
This paper deals with a particular aspect of psychoanalytic treatment, namely, with the manner in which defense organizations participate in the process of working through in the analysis of narcissistic personality disorders. Because the theory of treatment in psychoanalysis is based on the theory of the psychoneuroses, there is a circular feedback between the recommendations for technique and the psychoanalytic theory of the neuroses. The relatively narrow limits provided for psychoanalysis by the model of the psychoneurosis have limited contributions to the theory of psychoanalytic treatment.

Innovative ideas regarding the theory of treatment have been contributed by Kohut in his recent book *The Analysis of the Self* (1971). These contributions are based on the fact that Kohut could not accommodate his observations to existing clinical theories. He described his clinical observations as transference-like phenomena: transferences that were narcissistic in nature and could therefore not be understood in the context of the theory of the psychoneuroses. While differentiated from the patients with phallic-oedipal transference neuroses, this group of patients also has to be differentiated from those suffering from psychotic and borderline disturbances. Kohut describes them as patients with narcissistic personality disorders, because their significant disturbance is related to the narcissistic cathexis of the self and to those archaic objects which are cathected with narcissistic libido and which he therefore refers to as “self-objects.” While clinically the separation from psychotic and borderline patients may be difficult at times, the differences become clear in the course of analysis. Patients with narcissistic personality disorders are able to maintain cohesive narcissistic transferences and to regress within that transference without the danger of permanent fragmentation.

Much of the analytic work in narcissistic personality disorders relates to the working through of archaic, in many ways automatic, forms of defense structures that have become established in the patient’s psyche in response to early narcissistic injuries. In the course of the analysis, as these defense structures attain higher levels of consciousness, the
With the help of a brief clinical example, I hope to highlight that particular phase in the process of psychoanalysis where a conflict arises within the patient which is related, on the one hand, to the "dread to repeat" archaic infantile defense patterns and, on the other, to the wish to maintain the improved mental functioning that the patient experiences in a well-established narcissistic transference. This conflict leads to a compromise formation which is expressed by a particular form of behavior specifically related to the analytic situation. I shall describe such compromise formations as "transference symptoms," inasmuch as they occur within the transference. Metapsychologically, these are not true symptoms, however, for they do not constitute compromise formations between conflicting unconscious motives; rather, they constitute compromises between archaic derivatives of the repetition compulsion and the activity of the reality ego. The increased participation of the reality ego in such transference symptoms reflects the progress that takes place in the course of the analysis.

The conceptualization of the transference symptom in this manner is particularly useful in the understanding of the process of working through. In narcissistic personality disorders, the pathological defense structures establish themselves in response to childhood narcissistic traumata; the primitive rage reactions characteristic of narcissistic injuries are frequently bound into masochistic, depressive, and paranoid character features. With their insistence on revenge or on self-destruction,
of their grandiose selves; they are boastful and overly exhibitionistic. In these cases the primary mode of defense is that of disavowal, conceptualized, by Kohut, as a vertical split in the psyche. In the second group of patients the primary mode of defense against the intrusion of archaic narcissistic structures is repression, which is conceived of by Kohut as a horizontal split in the psyche. In this second group of patients the clinically manifest character traits include diminished self-esteem, vague depressions, lack of initiative, and the

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more complex manifestations of masochistic and paranoid character features.

Conceptualizing the working-through process as it occurs along the vertical and horizontal splits, the character defenses are best conceived of as “fortifications” of the primary modes of defense—disavowal and repression. In the course of the analysis, each of these character features can be traced separately along particular developmental lines. In the actual analytic situation, however, the emphasis usually shifts from one feature to the other, thereby betraying their common, genetic developmental roots. Which particular feature gains prominence at any given moment in the analysis is subject to changes that are due to the steadily occurring dynamic and economic intrapsychic shifts. For my discussion in relation to the process of working through, I shall refer to these character features either as character defenses or, more simply, as defense structures.2

In order to appreciate the complex interaction of pathognomonic regression (i.e., regression to the pathogenic fixation points) and character defenses, it will be helpful to take a closer look at the defense structures themselves.

