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Further Contributions to the Treatment of Narcissistic Personalities

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This paper continues my earlier studies of the diagnosis and psychoanalytic treatment of a specific constellation of character pathology, that of the narcissistic personality **(Kernberg, 1967)**, **(1970a)**, **(1971a)**. In recent years, a consensus has been gradually developing regarding the definition of this pathological character structure and the indication of psychoanalysis as the treatment of choice **(Jacobson, 1964)**; **(P. Kernberg, 1971)**; **(Kohut, 1966)**, **(1968)**, **(1971)**; **(Rosenfeld, 1964)**; **(Tartakoff, 1966)**; **(E. Ticho, 1970)**; **(van der Waals, 1965)**. However, despite the evolving agreement about the descriptive, clinical characteristics of this constellation, divergent views have developed regarding the underlying metapsychological assumptions and the optimal technical approach within a psychoanalytic modality of treatment. In particular, Kohut's approach to the psychoanalytic treatment of narcissistic personality disorders **(1971)** is very different from the approach I outlined in an earlier paper **(Kernberg, 1970a)**, which is more closely related to the views of Abraham **(1919)**, Jacobson **(1964)**, Riviere **(1936)**, Rosenfeld **(1964)**, Tartakoff **(1966)** and van der Waals **(1965)**. Therefore, in this paper I will focus particularly on those aspects of my approach to the understanding and treatment of narcissistic personalities which highlight agreements and disagreements with Kohut's approach.

CLINICAL CHARACTERISTICS OF THE NARCISSISTIC PERSONALITY AS A SPECIFIC TYPE OF CHARACTER PATHOLOGY

With respect to clinical characteristics, there is agreement between Kohut's view and that of the other authors whom I have mentioned as representing an alternative view and myself. I describe patients with narcissistic personalities as presenting excessive self-absorption usually coinciding with a superficially smooth and effective social adaptation, but with serious distortions in their internal relationships with other people. They present various combinations of intense ambitiousness, grandiose fantasies, feelings of inferiority, and overdependence on external admiration and acclaim. Along with feelings of boredom and emptiness, and continuous search for gratification of strivings for brilliance, wealth, power and beauty, there are serious deficiencies in their capacity to love and to be concerned about others. This lack of capacity for empathic understanding of others often comes as a surprise considering their superficially appropriate social adjustment. Chronic uncertainty and dissatisfaction about themselves, conscious or unconscious exploitiveness and ruthlessness towards others are also characteristics of these patients. Perhaps one difference in my description from that derived from Kohut's work is my stress on the pathological nature of their internalized object relations, regardless of the superficially adaptive behaviour of many of these patients. In addition, I stress the presence of chronic, intense envy, and defences against such envy, particularly devaluation, omnipotent control and narcissistic withdrawal, as major characteristics of their emotional life.

THE RELATIONSHIP OF NARCISSISTIC PERSONALITY TO BORDERLINE CONDITIONS AND THE PSYCHOSES

Regarding this point, important differences exist between my approach and that of Kohut. Kohut differentiates the narcissistic personality disorders from the psychoses and borderline states, but does not make a clear differentiation of 'borderline cases' from schizophrenic psychoses

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(1971p. 18). In my view, however, the defensive organization of narcissistic personalities is both strikingly similar to and different in a specific way from borderline personality organization, which I will outline below. In contrast to Kohut's view, I see important structural differences between borderline personality organization and psychotic structures, and I would not rule out psychoanalysis as the treatment of choice for some borderline conditions.

The similarity of the defensive organization of narcissistic personalities to that of borderline conditions is reflected in the predominance of mechanisms of splitting or primitive dissociation as reflected in the presence of mutually dissociated or split-off ego states. Thus haughty grandiosity, shyness and feeling of inferiority may coexist 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, narcissistic withdrawal and devaluation. From a dynamic viewpoint, pathological condensation of genital and pregenital needs under the overriding influence of pregenital (especially oral) aggression characterizes narcissistic personalities as well as borderline personality organization in general.

In this connexion, it is interesting that Kohut acknowledges the presence of 'conscious but split-off aspects of the grandiosity' **(1971p. 179)** and describes in detail 'the side-by-side existence of disparate personality attitudes in depth' (p. 183), and the analyst's need to relate the central sector of the personality to the split-off sector. In practice, therefore, Kohut acknowledges a defensive organization which is related to splitting as a predominant mechanism, although he does not relate it to particular vicissitudes of the structural development of the ego.

The difference between narcissistic personality structure and borderline personality organization is that in the narcissistic personality there is an integrated, although highly pathological grandiose self, which, as I have suggested earlier **(Kernberg, 1970a)**, reflects a pathological condensation of some aspects of the real self (the 'specialness' of the child reinforced by early experience), the ideal self (the fantasies and self-images of power, wealth, omniscience and beauty which compensated the small child for the experience of severe oral frustration, rage and envy) and the ideal object (the fantasy of an ever-giving, ever-loving and accepting parent, in contrast to the child's experience in reality; a replacement of the devalued real parental object). I am adopting here the term 'grandiose self', suggested by Kohut, because I think it expresses better 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 which is part of the underlying borderline personality organization: it explains the paradox of relatively good ego functioning and surface adaptation in the presence of a predominance of splitting mechanisms, a related constellation of primitive defences, and the lack of integration of object representations of these patients. This pathological, grandiose self is reflected in clinical characteristics which, as mentioned before, mostly coincides with the observations of all the authors mentioned. However, a basic disagreement exists between Kohut's views and mine regarding the origin of this grandiose self, and whether it reflects the fixation of an archaic 'normal' primitive self (Kohut's view), or whether it reflects a pathological structure, clearly different from normal infantile narcissism (my view).

Before examining this difference in views, a special group of patients needs to be mentioned, who, in my opinion, present the clearest illustration of the intimate relationship between borderline personality organization and the development of the pathological grandiose self. I am referring to those narcissistic personalities who, in spite of a clearly narcissistic personality structure, function on what I have called an overt borderline level, i.e. present the nonspecific manifestations of ego weakness characteristic of borderline personality organization, in addition to the generally similar defensive constellation mentioned. These narcissistic patients present severe lack of anxiety tolerance, generalized lack of impulse control, striking absence of sublimatory channelling, primary process thinking clearly noticeable on

psychological tests, and proneness to the development of transference psychosis. In these patients, the pathological narcissistic structure does not provide sufficient integration for effective social functioning, and they usually present a contraindication for analysis (often even for the modified psychoanalytic procedure that I have recommended for most patients with borderline personality organization). These patients characteristically present the repetitive, chronic activation of intense rage reactions linked with ruthless demandingness and depreciatory attacks on the therapist, i.e. 'narcissistic rage'. One also finds such intense outbursts of rage in borderline patients, usually as part of alternating activation of 'all good' and 'all bad' internalized object relations in the transference. However, the relentless nature of this rage, the depreciatory quality which seems to contaminate the entire relationship with the therapist, evolves as a complete devaluation and deterioration of all the potentially good aspects of the relationship for extended periods of time so that the continuity of treatment is threatened.

The following case illustrates this development. A patient with a rather typical narcissistic personality, a single woman in her early twenties, came to a psychiatric hospital after gradual breakdown of school performance and social relations, and sexual promiscuity characterized by her tendency to drop any man whom she could not completely control. Both her parents were rather narcissistic and withdrawn, and presented some mild antisocial trends. An older sister was in treatment for antisocial tendencies. Her lack of significant involvement with others started in nursery school, was later smoothed over by the patient's joining mother's efforts to control and manipulate their social environment, and culminated in the chaos of the patient's social life, work, and sexual involvements. After two months of treatment, in which subtle derogation of the therapist and all treatment staff and ongoing manipulation and splitting of staff were predominant features, the therapist absented himself for a week. The patient then changed her controlled derogation into overt anger and rage, and in spite of the efforts of staff managed to convince her parents to take her out of treatment two months later. Throughout this time, the sessions were characterized by ongoing attacks and derogation of the therapist, in short, by narcissistic rage, which could not be treated by an expressive approach.

Narcissistic personalities whose defences against primitive object relationships related to conflicts around oral aggression have been substantially worked through in analysis may present such rage reaction in the transference at advanced stages of treatment. At times, the transformation of a previously bland, mostly indifferent, apparently well-controlled narcissistic personality into such an openly and chronically raging person may be quite striking. However, it usually can be worked through in more advanced stages of the treatment, and may represent an important move forward. In this connexion, careful analysis of the history of such patients often reveals temper tantrums and aggressive outbursts which occurred in the past when they were frustrated, particularly under conditions when they felt they should be securely in control of the situation, and later again in life, when they felt superior to or in control of those against whom their rage was directed.

The situation, therefore, is different in cases where narcissistic rage appears as part of the initial clinical constellation (in narcissistic personalities functioning on an overtly borderline level), as compared to cases where it develops as part of the resolution of pathological narcissism at later stages of the treatment. Early and open expression of narcissistic rage represents a serious risk for the treatment. This is particularly true in narcissistic personalities functioning on a borderline level who present antisocial features or a sexual deviation with strong sadistic components, such as open physical violence toward the objects of their sexual exploits. Also, adolescents with narcissistic personality structure and antisocial behaviour frequently show such rage reactions.

For narcissistic personalities functioning on an overt borderline level (particularly the prognostically more guarded cases of narcissistic rage mentioned before), a supportive psychotherapeutic approach may be the treatment of choice. Ideally, the treatment may shift into the general approach for borderline patients that I have recommended, namely, consistent interpretation (not only of the origin of the narcissistic rage, but of the secondary gains derived from its

expression in the transference), and limit setting when such secondary gain cannot be avoided by interpretive means alone. When it is possible to structure the external life of the patient in such a way that acting out of narcissistic rage can be controlled and the treatment situation protected so that the analyst can maintain a relatively neutral stance, a systematic interpretation of the defensive functions of the expression of aggression toward the analyst may be possible, with ultimate resolution of the narcissistic rage. In addition to direct expression of primitive aggression, such rage reactions may have the defensive function of protecting the patient against primitive fears of the analyst, or against overwhelming guilt toward him, or against separation anxiety.

