The Psychoanalytic Treatment of Narcissistic Personality Disorders

Outline of a Systematic Approach

Introductory Considerations

The classification presented here of the transference-like structures mobilized during the analysis of narcissistic personalities is based on previous conceptualizations (Kohut, 1966b) of which only the following brief summary can be given. It was suggested that the child’s original narcissistic balance, the perfection of his primary narcissism, is disturbed by the unavoidable shortcomings of maternal care, but that the child attempts to save the original experience of perfection by assigning it, on the one hand, to a grandiose and exhibitionistic image of the self: the grandiose self,¹ and, on the other hand, to an admired you: the idealized parent imago. The central mechanisms these two basic narcissistic configurations employ in order to preserve a part of the original experience are, of course, antithetical. Yet they coexist from the beginning, and their individual and largely

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¹ The tautological term “narcissistic self” employed in “Forms and Transformations of Narcissism” (1966b) is now replaced by the term grandiose self.

independent lines of development are open to separate scrutiny. At this moment it can only be pointed out that, under optimum developmental conditions, the exhibitionism and grandiosity of the archaic grandiose self are gradually tamed, and that the whole structure ultimately becomes integrated into the adult personality and supplies the instinctual fuel for our ego-syntonic ambitions and purposes, for the enjoyment of our activities, and for important aspects of our self-esteem. And under similarly favorable circumstances, the idealized parent imago, too, becomes integrated into the adult personality. Introjected as our idealized superego, it becomes an important component of our psychic organization by holding up to us the guiding leadership of its ideals. If the child, however, suffers severe narcissistic traumata, then the grandiose self does not merge into the relevant ego content, but is retained in its unaltered form and strives for the fulfillment of its archaic aims. And if the child experiences traumatic disappointments in the admired adult, then the idealized parent imago, too, is retained in its unaltered form, is not transformed into tension-regulating psychic structure, but remains an archaic, transitional object that is required for the maintenance of narcissistic homeostasis.

Severe regressions, whether occurring spontaneously or during therapy, may lead to the activation of unstable, pre-psychological fragments of the mind-body-self and its functions that belong to the stage of autoerotism (cf. Nagera, 1964). The pathognomonically specific, transference-like, therapeutically salutary conditions on which I am focusing, however, are based on the activation of psychologically elaborated, cohesive configurations that enter into stable amalgamations with the narcissistically perceived psychic representation of the analyst. The relative stability of this narcissistic transference-amalgamation is the prerequisite for the performance of the analytic task in the pathogenic narcissistic areas of the personality.

The Narcissistic Transferences

I shall now examine the two narcissistic transferences delimited in accordance with the previously given conceptualizations: the therapeutic activation of the idealized parent imago, for which the term idealizing transference will be employed, and the activation of the grandiose self, which will be called the mirror transference.

Therapeutic Activation of the Idealized Parent Imago: The Idealizing Transference

The idealizing transference is the therapeutic revival of the early state in which the psyche saves a part of the lost experience of global narcissistic perfection by assigning it to an archaic (transitional) object, the idealized parent imago. Since all bliss and power now reside in the idealized object, the child feels empty and powerless when he is separated from it and he attempts, therefore, to maintain a continuous union with it.

Idealization, whether it is directed at a dimly perceived archaic mother-breast or at the clearly recognized oedipal parent, must genetically and dynamically be understood as a narcissistic phenomenon. The idealizing cathexes, however, although retaining their narcissistic character, become increasingly neutralized and aim-inhibited. It is especially in the most advanced stages of their early development that the idealizations (which now coexist with powerful object-instinctual cathexes) exert their strongest and most important influence on the phase-appropriate internalization processes. At the end of the oedipal period, for example, the internalization of object-cathedged aspects of the parental imago accounts for the contents (i.e., the commands and prohibitions) and functions (i.e., praise, scolding, punishment) of
the superego; the internalization of the narcissistic aspects, however, accounts for the exalted position of these contents and functions. It is from the narcissistic instinctual component of their cathexes that the aura of absolute perfection of the values and standards of the superego and of the omniscience and might of the whole structure are derived. The stream of narcissism that is subsumed under the term idealized parent imago remains vulnerable throughout its whole early development, i.e., from the stage of the incipient, archaic idealized object (which is still almost merged with the self) to the time of the massive reinternalization of the idealized aspect of the imago of the oedipal parent (who is already firmly established as separate from the self). The period of greatest vulnerability ends when an idealized nuclear superego has been formed, since the capacity for the idealization of his central values and standards that the child thus acquires exerts a lasting beneficial influence on the psychic economy in the narcissistic sectors of the personality.

The beginning of latency may be regarded as still belonging to the oedipal phase. It constitutes the last of the several periods of greatest danger in early childhood during which the psyche is especially susceptible to traumatization because, after a spurt of development, a new balance of psychological forces is only insecurely established. If we apply this principle of the vulnerability of new structures to the superego at the beginning of latency—to be specific, if we apply the principle not only to the content of the new values and standards but also, and especially, to the newly established idealization of these values and standards and to the newly established idealization of the rewarding and punishing functions of the superego—then it will not surprise us when we learn from clinical experience that a severe disappointment in the idealized oedipal object, even at the beginning of latency, may yet undo a precariously established idealization of the superego, may recathect the imago of the idealized object and thus lead to a renewed insistence on finding an external object of perfection.

Under optimal circumstances the child experiences gradual disappointment in the idealized object—or, expressed differently, the child's evaluation of the idealized object becomes increasingly realistic—which leads to a withdrawal of the narcissistic idealizing cathexes from the object imago and to their gradual (or more massive but phase-appropriate) internalization, i.e., to the acquisition of permanent psychological structures, which continue, endopsychically, the functions that had previously been fulfilled by the idealized object. If the child's relationship to the idealized object is, however, severely disturbed, e.g., if he suffers a traumatic (intense and sudden, or not phase-appropriate) disappointment in it, then the child does not acquire the needed internal structure, his psyche remains fixated on an archaic object imago, and the personality will later, and throughout life, be dependent on certain objects in what seems to be an intense form of object hunger. The intensity of the search for, and dependency on, these objects is due to the fact that they are striven for as a substitute for missing segments of the psychic structure. These objects are not loved for their attributes, and their actions are only dimly recognized; they are needed in order to replace the functions of a segment of the mental apparatus that had not been established in childhood.