From infancy on, not only in response to frustrated infantile needs but in response to disturbed interpersonal relations, defensive reactions become progressively integrated into more and more complex structures. Newly developing cognitive patterns and ego functions are drawn into this organization. In situations of intrapsychic conflict, or in patients with structural defects in response to states of overstimulation, the defense organizations will employ whatever possibilities cognitive or other ego functions afford for warding off threatening (intrapsychic) dangers (Wolff, 1960). As cognitive possibilities and ego functions develop, the organizations of the defenses attain higher degrees of complexity. The dividing line between well-sublimated and neutralized activities and the defense organizations cannot always be sharply drawn. When we speak of walled-off narcissistic structures or repressed infantile wishes, we have to conceptualize their presence within these complex organizations to which individual defense mechanisms, cognitive patterns, and ego functions have all made their contributions. This makes these infantile structures not more but less available to the reality ego. Considering their genetic roots, these endopsyhic structures are the carriers of the most significant intrapsychic events.

Defenses have been conceptualized in the clinical situation as

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2 Structures are differentiated from ad hoc functioning may take place according to either the primary or secondary process. “When a particular form of discharge becomes regular and habitual, a structure has been formed which regulates the discharge of what was at first either primary- or secondary-process ad hoc discharge. Once a structure has been formed it constitutes a fixed organization, so that neither the structure nor the function it regulates undergoes any change” (Gill, 1963, p. 113).

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manifesting themselves primarily as resistances against regression and also as resistances against the uncovering of unconscious impulses, wishes, and memories. The equation of defense with resistance in clinical practice has led to formulations like “lifting of the repression barrier” or “the removing of resistances”—formulations that describe the process of working through without considering the character defenses as part of the transferences. Since therapeutic transferences are established by the projection of repressed infantile structures onto the analyst, it would appear that pathological
defense organizations, particular cognitive styles, and unconscious behavior patterns are as much part of the transferences as are repressed infantile wishes and impulses. What has developed over a lifetime into a defensive-adaptive organization is not simply undone by therapeutic regression.

Viewing the defense structures as essential features of the transference manifestations raises the question of how these structures affect the patient's experiences during the therapeutic regression and how their presence in the transference manifestations affects the nature of the transference interpretations. This is particularly important to consider during the process of working through, because the defense structures participate in the therapeutic regression to varying degrees of neutralization and cohesiveness.

From clinical observations and theoretical considerations primarily formulated by Schafer (1968), Gill (1963), and Rapaport (1957), it would appear that, to the degree to which the defense organizations are automatic, unconscious, and walled off from the rest of the psyche, they should be considered pathological, but that, to the degree to which they attain secondary process attributes, they are adaptive and not different from other ego functions. Gill's theories (1963), in particular, highlight the gradual transition of defenses from primitive to higher forms and their arrangement in a hierarchical fashion in which the lower levels must be unconscious and automatic and maybe pathogenic. Defenses high in the hierarchy must be conscious and voluntary and maybe adaptive. The differentiation between low and high levels is made by the transition from primary to secondary process thinking. Gill quotes Gero in reference to the technical implications of the theory that defenses are arranged in a hierarchical fashion:

"The effect of the foregoing considerations on the analytic process is best reflected by the emphasis the analyst places on these endopsychic structures when he is making transference interpretations and when he attempts a genetic reconstruction of the patient's psychopathology.

