The path from narcissism to self pathology is described through five case vignettes. In Analysis Terminable and Interminable Freud presented a case illustration to argue that when a negative transference is not present, it can not be analyzed. After Freud, some analysts seem to have taken this argument a step further. They assumed that a patient's admiration of the analyst invariably conceals devaluation and therefore, beneath the positive transference there always lurks a negative transference. In this same paper Freud also described two “bedrocks”, which psychoanalysis can not penetrate. A man must accept his passive, feminine attitude toward another man. A woman must accept that she lacks a penis. Subsequently, these clinical and theoretical narcissistic issues have been reconceptualized within self pathology.

The diagnosis of narcissism was based on an inability to relate to other people due to a fixation to an early stage of development. Additionally, narcissism signified defenses against rage, envy and dependency. A vignette from a published case illustrates the analyst's use of interpretations and confrontations to point out a patient's denial of envy and hostility toward him. A contrasting, published, case vignette illustrates that resistances to analysis and concealed motives to devalue or depreciate the analyst, can be better understood as self protective and as deeply felt needs to be recognized. Significant differences between the theories of narcissism of the treating analysts are described. The two analyst-patient pairs created different pictures of narcissistic pathology, ushering in the shift from narcissism to self pathology. A fourth vignette illustrates the value of recognizing a normal Oedipal phase in the transference and a fifth vignette highlights the pitfalls when the analyst assumes that his or her reactions to the patient provide an insight into the patient's motivations. The question posed by the title of the paper is answered: self pathology is both a new perspective on pathology and a new pathology.

An analyst described the following experience with a former patient. This patient had initially consulted the analyst because he thought him to be someone superior to himself. Many years after having completed a successful analysis this patient consulted the analyst. For no apparent reason, he again felt troubled. In this consultation the patient reproached his former analyst for having given him an incomplete analysis. He argued that the analyst should have known that “… a transference-relation can never be purely positive; he should have given his attention to the possibilities of a negative transference” (1).

The analyst was Freud and he presented this vignette in Analysis Terminable and Interminable. He argued that at the time of the analysis, there was no sign of a negative transference. He added that an analyst cannot analyze what is not present. In this same paper Freud also described two “bedrocks,” which psychoanalysis can not penetrate. A man must accept his passive, feminine attitude toward another man. A woman must accept that she lacks a penis. That was in 1937.

By the middle of the 20th Century the topics referred to by Freud, the positive or idealizing transference, and the “bedrocks” in development, were re-opened by new conceptualizations of narcissism. Freud's patient's accusations became analyzable transferences and the “bedrocks” became metaphors for feelings of disappointment, powerlessness, injury, and vulnerability. To bring us into the 21st Century, I will trace one path leading from these reconceptualizations of narcissism and describe four cases that illustrate steps toward the broader conceptualization of self pathology.
In effect Freud asked his former analysand to be reasonable and not entertain such unrealistic expectations of perfection. With respect to the “bedrock” issues, a man's fear of his feminine attitude and a woman's penis envy, Freud took a similar position. He had taken fantasies, bodily allusions, and imagery quite literally. Rather than viewing them as metaphors open to further investigation, he had concluded that they were realistic limitations and not analyzable. In this light the only path left open to Freud and his patients was acceptance of one's anatomy and renunciation of claims to the contrary. According to these early views, narcissistic people could not accept conventional constrictions and anatomical limitations. In their boundless grandiosity they expected unquestioned control over others and omniscience and perfect attunement of those from whom they expect caretaking. That is, narcissistic people were viewed as insisting that their unrealistic expectations be met, whether in analysis or in life.

The diagnosis of narcissism was based on an inability to relate to other people due to a fixation to an early stage of development. Additionally, narcissism came to signify defenses against rage, envy and dependency (2). Such patients could not feel for or relate to other people. They could not form analyzable transferences and required a treatment approach that used confrontations to prompt a renunciation of infantile narcissism. Typical of analyses guided by this view, is the following case published by Kernberg in 1970. It illustrates psychoanalytic treatment of a patient with a narcissistic character structure. His narcissism and its transference manifestations were viewed as obstacles to psychoanalytic treatment.