The structural defects resulting from early disturbances in the relationship with the idealized object cannot be discussed within the confines of this essay. The following clinical illustration will, instead, focus on the effect of later traumatic disappointments, up to and including early latency.

Mr. A., a tall, asthenic man in his late twenties, was a chemist in a pharmaceutical firm. Although he entered analysis with the complaint that he felt sexually stimulated by men, it soon became apparent that his homosexual preoccupations constituted only one of the several indications of an
underlying broad personality defect. More important were periods of feeling depressed (with an associated drop in his work capacity), and, as a trigger to the preceding disturbance, a specific vulnerability of his self-esteem, manifested by his sensitivity to criticism or simply to the absence of praise from people he experienced as his elders or superiors. Thus, although he was a man of considerable intelligence who performed his tasks with skill and creative ability, he was forever in search of approval: from the head of the research laboratory where he was employed, from a number of senior colleagues, and from the fathers of the girls he dated. He was sensitively aware of these men and of their opinion of him. So long as he felt that they approved of him, he experienced himself as whole, acceptable, and capable and was indeed able to do well in his work and to be creative and successful. At slight signs of disapproval of him, however, or of lack of understanding for him, he became depressed, tended to become first enraged and then cold, haughty, and isolated, and his creativeness deteriorated.

The cohesive transference permitted the gradual reconstruction of a certain genetically decisive pattern. Repeatedly throughout his childhood, the patient had felt abruptly disappointed in the power of his father just when he had (re-)established him as a figure of protective strength and efficiency. As is frequent, the first memories the patient supplied subsequent to the transference activations of the crucial pattern referred to a comparatively late period. The family had come to the United States when the patient was nine, and the father, who had been prosperous in Europe, was unable to repeat his earlier successes in this country. Time and again, the father shared his newest plans with his son and stirred the child’s fantasies and expectations; but time and again he sold out in panic when the occurrence of unforeseen events and his lack of familiarity with the American scene combined to block his purposes. Although these memories had always been conscious, the patient had not previously appreciated the intensity of the contrast between the phase of great trust in the father, who inspired great confidence while he was forging his plans, and the subsequent disappointment.

Most prominent among the patient’s relevant recollections of earlier occurrences of the idealization-disappointment sequence were those of two events which affected the family fortunes decisively when the patient was six and eight years old respectively. The father, who during the patient’s early childhood had been a virile and handsome man, had owned a small but flourishing industry. Judging by many indications and memories, father and son had been very close emotionally, and the son had admired his father greatly. Suddenly, when the patient was six, German armies invaded the country, and the family, which was Jewish, fled. Although the father had initially reacted with helplessness and panic, he had later been able to re-establish his business, though on a much reduced scale, but, as a consequence of the German invasion of the country to which they had escaped (the patient was eight at that time), everything was again lost and the family had to flee once more.

The patient’s memories implicated the beginning of latency as the period when the structural defect was incurred. There is no doubt, however, that earlier experiences, related to his pathological mother, had sensitized him and accounted for the severity of the later-acquired structural defect.

Described in metapsychological terms, his defect was the insufficient idealization of the superego and, concomitantly, a recathexis of the idealized parent imago of the later pre-oedipal and the oedipal stages. The symptomatic result of this defect was circumscribed yet profound. Because the patient had suffered a traumatic disappointment in the narcissistically invested aspects of the father imago, his super-ego did not possess the requisite exalted status and was thus
unable to raise the patient's self-esteem. In view of the fact, however, that the patient had not felt equally deprived of those aspects of the father imago that were invested with object-instinctual cathexes, his superego was relatively intact with regard to those of its contents and functions that were built up as the heir to the object-instinctual dimensions of the oedipal father relationship. His nuclear goals and standards were indeed those of his cultural background, transmitted by his father; what he lacked was the ability to feel more than a fleeting sense of satisfaction when living up to his standards or reaching his goals. Only through the confirmatory approval of external admired figures was he able to obtain a sense of heightened self-esteem. In the transference he seemed insatiable in two demands he directed toward the idealized analyst: that the analyst share the patient's values, goals, and standards (and thus imbue them with significance through their idealization), and that the analyst confirm through the expression of a warm glow of pleasure and participation that the patient had lived up to his values and standards and had successfully worked toward a goal. Without the analyst's expression of his empathic comprehension of these needs, the patient's values and goals seemed to him trite and uninspiring, and his successes were meaningless and left him feeling depressed and empty.

The Genesis of the Pathogenic Fixation of the Idealized Parent Imago

As can be regularly ascertained, the essential genetic trauma is grounded in the parents' own narcissistic fixations, and the parents' narcissistic needs contribute decisively to the child's remaining enmeshed within the narcissistic web of the parents' personality until, for example, the sudden recognition of the shortcomings of the parent, or the child's sudden desperate recognition of how far out of step his own emotion-
stringent fashion. His exact feeding time, for example, and in later childhood his eating time, were determined by a mechanical timer—reminiscent of the devices Schreber's father employed with his children (Niederland, 1959b)—and thus the child felt that he had no mind of his own and that his mother was continuing to perform his mental functions long beyond the time when such maternal activities, carried out empathically, are indeed phase-appropriate and required. In later childhood, under the impact of the anxious recognition of the inappropriateness of this relationship, he withdrew to his room to think his own thoughts uninfluenced by her interference. When he had just begun to achieve some reliance on this minimum of autonomous functioning, his mother had a buzzer installed. From then on, she interrupted his attempts at internal separation from her whenever he wanted to be alone. The buzzer summoned him more compellingly (because the mechanical device was experienced as akin to an endopsychic communication) than her voice or knocking would have done. No wonder, then, that he reacted with rage to the return of the analyst after he had "rowed to the center of the lake to look at the moon."