In a well-conducted analysis, transference interpretations lead to the reconstruction of genetically significant childhood memories, which gives psychoanalysis its unique dimension as a psychological treatment. From its inception, therefore, genetic reconstruction has been considered one of the most important aspects of psychoanalytic treatment; the past explains the present. However, the confusion over what is being reconstructed in the course of an analysis has not yet been resolved. To follow Freud's (at times) contradictory statements and the attempted clarifications which have followed would take us too far afield; concepts like "screen memories" (Freud, 1899 Fenichel, 1927 Greenacre, 1949) and "telescopying of events" (Kris, 1956) are attempts to deal with the distortions that occur in the unconscious in relation to childhood memories and their reproduction in psychoanalysis. An attempt to reconstruct actual historical events is contradictory to psychoanalytic theory: the unconscious operates in such a way as to take once conscious percepts, thoughts, and feelings and distort, condense, or change them into their opposites. One generally accepted solution to this dilemma is to think of a "psychic reality," namely, to concern oneself with the patient's view of the past and not with the past experiences themselves. This orientation in relation to reconstruction still puts the emphasis on an external event (or events) that gave rise to the particular intrapsychic response: the reconstruction of historical events, then, constitutes part of a more comprehensive genetic reconstruction.

Matters are infinitely more complicated, however, when what we have to consider as being etiologically significant in the patient's psychopathology, in addition to constitutional and inherent developmental factors, is not a particular event but the chronic strain that was imposed on the growing child's psyche by the parents, particularly by the mother's own psychopathology. In such cases, transference interpretations should lead to the reconstruction of the mother's
psychological makeup at certain critical developmental periods in the patient's life, or rather to its construction (Freud, 1937). Interpretations of this nature will take into consideration that particular period in the patient's life which appears to have the greatest significance genetically in the development of his psychopathology. Its use in a transference interpretation could be demonstrated with an interpretive comment like this: "You are frightened and angry with me because you feel you cannot control my comings and goings, the way you must have felt when your mother, because of her worries and depression, spent most of the time in bed and you had to spend many hours alone." Such interpretations frequently fail to bring a sense of inner conviction to the patient. What makes such interpretations complete is not only the inclusion of the most likely age-appropriate responses to the mother's withdrawal and depression, i.e., fear, anger, and loneliness, but also the manner in which these infantile affective experiences have given rise to and have evolved into unique defense organizations for the patient throughout his lifetime. What one can attempt to reconstruct, then, is the patient's very unique, specific mode of dealing over time with the pathogenic issues: the evolution of his character defenses both in their pathological as well as in their adaptive features. In the course of the analysis, the analyst learns about the patient's characterological defense patterns during early childhood, latency, and adolescence. The reconstruction of the developmental sequence of intrapsychic experiences and their attendant behavioral consequences usually produces a strong "that's me!" feeling in the patient, an inner conviction which results in a powerful motivation for further analytic work. This is made possible not only on the basis of the patient's reports of his past self-evaluations and past behavior, but because, as mentioned earlier, defense structures of greater and lesser degrees of neutralization and cohesiveness participate in the therapeutic regression and constitute an integral part of the patient's transferences. It is of importance both in the analysis of the psychoneuroses and in the analysis of narcissistic personality disorders that, once transferences have been established, defense organizations from different layers of the mind (relative to the degree of their level of consciousness) and with different degrees of neutralization will participate in their expression.

