.

These final phase transference phenomena were reflected in his extra therapy experiences as well. It was during this time that John began a successful business of his own, embarked on a relationship with a woman he was ultimately going to marry, and began work on the novel he spoke about since the beginning of his treatment.

It was 2 months into this phase that John decided to terminate the treatment 6 months later.

THE CASE OF SARA²

When Sara first came into treatment she complained of feeling empty and resentful and was concerned that she was "not perfect yet." She was upset by the deterioration of her relationships with her parents as well as her live-in boyfriend. Sara was a 19-year-old intelligent college student, but was barely passing. The patient was unusually attractive, seductive, and vivacious despite her being overweight. Sara was reared in an upper middle-class Jewish family who lived in a nearby suburb and was emotionally and financially dependent upon her family.

Before deciding to start treatment, she and her father had had an angry scene in which slaps and obscene words were exchanged. Physical as well as

²The author is grateful to Dr. Bonnie Eggine, who contributed this clinical material. The author served as Dr. Eggine's supervisor on this case.

verbal fighting was not unusual in this family as there had been continuous arguments since Sara's adolescence, which sometimes resulted in beatings inflicted by her father. More recently the arguments focused around Sara's living arrangement with her boyfriend who was not Jewish and with her repeated failure to live up to the image of the perfect daughter in a perfect family. The father told Sara that if she was going to be his daughter, she had to "look right and do right for him in the town." Little emotional support was provided by the mother who was described by the patient as cool and indifferent. "She's just a blob. I have no idea what she feels or thinks." The patient feared that her family's financial support was contingent upon her "being a good girl" and that it was only a matter of time before they cut her off.

Sara was not only enraged with her family but equally angry with her boyfriend. He was expected to not only constantly reassure her that she was perfect, but he was also expected to participate in helping her achieve perfection. In relation to the latter issue, her recent conflicts with her boyfriend centered around his failure to keep his agreement with her to limit her binge eating, the abuse of laxatives, smoking, and so forth. In addition, since her boyfriend graduated from college and obtained a time-consuming job, he was devoting less time to her, causing Sara to complain that she was turning into a "glorified housewife, waiting around for him to come home and be with me." Sara stated that her way of getting back at him was to take care of the housework only minimally and to get fat. At one point, she became so angry at him for not being home that she called his employer without the boyfriend's knowledge to suggest ways to make the office more efficient so that he would be able to leave on time each evening. The relationship was fraught with repeated arguments and threats to leave. After a few months of therapy, Sara broke off with her boyfriend and started dating other men.

During the earliest phases of treatment, the patient presented an ongoing monologue of recent life events oblivious to the comments of the therapist and repeatedly asked not to be interrupted until finished. Attempts to focus on a theme were skirted and the sessions felt chaotic. Kernberg's (1975) image of the narcissistic exploitation of others, as if the patient were squeezing a lemon and repeatedly dropping and discarding the sour remains (p. 233), consistently came to mind as the therapist's feelings of impotence increased. Despite the efforts of the patient to the contrary, the analyst focused on the patient's resistance to hearing the former's interventions, or even recognizing her existence in the room. Because of this focus, the patient was gradually able to express her fears that an exploration of issues would indicate the patient's lack of substance and her insignificance. As Sara stated, "When you get past all the barriers, all we are left with is a microscope focused on an ant. And I don't like that you're holding the microscope and I'm the ant, so absolutely vulnerable and insignificant."

The therapy often focused on Sara's feelings about her sexuality. However, this did not seem to be a sexuality which was Oedipally based but rather had more to do with pathological narcissistic themes. Sexuality was used by Sara as confirmation that she was a seductive, desirable woman. Sara confessed that she was frightened of the power of men, fearing that she might be injured by them. Although her sexual behavior was promiscuous, it became clear that the patient was inorgasmic. Most of Sara's contacts were superficial. She flirted continuously to confirm her worthiness, desirability, and power over men. Men were presented in the therapy as interchangeable objects to be manipulated so as to appreciate her. Women were viewed as either competitors who invoked envy because they might be more physically attractive than she, or as objects deserving contempt and ridicule. These issues are depicted in the patient's associations related to her menses.

Sara began by stating how happy and peaceful the onset of her menses made her feel; she felt "clean and pure again." She had "outsmarted Mother Nature by washing the past month away and getting the bad parts out." When questioned about this, Sara revealed that her menses aided in purging the traces of the men that she had sex with in the past month.

I can now throw them away. . . . I get rid of men in a bloody way. Blood always brings to mind pain and hurt. It's almost like I'm killing them off and hurting them. It's a revenge but only in symbol. It's like the story of *Carrie* [a popular horror movie playing at the time]. Carrie was rejected by everyone so she destroys the prom with her kinetic powers. What stood out for me was her power. That's tied up with blood too. Her revenge is destruction.