The Process of Working Through and Some Other Clinical Problems in the Idealizing Transference

Little need be said concerning the beginning of the analysis. Although there may be severe resistances, especially those motivated by apprehensions about the extinction of individuality due to the wish to merge into the idealized object, the pathognomonic regression will establish itself spontaneously if the analyst does not interfere by premature transference interpretations. The working-through phase of the analysis can begin only after the pathognomonic idealizing transference has been firmly established. It is set into motion by the fact that the instinctual equilibrium that the analysand is trying to maintain is sooner or later disturbed. In the undisturbed transference, the patient feels powerful, good, and capable. Anything that deprives him of the idealized analyst, however, creates a disturbance of his self-esteem: he feels powerless and worthless, and if his ego is not assisted by interpretations concerning the loss of the idealized parent imago, the patient may turn to archaic precursors of the idealized parent imago or may abandon it altogether and regress further to reactively mobilized archaic stages of the grandiose self. The retreat to archaic idealizations may manifest itself in the form of vague, impersonal, trancelike religious feelings; the hypercathexis of archaic forms of the grandiose self and of the (autoerotic) body-self will produce the syndrome of emotional coldness, a tendency toward affectation in speech and behavior, shame propensity, and hypochondria.

Although such temporary cathectic shifts toward the archaic stages of the idealized parent imago and of the grandiose self are common occurrences in the analysis of narcissistic personalities, they may be precipitated by seemingly minute narcissistic injuries, the discovery of which may put the analyst's empathy and clinical acumen to a severe test.

The essence of the curative process in the idealizing transference can be epitomized in a few comparatively simple principles. A working-through process is set in motion in which the repressed narcissistic strivings with which the archaic object is invested are admitted into consciousness. Although the ego and superego resistances with which we are familiar from the analysis of the transference neuroses do also occur here, and although there are in addition specific ego resistances (motivated by anxiety concerning hypomanic overstimulation) that oppose the mobilization of the idealizing cathexes, the major part of the working-through process concerns the loss of the narcissistically experienced object. If
the repeated interpretations of the meaning of separations from the analyst on the level of the idealizing narcissistic libido are given with correct empathy for the analysand's feelings—in particular for what appears to be his lack of emotions, i.e., his coldness and retreat in response to separations, for example—then there will gradually emerge a host of meaningful memories concerning the dynamic prototypes of the present experience. The patient will recall lonely hours during his childhood in which he attempted to overcome a feeling of fragmentation, hypochondria, and deadness, which was due to the separation from the idealized parent. And he will remember, and gratefully understand, how he tried to substitute for the idealized parent imago and its functions by creating erotized replacements and through frantic hypercathexis of the grandiose self: how he rubbed his face against the rough floor in the basement, looked at the mother's photograph, went through her drawers and smelled her underwear; and how he turned to the performance of grandiose athletic feats in which he was enacting flying fantasies in order to reassure himself. Adult analogues in the analysis (during the weekend, for example) are intense voyeuristic preoccupations, the impulse to shoplift and recklessly speedy drives in the car. Childhood memories and deepening understanding of the analogous transference experiences converge in giving assistance to the patient's ego, and the formerly automatic reactions gradually become more aim-inhibited.

The ego acquires increasing tolerance for the analyst's absence and for his occasional failure to achieve a correct empathic understanding. The patient learns that the idealizing libido need not be immediately withdrawn from the idealized imago and that the painful and dangerous regressive shifts of the narcissistic cathexes can be prevented. Concomitant with the increase of the ability to maintain a part of the idealizing investment despite the separation, there is also an enhancement of internalization, i.e., the analysand's psychic organization acquires the capacity to perform some of the functions previously performed by the idealized object.

**TREATMENT OF NARCISSISTIC PERSONALITY DISORDERS**

**Psychological Activation of the Grandiose Self:**

**The Mirror Transference**

Analogous to the idealized object in the idealizing transference, it is the grandiose self that is reactivated in the transference-like condition referred to as the **mirror transference**.

The mirror transference constitutes the therapeutic revival of the developmental stage in which the child attempts to retain a part of the original, all-embracing narcissism by concentrating perfection and power upon a grandiose self and by assigning all imperfections to the outside.

The mirror transference occurs in three forms, which relate to specific stages of development of the grandiose self:

1. An archaic form in which the self-experience of the analysand includes the analyst; it will be referred to as **merger through the extension of the grandiose self**.
2. A less archaic form in which the patient assumes that the analyst is like him or that the analyst's psychological makeup is similar to his; it will be called the **alter-ego or twinship transference**.
3. A still less archaic form in which the analyst is experienced as a separate person who, however, has significance to the patient only within the framework of the needs generated by his therapeutically reactivated grandiose self. Here, the term **mirror transference** is most accurate and will again be employed. In this narrower sense, the mirror transference is the reinstatement of the phase in which the gleam in the mother's eye, which mirrors the child's exhibitionistic display, and other forms of maternal participation in the child's narcissistic enjoyment confirm the child's self-esteem and by a gradually increasing selectivity of these responses begin to channel it into realistic directions.
If the development of the grandiose self is traumatically disturbed, this psychic structure may become cut off from further integrative participation in the development of the personality. Insecurely repressed in an archaic form, it is, on the one hand, removed from further external influence, yet, on the other hand, continues to disturb realistic adaptation by its recurrent intrusions into the ego. In the mirror transference (in the narrower sense), however, it may become cohesively remobilized, and a new road to its gradual modification is opened.

