The Narcissistic Transference as a Resistance

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Freud felt that fixation at, or severe regression to, infantile levels of functioning could not be helped by psychoanalysis. If patients had not reached the stage of clear delineation of object and self, they could not develop a transference neurosis. However, in the past decade the intensive study of early infancy has brought increased understanding of what is required for age-appropriate maturation in the pre-oedipal period. It is now felt that with the encouragement of a narcissistic transference and a treatment planned to resolve the resistances of this period, a corrective experience can be provided to facilitate maturational processes. Growth to object relationship can then be achieved.

Understanding patients, their behavior, their symbolic and verbal communications, requires a knowledge of the libidinal levels of their functioning and the object-ego state of their relationships. In his paper "On Narcissism" (1914), Freud states that primary narcissism is the libidinal cathexis of the self between the phases of autoeroticism and object love. He explains that the isolated sexual instincts have come together into a single whole, taking as object the infant's own ego, a narcissistic organization never thereafter wholly abandoned even after external objects are cathected with libido in a constant way. This is part of normal development.

In the autoerotic stage independent parts of the body are used for tension discharge, functioning on the pleasure-unpleasure principle.

Such discharge tends to be reflexive. It is the mother's support and care of her child that leads to narcissism, with its beginning ego organization and developing perception of body image.

Annie Reich (1960) defines narcissism as

> libidinal cathexis of the self, in contrast to object cathexis. . . . it becomes pathologic only . . . when the balance between object cathexis and self cathexis has become disturbed, and objects are cathected insufficiently or not at all; . . . infantile narcissism consists of cathexis of the self at a time of incomplete ego differentiation and insufficient delimitation of self and object world. [p. 216]

Spotnitz (1967b.) attributes the pathological narcissistic defense

> to the disorganizing influence of unconscious aggressive impulses. The defense is understood to be a primitive mental structure, set up in the undifferentiated stage of emotional development, which interfered with the completion of maturational sequences. . . . It is reasonable to assume that the aggressive impulsivity was mobilized by frustration. . . . frustration-aggression presents itself as the central problem because of the pattern that was set up in early life to deal with impulsivity. [p. 274]

In pathological narcissism the person suffers disturbed relationships, poor development of sexual identity and isolation. Inadequate means of discharging aggression always basically interferes with the maturational process. In infancy tension is discharged in motor activity and against one's own body, as in sucking, biting, and scratching. Gradually aggression * is directed to the outer world. With psychic growth, important modifications take place—e.g., partially neutralized sexual and aggressive energy is diverted to ego and superego formation, and aggression is further bound through fusion with libidinal urges (Searles, 1965). In each successive libidinal phase there is an admixture of libidinal and aggressive energy. Where libidinal development is faulty, however, the result is inadequate fusion. Regression also brings defusion, creating the problem of primitive aggressive impulsivity.

Inadequate means of discharging aggression and defective maturation go hand in hand. They characterize the borderline group

* There is an excellent account of the aggressive instincts in Glover (1949).

generally—addicts, perverts, impulse-driven individuals. Pathological narcissistic defenses are numerous: they may be self-love to cloak self-hatred (Spotnitz, 1967b), the destruction of mental functioning to protect the external object, withdrawal, feelings of deadness, rage to defend against feelings of helplessness and dependency, omnipotent feelings to compensate for feelings of inadequacy and lowered self-esteem, and impulsive sexual activity as a screen against sexual castration anxiety and homosexuality.

THE NARCISSISTIC TRANSFERENCE

While words may be used early in the first year, language itself gains emotional significance only with maturation. Such significance is lacking with the narcissistic person. Thus the basic approaches of free association and interpretation used in the classical analysis of neurotics are undesirable with the preoedipal patient. He is already overconcerned with his own feelings and unconscious perceptions. It is important that his ego remain reality-oriented. Since he is fixated at or regressed to the preverbal state, interpretation can induce a sense of unreality, can increase confusion, and may be experienced as an attack.

