THE NARCISSISTIC TRANSFERRENE

Through its concern with the development of therapeutic responses to narcissistic patterns, modern psychoanalysis has opened the field of psychoanalysis to research and investigation into genetic, constitutional, and early environmental factors in personality development. But to develop a therapeutic response to the preverbal patient, it was necessary to explore what it meant to hide behind the narcissistic defense.

The narcissistic personality was poorly understood when these investigations began. The traditional view that the patient must have a sufficiently mature ego with which the analyst can establish a working alliance was abandoned when modern analysts became interested in studying persons with preoedipal, preverbal disorders to determine how they can be treated and their illnesses reversed.

Much of the modern analyst's time and attention has been devoted to the methods of treating narcis-
sism. To call modern psychoanalysis a new approach to narcissism seems fitting because it is in this area that the discipline has made its major contributions to the body of knowledge known as psychoanalysis. Working with individuals with fixations in the first year or two of life has led to the development of new techniques for the treatment of preverbal disorders.

The idea was new that analytic treatment of the preverbal patient could be based on Freud’s concepts of transference and resistance and that, through transference, the patient could re-experience the traumas of the first two years of life as well as later verbal conflicts. Although traditional analysis had proved successful with the hysterias, the phobias, and the compulsions, Freud was unable to modify the interpretive approach to suit the treatment of narcissistic disorders. Despite the numerous clues he gave his colleagues in his dreams and other disguised communications, he never revealed directly the nature of his own preoedipal wishes. As a result, he was unable to deal with the feelings induced in him by paranoid or schizophrenic patients or by other preverbal regressions.

THE NARCISSISTIC DEFENSE

Spotnitz (1969) discovered that the analyst resolves the adult patient’s repetitive self-attacks by changing the flow of destructive impulsivity. When the patient is frustrated, the appropriate way to
discharge his feelings is to put them into words. If he is prevented from doing so when frustrated and feeling deprived by the analyst, he usually bottles up the aggression: in other words, he turns these feelings inward and begins to attack the self. *This is referred to as the narcissistic defense.*

To explain the patient's need to resort to the narcissistic defense, we think of the interpersonal patterns that created pre-ego, prefeeling patterns of discharge. In a regression to this emotional level of development predating language, the patient's communications return to the timeless world of infancy with its lack of temporal and spatial continuity and the inability to predict or anticipate events. When regressed, the narcissistic person does not seem able to distinguish between inner and outer reality. In the words of one patient who got in touch with this process: "I want to kill you to get you out of my head."

The analyst tries to keep in mind that when the patient brings the narcissistic defense into the transference relationship, he is doing it to protect the analyst from his hostility, as he did the mother image, by attacking himself. When a patient tells an analyst that the failures in the analysis are his own fault, not the analyst's, the analyst attempts to redirect the patient's self-attacks and the inward flow of destructiveness if possible. If the analyst provides the proper environment, the patient will re-experience emotional reactions in his relationship with the analyst that resemble those he had at some point in the past.
when his maturation was blocked. To prevent motor discharge when old destructive impulses are aroused in the treatment, each patient returns to his own early adaptive modes, which in the context of the present situation may appear irrational. If the patient can relive that period with the analyst—that is, develop a transference—the analyst may be able to make the appropriate communications that will free the patient to mature.

The patient who is treated while regressed to the first years of life develops a narcissistic transference rather than an object transference. But analysts ask: "Do we want a narcissistic transference to develop?" We do because in a negative, regressed state, the patient may experience the analyst as being like him or part of him. Or the analyst may not exist for him. The syntonic feeling of oneness is a curative one, while the feeling of aloneness, the withdrawn state, is merely protective. Because traces of narcissism remain in everyone, we seek, when beginning treatment, to create an environment that will facilitate a narcissistic transference so that, first, we can work through the patient's narcissistic aggression. The extent to which the patient wards us off and avoids emotional contact tells us the degree to which he is narcissistically fixated. He will gradually increase his contacts with us if we create the appropriate environment. To establish the ego-syntonic atmosphere in which the patient can view us as being like him, or at least as non-threatening and nonjudgmental, modern analysts carefully avoid exposing the patient to any uninvited communication or interpretation. When
the patient feels that he can say and feel things without taking action, his emotional contacts with the analyst will increase. Bringing out whatever narcissism remains in the personality helps the person who has a minimum amount of narcissistic defensiveness to remain in treatment when his impulsiveness surfaces. By not providing the patient with excessive communication, the analyst can maintain the egosyntonic environment necessary to master his patient’s destructive impulses.