**The New Beginning and the Transference Symptom**

As mentioned earlier, whenever therapeutic transferences are established, the repressed infantile structures (narcissistic and otherwise) are projected and externalized. The projected structures enter into comparatively stable amalgamations with the psychic representation of the analyst and are eventually reinternalized. The difference between the psychoneuroses and the analysis of the narcissistic personality disorders in this respect is that, in the latter, the projected structures are narcissistic, that is, related to the grandiose self and to the idealized parent imagos, and the analyst is perceived not as an independent and separate object, but rather as part of the patient's self. It is essential to stress this difference: the transferences established in cases where the working through of the mobilized infantile narcissistic structures is central to the analysis are not true transferences in the classical sense; repressed infantile impulses are not transferred onto the analyst, but, rather, the analyst is viewed as the "direct continuation of an early reality ... [that could not be] transformed into solid psychological structures" (Kohut, 1959, p. 470). The transferences that these narcissistic structures establish are attempts to complete developmental arrests and correct developmental failures. Therefore, while processes of internalization are silently present in all analyses, in the analysis of the self, internalization of certain functions of the analyst is in the center of the analytic experience. The analogue to the therapeutic internalizations is taken from its developmental counterpart. Developmentally, under optimal conditions, transmuting internalization (i.e., internalization that leads to structure building) takes place because of the minor emphatic failures and delays on the part...
of the mother, which are part of every infant's experience. Such ordinary optimal degrees of frustration lead to the
"withdrawal of narcissistic libido from the archaic image of unconditional perfection" and "to the acquisition instead of a
particle of inner psychological structure which takes over the mother's functions in the service of the maintenance of
narcissistic equilibrium" (Kohut, 1971, p. 96). It was the failure of the mother-child unit to establish or to maintain
the narcissistic equilibria that had led to the original failure in structure formation. (In the narcissistic personality disorders
we deal not with gross structural defects in a particular ego function or with superego lacunae—though such may occur—but rather with the lack of narcissistic cathexis of these structures. It is the narcissistic cathexis of the ego and
superego functions which determines the degree to which these functions are experienced as part of a cohesive self;
the accretion of narcissistic libido to these structures occurs by transmuting internalization, as does structure building itself.)
Only when the patient and the analyst are capable of maintaining a narcissistic equilibrium of sufficient intensity and duration
can small, optimal degrees of ordinarily occurring frustrations on the part of the analyst lead to transmuting
internalizations. While the disturbance in the narcissistic equilibrium during infancy and childhood is primarily related to
the mother's minor empathic failures and ordinary delays, such disruptions in the analysis occur because failures in the
analyst's empathy reactivate archaic, automatic, defense patterns. The patient's reactions to such disruptions may be
expressed not only by infantile rage directly, but also by the masochistic and depressive or paranoid behavior patterns which
had been firmly established in his personality in response to infantile and childhood disappointments and frustrations.

One may ask, then, to what degree the narcissistic transferences are able to provide conditions that are similar to
optimal infantile conditions regarding structure building? One obvious difference between optimal infantile conditions and
the narcissistic transferences is the presence of character features in the patient that may resist the perception of the
analyst's empathy. The analyst's empathy and the patient's increased ability to perceive it are the conditions that constitute the
sine qua non for the establishment of relatively stable narcissistic equilibria in the

transference. Just as narcissistic equilibria, as they are established and maintained between the infant and the nurturing
adult, are of the essence for structure building in infancy, so the relative stability of narcissistic transferences must be
assumed to be of similar significance for structure building in the psychoanalysis of narcissistic personalities.

Benedek (1956) considers the availability of a "libido reservoir" which supplies "mobile integrative energy" essential
to structure building during infancy. Once the infant can sustain shorter and longer waking states, he begins to
establish communication on a psychological level. The infant's ability to establish psychological communication and his ability
to wait depend on the maintenance of a relatively undisturbed narcissistic equilibrium with his mother. The ability to
establish and to maintain psychological communication and the ability to wait are at first primary process ego functions which,
by becoming regular and habitual, eventually attain secondary process structure status. For example, when the mother
appears in the infant's visual field, pleasant memories are activated in the infant, and he will now attempt to continue the
original narcissistic unity by smiling at the mother. If the mother fails to respond, the infant's "integrative field disappears"—
his smile turns into crying, and the mother is lost as the needed object for the maintenance of his narcissistic equilibrium.
Since it is the mother's response to the infant's smile on which the infant's ability to wait depends, when the mother fails to
respond, the libidinous affects become dissociated and "the aggressive affects take over and mobilize the undirected 'storm of excitation'" (p. 400). Whereas such experiences are also internalized and may constitute nuclei of hostile self-perceptions,
they are not structure building, for only when the infant is "protected from the sense of frustration by an integrated,
libidinous, emotional state, can be learn to wait" (Benedek, 1956, p. 401).