An approach is called for that meets the patient within his own known emotional experience. Physically, organ transplants are in danger of being rejected as foreign bodies; psychologically, if such rejection is to be avoided, the analyst must become more powerfully cathected than was the preverbal mother. A narcissistic transference must develop in order to reactivate the chaotic, confused, undifferentiated feelings and impulses of early life. A corrective analytic experience can thus set the patient on the road to maturation.

Talking helps to establish the transference. It serves an integrative function, strengthening and organizing the ego, which is then better able to test reality. Verbalization also acts as a means of tension discharge. When impulses are inhibited in the process of talking, feelings manifest themselves and intellectual processes are set in motion. Frequently the patient and the analyst do not know the meaning of what is said. No matter! Eventually things become clear.

To start with, if the patient can verbalize even minimally, there

is progress in treatment. Gradually he will be educated from the nonverbal, indirect types of communication typical of the narcissistic stage to direct, adult language characteristic of the mature person.

Many of the analytic approaches echo that of the "good-enough mother." Object-oriented questions are constantly directed to the infant or toddler: "Shall Mommy get baby's blanket?" "Is the bottle too warm?" "Where's the cuddly white bunny?"

Mirroring, too, is part of the daily routine: "This is mommy's hand; this is baby's hand." Games of peek-a-boo and clap-hands are mirroring experiences that serve educational purposes and are models for identification. Children learn to understand their own feelings partly through the descriptions they hear; for example, "Bobby is sleepy (or hungry or angry)." It is desirable that parents show acceptance of their own feelings also by stating what they are. Thus healthy models for the child's identification are presented.

And of course the parent gradually educates the child to impulse control: "You can't throw that, but you can tell me you want to; you can say you are very, very angry." It conveys a comforting sense of security when a child is told clearly what is expected of him and knows he can rely on his parents to protect him until he matures into his own inner control.

A mother complained that her two-and-one-half-year-old son would hit her. Her analyst suggested that the child be told he could stamp his feet and say he was angry—but he could not hit her. The amazed mother later reported how the boy approached her, hands clutched behind his back. He stamped and jumped up and down, at the same time wailing, "I want to hit you—but I won't, I won't!"

The analyst, too, mirrors, describes feelings, and offers himself as a model for identification. In addition, while he is working to free fixated patterns so they may assume more mature forms, he respects the adult within whom the infantile patterns reside. The analyst shifts to meet communications with the grown-up when the mature ego takes over. A young woman had been bitterly complaining for some period about feelings of inadequacy, an unsatisfactory social life, and her conviction that things would never change. She mentioned some innovative teaching approaches she was trying. When I asked about these, it became obvious that she was using truly creative methods and I suggested she write about her ideas.

There followed an interesting exchange about the needs of children. This marked an increase in self-esteem with a positive influence on the therapeutic process.

The problem of inadequate channels for discharging rage is a special one for the schizophrenic who has to struggle against acting out particularly powerful aggressive impulses. He psychically kills himself to avoid attacking the object. One patient commented:

> "Occasionally if I feel rage I come close to fainting. I think if I really felt my anger I would simply explode into a million fragments like an atom that could never be put together again."
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> "People need practice in hating without guilt or fear," states another. [Searles, 1965]

In the following account, a patient eliminated me with a torrent of words; I mirrored this elimination with silence:

> Mr. L blocked me out by failing to contact me as he talked in a continuous, pressured way. He described his unhappy and deprived childhood, the hospitalization of his mother after a breakdown when he was nine, and his father's subsequent hospitalization with a number of physical illnesses. He kept banging his head on the pillow as he described his miserable life in an orphanage. It was clear from his inability to contact me that he required distance to provide urgently needed insulation.
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> By the end of the second year of treatment he felt secure in his ability to remain on the couch. I had modeled for him a quiet, controlled person to identify with, had mirrored his distance, and had accepted him with all his difficulties. When to an infrequently asked question I responded, "How should I answer that?" and the patient exploded in words, the resistance finally had been resolved!
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> He hurled hostile feelings and thoughts at me for half the session. I should be tortured, dismembered, my nipples cut off, my nails pulled out, my eyes gouged. As the hour ended, Mr. L stood up, red-faced, averting his gaze. I said, "Your next session is. . . ."
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> When he came in for his next session, looking at me anxiously, I commented on what a fine job he had done in expressing all his feelings. He sighed with relief at my reaction.