The patient was described as spending hour after hour over many months complaining how monotonous, hopeless, and boring analysis had become. But, outside the analytic hours he felt rather good. The analyst pointed out to the patient that implicit in his description of analysis was a description of the analyst as the provider of useless and silly treatment. That is, the patient's criticism of analysis was interpreted as a covert denigration of the analyst. The case report continued with the analyst's description of his conscientious, relentless confrontations of the patient's denial of aggression, envy, and dependency. Eventually the patient expressed admiration for the analyst at not having become confused and discouraged by him. The patient indicated that he would like to handle his detractors in a similar way. The analyst continued his confrontation of the patient's denial of aggression and suggested that the patient could not acknowledge the analyst's help and instead tried to “steal” his interpretations.

This case illustrates the confrontation of narcissistic transferences. The patient's boring monotonous manner was viewed as symptomatic of his interpersonal detachment. Devaluation of the analyst was viewed as reflecting grandiosity. In interpretations and confrontations, the patient was apprised of inconsistencies that pointed to a denial of envy and hostility toward others including the analyst. Furthermore, the analyst distrusted the genuineness of the patient's admiration of him and viewed it as concealing envy and aggression. A theoretical perspective of narcissism dictated this treatment approach and influenced the patient-analyst interaction. When treatment is based on this perspective, the patient can be subjected to rapid fluctuations in self esteem as confrontations threaten the integrity and maintenance of his self organization. The patient's demand for support from the analyst then increases. Thus manifestations of narcissistic pathology, feelings of vulnerability and disorganization, as well as the patient's detachment in the transference may be increased by the analyst. As with some other forms of psycho-pathology, the impact of the analyst, including his theory and his technique, may exaggerate the very state of fragility that necessitated the development and formation of the pathological character structure.

After Freud, some analysts seem to have taken the vignette of his critical former analysand a step further. They assumed that admiration and idealization of the analyst invariably conceals criticism and devaluation. That is, they assume that beneath the positive transference there always lurks a negative transference. This assumption has been handed down by one generation of analysts to the next. It can be contrasted with a quite different set of assumptions illustrated by Kohut's (3) treatment of a patient, Miss F.

Miss F described a diffuse sense of dissatisfaction. Like the previous patient who felt good outside the analytic hours, Miss F's life outside analysis was active although she was not intimate with anyone. During phases of the analysis, Kohut noted that he could not maintain his customary
attitude of interested attention. However, he did not ascribe his lapses of attention to hostile or evasive
motives of the patient. Rather, he eventually recognized that his patient required a specific response and she
rejected those that did not feel right to her. Kohut did not interpret her rejection of his responses as
resistance, grandiosity, or as indicative of her overwhelming sense of entitlement. Specifically, he reported,
“(…) at approximately the midpoint of the session, she would suddenly get violently angry at me for being
silent. (…) she would immediately become calm and content when I, at these moments, simply summarized
or repeated what she had in essence already said. But if I went beyond what the patient had already said or
discovered, even by a single step (…) she would again get violently angry, and would furiously accuse 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” (3). In the analysis of Miss F, Kohut was “led on the right
track (by) (…) 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, here to fore unexpressed conviction.” He came to recognize a
specific analyzable transference, a narcissistic mirroring transference, rooted in a supressed childhood need
that required recognition and validation. Miss F was understood to require a specific tie to her analyst and
to prevent him from veering from the narrow range of responses left open to him. When he added a remark
to what Miss F had come to on her own, he repeated her childhood experience with her depressed mother
who subtly and continuously deflected attention from the child to herself.

What had been previously seen as resistances to analysis and as concealed motives to devalue or
depreciate the analyst, was understood by Kohut as self protective and as a deeply felt need to be
recognized. In the only way she could communicate, Miss F indicated that she needed her analyst to supply
the echo that provided an essential validation for her affectivity.