Similarly, in the analytic situation, one can observe that, once narcissistic transferences have been established and are
relatively undisturbed, the patient strives to maintain the atmosphere that in the ensuing "narcissistic peace" leads to a sense
of well-being and to his improved functioning. In the idealizing transference, for example, during the undisturbed union,
the patient feels "whole, safe, powerful ... so long as his self experience includes the idealized analyst whom he feels he
controls and possesses with a self-evident certainty that is akin to the adult's experience of his control over his own body
and mind" (Kohut, 1971, p. 90).
A great deal of analytic work must precede that time in the analysis when the patient is capable of experiencing this kind of narcissistic contentment. The first steps toward the establishment of fairly stable narcissistic transferences occur in the early transitional phase, when the patient begins to be able to perceive the analyst’s emphatic, nonthreatening attitude. These are short-lived moments at first, as again

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and again the analyst is drawn into a paranoid-masochistic self-system where everything he says (or does not say) is made to fit into that familiar concept of the patient’s self. Under these conditions, when the analyst responds with empathic acceptance and offers understanding in relation to what the patient experiences about himself as fraudulent, dishonest, petty, or outright sadistic, the patient, unable to perceive the analyst’s empathy, feels the analyst does not understand him. The masochistic-paranoid patient, for example, feels “at home” with a percept of himself which includes chronically repressed rage and suspicion. It is the painstaking working through of the defense organizations which have established themselves in relation to the infantile narcissistic rage experiences that will permit the patient to experience the analyst’s empathy. Because, as mentioned earlier, empathic communication is crucial for the establishment of a narcissistic equilibrium in the analysis of the narcissistic personality disorders, one finds that the defense structures, in such instances, operate as powerful resistances against the perception of the analyst’s empathy. The analogue to this occurs in childhood, when the child is unable to accept changes for the better in parental attitudes, or, later in life, when he cannot perceive the environment as essentially benign because of the insistence on revenge of the infantile archaic defenses for the original narcissistic hurt.

After the establishment of a stable narcissistic transference, the patient experiences a sense of helplessness whenever he is threatened with the need to repeat the old, self-defeating patterns; this helplessness works as signal anxiety to ward off the repetition of deeply ingrained, archaic defenses, since such repetition, with its insistence on revenge, would mean to the patient the loss of the (self-object) analyst. With the narcissistic transferences established, the patient (like the infant) strives to maintain the narcissistic equilibrium he had experienced as an emotional state that had provided him with a sense of well-being and optimal functioning. Such states are experienced as chances for a new beginning, an expression Balint used in several of his writings for these particular experiences in the analysis. To achieve a new beginning means to reach a point in the therapeutic regression that permits the patient to experience the analyst’s empathy, and to maintain in the transference a degree of stability in his narcissistic equilibrium which is essential to the transmuting internalization. Balint describes these states of “regression in the service of progression” this way: “If we bear in mind that the ongoing harmonious relationship in this phase between subject and object or expanse is as important as the ongoing supply of air, we understand that loud, vehement and aggressive symptoms appear when the harmony between the subject and its primary object or substance is disturbed” (Balint, 1968, p. 71). This is essentially the description of a narcissistic transference and its vulnerability to disruption.

When we consider, therefore, the importance that the narcissistically

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and anxiety related to the threat of his potential loss. This is particularly true when ordinary degrees of disappointment (which the patient can now recognize as such) caused by the analyst activate in the patient archaic responses which he now associates with his (nuclear) self and for which he therefore feels responsible. The sense of helplessness, then, relates not to the impotent rage at not being able to control the analyst’s responses, but to the patient’s own inability to forgive the analyst. This creates an intrapsychic conflict: a conflict between the dread of repeating the old patterns of revenge (or its equivalent in the form of a masochistic attitude) toward the analyst and the hope for a new beginning in the analysis.
Because this conflict arose within the analytic situation, its solution will be expressed by some behavior specifically related to the analysis. It is, as I have said, metapsychologically incorrect to refer to such forms of behavior as symptoms, inasmuch as they are not completely unconscious compromise formations. Nevertheless, they do take on symptom characteristics because of their persistence in the transference and because of the participation of archaic structures in their formations. In these instances, the transference symptom is not a replica or a representation of the original neurosis, but is specifically related to the intrapsychic conflict that arose in relation to the analytic experience.