Sara maintained a friendly relationship with each of her lovers during the previous month in case she got pregnant and needed them to stand by her during an abortion. Sara's sexual involvement with men was necessary as an affirmation of her attractiveness and worthiness. This was highly conflictual because she felt powerless and devalued in relationships particularly with men. Her retaliation was the monthly symbolic destruction of the men with whom she was involved and to whom she felt vulnerable.

The process of symbolic cleansing was also apparent in her patterns of bingeing and purging with food and laxatives. An aspect of her idealized self-image included having a perfect body. Therefore, she consistently became involved in a cycle of dieting, bingeing, and purging, followed by a sense of shame and remorse. Frequently the purging followed real or imagined fluctuations from an idealized image of self to a devalued one. The purging was analogous to her menses because it gave her a new chance at perfection.

As therapy progressed, this cyclical pattern of idealization-devaluation of both self and others were confronted, interpreted, and gradually modified allowing the patient to move toward a more central position between these polarities. The patient began to become aware that her wish for perfection

was not only an impossible goal but one that was contributing to her self-defeating cyclical behavior and her general feeling of misery. Deviations from perfection would no longer plunge the patient into feeling worthless.

The transference patterns gradually shifted from those characteristic of the patient viewing the analyst as a potential violator of a vulnerable personality structure to be warded off at all cost, toward a perception of the analyst as a possibly emotionally nourishing figure who could acknowledge the patient's lack of perfection and yet accept her.

A confirmation of analytic progress was the patient's new ability to internalize the experience of being taken care of by the analyst. As the patient's characterological need to resist penetration by the analyst yielded to interpretation, Sara began to have and report (first in a shameful way and then more comfortably) soothing dialogues with herself in times of stress. The patient stated that this was the first time in her life that she could remember being able to comfort herself.

This shift in internal object relations was also expressed in the reduction of symptoms and in her life generally. As Sara stated, "I don't want junk food or junk men any more. I can feed myself now better than that."

DISCUSSION OF CASES

Although both John and Sara fulfilled the diagnostic criteria for narcissistic personality disorders as described by Kohut (1977) and Kernberg (1975) as well as in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* (American Psychiatric Association, 1980), it is clear that these patients represent two forms of narcissism with important clinical implications. As one can judge from the case material presented, there is a sharp difference between the two patients on the relative predominance of aggression in the patient's history, object relations, and transference. In the case of John, the patient's experiences were more marked by superficiality and lack of contact than aggressive material. This was particularly true in the transference. It was not until the termination phase, that aggressive material began to emerge, manifested most strongly in the dream of his argument with another man. John's history points to data concerning significant disappointments with his parents for not being available to him. It is striking that, although he felt his parents were not fit to be parents, he never remembered being angry with them or even they with him. In his extratherapeutic object relationships, particularly in his relationships with women with whom he had one-night stands, John described his feelings about these partners as nonexistent. It was clearly an exploitative relationship, John getting confirmation of his sexual identity through these macho conquests. The primary motivation was self-confirmation, not aggression directed toward his partners.

This of course is not characteristic of the case of Sara where history, object relations, and transference are dominated by aggressive material. In her history is the combative, often physically abusive relationship with her father. In her object relationships outside the treatment, is her wish each month to "get rid of men in a bloody way, to kill them in symbol." In the transference, particularly in the beginning phases of the analysis, is the patient's aggressive need to keep the analyst away, not allowing the analyst to speak, demanding that the analyst not interrupt the patient's free associations, and so forth. Sara's wish is to stay involved with the analyst but not in any way that may expose the patient to who she feels she really is. Thus she develops an abrasive and resistant style of handling the treatment relationship.

Of interest also is the difference between the two patients in their reaction to the analyst's empathic interventions. In John's case, the analyst's empathic mirroring, in the beginning phase, and the analyst's allowing the patient to idealize the analyst in the middle phase were requirements of the analysis. When John experienced the analyst's empathy, the patient became tranquil. Often, in fact, the patient described the experience of the analysis as "being in perfect harmony, perfectly tuned instruments." The patient seemed to crave and delight in the experience of having another person focus on him and understand his phenomenological experience.

This was not the case in the analysis of Sara. Sara not only defended against maintaining contact with the analyst, but particularly defended against initiating empathic contact. Any true understanding of the patient would expose her "badness, lack of concern for others . . . what I have been trying to cover up. . . . I just wanted you to sit there, not bother me and not look too carefully." The analyst's empathy had to be defended against as a way to maintain her self-image too vulnerable to withstand interest, scrutiny, and understanding.

The countertransferences characteristic of the two analyses also demonstrated significant divergencies. In the analysis of John, the analyst's major preconscious fantasy about the patient was that John was a teenage son who was shaken by experiences he had in the world and who needed solid paternal guidance to consolidate a coherent self-image and particularly his masculine identity. This countertransference makes it relatively easy to provide John with a consistent empathic environment as Kohut (1971, 1977, 1984) and Kohut and Wolf (1978) described the stance of the analyst.