This interview marked an important change. As the resistance to expressing rage continued to resolve, the patient contacted the analyst more freely. Positive narcissistic transference developed with ex-

pressions of loving and tender feelings, and the road to object cathexis, both positive and negative, lay ahead.

While aggression is often verbalized explosively, the negative narcissistic transference also shows itself in milder forms. A patient said she felt awful, had a pain in her chest; maybe she had a heart attack coming. When I said I'd be glad to call an ambulance, she turned to look at me critically and said, "You look awful in black; makes me think of a funeral." When I asked, "Is it my funeral?" she laughed gleefully.

A frequent resistance to communication is unwillingness to accept and verbalize feelings of shame, inadequacy, failure, rage, confusion, rejection, sadness, helplessness, and dependency. The distorted assumption is that healthy people experience only feelings of happiness, success, joy, love, independence, and power. It is a great relief when the patient learns that so-called "bad" feelings are normal, that all feelings are part of the human condition. As their resistance to recalling and verbalizing their "undesirable" feelings resolves, patients find such feelings are less powerful and more easily accepted. In this regard group therapy and paradigmatic techniques are very helpful (Nelson, 1962).

Some patients' resistance is due to the primitive belief that thoughts and words automatically lead to action. One teacher struggled to speak, saying she could not. I replied that it was not necessary and asked about school. *(Joining.)* Should I read to her, I asked? *(Feeding for identification.)* She assented, but after two or three minutes she burst out: "I want to tell you I'm angry with you. I've been thinking of ways to do you in—put a bomb under your chair and blow you up! Now I feel terrible. I guess words will really kill you; you will disappear; it worries me to think you won't be here. . . ." I said that I was proud of the fine job she was doing, that I had not vanished—words would not blow me away. Miss B laughed with relief and pleasure.

Many of my patients have to be taught to ask questions. They feel worthless and they deserve nothing, or they will not get what they want and will be rejected. They have to be educated to ask for what they want, learn they will sometimes be gratified, and sometimes will have to tolerate the frustration of rejection.

The following is a second interview with Miss L, a new patient, in which a treatment-destructive resistance emerged. In it I accept

all criticisms of myself and my behavior and—while stating she may leave in order to reduce the pressure for action—explore why I am behaving unsatisfactorily, how I should be acting, and what I should be saying:

> Miss L complained at length of her employer: he disregarded her lunch hours, assumed she would stay overtime whenever he asked her to, and was generally insensitive. She felt imposed upon, but what could she do?
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> When I asked if it would be possible to discuss this problem frankly, Miss L began to weep bitterly. After a brief period I wondered how my question had upset her. She said, "Oh, this will be another failure; I can't find the right analyst." I agreed I might be wrong for her, but could she describe the kind of analyst she needed; I would be glad to refer her if I understood the qualifications required.
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> "I want one," she said, "who would be in tune with me, would have empathy, and understand what I have in mind without my saying it." She was told that would be pleasant, it was an experience we all had with our mothers in our infancy, but could one depend on that kind of reaction as one grew older? Miss L responded with animation that she had felt intuitive understanding from others, and had herself acted in this way.
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> I agreed we all had such experiences occasionally, but they were comparatively rare. At least if one asked for what one wanted, there was a chance of getting it; anyway one had the satisfaction of knowing one had asked.
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> She was stubbornly silent, then she commented, "That's the kind of analyst I would really like." I commented she was free to leave, she could go to a hundred analysts, but not one would cure her; to be cured it was necessary to talk. Of course, patients need help in overcoming a reluctance to talk; such help I would be glad to give, but there was no therapy based on empathy alone.
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> Miss L said reflectively, "Perhaps that's why I've had so many therapists for such brief periods. I've also had a number of short-lived friendships. It's all or nothing with me." She agreed to continue therapy.