A comparison between the two case reports suggests some similarity between the patients with respect
to their inaccessibility, the obstacles they presented to analysis, fluctuations in their self esteem, and
subjective states of depletion and emptiness. But, there were significant differences between the analysts.
Narcissistic pathology came to be seen by Kohut not at the expense of relatedness but at the expense of
mature forms of narcissism such as empathy and self esteem regulation. Rather than confront the patient's
inability to relate, the task for the analyst was to accept the only way the patient could relate. In so doing,
Kohut proposed, analyzable narcissistic transferences would become engaged and evolve. Furthermore, by
investigating transference ruptures that inevitably occur, a mature integration of the sense of self would
follow.

Beyond the intrinsic differences between the two patients, the two analyst-patient pairs created
different pictures of narcissistic pathology. These differences in the analyst-patient dyads usher in the shift
from narcissism to self pathology. Subsumed within this shift is an expanded view of transference as co-
constructed by analyst and patient (4). When narcissism is viewed from this new vantage point, an uniquely
different picture of the patient, the transference, and the pathology emerges.

Soon after his analysis of Miss F, Kohut (5) replaced the term “narcissistic transferences” with the
term “selfobject transferences” to capture the manner in which another person is experienced as providing
functions that pertain to the maintainance or restoration of one's sense of self. A patient's feelings of
depletion and boredom in analysis were understood as a consequence of repeated ruptures, failures, or
disappointments in their ties to parental figures in childhood. That is, when parents fulfill their parental
functions, they can be experienced by the child as providing needed self regulation, self maintainance, and
self enhancement. They are experienced as fulfilling selfobject functions. Their “failures” to enable their
child to have selfobject experiences can be accounted for on the basis of parental pathology, or to a poor fit
between the capabilities of the parents and the needs of the child. Self pathology may then become
manifested in the developing child and adult as evidenced by a cold, detached, or depressed manner,
fluctuations in self esteem such as feelings of inadequacy and grandiosity, and hypochondriacal symptoms.

Formulating psychopathology in terms of the vulnerability of the sense of self has had important
therapeutic implications. The analytic approach to self pathology addresses the patient's attempts in
overwhelming. This approach can be illustrated by an analysis, under my supervision (6). The patient, a graduate student in psychology, was riddled with feelings of inadequacy and social anxiety. His Oedipal development was characterized by open fear of and hostility toward his father and a wariness about his mother's seductiveness and over protection. From early adolescence onward, the patient sexual life remained on a fantasy level. He lived vicariously through the heterosexual exploits of a male friend. Direct contact with women was anxiety ridden as he imagined that they would mock his inexperience. He was socially reclusive, had friendships with some “older” women and was quite anxious in relation to male peers.

In the fourth year of his analysis, the patient went through a moderately intense competitive transference phase. Initially quite tentatively but then more boldly, he announced that he was more knowledgable than his analyst in matters of religion, psychoanalysis and music. He also implied that he was physically more attractive and more athletic than his analyst. These convictions were explored with the recognition that they signalled the patient's increased feeling of gender-related self-confidence. They were not interpreted as attempts to denigrate or devalue the analyst but understood as indications that he felt “safe” enough to risk competition. A belated Oedipal phase emerged in the analysis, one that had previously been suffused with anxiety, shame, and parental aggression and seductiveness. The patient's sexual attachment to his classmate had combined longings for an idealizable father with fears of becoming overstimulated by his mother's overt seductiveness. Carrying on a heterosexual relationship, vicariously, had been his just barely tolerable compromise.

With the exploration of the risks and the increased confidence and assuredness that accompanied these themes, the patient's interest in women lost its defensive coating of shame, criticism, dissatisfaction, and anxiety. In the phase of analysis that followed, he felt more adequate in his approach to women. However, he then became afraid of the intensity of his sexual desires and feared that the analyst would want to protect women from him.

The patient's competitiveness was made possible by the prior analytic work. He felt secure and could thus challenge the idealized analyst. The analyst had accepted the idealizing selfobject transference, which included the patient's need to experience the analyst as a source of strength which would encompass him. As with Miss F, where the analyst accepted the patient's need to be mirrored, a stable selfobject transference was engaged. In both instances, the patients established and were enabled to sustain vital ties to their analysts. Eventually, their self organization required less concrete, external supports and became more flexible and self sustaining. The necessity for drastic self protection then diminishes.