The analysis of Sara was characterized by a different countertransference. Often the analyst felt used, exploited, and superfluous to the patient and impotent. These are reactions characteristic of working with a resistant patient. If the analyst offered an empathic environment as described by Kohut, it would have to be forced by a playing of a role. It probably would have been experienced by the patient as confirming her conviction that, "all people are as big a bunch of phonies as I am." Given the picture that emerges of this pa-

tient, the most “empathic” way of intervening with her was to consistently confront her with her need to keep the analyst at a distance.

TREATMENT IMPLICATIONS

The differentiation of the two forms of narcissism is extremely important given the radically different treatment that is warranted in each case. Therefore, it is crucial that the practicing psychoanalyst learn ways by which he or she can distinguish between these two types of narcissistic patients. There are three major clinical cues that one can use to make this important distinction. They are (a) the way in which the patient expresses aggressive material in relation to his or her history, transference, and extratherapeutic object relationships, (b) the patient’s response to empathic interventions offered by the analyst, and (c) the analyst’s countertransference reaction to functioning as an “audience” or “mirror” in the analysis.

These two theories of narcissism describe these patients in a different way on the issue of aggression. Although there has been a great deal of discussion concerning the differences of opinion on this question, the debate sometimes regresses to a discussion of which theoretician has more flaws in his character—the proponents of Kernberg claiming that Kohut is not comfortable with his own aggression; the Kohut proponents claiming that Kernberg has a need to blame the patient. When one grasps that these theories are focusing on different types of narcissistic patients, the issue is more adequately addressed. Those patients whose narcissism is a result of a developmental arrest (à la Kohut) express aggression in a different way than those whose narcissism is a result of an instinctual conflict. In the former case, the narcissistic patient seems more innocent than aggressive; in the latter case, the patient and the patient’s life is dominated by aggression. This clinically useful distinction is demonstrated in the difference between John and Sara in the material presented. It is important that the analyst keep in mind that a patient’s aggressive stance might be a defense against other feelings and wishes and conversely, that a patient’s innocence might be a defense against his or her aggression. Yet, we believe that when the analyst takes into account all three factors of history, transference, and object relationships in combination with other clues to be described, one can learn much from assessing the patient’s level of aggression.

Another clue useful to the practicing psychoanalyst is the differential reactions of these patients to empathic interventions by the analyst. Those patients whose narcissism is a result of a developmental arrest seem to crave and become more peaceful within the analysis when the analyst is in empathic connection with him or her (i.e., when the analyst’s interventions harmonically resonate with the patient’s experience). There is a feeling in the room of

tranquil union. This is not the predominant feeling when treating a patient who is more characteristic of those described by Kernberg. Frequently, these patients respond to the analyst's empathy with contempt. Stolorow and Lachmann (1978) made the point that it is the wiser plan to respond to a narcissistic patient with empathic interventions while the analysis is in the beginning stages. For, in this case,

to interpret a defense as a developmental arrest may make the analyst appear at least too benign or at most pollyanish . . . It may be referred to as a "technical error" as compared with the less forgivable "error in humanity" which comes about from the analyst's failure to acknowledge the validity of a developmental step by dismissing it solely as an aspect of the patient's pathological defenses. (p. 97)

I feel this is a clinically useful point but in addition, because of the differential reactions of these two types of narcissistic patients, we have observed that empathic interventions can also be useful as a diagnostic tool helpful in making this therapeutically significant distinction.

The third point involves the use of the analyst's countertransference in the analysis of the narcissistic patient as a tool helpful in making the distinction between the two forms of this disorder. It has been our experience that, when an analyst is treating a patient whose narcissism is a product of a developmental arrest (Kohut & Wolf, 1978) the analyst feels comfortable in his or her functioning in the role of an "audience" to, and a "mirror" of, the patient. Although, the patient is reacting to the analyst only as a self-object (i.e., only minimally perceiving the analyst as a separate person), with these patients, there is a sense that he or she needs this, and the role is comfortable. This is not the case with the narcissistic patient whose pathology is a result of an instinctual conflict (Kernberg, 1975). To these patients, the role of mirror often is experienced by the analyst as superficial, artificial, deceptive, hypocritical, and therefore extremely uncomfortable. Kernberg (1975) described the transference with the narcissistic patient as the patient "merely tolerating the analyst's satellite existence" (p. 291). It is this transference attitude that creates the discomfort with the "audience" or "mirror" role and causes the truly attuned analyst to let empathic interventions yield to a more confrontative and interpretive technique.

As is true of most technical issues that arise in psychoanalytic treatment, our choice of interventions follow our conception, conscious, preconscious, and unconscious, of the patient. Yet, in the area of narcissism there has been a particular challenge (i.e., to be able to put aside our strong theoretical and political alliances). This will make it possible for us to truly see the patient for who the patient is and treat him or her in a way that is consistent with this fresh conception (i.e., in a way that will lead ultimately to more consistent

psychoanalytic success with these patients who seek treatment in increasing numbers).

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