One patient was treated with many reflective techniques in order to help reverse self-hatred and direct it outward onto the analyst. In the course of doing this, I would speak at length, supplying

psychological food, since she had been seriously deprived orally. As her resistances to expressing anger were resolved and I became a real object, eventually, she said, "You are helping me a lot. More than anyone else you are getting me to like myself. Because I feel you accept me even when I'm rotten, I have to accept myself and like myself—and that's very good."

Some patients need to have a "baby-sitting" experience during which they are looked upon with approval. This is analogous to the early period in life when babies experience a kind of "adoration" from their mothers which acts like the sun in helping them to grow.

> Mark, an adolescent of twelve, diagnosed as schizophrenic, came for two solid years and never initiated communication, although he occasionally responded to questions. He happily built all kinds of ship and plane models, content with my acceptance and interest.
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> At home his mother had been constantly critical and belittling. She described a frightening and hateful world, presented goals impossible to achieve, such as becoming a Supreme Court Justice or an international lawyer. Her behavior made it impossible for him to function academically. Fortunately she ignored his excellent mechanical ability and he was free to develop this on his own. I admired his constructions, which were truly excellent. I was serving the same function as the mother who approves of and accepts her infant; he needs this kind of attention to develop appropriate narcissistic self-cathexis.
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> Although he did not speak in the sessions, his performance in the outer world improved both in school and in relationships with his peers. At the end of two years he did start to talk, and he later revealed how important this period of "baby-sitting" had been.

Mark, like many other patients, really did not know what his feelings were. Some patients show discomfort by talking of unhappy things or complaining of body pains instead of feeling feelings as the treatment situation transports them to preverbal levels. When Mark would describe a situation in which anger might have been the appropriate response, I would ask if he did not feel angry, or would comment that such situations would have made some boys furious. He would respond that he was never angry. It took many months of questioning and offering modes of rage discharge before this resistance was resolved and fury could finally be expressed.

Impulsive acting-out may interfere with self-knowledge. It is necessary to inhibit action in order to develop feelings, and the analyst, at an appropriate time, may suggest that for the sake of the therapy certain behavior be given up for a time. One patient had no energy for work as he indulged in continual sexual acting-out. Finally he decided to cooperate and abstain.

For months he had boasted of his sexual prowess and his endless conquests. As the result of abstinence he became aware of extreme fear. As this became a transference fear, it was questioned and explored: How was the analyst a danger? What would the analyst do? etc. After some weeks this resistance resolved. He burst out with verbal expression of a real hatred of women: they threatened him with castration unless he would gratify their insatiable sexual demands. He then recalled early experiences with a seductive and dominating mother. Sexual acting-out is frequently a defense against pregenital anxiety.

In the process of cure, the resolution of resistances leads to progressive communication. The patient has to learn to enjoy the expression of all thoughts, feelings, and memories—even when the content is of unhappy events—and take pleasure from doing his job as analysand. The analytic situation has to become a pleasant experience for both the analyst and the patient.

There are patients who make the analytic sessions tortured, unhappy, miserable ones. This is a resistance which stems from a thwarted experience of being loved in their early years. Such patients must be educated to change from communicating exclusively with negative feelings to progressive communication which includes both positive and negative feelings. This "torture" resistance presents a powerful block against analytic progress and cure. These patients require a good deal of verbal nourishment.