In patients with narcissistic personalities in which narcissistic rage develops during later stages of the treatment it is usually less difficult to analyse the origin and functions of rage in the transference. The patient's angry outbursts over minor frustrations, real or fantasied, from the analyst may be an important move forward from the previously subtle devaluations of the analyst so characteristic of narcissistic resistances. To angrily devalue the analyst in an effort to eliminate him as an important object who would otherwise be feared and envied, and on whom the patient so desperately needs to rely, is a characteristic function of the rage reaction. The analyst's internal security and his conviction in what he has to offer realistically to the patient are very important in reassuring the patient against his fantasies of the overwhelming nature of his own aggression.

In summary, then, the pathological grandiose self compensates for the generally 'ego weakening' effects of the primitive defensive organization, a common characteristic of narcissistic personalities and patients of a borderline personality organization, and explains the fact that narcissistic personalities may present an overt functioning which ranges from the borderline level to that of better integrated types of character pathology. The differential diagnosis of narcissistic personalities from other types of character pathology can usually be arrived at in a careful analysis of the clinical features; I have examined in earlier papers the differential diagnosis of narcissistic personalities with hysterical personalities, infantile personalities, and obsessive compulsive personalities **(Kernberg, 1967)**, **(1970a)**, **(1970b)**. In cases where doubts persist, or the diagnosis cannot be made before the initiation of treatment, the characteristic development of a narcissistic transference differentiates narcissistic personalities from the usual transference neurosis of other cases. On this point, I think, Kohut and I agree.

THE RELATIONSHIP OF NORMAL TO PATHOLOGICAL NARCISSISM

Developmental arrest or pathological development?

Kohut **(1971)** thinks that narcissistic personalities remain 'fixated on archaic grandiose self-configurations and/or on archaic, overestimated, narcissistically cathected objects' (p. 3). He clearly establishes (p. 9) a continuity of pathological and normal narcissism, in which the grandiose self represents an archaic form of what normally, and in the course of treatment, may become the normal self in a continuous process. 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. Kohut **(1971)** states (p. xv): 'Specifically, this study concentrates almost exclusively on the role of the libidinal forces in the analysis of narcissistic personalities; the discussion of the role of aggression will be taken up separately.' In addition, Kohut examines narcissism so predominantly from the viewpoint of the quality of the instinctual charge, that he seems to imply the existence of two entirely different, narcissistic and object-oriented, libidinal instincts determined by intrinsic qualities rather than by the target (self or object) of the instinctual investment. In his words (p. 26): 'Narcissism, within my general outlook, is defined not by the target of the instinctual investment (i.e. whether it is the subject himself or other people) but by the nature or quality of the instinctual charge.' He repeats the essence of this statement later (p. 39, footnote) and considers the development of object love largely independent from that of lower to higher forms of narcissism (pp. 220, 228, 297). Kohut conveys the impression that he

analyses the vicissitudes of normal and pathological narcissism and of normal and pathological object relationships as mostly dependent upon the quality of libidinal cathexes rather than in terms of the vicissitudes of internalized object relations.

I disagree with these viewpoints, and like Jacobson **(1964)**, Mahler **(1968)** and van der Waals **(1965)**, I think that one cannot divorce the study of normal and pathological narcissism from the vicissitudes of both libidinal and aggressive drive derivatives, and from the development of structural derivatives of internalized object relations **(Kernberg, 1971b)**, **(1972)**. In what follows, I will provide clinical material as well as theoretical considerations in support of the following viewpoints:

1. The specific narcissistic resistances of patients with narcissistic personalities reflect a pathological narcissism which is different from both the ordinary, adult narcissism and from fixation at or regression to normal infantile narcissism. The implication is that narcissistic resistances that develop in the course of interpretation of character defences in patients other than narcissistic personalities are of a different nature, require a different technique, and have a different prognostic implication than narcissistic resistances of patients presenting pathological narcissism.
2. Pathological narcissism can only be understood 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 pathological self has defensive functions against underlying libidinally invested and aggressively invested primitive self and object images which reflect intense, predominantly pregenital conflicts around both love and aggression.
3. 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. They are 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.

To summarize these three viewpoints into one overall statement: Narcissistic investment (i.e. investment in the self), and object investment (that is, investment in representation of others and in other human beings), occur simultaneously, and intimately influence each other, so that one cannot study the vicissitudes of narcissism without studying the vicissitudes of object relationships, in the same way one cannot study the vicissitudes of normal and pathological narcissism without relating the development of the respective internalized object relations to both libidinal and aggressive drive derivatives.

Differential qualities of infantile and pathological narcissism

What follows are some pertinent clinical observations. The differential diagnosis of narcissistic personalities with obsessive, depressive-masochistic, and hysterical personalities (i.e. of the relatively better functioning narcissistic patients with other types of character pathology) illustrates how narcissistic patients not only seem to love themselves excessively, but do so in a rather poor, often self-demeaning way, so that one concludes that these patients do not treat themselves better than the other people with whom they have relationships. Their conviction of being 'phony', their deep lack of confidence in anything basically good and worthwhile that could emerge from honest self-exploration, and their occasionally surprising neglect and disregard for their 'public image' in terms of honesty, decency and convictions about values, are poor ways of loving oneself.

The following features distinguish pathological narcissism from the normal narcissism of small children: (1) The grandiose fantasies of normal small children, their angry efforts to control mother and to keep themselves in the centre of everybody's attention, have by far a more realistic quality than is the case of narcissistic personalities. (2) The small child's overreaction to criticism, failure, and blame, as well as his need to be the centre of attention, admiration and love, coexist with simultaneous expression of genuine love and gratitude, and interest in his object at times when he is not frustrated,

and above all, with the capacity to trust and depend upon significant objects. A two and a half year old child's capacity to maintain a libidinal investment in mother during temporary separations is in striking contrast to the narcissistic patients' inability to depend upon other people (including the analyst) beyond immediate need gratification. (3) Normal infantile narcissism is reflected in the child's demandingness related to real needs, while the demandingness of pathological narcissism is excessive, cannot ever be fulfilled, and regularly reveals itself to be secondary to a process of internal destruction of the supplies received. (4) The coldness and aloofness of patients with pathological narcissism at times when their capacity for social charm is not in operation, their tendency to disregard others except when temporarily idealizing them as potential sources of narcissistic supply, and the contempt and devaluation prevalent in most of their relationships are in striking contrast to the warm quality of the small child's self-centredness. Pursuing this observation into the historical analysis of narcissistic patients, one finds from the age of two to three years a lack of normal warmth and engagement with others, and an easily activated, abnormal destructiveness and ruthlessness.

(5) The normal infantile narcissistic fantasies of power and wealth and beauty which stem from the pre-oedipal period do not imply an exclusive possession of all that is valuable and enviable in the world; the normal child does not need that everybody should admire him for being the exclusive owner of such treasures; but this is a characteristic fantasy of narcissistic personalities. In normal infantile narcissism, fantasies of narcissistic triumph or grandiosity are mingled with wishes that acquisition of these values will make the child lovable, acceptable by those whom he loves and by whom he wants to be loved.

The implication of all this is that pathological narcissism is strikingly different from normal narcissism.

Manifestations of pathological narcissism in the analytic situation

In the transference, one main 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'; over many months and years there are likely to be frequent role reversals in the transference relationship, without any basic change in the total transference constellation. The grandiose self permits the denial of dependency on the analyst. Regularly, however, when it has been possible to work through this defensive constellation, it turns out that this denial of dependency on the analyst does not represent an absence of internalized object relations or of the capacity to invest in objects, but a rigid defence against more primitive, pathological object relations centred 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 strikingly different from the activation of narcissistic defences in other types of character pathology.

In patients who do not have the narcissistic personality structure, resentment toward the analyst, disappointment reactions, feelings of shame and humiliation in the process of character analysis are temporary and less intense; and their reactions coexist with a clear capacity for dependence upon the analyst as indicated by separation anxiety or mourning reactions in the transference. In contrast, generalized devaluation and contempt of the analyst are prevalent in the case of narcissistic personalities, often rationalized as 'disappointments'. There is a persistent absence of separation anxiety or mourning reactions at weekends, vacation, or illness of the analyst, so that even at times of apparent idealization of the analyst the difference between such idealization and that which obtains in other transferences is striking.

Expression of anger and rage in the course of the predominantly negative transference related to the analysis of character defences in nonnarcissistic patients will not bring about the massive devaluation of the analyst which is typical of narcissistic personalities. The alternation of childlike demands in times of anger with manifestations of love, gratitude, and guilt-activated idealization characteristic of nonnarcissistic patients, gives an entirely different

quality to the transference. Narcissistic personalities' curiosity about the analyst's life in areas other than those related to the immediate needs of the patient is often absent for many months or years. The presence of what on the surface seems 'normal' (although infantile) idealization simultaneous with almost complete obliviousness toward the analyst alerts us to the difference between normal and pathological idealization. The absence of the capacity to depend upon others on the part of narcissistic personalities, in contrast to the clinging dependency 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 from usual borderline patients. Other elements in this differential diagnosis are the specific characteristics of pathological idealization, the prevalence of omnipotent control and particularly of contempt and devaluation, and the narcissistic withdrawal in the case of narcissistic personalities. Again, the analytic situation provides abundant clinical evidence of a fundamental difference between normal infantile narcissism, fixation at infantile narcissism typical of patients with character pathology other than narcissistic personalities, and the pathological narcissism of narcissistic personalities.