Selfobject transferences are activated spontaneously by the patient and engaged when the analyst does not interfere with this process. In a variety of ways this tie is subject to ruptures, for example, the session comes to and end, the analyst's affect is jarring to the patient, an interpretation misses the mark and disappoints the patient, or the patient has silent expectations that the analyst does not surmise. Repair is accomplished through the analyst's attention to the patient's ongoing experience in the analysis. For example, the analyst may note a sudden silence or a colder, distant, detached tone as the patient's signal of a rupture. Or the patient may become “unreasonably” enraged, eroticize the transference, or “act out.” These reactions can be understood as attempts to maintain and shore up a vulnerable sense of self, to regulate affects, and to avoid over-stimulating contact with the analyst. The meaning of the rupture and, eventually, the genetic roots of the patient's vulnerability are then investigated. Understanding the rupture and the specific vulnerability exposed, repairs the rupture.

In treating the graduate student, no matter how tactfully intended, had the analyst confronted his emerging competitiveness, the patient might too readily have felt squelched, ashamed and retraumatized. Confrontative analytic interventions are conceptually difficult to distinguish from countertransference reactions even when the analyst justifies them as “presenting reality to the patient,” or “correcting interpersonal distortions,” or even straightforward attempts to deflate the patient's grandiosity.

Thus, confrontative intervention organize and evoke a distinct analyst-patient dyad, one that is vastly different from the picture of pathology that evolved in the treatment of the competitive graduate student. However, with a different patient, an analyst's tactful challenge may convey the impression that the analyst considers the patient to be a viable adversary (7), someone who does not have to
be coddled. Confrontations are thus not ruled out in the treatment of self pathology (8). Their therapeutic action depends on the patient's character pathology, self cohesion, and the nature of the transference.

The differences among the theoretical perspectives that guide treatment are sometimes further complicated when the analyst assumes that his or her personal reactions to the patient constitute evidence of the patient's unconscious motivations. For example, a patient's attempt to avoid retraumatization or to transform a past traumatic experience may elicit from the analyst the interpretation that they are unconsciously trying to flee from painful material and control the analysis.

I treated a 35 year old woman for 5 years on a once a week basis. She sought treatment after she had five miscarriages. Her confidence in the reliability of her body was shattered. Though she did give birth to a child prior to beginning treatment, her self confidence never returned. Anxiety and depression persisted, especially in her work situation. Furthermore, a vocal constriction brought her non-professional singing career to a halt. During her first year of treatment, she devised a sophisticated computer program for her employer which was so effective that it made her high-paying position superfluous. She felt her employer was totally justified in regretfully letting her go. With a sense of extraordinary fairness, she helped train an entry level employee who took over her job.

Unemployed, her feelings of inadequacy, depression, and social withdrawal increased. She was unable to look for work. Instead, she became obsessed with a television soap opera. For the next two years she spent about half of each of her sessions keeping me abreast of the story with predictions about future turns of the plot. She read soap opera gossip magazines to note which actors from her soap opera were to be hired for other programs. Such moves would affect the characters and plot twists of the story she was following. When she told me the latest escapades and her predictions for future episodes, she sounded confident, excited, alive, determined, effective, and clever.

The patient was raised in a politically conservative southern border state where her father was a courageous newspaper editor who always supported liberal causes. Throughout her childhood, she was a bright student, an accomplished singer, and a fine pianist. At night, however, the dinner table was dominated by her father. He was a true hero. She admired him enormously. His values, courage, morality, and accomplishments were impeccable. But, she could never get a word in edgewise. He was idealized in the community and by the family. She could only sit there in silent amazement.

At the point where she began therapy, the patient's self regulation and self control with respect to her body and its states had become severely compromised. Self confidence based on her ability to rely on her body, her vocal chords, fingers, and later her uterus, was badly shaken. Her capacity to assert herself, explore her world, and gain competence pleasure then crumbled. In the face of this loss of self cohesion, why had she become so obsessed with a television soap opera?