> Mr. T, a lawyer of forty-five, had had three long analyses over a period of twenty-five years. There was not an hour that was not filled with rage as he attacked previous analysts and myself; his friends and family were no good; relationships with them were meaningless; his clients were horrible. He practically seethed. There was good reason for this. His father had been distant, his mother a nagging, furious, seductive woman. His continuous resistance was one of negativism and complaint.

I pointed out that this negativism and complaint—a status quo resistance—would not cure him, that there was a need for an ongoing account of all his experiences, past and present. The misery continued. He stated that there was a constant battle going on in his head. He wanted to make money. He had to understand everything himself, do everything himself, cure himself. He could do this if he understood things and liked himself.

I told him that he had not been able to accomplish this in twenty-five years, that the only way to cure was through talk and my help. I wanted to cure him and have a pleasant time with him. He sneered at me: "How could I have a happy time with you when life is so miserable outside?" He reported dreams in which he had to defend his mother; he was a criminal; he was murdered.

I explained that I was making no demands on him; he did not have to defend me or make money for me. Anything positive he wanted for himself was fine; all I wanted to do here was talk and have a pleasant time. He challenged me: Wasn't he supposed to put everything in words, free associate? I told him, "You are to talk only of pleasant things. Life is difficult enough in reality; I want you to talk of pleasant, happy, successful things."

As he talked of his childhood, it was pathetic to hear him say that up until age two he had been a "good" boy, but then, with the birth of a sister, suddenly he had become a "bad" boy. Then I commented that I would have told him he was a good boy all along if I had been his mother; that he was extremely bright and had not reached his full potential, which he complained of constantly, because he had been deprived. But I wanted to cure him; I wanted to have a pleasant time with him.

As I continued to accept him, his rage resistance began to resolve and he revealed his fear and anxiety as well as his intense desire to be sheltered and cared for. I would ask him how I should care for him in the session. Once he expressed with great urgency a powerful desire for total dependency. I provided psychological support by accepting his wish, saying I understood it; that his wife could gratify a great many of his needs; that I could give him only words which I would be glad to provide.

He began to examine his behavior more objectively, to say he wished he did not have to react impulsively but could quietly go on with his life; he saw clearly that he was constantly looking for love and approval and exploding when it was not immediately forthcoming.

> One day, after some years of treatment, he came in quietly and spent the whole hour talking about an interesting approach he had thought of in connection with a legal problem. It was stimulating, he communicated in an adult and pleasant way. I told him he had functioned extremely well, that I had enjoyed the hour greatly—as indeed I had.

Many kinds of interventions were used to resolve Mr. T's powerful negative narcissistic transference resistance, which he expressed by saying that he had to cure himself, understand everything by himself, and love himself, that he did not trust me and never would. At times I talked to him at length, correcting distortions that he could cure himself by understanding and by loving himself. I joined him in stating he did not have to trust me at all but could talk about his past and present life, and I assured him of my continuing and reliable interest by stating over and over in many ways that I wanted to help him.

Improvement is not due to the expression of any one feeling. It is a maturational process. Energy formerly invested and discharged in impulsivity, archaic patterns of functioning, primitive aggression and pathologic defenses is gradually released and made available for more adequate, more desirable psychological organization. There is a general maturing and redistribution of energy in the intrapsychic structure. There is decreased tension and frustration-aggression is handled more constructively. All this produces an increased ability to lead a satisfactory life.

SUMMARY

This paper deals with the narcissistic or pre-oedipal transference. The analyst facilitates the development of the narcissistic transference by functioning as an ego-syntonic object, with which the patient feels as one. This is typical of the symbiotic state. As the narcissistic transference becomes a resistance, appropriate interventions are used. When these interventions are successful, the experiential history leading to the development of this particular resistance is reconstructed. Suitable interventions may take the form of communications similar to those used by the mature mother in early mother-child relationships.

Some examples were given illustrating frequently occurring types of resistances encountered with narcissistic patients, and how they may be resolved. With successful treatment the narcissistic individual matures to the state of object relationship. He then perceives and feels himself as a separate person with feelings of his own.

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