Genetic considerations

This difference becomes even more striking when, in the course of psychoanalytic treatment, the genetic determinants of these patients' narcissistic resistances and related character defences are analysed. Such genetic analysis reveals that in contrast to fixation at infantile narcissistic stages of development directly related to frustrations and failures of the mothering figure and other significant childhood objects, narcissistic personalities repeat in the transference early processes of devaluation of significant external objects and of their intrapsychic representations as a secondary elaboration and defence against underlying conflicts around oral rage and envy. They need to destroy the sources of love and gratification in order to eliminate the source of envy and projected rage, while simultaneously withdrawing into the grandiose self which represents a primitive refusion of the idealized images of the parental figures and idealized images of the self, so that they escape from a vicious circle of anger, frustration and aggressive devaluation of the potential source of gratification at the cost of serious damage to internalized object relations. In short, devaluation processes rationalized as 'disappointment' reactions in the transference repeat pathological devaluation of parental images, while the defensive structure of the grandiose self actualizes the pathological condensation of components stemming from object relationships reflecting those conflicts.

I mentioned in an earlier paper **(Kernberg, 1970a)** that it is an open question to what extent inborn intensity of aggressive drive participates in this picture, and that the predominance of chronically cold, narcissistic and at the same time overprotective mother figures appears to be the main etiological element in the psychogenesis of this pathology. The inclusion of the child in the narcissistic world of mother during certain periods of his early development creates the predisposition for the 'specialness' of the child, around which the fantasies of the grandiose self become crystallized. The narcissistic character defences protect the patient not only against the intensity of his narcissistic rage, but also against his deep convictions of unworthiness, his frightening image of the world as being devoid of food and love, and his self-concept of the hungry wolf out to kill, eat and survive. All these fears are activated in the transference at the time when the patient begins to be able to depend upon the analyst. The patient now fears his destructive envy of the analyst, and he is uncertain whether his need for love will survive or be stronger than his aggressive onslaughts on the analyst. These developments determine an intensively ambivalent and frightening transference paradigm which needs to be worked through.

Types of idealization and the relationship of narcissistic idealization to the grandiose self

Regarding the nature of the defensive operations in pathological narcissism, I have already alluded to the fact that these patients' idealization of the analyst is markedly different from the primitive idealization of borderline patients, and from the idealization that occurs in other types

of character pathology. Borderline conditions are characterized by what I have called 'primitive idealization', namely an unrealistic, 'all good' image of the analyst as a primitive good, powerful gratifying object, used as a protection against the 'contamination' of the analyst with paranoid projections of an 'all bad', sadistic, primitive object. In other words, this primitive level of idealization is related to the predominance of splitting mechanisms. In contrast, in the non-narcissistic types of character pathology and the symptomatic neuroses, the idealization of the analyst as a good, loving, forgiving parental image is related to the patient's ambivalence, his guilt and concern over the simultaneous presence of both intense love and hatred for the analyst. At this higher level of idealization, the analyst is seen as a parental figure who is all-understanding and tolerant and who loves the patient in spite of his 'badness'. This higher level of idealization is followed by the still more mature type of idealization which includes the projection on to the idealized objects of higher level superego functions dealing with abstract, depersonified value systems: in essence, a normal phenomenon which is characteristic particularly of adolescence and falling in love.

These different types of idealization can be seen as a continuum, from normal primitive to normal adult functioning. All of them, however, are in striking contrast to the idealization of the narcissistic personality, which reflects the projection on to the analyst of the patient's grandiose self. The narcissistic patient extends his own grandiosity to include the analyst, and thus, while apparently free associating in the presence of the analyst, really talks to himself expanded into a grandiose 'self-observing' figure to which the patient becomes, temporarily, an attachment or satellite. It needs to be stressed that insofar as the patient 'withdraws' that idealization at the end of the hour, and shows a complete absence of real dependency on the analyst, there is no real merger taking place, thus indicating the difference of this reaction from more primitive self–object fusion which characterizes what Jacobson **(1954)** calls psychotic identification and Mahler **(1968)** described as the symbiotic phase of development. Rather than a fusion of self and object image reflecting regression to a very early level of development at which ego boundaries have not yet stabilized, reality testing in a strict sense is maintained in the hours, and transference psychosis does not develop.

Also, insofar as the idealization of the analyst does not alternate with intense projection of a 'bad object' on to him (as in the usual borderline conditions), nor involve guilt and reparation (as in normal infantile types of idealization during transference neurosis), narcissistic idealization is a pathological process rather than a normal developmental stage. The genetic origins of this pathology must be located somewhere in between the stage of self–object differentiation (i.e. beyond the level of development characteristic of the psychoses) and the stage of normal integration of self-images into a normal self-structure and of object images into integrated object representations (i.e. the object-relations-derived structures underlying the usual forms of character pathology and symptomatic neuroses). Insofar as a pathological, grandiose self is projected on to the analyst and the patient's 'empathy' with that projected self remains, and he attempts to exert maximum control to have the analyst follow exactly what is required in order to maintain the projection and to avoid the emergence of the analyst as an independent, autonomous object, this entire defensive operation reflects what I have described operationally (reformulating Melanie Klein's use of this term) as 'projective identification' **(1967)**, another characteristic mechanism of borderline conditions and narcissistic personalities. The practical consequences of the patient's continuing efforts to force the analyst to behave exactly as the patient needs to see him correspond quite closely to Kohut's descriptions of the mirror transference. What I want to stress again, however, is the specific, peculiar nature of the constellation of pathological narcissism in contrast to narcissistic developments in other types of pathology.

Kohut's thinking about narcissistic idealization is in contrast to the foregoing formulation. He sees narcissistic personalities as suffering from a lack of optimal internalization of the archaic, rudimentary self–object—the idealized parent imago **(1971pp. 37–47)**. He stresses that the small child's idealizations belong genetically and dynamically into a narcissistic context, a

proposition which makes sense in the context of Kohut's stress that it is the quality of the libidinal cathexes and not the target of the instinctual investment which 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:

> The intensity of the search for and of dependency on these objects is due to the fact that they are striven for as a substitute for the missing segments of the psychic structure. They are not objects (in the psychological sense of the term) since they are not loved or admired for their attributes, and the actual features of their personalities, and their actions, are only dimly recognized. They are not longed for but are needed in order to replace the functions of a segment of the mental apparatus which had not been established in childhood (pp. 45–6).

In short, he 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. Thus, what Kohut calls the mirror transference, and what he calls idealizing transference correspond in my thinking to the alternative activation of components belonging essentially to a condensed, pathological self. This self stems from the fusion of some aspects of the real self, the ideal self, and the ideal object. This condensation is pathological, and does not simply represent fixation at an early stage of development. Kohut himself, in referring to the idealized parent imago, refers to it as an archaic, rudimentary 'self–object', and describes 'typical regressive swings' during the analysis of narcissistic personality disorders **(cf. 1971, diagram 2p. 97, illustrating how shifts occur from idealizing transference to activation of grandiosity in the patient)**. I have found the alternative projection of the grandiose self on to one participant of the analytic relationship, while the other one represents the remnants of the real self incorporated as it were in a magical union with the idealized partner, a regular feature of narcissistic resistances.

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 on to 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 representing 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 make his. The early idealization is also a defence against the danger of 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 also destroys his hope of receiving something new and good, and, on a deeper level, reconfirms his fear of not ever being able to establish a mutually loving and gratifying relationship.

Thus, in the early stages of analysis, narcissistic patients typically develop fantasies that their analyst is the best analyst that exists; they do not need to envy any other patients having another analyst; they are the only patients of the analyst, or at least the most interesting patient whom the analyst prefers over all others, etc. Gradually, the idealized features of the analyst, which at first reflect rather conventionally ideal attributes, shift into directions which reveal a particular nature of the patient's grandiose self. Throughout this entire process, switches occur during which the otherwise ideal analyst is supposedly lucky to have such an unusual patient, and the patient can be reassured of the analyst's exclusive interest because no other patient of any other analyst could match such a gratifying analytic experience, etc. This sudden shift from periods in which the analyst is seen as a perfect, God-like creature, into a complete devaluation of the analyst and self-idealization of the patient, only to revert later to the apparent idealization of the analyst while the patient experiences himself as part of the analyst, indicate the intimate connexions of the components of the overall condensed structure—the grandiose self—which characterizes narcissistic resistances. The analysis of all these components of this pathological structure

reveals defensive functions against the emergence of direct oral rage and envy, against paranoid fears related to projection of sadistic trends on the analyst (representing a primitive, hated and sadistically perceived mother image), and against basic feelings of terrifying loneliness, hunger for love, and guilt over the aggression directed against the frustrating parental images.

One patient, a fellow professional in treatment with a colleague, felt in the early stages of his treatment that his psychoanalyst had a perfect technique of interpretation. From what he said he had heard and from his own observations about his analyst, he construed the picture of a very thorough, meticulous, somewhat cold and distant but perfectionistic technician, who would see to it that all of the patient's defences and conflicts would be resolved systematically in the right order. The patient gradually elaborated this vision of his analyst into that of a man who was absolutely certain of himself, incorruptible, rigid but completely stable and reliable, who would not let emotions get in his way, and would interrupt the patient with scientific precision only when and if needed. He felt very reassured by this image of perfection, and one might have thought that this transference constituted an idealization of the analyst as an external object. However, it gradually turned out that the patient had been reading the technical work of a leading psychoanalyst from another city, with the intention of shifting from the present analyst to the other one in case he discovered any shortcoming in his present analyst. In a subtle way, he attempted to force his analyst into conforming with his picture of the perfect analysing machine, with the qualities of coldness, distance, and olympian untouchability emerging as the main features. This patient presented characterological attitudes very similar to those of the analyst of his fantasies, and had a distant and unfeeling attitude about his own patients while attempting to copy the technique of this analyst. The patient was very proud of his careful, precise, intellectual approach; he also became extremely irritated when anybody invaded what he considered his personal space or time. He presented strong disappointment reactions when the analyst did not conform to the patient's self-image, or when the analyst would give indications of personality characteristics different from those known and particularly understood by the patient thus threatening him with the presence of an independent, autonomous person. This case illustrates the intimate connexion of the idealization of the analyst as representing part of the patient's grandiose self, and the related pathological nature of the idealization process.