The analysis of such transference symptoms is particularly productive since they not only contain the archaic and maladaptive aspects of the patient's defenses, but also express an increase in the patient's reality-testing function.

A Transference Symptom and its Interpretation

A brief clinical example will demonstrate (1) how a transference symptom made itself evident and (2) how the interpretation of the transference symptom not only helped in the reconstruction of the defense organizations which the patient developed in response to her mother's psychopathology, but also in the analyst's appreciation of the patient's attempts to protect the precariously established narcissistic equilibrium of the analysis.

A 35-year-old woman patient in the second year of her analysis regularly entered the office looking painfully unhappy. This would be followed by a long (up to 20-minute) silence. When she finally spoke, her voice was barely audible; all this created a gloomy, oppressive atmosphere. This mood was in sharp contrast to her behavior elsewhere. In the waiting room, she engaged in animated conversations with other patients. At this time in the analysis she had begun to feel better, was working with zest, was spending less time in daytime sleeping, and had begun to take up some of the activities she had dropped prior to the analysis.

The patient had entered analysis because of increased restlessness and a sense of the futility of her life. Though frequently she consciously thought of suicide, she was afraid she would actually kill herself when she felt "far off," as if in a daze. She had a sense of disconnectedness about herself; things often looked blurred, and voices seemed to come from a distance. After an early marriage at age 19, she had a son, and divorced her husband two years later. Now she has a close and fairly comfortable relationship with her 14-year-old son; the boy had suffered briefly from separation problems, and mother and son still don't like to be apart. Separation was a very important issue for the patient in the analysis—weekends appeared terribly long, and she could not take even short trips out of the city.

Briefly, about her background: The patient comes from the rural South; her mother is alive, but the patient rarely sees her. When she occasionally has to go home to attend a family function, she is close to panic and tries to prepare herself in every way for the series of unpleasantnesses she anticipates will occur. She is particularly worried about her own inability to be "civil" to her mother. She is conscious of and much disturbed by her hatred for her. Her father died when the patient was 10 years old. She had idealized her father; his death was sudden, and the patient recalls that nobody had expected her to react in any way. Life had to go on as usual. The patient has a younger sister, the kind of girl her mother has always preferred—quiet and obedient.

The atmosphere of the first year of analysis was characterized by very intense erotic feelings for the analyst. The analysis was the direct continuation of her "love life." The patient had had many affairs, all of relatively short duration. "I don't think I'm capable of love," she said, "sex is different—it's exciting, it fills you up; love is to give, the excitement is the thing, it's more important than love." Her erotic feelings for the analyst served to insure her against leaving analysis, which she feared, insofar as she had been compelled to break off all of her relationships in the past. She worried when she could not maintain a pitch of excitement about me; "I lost you," she said once, "I could not think of you sexually." The significance of this need to be filled up by erotic excitement without the ability for meaningful object love was of diagnostic importance. Without a new affair (the analysis was, at first, one of them), she felt empty and worthless. Sexual relations with this man of need not only filled her with momentary excitement, but made her feel powerful and appreciated.
There was a period during the analytic process when the particular transference symptom I described earlier was most evident. I am referring here to the gloomy, oppressive silences. This was a transitional period during which the pathognomonic regression had reached considerable depth and the patient was struggling to maintain those “good feelings” in herself which she felt were essential not only to her temporary sense of well-being but also to her total recovery. One can follow reasonably well those signs of the working-through process which indicate that she was actively dealing with archaic defense patterns, which had now become disturbing to her, as her infantile narcissistic (primarily exhibitionistic) structures were permitted to emerge slowly into consciousness, with only minimal concomitant shame. This could be clearly observed by a series of dreams which the patient herself was able to analyze.