The central activity in the clinical process during the mirror transference concerns the raising to consciousness of the patient’s infantile fantasies of exhibitionistic grandeur. In view of the strong resistances that oppose this process and the intensive efforts required in overcoming them, it may at times be disappointing for the analyst to behold the apparently trivial fantasy that the patient has ultimately brought into the light of day.

True, sometimes even the content of the fantasy permits an empathic understanding of the shame and hypochondria, and of the anxiety the patient experiences: shame, because the revelation is at times still accompanied by the discharge of unneutralized exhibitionistic libido, and anxiety because the grandiosity isolates the analysand and threatens him with permanent object loss.

Patient C., for example, told the following dream during a period when he was looking forward to being publicly honored: “The question was raised of finding a successor for me. I thought: How about God?” The dream was partly the result of the attempt to soften the grandiosity through humor; yet it aroused excitement and anxiety and led, against renewed resistances, to the recall of childhood fantasies in which he had felt that he was God.

In many instances, however, the nuclear grandiosity is only hinted at. Patient D., for example, recalled with intense shame and resistance that as a child he used to imagine that he was running the streetcars in the city. The fantasy appeared harmless enough, but the shame and resistance became more understandable when the patient explained that he was operating the streetcars via a “thought control” which emanated from his head, above the clouds.

Although the content of the grandiose fantasy cannot be further discussed here, it is important to clarify the role of the mirror transference which enables its emergence. As indicated before, the patient’s major resistances are motivated by his attempt to avoid dedifferentiating intrusions of the grandiose self and the narcissistic-exhibitionistic libido into the ego because he reacts to them with uneasy elation alternating with fear of permanent object loss, painful self-consciousness, shame-tension, and hypochondria. The transference functions as a specific therapeutic buffer. In the mirror transference, in the narrower sense, the patient is able to mobilize his grandiose fantasies and exhibitionism on the basis of the hope that the therapist’s empathic participation and emotional response will not allow the narcissistic tensions to reach excessively painful or dangerous levels. In the twinship and the merger, the analogous protection is provided by the long-term deployment of the narcissistic cathexes upon the therapist, who now is the carrier of the patient’s infantile greatness and exhibitionism.

Later, especially with the aid of the final clinical example given in this presentation, some of the specific, concrete clinical steps by which the mobilized infantile narcissistic demands gradually become tamed and neutralized will be demonstrated. But first we will examine the general significance of the mirror transference in the context of therapy.

The rational aims of therapy could not by themselves persuade the vulnerable ego of the narcissistically fixated analysand to forego denial and acting out and to face and examine the needs and claims of the archaic grandiose self.
In order to actuate and maintain in motion the painful process that leads to the confrontation of the grandiose fantasies with a realistic conception of the self and to the realization that life offers only limited possibilities for the gratification of the narcissistic-exhibitionistic wishes, a mirror transference must be established. If it does not develop, the patient's grandiosity remains concentrated upon the grandiose self, the ego's defensive position remains rigid, and ego expansion cannot take place.

The mirror transference rests on the therapeutic reactivation of the grandiose self. That the analyst can be enlisted in the support of this structure is an expression of the fact that the formation of a cohesive grandiose self was indeed achieved during childhood; the listening, perceiving, and echoing-mirroring presence of the analyst now reinforces the psychological forces that maintain the cohesiveness of the self-image, archaic and (by adult standards) unrealistic though it may be. Analogous to the therapeutically invaluable, controlled, temporary swings toward the disintegration of the idealizing parent imago when the idealizing transference is disturbed, we may encounter, as a consequence of a disturbance of the mirror transference, the temporary fragmentation of the narcissistically cathected, cohesive (body-mind) self and a temporary concentration of the narcissistic cathexes on isolated body parts, isolated mental functions, and isolated actions, which are then experienced as dangerously disconnected from a crumbling self. As is the case in the idealizing transference, these temporary disturbances of the transference equilibrium occupy, in the analysis of narcissistic personalities, a central position of strategic importance which corresponds to the place of the structural conflict in the ordinary transference neuroses, and their analysis tends to elicit the deepest insights and leads to the most solid accretions of psychic structure.

The following constitutes an especially instructive illustration of such a temporary regressive fragmentation of the therapeutically activated grandiose self.

Mr. E. was a graduate student who sought relief from painful narcissistic tension states by a number of perverse means in which the inconstancy of his objects and sexual goals were indicative of the fact that he could trust no source of satisfaction. This brief report concerns a weekend during an early phase of the long analysis when the patient was already beginning to realize that separations from the analyst upset his psychic equilibrium, but when he did not yet understand the specific nature of the support provided by the analysis. During earlier weekend separations, a vaguely perceived inner threat had driven him to dangerous voyeuristic activities in public toilets during which he achieved a feeling of merger with the man at whom he gazed. This time, however, he was able, through an act of artistic sublimation, not only to spare himself the aforementioned cruder means of protection against the threatened dissolution of the self, but also to explain the nature of the reassurance he was receiving from the analyst. During this weekend the patient painted a picture of the analyst. The key to the understanding of this artistic production lay in the fact that in it the analyst had neither eyes nor nose—the place of these sensory organs was taken by the analysand. On the basis of this evidence and of additional corroborative material, the conclusion could be reached that a decisive support to the maintenance of the patient's narcissistically cathected self-image was supplied by the analyst's perception of him. The patient felt whole when he thought that he was acceptingly looked at by an object that substituted for an insufficiently developed endopsychic function: the analyst provided a replacement for the lacking narcissistic cathexis of the self.