Unfortunately, it is difficult for the analyst to remain objective when the patient expresses a narcissistic transference, or later when he attacks ceaselessly the analyst’s faults, pinpointing the sensitive spots in the analyst’s personality and treatment methods. If the patient announces that he is destroying himself, has done terrible things to himself, and is not finished being self-destructive, the analyst’s defenses are usually aroused against induced feelings of hopelessness, isolation, or rage. It is easier to put distance between himself and this unpleasant, provocative patient by thinking, “Poor fellow, he needs my help. Perhaps I should be supportive or gratifying to the patient.” But this approach leads the patient to attack himself even more and increases the analyst’s feeling of hopelessness.

NARCISSISM IN A PHOBIC CASE

The following case, reported by Meadow, revealed a pattern in which a patient who had lived
most of her life behind the manic defense, developed a thin disguise for her narcissism in phobic symptomatology. Barbara presented an interesting combination of phobias and hypomanic defenses used to deal with intolerance of negative affects. Using the manic defense, this patient externalized her badness and was able to turn her destructive impulses against the environment. This enabled her to maintain a relatively comfortable internal state.

Barbara worked as an executive in a large male-dominated firm and devoted enormous amounts of energy to the fight for women's rights. These efforts kept her relatively symptom-free for years. Later, she was an active crusader against injustice. These crusades were a further attempt at stabilization. Eventually, however, because these activities did not satisfy her desire for revenge against the original parent figures, Barbara became more concerned with the evil around her. Her need to distort events into black and white issues intensified the good/bad split, which took on paranoid overtones. Previous therapy had not successfully integrated these good and bad images and the split had occurred when her former therapist, appearing unethical to Barbara, necessitated further defensive measures.

Between the time her first treatment ended and the second began, Barbara's phobic symptomatology appeared. The phobias served to limit her social contacts and apparently protected her from a desire to act on her destructive impulses. The price she paid was to remain in suspended animation and a double
bind. Her longing to be close to others and to be with a much admired person aroused fears that she would lose the protective barrier against past feelings and led to the symptom of agoraphobia, which kept her reclusive. When she did allow herself to approach a personal relationship, she experienced a strong desire to get away from the person and be liberated from the critical feelings that emerged. This resulted in the symptom of claustrophobia.

Barbara considered herself to be an independent woman and felt disdain for her female friends who tolerated unhappy marriages. She would rather be free to enjoy herself than be married; she could sleep as long as she wished, soak in a warm tub as long as she wanted, and have sexual relations when and with whom she wanted, according to her mood. She did not have to "submit" as her married friends did, and best of all, she could avoid the constant bickering that her married friends considered normal. She also enjoyed being free to go wherever and whenever she pleased.

This patient could not tolerate tight-fitting clothing. She had difficulty finding dresses that were bearable; belts were an impossible restriction. She preferred the kind of dress that one can forget about.

In a group, Barbara usually felt tense—as if everyone was "on top of her." Although she did not like to ride in a car too long with another person, long drives alone were tolerable. When she entered treatment for the second time, one of her presenting symptoms was a fear of elevators. The analyst's first
impression was that she was suffering from a phobic reaction—that her symptoms served to ward off feelings of helplessness and dependency—and her basic struggle was to rid herself of attachments that created these feelings. Her history revealed that the desire to rid herself of longings was in the service of object protection. Her claustrophobia, panic about tight-fitting clothing, and fear of small crowded rooms, elevators, and the intensity of marital relations protected her from the narcissistic defense as it is manifested in schizophrenia. She wanted to be free, but the message of her agoraphobia was “I do not want the freedom that I consciously crave; I want to be tied to people, but I cannot tolerate the feelings.”

Analysts have written extensively about the oedipal conflicts expressed in the phobia, so these conflicts will not be detailed here. In fact, these conflicts were not significant in Barbara’s case. Fear of circumscribed events and objects (the phobic reaction), provided adequate protection against total emotional withdrawal, allowing some fluctuations and conflict. A modern psychoanalyst would not attempt to disrupt this defense until the underlying aggression could be discharged sufficiently.

The removal of Barbara’s phobias at the point described here could predictably lead to a more severe regression. Treatment in such cases entails the development of a narcissistic transference in which the patient can be presented with a faithful twin image.