Structural characteristics and origins of the grandiose self

What are the structural origins and functions of the pathologically condensed grandiose self? In my view, idealized object images which normally would be integrated into the ego ideal and as such, into the superego, are condensed instead with the self-concept. As a result, normal superego integration is lacking, ego–superego boundaries are blurred in certain areas, and unacceptable aspects of the real self are dissociated and/or repressed, in combination with widespread, devastating devaluation of external objects and their representations. Thus, the intrapsychic world of these patients is populated only by their own grandiose self, by devaluated, shadowy images of self and others, and by potential persecutors representing the non-integrated sadistic superego forerunners, as well as primitive, distorted object images on to whom intense oral sadism has been projected. It needs to be stressed again that these developments occur at a point when self and object images have been sufficiently differentiated from each other to assure stable ego boundaries, so that the pathological condensation occurs after the achievement of the developmental line which separates psychotic from non-psychotic structures. Thus created, the pathological grandiose self permits a certain integration of the ego providing a better overall social adaptation than achieved by borderline patients in general. The splitting of the self characteristic of borderline patients is thus compensated for, but at the price of a further deterioration of object relationships, the loss of the capacity to depend, and an ominous capacity for self-protection from emotional conflicts with others by withdrawing into the splendid, grandiose isolation which gives the specific seal to the narcissistic organization.

Another consequence of these developments is that, insofar as superego elements and ego

elements are condensed into the grandiose self, certain superego elements will not be available for superego integration, particularly the normal components of the ego ideal. Under these circumstances, the sadistic forerunners of the superego predominate, and superego integration would represent a terrible danger for the ego of pressure from a sadistic, primitive superego. Also, as the normal integration of the ego ideal with other superego structures is missing, the forerunners of later value systems are also missing, and so is the precondition for the internalization of later superego components, mainly the more realistic parental images derived from oedipal conflicts which normally constitute a major cement of superego integration **(Jacobson, 1964)**. Devaluation of the parents, rationalized as disappointment reactions, is also fostered by this defective development of advanced superego functions, and further interferes with the normal integration of value systems as part of the total personality and the related development of sublimatory potentials.

The final, and most crucial consequence of the establishment of the grandiose self, is the rupture of the normal polarity of self and object images which have been part of the internalized units which fixate and reproduce satisfactory relations with others. The grandiose self permits the denial of dependency on others, protects the individual against narcissistic rage and envy, creates the precondition for ongoing depreciation and devaluation of others, and contributes to distort both the future narcissistic and object investments of the patient.

For all these reasons, pathological narcissism cannot be considered simply a fixation at the level of normal primitive narcissism. Normal narcissism stems from the libidinal investment in an originally undifferentiated self and object image from which later, libidinally invested self and object images will develop. These will eventually determine an integrated self, which incorporates libidinally determined and aggressively determined self-images under the predominance of the libidinally determined ones. This integrated self is surrounded by integrated object representations which in turn reflect the integration of earlier, libidinally invested and aggressively invested object images, the integration also occurring under the predominance of predominantly libidinal object images. In pathological narcissism this normal 'representational world' **(Sandler & Rosenblatt, 1962)** is replaced by a pathological constellation of internalized object relations.

Thus, in contrast to Kohut's view about the nature of the superego pathology in narcissistic personalities, I think these cases do not simply reflect a lack of development of the idealized fore-runners of the superego (the components of the ego ideal), but the pathological condensation of such fore-runners with ego components. Thus, normal ego and superego boundaries are blurred, and the development of primitive superego structures into an advanced, normal superego is interfered with. There is not merely a 'lack' of internalization of certain normal idealized superego forerunners, but an active distortion of them simultaneously with pathological devaluation of the external objects. In more general terms, there is not simply an 'absence' of certain structures, but a pathological development of earlier structures so that the later normal ones cannot develop.

PSYCHOANALYTIC TECHNIQUE AND NARCISSISTIC TRANSFERENCE

If I understand him correctly, Kohut's overall 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 that of 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' **(1971p. 264)**. The analyst, Kohut adds,

> 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 **(1971p. 272)**.

Kohut acknowledges, 'At first hearing I might seem to be stating that, in instances of this type, the analyst must indulge a transference wish of the analysand; specifically, that the patient had not received the necessary emotional echo or approval from the depressive mother, and that the analyst must now give it to her in order to provide a "corrective emotional experience"' (p. 290). In objecting to this interpretation, Kohut states, 'Although for tactical reasons (e.g. in order to insure the cooperation of the segment of the patient's ego), the analyst might in such instances transitorily have to provide what one might call a reluctant compliance with the childhood wish, the true analytic aim is not indulgence but mastery based on insight, achieved in a setting of tolerable analytic abstinence' (p. 291).

In discussing the results of his approach, he states, 'The primary and essential results of the psychoanalytic treatment of narcissistic personalities lie within the narcissistic realm, and the changes achieved, constitute in the majority of cases, the most significant and therapeutically decisive results' (p. 298). He considers the increase and the expansion of the patient's capacity for object love as 'the most prominent non-specific change' (p. 296), and says that 'the increasing availability of object-instinctual cathexes as the analysis proceeds usually does not indicate that a change of the mobilized narcissism into object love has taken place; it is rather due to a freeing of formerly repressed object libido; i.e. it is the result of therapeutic success in sectors of secondary psychopathology (transference neurosis) in a patient who is primarily suffering from a narcissistic personality disorder' (pp. 296–7).

In my view, Kohut's approach neglects the intimate relationships between narcissistic and object related conflicts, and the crucial nature of conflicts around aggression in the psychopathology of patients with narcissistic personality. While I certainly agree that it is important to permit a full development of the transference rather than prematurely interpreting 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 unwillingly foster an interference with the full development of the negative transference aspects, 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 centres on the activation of the grandiose self and the need for helping the patient achieve full awareness of it in a neutral analytic situation, but I think that focusing exclusively on narcissistic resistances from the viewpoint of libidinal conflicts with an almost total disregard of 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 of and the omnipotent control over the analyst need to be interpreted systematically; the patient needs to become aware, obviously in a non-critical atmosphere, of his need to devalue and depreciate the analyst as an independent object, in order to protect himself from the reactivation of underlying oral rage and envy and the related fear of retaliation from the analyst. Fear of retaliation from the analyst (derived from projected sadistic reactions activated by real or fantasied frustrations from him), and fear of guilt (because of the patient's attack on the analyst as a primitive giving object) are prominent motives against which narcissistic resistances have been erected. They need to be explored and interpreted systematically before the transference shifts into the ordinary transference paradigms characteristic of transference neurosis. The patient's

efforts to hold on to his grandiose self, and to avoid acknowledging the analyst as an independent, autonomous person, consistently reveal his defence against the intense envy, against the feared relationship with the hated and sadistically perceived mother image, and his dread of a sense of empty loneliness in a world devoid of personal meaning.

In the course of this work, what regularly emerges is that behind the consciously remembered or rediscovered 'disappointments' from the parents are the devaluations of the parental images and the real parental figures, carried out in the past in order to avoid the underlying conflict with them. The patients' 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 an 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 defences 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 defences against deeper relationships with the parents, and only then the real past relationships with them. As is true in so many cases with borderline conditions, the parents did, indeed, disappoint the patient, but in ways and areas which the narcissistic patient usually did not suspect and which only become clear in the later part of the treatment. In short, disappointments in the analyst, unrealistic idealization of him which hides the patient's refusal to acknowledge him as an independent object, and the complex motives for narcissistic withdrawal, need to be carefully scrutinized for underlying contempt and devaluation. This is a striking difference from the technical requirements in the analysis of infantile narcissistic reactions in other types of character pathology.

A crucial technical issue with these patients is the focus on such remnants as the patient possesses of the capacity for love and object investment, and on his realistic appreciation of the analyst's efforts, in order to help the patient avoid misinterpreting the focus on the latent negative transference as the psychoanalyst's conviction that the patient is 'all bad'. In short, the analyst needs to focus both the positive and negative transference. In this connexion, Kohut quotes me as saying that ego distortions 'temporarily require a bit of educational pressure' **(1971p. 179)**, which is a misunderstanding of my views. The analyst certainly needs to avoid educational pressures or a moralistic stance, and I think that the best way to achieve this is by analysing the motives which determine narcissistic defences, 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 fear such feelings will 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. Narcissistic patients also attempt, in denying the reality of their emotional relationship with the psychoanalyst, to deny the danger of their destructiveness and to preserve the illusion of being able to 'start all over again'. This can be observed in some patients with sexually promiscuous narcissistic behaviour, in which one function of the promiscuity is to preserve the hope for a better relationship with new objects, and to protect the objects of the patients' sexual impulses from destruction. Often, neglecting to interpret the negative aspects of the transference may heighten the patient's fear over 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 the systematic interpretation of both the positive and negative transference aspects rather than focusing exclusively on libidinal elements, or the misunderstanding that interpretation of latent negative resistances means exclusive focus on aggression.

It is important to keep in mind that, except in the most severe cases of narcissistic personality,

there are certain normal ego functions which are maintained and certain realistic aspects of the self-concept which continue in existence, side-by-side with the grandiose self. These, of course, constitute the basis for the establishment of a therapeutic alliance, and the related capacity to really listen to the analyst and to identify with him in thinking psychologically about himself. These normal self-aspects can be diagnosed, preserved, and expanded by focusing upon the patient's tendency to split off or devaluate these very functions in himself. The realistic wish to maintain a good relationship with the analyst and to be helped by him is the starting point, one might say, of the recuperation of normal infantile and mature dependency and self-evaluation. Insofar as narcissistic resistances against full awareness of the underlying rage and contempt are also at the service of preserving the good relationship with the analyst, the interpretation of this double function of the narcissistic resistance may greatly help the patient face his split-off contempt and envy. In short, non-critical interpretation of the negative aspects of the transference may help reduce the patient's fear of his own destructiveness and doubts about his goodness.