This analysis was carried out by a senior student at the Chicago Institute for Psychoanalysis under regular supervision by the author.
Some General Therapeutic Considerations
Concerning the Mirror Transference

The analysand's demands for attention, admiration, and for a variety of other forms of mirroring and echoing responses to the mobilized grandiose self, which fill the mirror transference in the narrow sense of this term, do not usually constitute great cognitive problems for the analyst, although he may have to mobilize much subtle understanding to keep pace with the patient's defensive denials of his demands or with the retreat from them when the immediate empathic response to them is not forthcoming. Here, it is of decisive importance that the analyst comprehend and acknowledge the phase-appropriateness of the demands of the grandiose self and that he grasp the fact that for a long time it is a mistake to emphasize to the patient that his demands are unrealistic. If the analyst demonstrates to the patient that the narcissistic needs are appropriate within the context of the total early phase that is being revived in the transference and that they have to be expressed, then the patient will gradually reveal the urges and fantasies of the grandiose self, and the slow process is thus initiated that leads to the integration of the grandiose self into a realistic structure of the ego and to an adaptively useful transformation of its energies.

The empathic comprehension of the reactivation of the earlier developmental stages (the alter-ego or twinship transference—the merger with the analyst through the extension of the grandiose self) is not easily achieved. It is, for example, usually difficult for the analyst to hold fast to the realization that the meagerness of object-related imagery with regard to current and past figures as well as with regard to the analyst himself is the appropriate manifestation of an archaic narcissistic relationship. A frequent misunderstanding of the mirror transference in general and of the therapeutic activation of the most archaic stages of the grandiose self in particular thus consists in its being mistaken for the outgrowth of a widespread resistance against the establishment of an object-instinctual transference. And many analyses of narcissistic personality disorders are either short-circuited at this point (leading to a brief analysis of subsidiary sectors of the personality in which ordinary transferences do occur while the principal disturbance, which is narcissistic, remains untouched) or are forced into a mistaken and unprofitable direction against the analysand's diffuse, nonspecific, and chronic ego resistances.

If, however, the establishment of a mirror transference is not prevented, the gradual mobilization of the repressed grandiose self will take place and a number of specific pathognomonic, and therapeutically valuable resistances will be set in motion. The principal end of the working-through processes in the idealizing transference is the internalization of the idealized object, which leads to the strengthening of the matrix of the ego and to the strengthening of the patient's ideals; the principal end of the working-through processes in the mirror transference is the transformation of the grandiose self, which results in a firming of the ego's potential for action (through the increasing realism of the patient's ambitions and in increasingly realistic self-esteem.

An important question posed by the analysis of narcissistic personalities, especially in the area of the grandiose self, concerns the degree of therapeutic activity that needs to be employed by the analyst. In applying Aichhorn's technique with juvenile delinquents (1936), for example, the analyst offers himself actively to the patient as a replica of his grandiose self, in a relationship resembling the twinship (or alter-ego) variant of a mirror transference (see also A. Freud's illuminating summary [1951]). A delinquent's capacity to attach himself to the analyst in admiration indicates that an idealized parent imago and the deep wish to form an idealizing transference are (preconsciously) present, but, in con-
sequence of early disappointments, they are denied and hidden. It was Aichhorn's special understanding for the delinquent that led him to offer himself as a mirror image of the delinquent's grandiose self. He was thus able to initiate a veiled mobilization of idealizing cathexes toward an idealized object without disturbing the necessary protection of the defensively created grandiose self and its activities. Once a bond is established, a gradual shift from the omnipotence of the grandiose self to the more deeply longed-for omnipotence of an idealized object (and the requisite therapeutic dependence on it) can be achieved.

In the analytic treatment of the ordinary cases of narcissistic personality disturbance, the active encouragement of idealization is not desirable. It leads to the establishment of a tenacious transference bondage, bringing about the formation of a cover of massive identification and hampering the gradual alteration of the existing narcissistic structures. But a spontaneously occurring therapeutic mobilization of the idealized parent imago or of the grandiose self is indeed to be welcomed and must not be interfered with.

There are two antithetical pitfalls concerning the form of interpretations that focus on the narcissistic transferences: the analyst's readiness to moralize about the patient's narcissism and his tendency to theorize instead of interpreting the genetics and dynamics of the patient's narcissism with reference to his concrete experiences.

The triad of value judgments, moralizing, and therapeutic activism in which the analyst steps beyond the basic analytic attitude to become the patient's leader and teacher is most likely to occur when the psychopathology under scrutiny is not understood metapsychologically. Under these circumstances the analyst can hardly be blamed when he tends to abandon the ineffective analytic armamentarium and instead offers himself to the patient as an object to identify with in order to achieve therapeutic changes. If the analyst can tolerate lack of success in areas he does not yet understand metapsychologically without abandoning analytic means, then the occurrence of new analytic insights is not prevented and scientific progress can be made.

Where metapsychological understanding is not entirely lacking but is incomplete, analysts tend to supplement their interpretations with suggestive pressure, and the weight of the therapist's personality becomes of greater importance. There are certain analysts who are said to be exceptionally gifted in the analysis of "borderline" cases, and anecdotes about their therapeutic activities become widely known in analytic circles. But just as the surgeon, in the heroic era of surgery, was a charismatically gifted individual who performed great feats of courage and skill, while the modern surgeon tends to be a calm, well-trained craftsman, so also with the analyst. As our knowledge about the narcissistic disorders increases, their treatment becomes the work of analysts who do not employ any special charisma, but restrict themselves to the use of the tools that provide rational success: interpretations and reconstructions. There are, of course, moments when a forceful statement is indicated as a final move in persuading the patient that the gratifications obtained from the unmodified narcissistic fantasies are spurious. A skillful analyst of an older generation, for example, it is asserted by local psychoanalytic lore, would make his point at a strategic juncture by silently handing over a crown and scepter to his unsuspecting analysand instead of confronting him with yet another verbal interpretation. In general, however, the psychoanalytic process is most enhanced if we trust the spontaneous synthetic functions of the patient's ego to integrate the narcissistic configurations gradually, in an atmosphere of analytic-empathic acceptance, instead of driving the analysand toward an imitation of the analyst's scornful rejection of the analysand's lack of realism.