In the 245th hour, breaking her, by now, customary initial silence, she spoke of the fact that it was difficult for her to say anything because my reaction to what she said was so important to her. Because she was responsible for the way I responded to her, she had to be very cautious. I well understood the importance my responses had for her, I said, but we would still have to understand why she felt so responsible for them. She then spoke of me as her “lifeline”; she had to make sure she remained “plugged in” and got “recharged” during the hour. “I’m afraid what could happen to these feelings. I’m always afraid what I may hear in your voice; this is not fair to you.” I responded by saying that there must be some old fears coming to the fore now which seemed related to the possible disruption of a very important relationship. Obviously, she now, in contrast to her previous experiences in the analysis, experienced the danger of disruption as originating in her, rather than in my own behavior.

The Monday hour that followed started with a very long silence. Eventually she said: “I had a good weekend, but you are not interested when I feel good.” She added that although she knew that this was not true something had made her say this.

Only my misery assures your concern; this is a distressing thought—it doesn’t make sense, but it is very real at the same time. It doesn’t make sense because when I’m good, you are good. But something inside me has to make you bad—there is a temporary satisfaction in that. But then I get scared—if I make you bad and unhappy my chances are lost for good. I fabricate situations in which you frustrate me. Then I can imagine you don’t care. Even when I hear you speak I can make you sound “my way” by thinking that you only sound that way (namely, interested) because you have to …. when I don’t care for myself, I can’t see how you can …. I’m closer to you in some strange way when I’m miserable—that’s the way it used to be at home.

These associations were partly a repetition of earlier material, when the patient felt that I could not possibly put up with her; she felt that she was shallow and stupid; besides, she did not feel capable of love, so how would anyone ever care for her? She used to listen in my voice for expressions which would confirm her expectation of a rejecting, disgusted attitude. But now she was disturbed by having to “fabricate” situations in which she felt frustrated by me. Also, she said, “if I make you bad and unhappy, my chances are lost for good.” The need to make me bad brought only temporary satisfaction; more important, it interfered with those harmonious, good feelings she now considered essential to her recovery.

These associations helped us understand the silences and also helped us toward the reconstruction of some of the intrapsychic responses to her childhood traumata and the behavioral expressions which the patient had developed into unique defensive-adaptive patterns throughout her lifetime.

Her silence, and the gloomy, depressive facial expression that accompanied it, was a compromise formation. On the one hand, the silence recreated the atmosphere surrounding her chronically depressed and detached mother, but, on the other, it was a contrast to the patient’s childhood response, which was to escape the mother’s depression and thereby lose contact.
with her altogether. Now she was striving toward the maintenance of a narcissistic equilibrium with the analyst. Feeling totally undeserving of attention and care or deserving only of abuse (this expectation was related to her masochistic-paranoid defense organization), she felt that she could assure my involvement with her only if we were both miserable and bad. The temporary satisfaction would then be derived from a twinship-merger transference: “I’m closer to you in some strange way when I’m miserable—that’s the way it used to be at home.” She could be close to her mother and not disrupt their relationship if she joined her mother in her misery. However, as a young child and also during latency and adolescence, the patient had escaped her mother’s depressive moods by finding pleasure with other people outside of the home, first with her friends; later with boys and young men. She was a willful, provocative little girl, who early in life “tortured” her mother by running away from home and by pretending to be happy when at age nine she was sent to live with her aunt. During latency in particular, she was possessed by the need to spite her mother. Her favorite fantasy was to do something dreadful to herself in order to hurt her mother. To take revenge on people in this masochistic manner remained one of her important character features. By defensively escaping her mother’s depression and by frustrating her mother’s own narcissistic need for closeness with her, she had lost contact with her altogether. Throughout her adult life, her provocative, flirtatious encounters with men were experienced as hollow attempts to fill an inner emptiness.