However, there are cases in which the narcissistic resistances cannot be worked through, and the patient after lengthy periods of stalemate prefers to terminate the treatment, or the analyst feels that he cannot help the patient any further. Under these conditions, a shift into a more supportive approach of the kind which in my opinion is implied (although not intended) in Kohut's approach may be very helpful. This is particularly true for patients with relatively effective social adaptation, who consult because of a symptom which improves in the course of the analysis before working through of their basic narcissistic resistances; and for cases in which secondary gains, particularly important narcissistic gratifications linked to their pathological character structure, militate against the painful nature of analytic work. There are also patients with intense negative therapeutic reactions who can accept certain improvement only at the cost of simultaneously defeating the analyst in his purpose to bring about further change. In many cases of this kind, the treatment may have to shift at some point, into a supportive tolerance of the narcissistic constellation in combination with preparation for termination of the treatment.

There is, however, a dramatic difference between the changes brought about under these circumstances, and the changes brought about when pathological narcissism is systematically worked through. When the pathological narcissism cannot be worked through, and analysis shifts into a supportive approach, the patient's social functioning usually improves noticeably, and his capacity to understand better what goes on in other people and in his interactions with them improves the patient's relationships with others and himself. The patient's ambitions become more realistic, the ways to achieve them more in harmony with his overall life situation and goals, and there is usually an increase of the tolerance of the feelings of boredom and restlessness which are so typical of narcissistic personalities. However, there usually persists a lack of capacity for empathy in depth with others, and a lack of capacity for full development of love relations. Their attitude toward work often reveals the pursuit of some specialized interest or small area of personal investment—whether it is in business, professions, studies, hobbies or collections—where the patient obtains a sense of control and superiority while isolating himself from the broader area of which this particular interest is part.

Paradoxically, narcissistic personalities functioning rather poorly on an overt borderline level, who have undergone supportive psychotherapy, may present a higher level of improvement than patients who originally functioned more effectively and were more intelligent, creative and ambitious. The persistent feelings of emptiness, the 'burned out' quality of interests and ambitions that one observes in narcissistic personalities functioning on a borderline level leaves them more willing to settle for rather conventional, often over-conventional ways and styles, replacing their old ambitiousness and flamboyance with a gratification of having their life and immediate needs stable and under control. In contrast, the highly gifted, brilliant narcissistic personalities who have undergone psychoanalytic treatment which did not resolve their narcissistic personality structure, tend to experience more dissatisfaction with themselves and with life. They feel that while

they can no longer hold on to their old grandiosity, they cannot accept the essentially 'mediocre' nature of ordinary life.

The observation of former psychoanalytic candidates (graduated or not) who have undergone psychoanalytic treatment in which the narcissistic resistances were not systematically analysed and resolved (usually in connexion with lack of full exploration of the negative transference dispositions) provide a good illustration of these developments. A composite picture of traits one particularly finds among this group are: a gradual disappointment with intensive psychotherapeutic work with patients, a feeling of boredom when considering the perspective of intensive work with a patient over a period of months or years, and rationalizations of this loss of interest in clinical work in terms of theoretical criticisms of psychoanalytic theory or technique. Frequently these former candidates—or analysts—eagerly explore new treatment methods, particularly those which promise to bring about an immediate activation of emotional reactions or regression. They feel more comfortable with methods which permit 'instant intimacy' of a non-differentiated nature rather than the lengthy, complex building-up of personal relationships in depth. Intelligent and gifted therapists with this character constellation may have a great sensitivity for 'small and complex issues' in the treatment, but lose sight of the emotional constellation expressing what is going on between them and the patient. It is interesting to observe how in the post-analytic stage patients with narcissistic personality who have not undergone systematic working through of the narcissistic resistances continue to idealize their analyst for a time, and then gradually shift into a basic indifference. Their retrospective evaluation of analysis is that while it was a very helpful experience, they did not learn anything really new about themselves.

The following case illustrates the patient's pressure for premature termination of the treatment and a consequent shift into a supportive approach. This patient, a businessman in his early 40s with a typical narcissistic personality structure, came because of homosexuality. Over a period of four years of psychoanalysis he improved to the extent that his homosexual impulses and acting out disappeared, and his general adaptation to his family life and work improved markedly. He felt he had achieved the main goal for which he had entered treatment, and was satisfied with his present life in spite of the persisting sensation of boredom, difficulty in empathizing with other people, and an awareness of his limitations in caring for others. His chronic conflicts about envy had decreased, partly because his wishes for wealth and prestige had been gratified. After a lengthy period in which he met my interpretive efforts by insisting that he had achieved all he had expected from psychoanalysis, we finally agreed to consider termination. In the six months before the termination of the analysis, and after a date for termination had been set, his main fear was that I was angry and disappointed because of this decision, and, on a deeper level, he felt that termination represented his escape from a perfectionistic, never-satisfied analyst-mother. At this point, I focused on the patient's fear of rejection by me without persisting in my previous attempts to analyse the underlying conflicts (mainly his paranoid fear of attack and betrayal by me as a sadistic, withholding primitive mother). I did, however, point out to him his fear that I was seeing him as sadistically withholding further analytic work from me, and that he was attributing to me the kind of suspiciousness which he had previously experienced toward me. I also explored with him his fear that I would not accept him as a person in his own right if he did not live up to some kind of perfect standards, which reflected a projection on to me of his own, highly unrealistic aspirations for perfection that we had explored in the past. In the course of this process, the patient's experience of me as an idealized person who could accept him as he was in his own right provided an important source of support to him, helped him tone down his own narcissistic aspirations and achieve further improvement in his relationship with himself as well as with his family. This patient did not experience a full-blown mourning process during the last part of the analysis, nor, as I learned from follow-up information years after the termination of this analysis, did he experience such a period of mourning after the termination. Over the years, his general symptomatic improvement has persisted, and he has gradually accepted the limitation

of his internal emotional life. In short, this case illustrates how the protection of narcissistic defences as part of the process of treatment termination may be helpful when full resolution of the pathological narcissism cannot be achieved.

However, whenever possible, one should attempt to resolve this serious psychopathology in order to achieve a fundamental change in the patient's internal relationship with himself and with others—a shift, in short, from pathological narcissism and object relationships to normal narcissism and object relationships.

The following vignettes illustrate various features of narcissistic transferences.

Vignette 1

A male patient reacted to the information that I would not be able to see him for one of his appointments later that week with anger, and then, feeling distant and empty in the hour, withdrew into a monotonous recital of disconnected thoughts going through his mind. Exploration of his anger revealed that he felt shocked about the suddenness of the announcement, and about the fact that it did not fit into what he considered to be a predictable pattern (my letting him know weeks ahead when I would not be able to see him, or my secretary letting him know about some unexpected development, i.e. an illness on my part). This patient showed no reactions to weekend separations, and would resume his sessions after vacations as if his last hour had been yesterday. We had explored in some depth his angry reactions to minor frustrations on my part, and his tendency to forget me completely (and his fantasies that, actually, I ceased to exist in between hours) when he felt I had behaved in a stable, completely predictable manner (for example, my comments would confirm his own observations, and I would thus show neither more nor less knowledge about him that he had). During this session, his associations to his anger led into fantasies that one of my children must be ill, and that I was cancelling my appointments because I wanted to be with the child. He then expressed fantasies that I had unusually bright or attractive children, and speculated about the ways in which I was spending my free time with my family. In the course of these associations, it became clear that he saw me as a potential source of love and concern for him, and as teasingly withholding that love and concern from him, giving it instead to my children, of whom he felt intensely jealous. At this point he became sad, and commented that it was understandable enough that I should prefer my children rather than a demanding, self-centred person such as he. His reaction then shifted abruptly to a feeling of annoyance with me and of having been trapped by me. At that point, he felt that I was demanding and selfish, asking him to come at hours which were convenient to me, and cancelling his hours without any regard to his needs. He felt it was a typical analyst's manipulation to have him think about his motivations when obviously something was wrong with me. His associations then focused on other aspects of my personality which seemed to confirm to him that I had a self-centred, manipulative character, and that I really did not care about him at all. He felt I had simply cancelled his hour in order not to have to change my schedule.

What I wish to stress is the suddenness of the shift in the emotional relationship of the patient with me: in contrast to the consistent, many hours of 'calm' narcissistic control, he presented a brief period of intense and changing emotional reaction. His reaction illustrates the utilization of the narcissistic defence against his feeling rejected by a hypocritical mother, and the feelings of guilt and unworthiness because of what he considered his excessive demandingness on her. His reaction also illustrates the projection of his demandingness and self-centredness on her, and the secondary disappointment and devaluation of this maternal image in the transference, thus reestablishing the narcissistic balance.

There was abundant evidence in this case that his mother was, indeed, very self-centred, and had a chronic tendency to manipulate him through guilt feelings; but his feelings of abandonment and unworthiness were intolerable to him, because they were compounded by guilt over his anger toward his mother, and by the projection on to her of his own angry, revengeful feelings.

In this case, the feeling of sadness reflected a temporary awareness of his angry, demanding behaviour toward me, and toward his mother in the last resort. However, the sadness also involved his acknowledgement that, in spite of the frustration that he had just experienced from me, I was also the person who could give him love and concern. It was also sadness over his feeling that he could not respond in a loving way to me, that is, to his mother image. I pointed out to the patient that one of the reasons he felt it was so difficult to tolerate his anger and loneliness, and his longing for a good relationship with his analyst (mother) was his despair over his own badness, as if his aggressive fantasies and feelings would eliminate or destroy his right to expect a loving relationship, and his trust in his capacity to give. Again, systematic interpretation of both the positive and negative transference reactions defended against by pathological narcissistic resistances help to integrate love and hatred and, in the last resort, the contradictory self and object images which are split off as part of the primitive ego organization of these patients.