As treatment progressed, Barbara continued to
present her fears. She was concerned with her fear of enclosed and open spaces. Her phobias served precisely the same function that withdrawal serves, but they allowed her to preserve the perceptual and cognitive functions. Rage, not sexuality, was to be avoided. So long as the therapist kept her distance, Barbara did not fear the couch, and by focusing on the content of her phobias and her life, she avoided real closeness during the sessions. When she was tottering on the narrow divide between her fear of closed and open spaces, what surfaced in the session was that being liberated meant freedom from the feelings that relationships aroused in her, and particularly the feeling of helpless rage. In the transference, she revealed her desire to annihilate anyone who aroused in her longings for emotional closeness. Longings made her feel weak, inadequate and helpless. The phobic anxiety was a reaction to reemerging feelings. But loss of closeness aroused the counter phobia that she would find herself in an objectless world; at that point, she wanted to return to closed-in places and to some contact with people. The clausrophobic response appeared when people were overstimulating. Clearly, Barbara was symbolically asking: “Should I enter human relations, get involved, and suffer all the pain of hostile feelings, or should I keep myself safe?”

Barbara arranged her social life so that her male friends appeared on demand. She had a list of three or four current boyfriends, and when she wanted a sexual relationship, she telephoned one of them.
On the oedipal level, Barbara’s sexual arrangements and fear of her sexuality can be considered a compromise, but we are concerned here with the nurturing conflict. Barbara was drawn to a potentially nurturing situation, but she protected herself from it by demeaning the object. The men in her life served two purposes: providing intimate relationships without intimacy and the freedom to back off when closeness threatened. In other words, these men provided partial relationships. Barbara thought of all people, male and female, as mother figures: i.e., her relationships were preoedipal. The phobias served to provide her with controlled mothering that was similar to the infant’s desire to have its mother on call to provide services. The phobia’s deepest disguised message, however, was infantile longing and the wish to destroy or incorporate the object as it was perceived during Barbara’s first year of life.

Barbara’s first adjustment was a mania that worked for her. Later she created phobias that also worked. The symbiotic struggle between self and introject is seen in alternating states of claustrophobia and agoraphobia in which the fear of losing the needed images oscillated with the wish to destroy the unsatisfying image. When her fear of destructive impulses dominated, Barbara became claustrophobic. This type of patient may consciously experience an internal restriction (the counterforce) on the somatic level and express thoughts of the wish for unrestricted freedom.

Phobias are common enough symptoms in
mental hospitals, where we find patients who rip off their clothes or are unable to leave a room or a particular area. These symptoms often appear as part of the schizophrenic picture.

In cases such as Barbara's, the determining factor in the symptomatology and how the patient will play out his interpersonal relations is a result of the way he visualizes the early maternal environment and his feelings about the quality of mothering he received. As he learns to give up old pathways of discharge and differentiate between the self and other, he discovers the rewards of personal relationships.

CONCLUSION

The psyche of the preverbal patient contains a strong libidinal attachment to others and a strong desire for the warmth and closeness that others can provide. This is the kind of closeness one expects during the first year of life—to be held, to be walked, to be rocked, to be talked to, and in general to be soothed. It is these longings that are reactivated in the narcissistic transference. In fact, these longings help the patient decide to protect the significant persons in his life. When he becomes murderously enraged, because of frustration, all that stands between him and his impulses are his libidinal feelings for his mother. In the treatment relationship, the analyst eventually becomes the person with whom the patient must work out and resolve his emotional prob-
lems. Of course, every patient hopes that the analyst will eventually provide the gratification he seeks. But, as analysts, we are interested in training the patient to seek gratification outside the analysis.

The modern analytic view is that the mature personality can experience frustration and object hatred without the necessity of destroying either itself or the other person. In regression, pathways established in infancy may be reactivated when the object does not provide the needed tension-reducing gratification. Thus, the available supply of libido is tied in defensive functions, in the denial of feelings, in attempts to control destructive thoughts and impulses. When these views are applied to the garbled communications of patients, the messages become clearer. We see the attack on the patients’ secondary mental processes when they report their confused states of mind, distort external reality to ward off impressions, and withdraw cathexis from the external world. When frustrated, patients resort to increasingly pathological retreats from their destructive impulsiveness to maintain tolerable levels of tension.

In treating narcissism we have found that patients protect the analyst, deny destructive impulses, and turn destructive impulsiveness against the self. The patient’s need to deny feelings of hate is eventually brought into the transference. Typically, the narcissistic personality chooses to attack a part of itself. The analyst is then confronted with the task of resolving the patient’s repetitive self-attacks. To ana-
lyze the narcissistic resolution of conflict, it is helpful to view the self-destructive reactions as organized responses in which the flow of libidinal and aggressive energy can be understood by studying the organism's early attempts to master tension.