The second danger—that interpretations regarding the
narcissistic transference might become too abstract—can be
much diminished if we avoid falling victim to the widespread
confusion between object relations and object love. We must
bear in mind that our interpretations about the idealizing
transference and the mirror transference are statements
about an intense object relation, despite the fact that the
object is invested with narcissistic cathexes, and that we are
explaining to the analysand how his very narcissism leads him
to a heightened sensitivity about certain aspects and actions
of the object, the analyst, whom he experiences in a narciss­
istic mode.

If the analyst's interpretations are noncondemnatory; if he
can clarify to the patient in concrete terms the significance
and the meaning of his (often acted-out) messages, of his
seemingly irrational hypersensitivity, and of the back-and­
forth flow of the cathexis of the narcissistic positions; and
especially if he can demonstrate to the patient that these
archaic attitudes are comprehensible, adaptive, and valuable
within the context of the total state of personality develop­
ment of which they form a part—then the mature segment of
the ego will not turn away from the grandiosity of the archaic
self or from the awesome features of the overestimated, nar­
cissistically experienced object. Over and over again, in
small, psychologically manageable portions, the ego will deal
with the disappointment at having to recognize that the
claims of the grandiose self are unrealistic. And, in response
to this experience, it will either mournfully withdraw a part
of the narcissistic investment from the archaic image of the
self, or it will, with the aid of newly acquired structure,
neutralize the associated narcissistic energies or channel them
into aim-inhibited pursuits. And over and over again, in
small, psychologically manageable portions, the ego will deal
with the disappointment at having to recognize that the
idealized object is unavailable or imperfect. And, in response
to this experience, it will withdraw a part of the idealizing

investment from the object and strengthen the corresponding
internal structures. In short, if the ego learns first to accept
the presence of the mobilized narcissistic structures, it will
gradually integrate them into its own realm, and the analyst
will witness the establishment of ego dominance and ego
autonomy in the narcissistic sector of the personality.

Reactions of the Analyst

Reactions of the Analyst during the Mobilization of the
Patient's Idealized Parent Imago in the
Idealizing Transference

Some time ago I was consulted by a colleague concerning
a stalemate that seemed to have been present from the
beginning of the analysis and to have persisted through two
years of work. Since the patient, a shallow, promiscuous
woman, showed a serious disturbance of her ability to estab­
lish meaningful object relations and presented a history of
severe childhood traumata, I tended initially to agree with
the analyst that the extent of the narcissistic fixations pre­
vented establishing that minimum of transference without
which analysis cannot proceed. Still, I asked the analyst for
an account of the early sessions, with particular attention to
the activities on his part that the patient might have expe­
rrienced as a rebuff. Among the earliest transference mani­
festations, several dreams of this Catholic patient had con­
tained the figure of an inspired, idealistic priest. While these
early dreams had remained uninterpreted, the analyst re­
membered—clearly against resistance—that he had subse­
quently remarked that he was not a Catholic. He had justified
this move by her supposed need to be acquainted with a
minimum of the actual situation, since, in his view, the
patient's hold on reality was tenuous. This event must have
been very significant for the patient. We later understood
that, as an initial, tentative transference step, she had revived a specific attitude that had been present in early adolescence, namely an attitude of idealizing religious devotion. Her adolescent religiosity, it may be added, had been in turn the revival of certain states of awe and admiration that had occurred in her childhood. These earliest idealizations, as we could conclude later, had been a refuge from bizarre tensions and fantasies caused by traumatic stimulations and frustrations from the side of her pathological parents. The analyst’s misguided remark that he was not a Catholic—i.e., not an idealized good and healthy version of the patient—constituted a rebuff for her and led to the stalemate, which the analyst, with the aid of a number of consultations concerning this patient and his response to her, was later largely able to break.

I am focusing neither on the transference nor on the effect of the analyst’s mistake on the analysis, but on the elucidation of a countertransference symptom. A combination of circumstances, among them the fact that I have observed other similar incidents, allows me to offer the following explanation with a high degree of conviction. An analytically unwarranted rejection of a patient’s idealizing attitudes is usually motivated by a defensive fending off of narcissistic tensions, experienced as embarrassment and even leading to hypochondriacal preoccupations, which are generated in the analyst when repressed fantasies of his grandiose self become stimulated by the patient’s idealization.

Are these reactions of the analyst in the main motivated by current stress, or are they related to the dangerous mobilization of specific repressed unconscious constellations?

In a letter to Binswanger (1957), Freud expressed himself as follows about the problem of countertransference: “What is given to the patient,” Freud said, must be “consciously allotted, and then more or less of it as the need may arise. Occasionally a great deal . . . .” And then Freud set down the crucial maxim: “To give someone too little because one loves him too much is being unjust to the patient and a technical error” (p. 50).

If a patient’s incestuous object-libidinal demands elicit an intense unconscious response in the analyst, he may become overly technical vis-à-vis the patient’s wishes or will not even recognize them; at any rate, his ego will not have the freedom to choose the response required by the analysis. A parallel situation may arise in the analysis of a narcissistic personality disturbance when the remobilization of the idealized parent imago prompts the analysand to see the analyst as the embodiment of idealized perfection. If the analyst has not come to terms with his own grandiose self, he may respond to the idealization with an intense stimulation of his unconscious grandiose fantasies and an intensification of defenses, which bring about his rejection of the patient’s idealizing transference. If the analyst’s defensive attitude becomes chronic, establishment of a workable idealizing transference is interfered with and the analytic process is blocked.