Vignette 2

A college student in her early 20s was furious because I would be gone for a week, and expressed ragefully her disappointment in what she experienced

as my callousness and negligence. She threatened to terminate the treatment, and made me responsible for anything that might happen to her during the time I was away. I interpreted to her the anger over my leaving her, and her projection of that anger on to me so that my going away acquired dangerous, sadistic qualities. I also pointed out to her that because she was so angry with me she was disqualifying me completely not only as a professional, but also, as it were, tearing apart my image inside of her, so that nothing was left but bleak emptiness and my leaving became much worse. In earlier hours, she had expressed the fantasies that I would go away on a professional trip to boastfully let others know about my success with patients, and she had imagined my trip as an ongoing series of feasts which would start out with my proclaiming my greatness and continue with huge, endless dinner parties in which I would greedily devour food ordinarily only available to a select few. These fantasies, expressed in the middle of intense rage, alternated with periods of disdainful calmness in which the patient would act completely indifferent and bored. I now reminded her of these fantasies, and suggested that one of the functions of her intense rage was to erase me as the source of unending envy for her. At this point, still angry but somehow more thoughtful, she exclaimed that what she was really envious of was that I could be satisfied with myself, that I would not crumble under the guilt feelings which she would try to evoke in me, and that I could tolerate feelings of guilt without losing my determination to do what I had decided to. This same patient, at another time when she was again considering termination of her treatment, said that although she knew she really did need to continue in treatment, the idea that she would rob me of the treatment success would go a long way to make life more pleasurable without continuing in treatment.

Vignette 3

Another patient, after many months of what appeared on the surface to be detachment, gave continuous indication of his need to reassure himself against relentless envy. This was a young college professor who continuously compared the achievements of all other people with his own, and obtained endless gratification from the reassurance that he had achieved much more than anybody else at the same age. He would calculate the relationship between the level of income and the age of friends, the size of houses in relationship to the age of the owner, the number of professional honors and publications of other colleagues in comparison to what he had achieved at the same age, etc. Although he speculated intellectually that perhaps his complete indifference toward me might be related to the fear that he might develop the same reaction with me, and, feeling superior, might evoke my envy and hatred, it took many months until this became an emotional reality. At one point he was able to face the humiliating and painful awareness that to really feel he needed me caused him to envy me because of this very need. If I really had understanding to offer which he lacked, every confirmation of this would create a pang of envy.

Vignette 4

Still another patient, an industrialist in his middle thirties, came to analysis with the expectation that he was to be 'brain washed' into a state of satisfaction with himself, and to be given a clear system of values and principles for guiding his daily life to replace his chronic sense of uncertainty and futility and his feelings of being 'phony'. He had become disillusioned with religion, in spite of strenuous efforts in early years to find magic help through a religious commitment, and he was quite aware of his efforts to replace his search for religion with psychoanalysis. In the early stages of his analysis, he saw me as a rigid, dogmatic but deeply convinced high-priest of psychoanalysis, an ambivalent idealization which turned out to be a protective structure against his vision of me as a hypocrite, a man who went through empty rituals because it fitted his pocket—in short, a 'phony' as the patient saw himself. It became quite striking to him that there were only three ways in which he could perceive me: either I was a convinced, dogmatic, arbitrary 'brain washer' who could sadistically force him to submit to psychoanalytic dogma; or a cynical manipulator who could exploit him financially; or, even worse, an impotent fool who would believe in a phony method and theory such as psychoanalysis. It took many months for the patient to become aware that in these three alternatives he had excluded the possibility that I, as a psychoanalyst, might have something real and concrete to offer, and that my convictions might reflect my awareness of this fact. This patient insisted on acquiring the 'magical' tools of psychoanalysis for achieving happiness, instead of carrying out a realistic work in collaboration with the analyst, partly because he was fearful of his envious impulses.

At one point, he became aware that he used to rapidly scan my office at the beginning of the sessions to make sure everything was exactly as it had been before. It turned out that he was afraid that new objects, books or papers would appear on my desk indicating new acquisitions or tributes that I had received, and it was with a great sense of relief that the patient reassured himself that there was nothing new that would upset him. He also became aware that, at times when he did find new acquisitions in the office, the intrusive thoughts would come to mind that I was Jewish, that Jewish people were extremely grabby and voracious, and that new possessions of mine confirmed my belonging to an empty, hungry, exploitative race. The patient was very much afraid of exploring these fantasies about me, fearing that my self-esteem would crumble under these 'poisonous' attacks, and that therefore he

would be unable to obtain help and relief in the analysis. Systematic interpretation of the fear over his own aggression, with implicit acknowledgement of the patient's wish to preserve me as an intact, potentially helpful person in the transference as part of his total reaction, permitted the gradual uncovering of the conflicts around contempt, greediness, and hatred against which narcissistic defences had been erected.

COUNTERTRANSFERENCE AND THERAPEUTIC MODIFICATION OF THE NARCISSISTIC RESISTANCES

Kohut suggests that unresolved narcissistic disturbances in the analyst may cause the analyst's uneasiness at being idealized, and bring about a subtle tendency to reject the patient's idealization **(1971p. 263)**. While I agree that unresolved narcissistic conflicts of the analyst may bring about pathological reactions in him to the patient's idealization, I also feel they may foster excessive acceptance as well as rejection of the patient's idealization. Unfortunately, at times analysts treating these patients accept uncritically some aspects of the patient's idealization. To accept the admiration seems to me an abandonment of a neutral position in the same way as does critical 'over-objectivity'. Narcissistic patients readily react to interpretations as if they were 'rejections' and if acceptance of the patient's admiration means to abandon a neutral interpretative stance, there exists a danger of the analyst being forced into a situation which the patient can easily interpret, sometimes with justification, as a seduction of the analyst. I have been impressed by how skilfully some narcissistic patients sense those aspects of their idealization of the analyst which fit into the analyst's own narcissistic 'weak spots'.

The 'analyst's uneasiness' regarding the idealization may stem from the peculiar quality of this idealization, namely the combination of the controlling elements in it, and its particular 'switch on–switch off' quality. In other words, the analyst may sense the negative as well as the positive transference implications.

In my experience, the main problem regarding the counter-transference reactions to narcissistic patients is related to the patient's consistent efforts to deny the existence of the psychoanalyst as an independent person. In this regard, I agree with Kohut's description of the reactions of the analyst to the primitive forms of the mirror transference. Kohut says that, while the analyst 'may feel oppressed by the patient's unqualified yet silent demands which, from the point of view of the target of the merger transference, are tantamount to total enslavement—the absence of object-instinctual cathexes often makes it difficult for him to remain reliably attentive during prolonged periods' (p. 275). But I disagree with the implication that the problem is one of the nature of the cathexes, for it seems to me that what is involved is the unconscious tendency to control the analyst, the unconscious mechanisms of devaluation, and the activation of primitive types of projection related to the grandiose self.

A careful study of Kohut's case of Miss F. **(1971p. 283–95)**, illustrating the analyst's reactions to mirror transferences, lends itself to an interpretation along the lines I have suggested in this paper. At one point, the patient was able to 'establish connexions between the rage which she experienced against me when I did not understand her demands and the feelings she had experienced in reaction to the narcissistic frustration which she had suffered as a child' (p. 293). Kohut states: 'I was finally able to tell her that her anger at me was based on narcissistic processes, specifically on a transference confusion with a depressed mother who had deflected the child's narcissistic needs on to herself. These interpretations were followed by the recall of clusters of analogous memories concerning her mother's entering a phase of depressive self-preoccupation during later years of the patient's life' **(1971p. 292)**. In the light of the overall information given about this case, I would raise the question to what extent, in making this interpretation, was the analyst implicitly blaming the patient's mother for having caused the patient's anger and protecting the patient from full examination of the complex origins of her own rage? In more general terms, I see a danger of a seductive effect given by the combination of the analyst's unquestioning acceptance of the patient's idealization, and by the immediate referral back to the original object of the negative transference without exploring fully the patient's participation in the development of pathological rage within the here and now of the transference.

I have suggested that the patient's subtle, unconscious efforts to deny meaning to the

analytic relationship (which may induce in the analyst a chronic sense of frustration, helplessness, boredom, and lack of understanding) are much more difficult for the analyst to tolerate than the unrealistic, primitive idealization, which by its very nature alerts the analyst to the narcissistic functions of this idealization. While it is true that analysts with unresolved conflicts regarding their own narcissism may react with anxiety and rejection, or with uncritical acceptance of the patient's idealization, the main danger is the internal rejection by the analyst of the patient because of the patient's chronic devaluation of the analyst. The analyst may feel, at times, as if the patient were convincing him that there is no such thing as an internal life, that psychological matters are incomprehensible and senseless, and that the patient as well as the total analytic situation has a strange, lifeless, mechanical quality. At other times, the analyst may have a sense of understanding but of complete paralysis, as if he no longer would be able to decide regarding what or when to intervene, or as if the emotional connexions among the different aspects of the material were unavailable. At times, there are strong temptations for the analyst to just sit back and let things go, hoping that he will find a way back to an intuitive understanding of the patient later on. If at this point, alerted by this development, the analyst is able to gather the objective evidence in the verbal and non-verbal manifestations of the patient which is related to treating the analyst as non-existent, immediate changes may occur in the transference making the analytic relationship come alive. The sense of deadening monotony in the analytic situation may derive from very specific aspects of the patient's associations and non-verbal behaviour which need to be diagnosed and interpreted.