Were the patient's reports of the soap opera an obstruction to the analytic process? Did I contribute to an enactment that obstructed here treatment when I listened to her continuing reports of the soap opera? Of course I participated, probably through my “amazement” at the ingenuity of her deductions and predictions. These were qualities that had previously been admired only in her father. However, salient themes that organized her experience were gradually revealed. Derived from a repetitive experience at the dinner table with her family and her amazement of her father's authoritative presence, we constructed a “model scene” (9). I described her as an “investigative reporter.” She presented the details of her research and observations, the goings on at the soap opera, “the news behind the news,” the behind-the-scenes machinations, and drew cautious conclusions. Characterizing her as an investigative reporter was joyfully received by her. Subsequently, she was able to go back to work. She shifted the kind of work she sought and became a consultant to organizations, ferreting out their organizational problems.

In presenting this vignette to various analytic groups, invariably a question is asked about my feelings in response to this patient's report of the soap opera plots. Did I not feel angry, bored or controlled? I did not. I felt intrigued and amazed by her ingenuity, a reversal of her “dinner table” scene. Some analysts suggested that my not feeling angry, bored or controlled was a typical self psychological denial of aggression, mine and the patient's, suggesting that “anger” was the only reasonable response in these circumstances. However, even if I had felt angry, I would not assume that the patient was motivated
to make me angry. My reactions do not represent any privileged access to the motivations of the patient. My perception of patient's attempt to bore or control me, or destroy the analysis, is open to investigation as a mutually organized interaction to which both the patient and I have contributed, though neither equally nor similarly. The dangers of ascribing the analyst's experience to the intent of the patient cannot be overestimated.

A person's disavowed, repressed or otherwise unintegrated expectations of control over another person may organize the transference. According to the earlier view of narcissism, this “grandiosity” was confronted and interpreted as “resistive,” motivated by a destructive wish. From the vantage point of self psychology, such strivings to control the analyst must be accepted, nonjudgmentally. Eventually, their meaning and function will emerge as they did in the analysis of Miss F, the graduate student, and the investigative reporter. Thus, when the patient's heroic efforts at self protection and avoidance of retraumatization are viewed as obstructions to the treatment, the dividing line between self psychology and other analytic schools is clearly drawn.

Now for my answer to the question posed by my title, “From Narcissism to Self Pathology: New Pathology or New Perspective on Pathology?” It is both. Certainly, the symptoms that bring a patient into analysis have had a long history. But, analysis may repeat the patient's accustomed experiences of having vulnerability misinterpreted as arrogance or withdrawal misinterpreted as hostile detachment. Treatment can then reinforce past painful experience, confirm past dreaded expectations, and thereby solidify character defenses. Analysis may also provide a new perspective and thereby create a new pathology. The narcissistic patient who feels safe to reveal feelings of vulnerability and shame filled experiences, is different from the narcissistic patient who learns that his distancing and detachment conceal envy and rage. What emerges between patient and analyst from a new analytic perspective is a new pathology, codetermined by the patient and the analyst in the course of their work. Different transferences and expectations are organized by the different analyst-patient pairs.

When we continue to view narcissism as the maintainance of an infantile selfcenteredness of which the patient must be disabused so that he or she can learn to care about others, we organize with the patient a continuation of pathological narcissism. The resistive, angry response of many patients to this treatment approach speaks of their desperate efforts to hold on to their integrity. When we view narcissism as an attempt to attain and maintain a cohesive sense of self, a new perspective organizes a new analyst-patient interaction.

At the threshold of the twentieth century, we stood before the discovery of the Unconscious. At the threshold of the twenty-first century we recognize the interactive organization of experience. When we investigate the analysand's experience from within their subjective world, we and our patients discover that admiration does not necessarily conceal envy but expresses a longheld yearning, competitiveness does not necessarily express denigration or grandiosity but attempts to relate and find acceptance, controlling others may be in the service of shaping a vitally needed experience, and rage may be a response an analyst evokes rather than uncovers in a patient. We are then able to treat not only the psyche, but the patient in a context in which the input from both the patient and the analyst is monitored. At the threshold of the twenty-first century we recognize that man is not motivated by unconscious alone.

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