It makes little difference whether the rejection of the patient’s idealization is blunt, which is rare, or subtle (as in the instance reported), which is common, or, which is most frequent, almost concealed by correct but prematurely given genetic or dynamic interpretations (such as the analyst’s quickly calling the patient’s attention to idealized figures in his past or pointing out hostile impulses that supposedly underlie the idealizing ones). The rejection may express itself through no more than a slight overobjectivity of the analyst’s attitude, or it may reveal itself in the tendency to disparage the narcissistic idealization in a humorous and kindly way. And finally, it is even deleterious to emphasize the patient’s assets at a time when he attempts the idealizing expansion of the ingrained narcissistic positions and feels insignificant by comparison with the therapist—appealing though it might seem when the analyst expresses respect for his patient. In
short, during those phases of the analysis of narcissistic personalities when an idealizing transference begins to germinate, there is only one correct analytic attitude: to accept the admiration.

Reactions of the Analyst during the Therapeutic Mobilization of the Patient’s Grandiose Self in the Mirror Transference

The mirror transference occurs in different forms which expose the analyst to different emotional tasks. In the mirror transference in the narrower sense, the patient reacts to the ebb and flow of the analyst’s empathy with and response to his narcissistic needs, and the presence of the analyst is thus acknowledged. Even these circumstances may elicit reactions in the analyst that interfere with the therapeutic reactivation of the grandiose self, since the analyst’s own narcissistic needs may make him intolerant of a situation in which he is reduced to the role of mirror for the patient’s infantile narcissism. In the twinship (alter-ego) and merger varieties of the remobilization of the grandiose self, however, the analyst is deprived of even the minimum of narcissistic gratification: the patient’s acknowledgment of his separate existence. Whereas in the mirror transference the analyst may become incapable of comprehending the patient’s narcissistic needs and of responding to them, the most common dangers in the twinship or merger are his boredom, his lack of emotional involvement with the patient, and his precarious maintenance of attention. A theoretical discussion of these failures must be omitted here. It would require, on the one hand, an examination of the psychology of attention in the absence of stimulation by object cathexes, and, on the other hand, the study of certain aspects of the vulnerability of empathy in analysts that are genetically related to the fact that a specific empathic sensitivity, acquired in an early narcissistic relation-

ship, often contributes decisively to the motivation for becoming an analyst. Instead of a theoretical discussion, the attempt will be made to illuminate the subject matter with the aid of a clinical example.

Miss F., age twenty-five, had sought analysis because of diffuse dissatisfactions. Although she was active in her profession and had numerous social contacts, she was not intimate with anyone and felt different from other people and isolated. She had a series of love relationships, but had rejected marriage because she knew that such a step would be a sham. She was subject to sudden changes in her mood with an associated uncertainty about the reality of her feelings and thoughts. In metapsychological terms, the disturbance was due to a faulty integration of the grandiose self, which led to swings between states of anxious excitement and elation over a secret “preciousness” that made her vastly better than anyone else (during times when the ego came close to giving way to the hypercathcted grandiose self) and states of emotional depletion (when the ego used all its strength to wall itself off from the unrealistic grandiose substructure). Genetically, the fact that the mother had been depressed during several periods early in the child’s life had prevented the gradual integration of the narcissistic-exhibitionistic cathexes of the grandiose self. During decisive periods of her childhood, the girl’s presence and activities had not called forth maternal pleasure and approval. On the contrary, whenever she tried to speak about herself, the mother deflected, imperceptibly, the focus of attention to her own depressive self-preoccupations, and thus the child was deprived of the optimal maternal acceptance that transforms crude exhibitionism and grandiosity into adaptably useful self-esteem and self-enjoyment.

During extended phases of the analysis, beginning at a time when I did not yet understand Miss F.’s psychopathology, the following progression of events frequently occurred.
during analytic sessions. The patient arrived in a friendly mood, settled down quietly, and began to communicate her thoughts and feelings: about current topics, the transference, and insights concerning the connection between present and past and between transferences upon the analyst and analogous strivings toward others. In brief, the first part of the sessions had the appearance of a well-moving self-analysis when the analyst is indeed little else than an interested observer who holds himself in readiness for the next wave of resistances. The stage in question lasted much longer, however, than the periods of self-analysis encountered in other analyses. I noted, furthermore, that I was not able to maintain the attitude of interested attention that normally establishes itself effortlessly and spontaneously when one listens to an analysand's work of free associations during periods of relatively unimpeded self-analysis. And, finally, after a prolonged period of ignorance and misunderstanding during which I was inclined to argue with the patient about the correctness of my interpretations and to suspect the presence of stubborn hidden resistances, I came to the crucial recognition that the patient demanded a specific response to her communications and that she completely rejected any other. Unlike the analysand during periods of genuine self-analysis, Miss F. could not tolerate the analyst's silence; at approximately the midpoint of the sessions, she suddenly became violently angry at me for being silent. (The archaic nature of her need, it may be added, was betrayed by the suddenness with which it appeared—like the sudden transition from satiation to hunger or from hunger to satiation in very young children.) I gradually learned that she immediately became calm and content when, at these moments, I simply summarized or repeated what she had in essence already said (such as, "You are again struggling to free yourself from becoming embroiled in your mother's suspiciousness against men."). Or, "You have worked your way through to the understanding that the fantasies about the visiting Englishman are reflections of fantasies about me"). But if I went beyond what Miss F. herself had already said or discovered, even by a single step only (such as: "The fantasies about the visiting foreigner are reflections of fantasies about me and, in addition, I think that they are a revival of the dangerous stimulation to which you felt exposed by your father's fantasy-stories about you"), she again became violently angry (regardless of the fact that what I had added might be known to her, too), and furiously accused me, in a tense, high-pitched voice, of undermining her, that with my remark I had destroyed everything she had built up, and that I was wrecking the analysis.