In one session in the middle of his analysis, I pointed out to a narcissistic patient that I was puzzled by the fact that he seemed to talk about important memories of his past in such a monotonous, subdued tone that it was difficult for me to follow them, and that there seemed to be an obvious discrepancy between what he was saying and the way he was saying it. The patient first had a startled reaction, and after I finished talking, he said that he had not been able to listen attentively to what I was saying, but that he had all of a sudden become aware of my presence. In response to my suggestion to associate to this sudden shock, the patient became aware that he had felt very comfortable exploring his past, feeling that letting his thoughts go into all directions would throw them, as it were, into a big, expectant void—a kind of open, receptive world—which would order and automatically bring back into his mind all that he was expressing, with a clear understanding of what it meant and how it would increase the emotional wealth of his experience. The patient also felt annoyed about my intrusion, and he had the fantasy that I might feel frustrated and incompetent because he could do his analytical work alone. Later in the session, he said, smilingly, that perhaps he had not been able to pay attention to what I had said, because if I really had something to add which would make a change, this would be a very rude disruption of his feeling that he could do it all alone.

Gradually, in the course of working through of narcissistic resistances, the analyst will experience shifts in the sensation of paralyzing stalemate, such as acute awareness of fleeting emotional states of loneliness, or fears of loss of meaning or of love, or of fears of threatening attacks or of rejection by others, feelings within the analyst which reflect the dissociated, repressed and/or projected self and object images which are coming alive in the transference. These regressive 'flashes' of emotional experience, or a gradual shift in the analyst's emotional reaction to the patient's efforts to deny emotional meaning to the hours, is a useful index of the working through of narcissistic resistances. At times, a sudden feeling of becoming 'widely awake' to aspects of the material which earlier made no emotional sense, will indicate the shift in the transference–counter-transference equilibrium. Insofar as a patient will gladly accept any kind of intellectual explanation which he can 'learn' and absorb in his 'self-analysis', he will accept the analyst's interpretations; however, the analyst's reflection on such momentary states of mood perceived by him on the basis of what has been conveyed by the patient, or of the analyst's emotional perception of the patient's self-images or objectimages activated in the hours will often be arduously resisted by the patient and require

much emotional alertness on the analyst's part. It is as if at this stage the analyst would become the depository of the patient's more differentiated self and object images linked with the emotional experiences of abandonment, loneliness, frustration, hopelessness against which the patient was defending himself. It is as if the analyst were now experiencing that part of the normal infantile self of the patient which he had been unable to tolerate and had to dissociate or repress and replace by his pathological grandiose self.

At this stage of development in his analysis, a narcissistic patient drove past a sidewalk on to which a dead cat had been thrown, obviously run over by another car. There was something peculiar in his description of the dead cat, in the way he conveyed the sense of abandonment and total misery expressed in the frozen attitude of the dead animal, but before I had time to explore this matter further, other issues seemed to erase its emotional significance. A few days later, the patient mentioned a hungry cat that had been picked up by his children, and he talked about the desperate way this cat would devour food, always ready to escape from possible blows or attack. When I asked him to associate about this, the patient thought of powerful cats roaming the streets at night and chasing away all rivals while searching for food in garbage cans, with an obvious shift from the hungry, frightened, lonely kitten to the powerful, aggressive, 'callous' cat. The subject-matter came up again in a brief fantasy of a dark, rainy night and a lonely kitten having difficulty in finding shelter.

What is hard to convey in this brief vignette is the mutual isolation of these rather specific descriptions of a certain state of mind which the patient found very difficult to tolerate in himself. What predominated by far, during that stage, was the patient's haughty self-affirmation, his feeling of powerful superiority as a member of a social group which had inborn stamina and deep roots in the country, in contrast to people he despised, such as foreigners, particularly traumatized refugees. The transference was predominantly narcissistic-grandiose, and we explored consistently his tendency to disreagrd or forget my comments, to treat me as non-existent, and to analyse himself on his own. It was now, however, that my own experience shifted from that of meaningless, random listening to material with lack of emotional depth, to the strange experience of occasional moments of strong empathy with the isolated, fleetingly activated descriptions of this image of the hungry little cat, and for the dead cat thrown on to the sidewalk. Only then was I able to grasp the connexion between the image of the lonely kitten and the traumatized refugee. It was as if the patient was activating whatever deep sources existed in my own past implying a conviction of loneliness and agonizing incapacity to express the need for love and shelter. Again, these were only fleeting experiences in the hours with this patient, and at first it was hard for me to connect these experiences with the material.

However, these experiences and fantasies, and memories of relevant dreams of my own past, would only come up in the hours with this patient, and I gradually discovered their connexion with the peculiar cat fantasy material that regularly preceded them. I finally was able to interpret to the patient that he was projecting on to me an image of himself, of his early childhood in which he felt deeply unloved. I reconstructed with him the physical and familiar environment in the context of which he had these experiences on the basis of the different aspects of the 'cat material' as well as the general knowledge that we had developed to that point. Retrospectively, the connexion of the cat fantasy material with his past was pretty obvious, but I wish to stress how difficult it was to capture this material directly from isolated associations in a stage of the analysis in which the patient was engaged in a defensive deterioration of all meaningful communication, and in which the activation of projected, dissociated remnants of the real infantile self occurred in split-off bits in the countertransference over periods of many sessions.

Acting out of the countertransference reactions motivated by the patient's ongoing efforts of omnipotent control of the analyst may take the form of 're-educative' efforts on the analyst's part, such as pointing out to the patient how he is 'undermining' the analytic process, 'paying lip service to free association, ' etc. The analyst may be tempted, at such times, to become moralistic, or to concern himself excessively with the long-range prognosis of the case, in contrast

to evaluating his difficulty in empathizing with the immediate transference development. Psychoanalysts with important unresolved narcissistic conflicts may, during periods of lengthy devaluation on the part of the patient, react by suddenly rejecting narcissistic patients whom they previously considered extremely interesting and 'rewarding' (particularly at times when the projection of the grandiose self on to the analyst would feed into the analyst's own narcissistic needs).

The most general point I wish to stress again is that, underlying the narcissistic resistances there exist significant, primitive internalized object relations which are activated in the transference, and may be diagnosed gradually as the narcissistic resistances are worked through. This clinical observation constitutes, it seems to me, a most important documentation of the theoretical assumption that narcissism and object relationships always go hand-in-hand, a point articulately stressed by van der Waals **(1965)**.

What follows is the summary of the sequence of transference paradigms representing approximately two years of an advanced stage in the psychoanalytic treatment of a narcissistic personality. The patient was a successful architect in his late 30s, a senior partner of a large architectural firm. This patient's transference remained at a level of a typical narcissistic transference paradigm for over three years. During that time, an early phase of idealization of the analyst, reflecting mainly a reaction formation against pervasive devaluating tendencies, was followed by what might best be called an oscillating situation with alternative activation of the pathological grandiose self and the projection of such a grandiose self on to the analyst. The gradual working through of this paradigm activated intense primitive envy and competitiveness based upon oral envy (rather than oedipal strivings), and eventually, a more direct expression of ambivalence with shifts from oral demandingness and anger to longing for a dependency on a loving, protective father-mother image, and strong guilt feelings for his attacks on the analyst. This transference shifted, in turn, toward a more stable dependency on a loving, protective, father image in the transference, and the patient, after over three years of psychoanalysis, for the first time became really dependent upon the analyst with the development of neurotic mourning reactions to separations from the analyst, and the emergence of material from various levels of childhood conflicts. This stage was followed by a reactivation of emotional withdrawal, and a general emotional emptiness in the hours, which on the surface appeared as a repetition of the earlier stage of narcissistic resistances. However, there was a difference in the patient's reaction, which now had the quality of a suspicious, disgruntled withholding of material, together with what appeared as an unconscious attempt to put the analyst to sleep, or at least to maintain him in a chronic frustration created by monotonous repetitions. The patient, during this time, frequently referred to his mother's sadistic, withholding tendencies, and eventually became aware of his identification with such a mother image, while projecting his own, frustrated, infantile self on to the analyst.

This identification with the aggressor was different from the earlier narcissistic withdrawal in the transference, and the interpretation of this transference pattern brought about an immediate shift, with further deepening of the dependent relationship toward the analyst. The patient now saw him as a protective, loving father toward whom he could turn for the gratification of his dependent childhood needs; and he now felt he could 'abandon himself' to the analytic situation. He was struck by this new experience for him, which influenced the relationship with his wife and children, and made him understand the dependent needs of them as well as deepen his own involvement with his family. Now, for the first time, the patient became aware of how his entire attitude toward the analyst had been influenced by his basic conviction that no real relationship would ever occur between him and the psychoanalyst. For example, for a long time he harboured fantasies that a friendly although distant relationship with his psychoanalyst would occur after the termination of the analysis, and that he and the analyst had a secret understanding that in reality the analytic relationship had nothing to do with the descriptions of intense emotional conflicts supposedly occurring during the treatment.

The patient also became aware of the existence

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1 It needs to be stressed that it took over three years of analysis of the narcissistic resistances to bring about a transference situation which with less severe types of character pathology occurs during the early stages of the treatment.

of an internal world which was not under his conscious control, and of the excitement and fear in facing this world in the analytic situation.[1] A year later the full development of oedipal conflicts emerged in the transference, and the analysis acquired features of the usual resistances and manifestations of these conflicts.

In general, at times of heightened resistances, earlier, previously abandoned narcissistic resistances may become reactivated, similarly to what occurs with past, abandoned character defence during stages of shift into new lines of resistance. However, the context in which such reactivation of narcissistic defences occur, and the differentiated quality of the internalized object relations connected with these resistances, confirm the important structural changes that have taken place in the patient.

PROGNOSIS OF NARCISSISM, TREATED AND UNTREATED

I have referred to prognostic factors in the psychoanalytic treatment of narcissistic personalities in earlier papers **(Kernberg, 1970a)**, **(1971a)**, and will limit myself here to briefly enumerating these factors, modifying and adding to my earlier considerations.