Certain convictions can only be acquired first hand, and I am thus not able to demonstrate in detail the correctness of the following conclusions. During this phase of the analysis the patient had begun to remobilize an archaic, intensely cathected image of the self that had heretofore been kept in repression. Concomitant with the remobilization of the grandiose self, on which she had remained fixated, there also arose the renewed need for an archaic object that would be nothing more than the embodiment of a psychological function that the patient's psyche could not yet perform for itself: to respond empathically to her narcissistic display and to provide her with narcissistic sustenance through approval, mirroring, and echoing. The patient thus attempted, with the aid of my confirming, mirroring presence, to integrate a hypercathected archaic self with the rest of her personality. This process began with a cautious reinstatement of a sense of the reality of her thoughts and feelings; it later moved gradually toward the transformation of her intense exhibitionist needs into an ego-syntonic sense of her own value and an enjoyment of her activities.

Due to the fact that I was at that time not sufficiently alert to the pitfalls of such transference demands, many of my
interventions interfered with the work of structure formation. But I know that the obstacles that opposed my understanding lay not only in the cognitive area; and I can affirm, without transgressing the rules of decorum and without indulging in the kind of immodest self-revelation that ultimately hides more than it admits, that there were specific hindrances in my own personality standing in my way. There was a residual insistence, related to deep and old fixation points, on seeing myself in the narcissistic center of the stage; and, although I had of course for a long time struggled with the relevant childhood delusions and thought that I had, on the whole, achieved dominance over them, I was not up to the extreme demands posed by the conceptually unaided confrontation with the reactivated grandiose self of my patient. Hence, I refused to entertain the possibility that I was not an object for the patient, not an amalgam with the patient’s childhood loves and hatreds, but only, as I reluctantly came to see, an impersonal function, without significance except insofar as it related to the kingdom of her own remobilized narcissistic grandeur and exhibitionism. For a long time I insisted, therefore, that the patient’s reproaches related to specific transference fantasies and wishes on the oedipal level—but I could make no headway in this direction. It was ultimately, I believe, the high-pitched tone of her voice, which expressed such utter conviction of being right—the conviction of a very young child, a pent-up, heretofore unexpressed conviction—that led me to the right track. I recognized that whenever I did more (or less) than provide simple approval or confirmation in response to Miss F.’s reports of her own discoveries I became for her the depressive mother who deflected the narcissistic cathexes from the child upon herself, or who did not provide the needed narcissistic echo.

The clinical situation described in the foregoing pages, especially the analyst’s therapeutic responses to it require further elucidation. The first impression might be that I am advocating the analyst’s indulgence of the analysand’s transference wish; 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” (Alexander, French, et al., 1946).

There are indeed patients for whom this type of indulgence is not only a temporary tactical requirement during certain stressful phases of analysis, but who cannot ever undertake the steps leading to the increased ego dominance over the childhood wish that is the specific aim of psychoanalytic work. And there is furthermore no doubt that, occasionally, the indulgence of an important childhood wish—especially if it is provided with an air of conviction and in a therapeutic atmosphere that carries a quasi-religious, magical connotation of the efficacy of love—can have lasting beneficial effects with regard to the relief of symptoms and behavioral change in the patient.

The analytic process in analyzable cases, however, as in the one described in the present clinical vignette, develops in a different way. Although, for tactical reasons, 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. The recognition of Miss F.’s specific childhood demand was only the beginning of the working-through process concerning the grandiose self. It was followed by the recall of clusters of analogous memories concerning her mother’s entering a phase of depressive self-preoccupation during later periods of the patient’s life. Finally, a central set of poignant memories, upon which a series of earlier and later ones seemed to be telescoped, referred specifically to episodes when she came home from kindergarten and early elementary school. At such times she would rush home as fast as she
could, joyfully anticipating telling her mother about her success in school. She recalled how her mother opened the door, but, instead of the mother's face lighting up, her expression remained blank; and how, when the patient began talking about school and play and about her achievements and successes of the preceding hours, the mother appeared to listen and participate, but imperceptibly the topic of the conversation shifted and the mother began to talk about herself, her headache and her tiredness and her other physical self-preoccupations. All the patient could directly recall about her own reactions was that she felt suddenly drained of energy and empty; she was for a long time unable to remember feeling any rage at her mother on such occasions. It was only after a prolonged period of working through that she could gradually establish connections between the rage she experienced against me when I did not understand her demands, and feelings she had experienced as a child. This phase was followed by her disclosing, bit by bit, her persistent infantile grandiosity and exhibitionism, revelations that were accompanied by shame and anxiety. The working through accomplished during this period led ultimately to increased ego dominance over the old grandiosity and exhibitionism, and thus to greater self-confidence and to other favorable transformations of her narcissism in this segment of her personality.

Concluding Remarks

The foregoing examination must, in its entirety, be considered a summarizing preview of a broader study; therefore, no retrospective survey of the findings and opinions presented will be given. It must be stressed that some important aspects of the subject matter either could only be mentioned briefly or had to be disregarded altogether.

Thus, as mentioned initially, it was necessary to omit almost all references to the work of others, such as the significant contributions by Hartmann (1953), Eissler (1953), Jacobson (1964), and Reich (1960); furthermore, it was not possible to compare the approach toward our subject matter taken in the present study with that chosen by such important authors as Federn (1936), on the one hand, and Mahler (1952), on the other; and, finally, still within the same context, it was not possible to discuss the work of Melanie Klein and her school, which often appears to be concerned with disorders that are related to those scrutinized in this essay.

No attempt was made to define and delimit the area of psychopathology with which this study is dealing; the question of the appropriateness of the use of the term transference in the present context could not be taken up; the discussion of the role of aggression had to be by-passed; the recurrent traumatic states in which the focus of the analysis shifts temporarily to the almost exclusive consideration of the overburdenedness of the psyche could not be illuminated; many other difficulties, therapeutic limitations and failures were not considered; and, most regrettably, it was not possible to demonstrate the specific wholesome changes that occur as the result of the transformation of the narcissistic structures and of their energies. In all, it was the aim of this contribution to give the outline of a systematic approach to the psychoanalytic treatment of narcissistic personalities; a thorough scrutiny of the subject could not be undertaken.