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 in the resolution of narcissistic resistances. This is also the case when there is secondary gain from analytic treatment itself, such as in the case of candidates with narcissistic personality in psychoanalytic training. The question may be raised whether unusual life gratifications in early adulthood of gifted patients generally militate against treatment in some cases of narcissistic personalities, and whether psychoanalysis during middle and later adulthood might not have better prognosis in some of them.

Another major prognostic factor is the extent to which negative therapeutic reactions develop, typically linked with particularly severe, repressed or dissociated conflicts around envy. This is a type of negative therapeutic reaction not derived from superego factors and more severe than that seen in depressive-masochistic patients with a sadistic although integrated superego. Cases with relatively good quality of superego functioning (reflected in 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 behaviour, 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 favourable prognostic indicator for the analysis of narcissistic personalities. Insofar as a good development of sublimatory channels is intimately linked to the capacity for investment in value systems transcending narcissistic needs, the sublimatory potential of the patient is important too.

In contrast to the outstanding importance of the prognostic factors mentioned so far, tolerance of depression and mourning, and a predominance of transference potential for guilt versus a potential for paranoid rage, are of somewhat less overriding importance. Of even less prognostic importance are the non-specific manifestations of ego weakness, such as lack of impulse control and of anxiety tolerance, and even the potential for regression to primary process thinking if and when the patient does not function on an overt borderline level. This brings us to the general limitation of a strictly psychoanalytic approach for certain patients with narcissistic personality, namely, the disorganizing effect that psychoanalysis may have for narcissistic patients functioning on an over borderline level. For such people, I consider this approach generally contraindicated.

A particularly difficult prognostic estimate is involved in the case of potential candidates for psychoanalytic training with narcissistic personality structure. Obviously, the problem only comes up in those relatively well-adjusted narcissistic personalities whose social and professional functioning is satisfactory, who present high intelligence and particular talents, and at times appear unusually promising. In reviewing a number of cases in which, retrospectively, it

appeared that mistakes had been made both in accepting and rejecting some candidates, the two major prognostic factors that stand out as prognostically significant are the quality of object relationships and the integrity and depth of the value systems and superego functioning. It needs to be stressed again that I use the concept 'quality of object relations' to refer more to the quality of internalized object relations, i.e. the depth of the patient's internal relationships with others, rather than to the extent to which he is involved in social interactions. This clarification may be particularly relevant in discussing Kohut's work, because he tends to use the term 'object relation' in its behavioural sense rather than in the sense referred to in this paper. For instance, he states: 'The antithesis to narcissism is not the object relation but object love. An individual's profusion of object relations, in the sense of the observer of the social field, may conceal his narcissistic experience of the object world; and a person's seeming isolation and loneliness may be the setting for a wealth of current object investments' **(1971p. 228)**. Again (p. 283): 'The patient established object relations not primarily because she was attracted to people but rather as an attempt to escape from the painful narcissistic tensions.' In my view, narcissism (investment in the self), and object relations (investment in significant objects and their representations), go hand-in-hand, and their depth depends not only upon the vicissitudes of the libidinal investment, but, as stressed throughout this paper, on the aggressive investment as well. For practical purposes, object relations in depth involve the capacity both to love well, and to hate well, and particularly to tolerate varying combinations of loving and hateful feelings, and their toned down mingling in the relationship with the same object and with the self. Normal object relations as well as normal narcissism include an integrative conception in depth of others and oneself. All this is in striking contrast to the frequent blandness and uninvolvement, the lack of commitment to others as well as to any convictions about himself that one sees in narcissistic patients. Paradoxically, such lack of emotional depth and commitment may permit a better social functioning, for example, in certain political and bureaucratic organizations in which lack of commitments means survival and access to the top.

Applying all this to the particular case of prospective psychoanalytic candidates, systematic attempts to evaluate the realness, the aliveness of other people as they come through in the descriptions of the candidate, and the depth of the candidate as he describes himself, are important indicators of the quality of object relations, in addition to more observable aspects of stability, depth, and richness of the relationships with others and himself. The extent to which there is authentic human warmth and depth may be more difficult to evaluate but is even more important than the extent to which there is a commitment to ethical, intellectual, cultural or aesthetic values, the other major prognostic indicator in the special cases under examination. Sometimes the very good outcome in cases of psychoanalytic candidates who at first seemed highly questionable warrants to consider carefully all the elements of individual cases; and with the improvement in our therapeutic techniques there should be an increase in successful outcomes in the future.

While Kohut does not, as far as I can tell, refer specifically to prognostic differences with his approach for narcissistic personalities functioning on various levels of ego and superego integration, he conveys a generally optimistic outlook. Regarding the outcome with this approach he states: 'The most prominent non-specific change is the increase and the expansion of the patient's capacity for object love; the specific changes take place in the realm of narcissism itself' (p. 296). Kohut describes, as the result of his treatment approach, the internalization of the idealized parent imago (the archaic aspects of the imago) into the general structure of the ego and into the superego (the late pre-oedipal and oedipal aspects of the imago), leading to an improved functioning of the superego **(1971p. 288–9)**. Regarding the grandiose self, he states: 'The infantile grandiosity becomes gradually built into the ambitions and purposes of the personality and lends not only vigour to a person's mature strivings but also a sustaining positive feeling of the right to success' (p. 299). In my view, and on the basis of Kohut's published writings, his approach leads to a higher level functioning and better

adaptation of the grandiose self, in the context of the patient's shift from more primitive to more adaptive levels of mirror transferences, without a basic resolution of what I consider the pathological structure of the grandiose self. This may well be the reason 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 effects of his approach, if not his intentions and technique, have re-educative elements in them which foster a more adaptive use of the patient's grandiosity. A major question, that necessarily must remain open at this point, is what are the long-range effects of such an approach, or, for that matter, of both Kohut's approach and the alternative one I have outlined? A major test of the effectiveness of the treatment of narcissistic personalities is the adaptation of these patients to the stress and crises which the later stages of life unavoidably will bring about. We will need careful follow-up over long periods of time in order to separate the short-range consequences of treatment from the long-term consequences on their personality, intrapsychic as well as social functioning. This brings me to the last issue of this paper, namely, the prognosis of untreated narcissism.

I strongly agree with Kohut's conviction that narcissistic personality disorders should be treated by psychoanalysis whenever possible. Even in case which 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 that unresolved pathological narcissism often has during the second half of life. In my view, if psychoanalytic treatment can be carried out and is successful, improvement in these cases means a resolution of their pathological narcissism, the development of normal infantile and adult narcissism in the context of normal object relationships in depth, and what often amounts to a dramatic enrichment of life. In contrast, pathological narcissism has ominous long-range prognostic implications, even in cases of relatively young patients with excellent surface adaptation and very little awareness of illness or suffering on the patient's part. If we consider that throughout an ordinary life span most narcissistic gratifications occur in adolescence and early adulthood, and that even though narcissistic triumphs and gratifications are achieved throughout adulthood, the individual must eventually face the basic conflicts around ageing, chronic illness, physical and mental limitations, and above all, separations, loss, and loneliness—then we must conclude that the eventual confrontation of the grandiose self with 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 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. Perhaps the most frightening experience that narcissistic personalities need to ward off and eventually may have to face is that of a surrounding world empty of love and human contact, a world of dehumanized objects within which animate as well as inanimate objects have lost their previous, magically satisfying qualities.

One patient, a nationally known politician, had developed a serious physical illness which brought about the loss of his professional functions. He became depressed and developed deep feelings of defeat and humiliation accompanied by fantasies in which his political opponents were gloating with satisfaction over his defeat. His depression diminished. He went into retirement, but gradually devaluated the areas of political science in which he had been an expert. This was a narcissistic depreciation of that in which he was no longer triumphant, which brought about a general loss of interest in professional, cultural and intellectual matters. His primary areas of professional and intellectual interests no longer seemed exciting and reminded him again and again of his failure. He was

resentful of his dependency upon his wife and children, whom he had previously disregarded while dedicating all his energies to his professional life. His fears of being depreciated by his family motivated him toward ever increasing demands for reassurance and respect. Envious of the professional success of his children, and unable to obtain gratification of this success by means of empathic identification with them, he experienced an increasing sense of estrangement which finally evolved into the recurrence of a now severe, chronic depression, with a predominance of impotent rage over mourning processes as such.

The frightening sensation of futility and emptiness, the panic over the disintegration of the personal meaning of one's immediate environment that has been so dramatically evoked in the plays of Samuel Beckett, or in Eugene Ionesco's *The Chairs* and *Exit the King*, illustrate, it seems to me, the devastating effect of the conflicts of old age on persons with narcissistic personality. The normal reaction to loss, abandonment and failure is the reactivation of internalized sources of love and self-esteem intimately linked with internalized object relations, and reflects 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 reactivates, 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, to be in love, to feel empathy and deep gratification in identifying with loved people and values, a sense of transcendence with nature, of continuation within the historical process, and of oneness with a social or cultural group, are all 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 inability to come to terms with old age, to accept the fact that a younger generation now possesses many of the previously cherished gratifications of beauty, wealth, power and, particularly, creativity. To be able to enjoy life in a process involving a growing identification with other people's happiness and achievements is tragically beyond the capacity of narcissistic personalities. Therefore treatment geared to radically changing pathological narcissism may show its ultimate benefits over the entire life span left to the patient.

The clinical study of narcissistic personalities illustrates that the relationships of the individual with himself and with his surrounding human and inanimate world depends upon the development of normal or pathological internalized object relations. The loss of the world of loving and loved internal objects brings about the loss of meaning of the self and of the world. Psychotic depression represents, in many ways, the terrifying stage of awareness of the loss of love and meaning against which narcissistic personalities need to defend themselves, and schizoid emotional dispersal or a paranoid—not necessarily psychotic—reorganization of the world represents an alternative protection for these patients against the bleakness of depression, but at the cost of bringing about further dehumanization and emptiness. Therefore, and in spite of the limited number of patients whom 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 on the surface, looks deceivingly as if we were dealing with an almost 'normal' person.

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