The transference symptom of the gloomy entrances into the office first appeared when the patient began to feel better and when she began to enjoy her activities and her relationships outside of the analysis. This seemed to have worked as a signal affect: there was danger connected with moving away from me since finding pleasure in her independent activities in the past meant the loss of the relationship with her mother altogether.

It was essential to the interpretation of this particular piece of behavior to recognize that, besides its archaic, repetitive elements, it also was an attempt (by controlling the level of interaction between the two of us) to protect the narcissistic equilibrium from possible disruption. This solution, like compromise formations in general, did not truly solve the transference dilemma; the patient felt unhappy and constantly concerned lest her inability to speak and her insistence on projecting badness onto me would create an unmanageable distance between the two of us and make her lose her chances for change in the analysis.

A few weeks after this particular transference symptom became manifest, the patient had a dream from which she recalled the following fragment:

... there was an area with water, it was muddy, there were some coins at the bottom, some flowers growing in it too ... The coins were only partially visible, like my thoughts, I was digging for them, giving them to someone.

Her association was to ask herself whether she was still accepting her own argument that her mind was completely empty. “It’s more like it’s muddy, it’s confused, but something like flowers are growing there—and coins of value are partially hidden in it ...” In my interpretation, I focused on her giving the coins to somebody—her wish to show the valuable and growing things inside of her to someone. Apparently, something was now happening in the analysis that permitted her to see the coins and the flowers in the muddy water (in her mind). They were barely visible through the mud, but she could now perceive their presence. I then recalled a dream she had had several weeks before, about a pool of water where half of the water was crystal clear and the other half muddy; nothing visible was dividing the two bodies of water, but they remained strangely separated. I thought there was some connection between these two dreams. The patient explained the connection: “You compare this to the swimming pool dream, it wasn’t so ... there was a split there. I didn't feel the clear part, the pennies and the flowers in this dream are part of the muddy water ... the two things are integrated, I feel more integrated.” The mud, she felt, represented all the bad, angry feelings that had been covering the coins and the flowers—the good things inside of her.

A full analysis of these dreams is beyond the confines of this paper. It should be noted, however, that the patient’s perception of the difference between the two “water dreams” impressively summarizes her own awareness of the dissolution of the vertical split. She experienced herself as being better integrated and better able now to perceive valuable things inside.
herself. Her ability to perceive good things in herself and her wish to be admired for them signaled the end of the merger transference (during which she had to project badness onto the analyst in order to keep him united with her) and the beginning of a mirror transference. The conflict that arose in response to the patient's emotional growth beyond the merger transference is poignantly demonstrated by her next dream:

someone was turning over soil, plowing … shoots of plants were coming up, they were destroyed as they were turned over … because the shoots were attached to each other …

The patient's associations reflected her concern that she was taking a terrible chance in exposing her growing ability to enjoy her work and relationships away from the analyst: will the analyst appreciate her growing independence and handle it with care, or will this lead to the destruction of the relationship altogether? She had left her mother "gleefully" when she was still a young child; she did so to escape her mother's angry and depressive moods. But this meant losing her mother altogether and not experiencing her mother's echoing approval, which could have affirmed her inner resources as being reliable and valuable.

In the brief segment of this analysis, one can recognize that the patient revived the pathognomonic situation in a merger transference. From this pathological form of merger (which had to be maintained by repeated projections of the patient's anger and misery), one can trace the movement to a form of the mirror transference; she began to experience herself, with the help of the analyst's recognition and appreciation, as better integrated and capable of independent pleasures, but the slowly emerging (exhibitionistic) narcissistic structures had to overcome repeated resistances before their full integration into the reality ego could occur. Such movement from archaic to higher forms of narcissistic transferences assumes a process of transmuting internalization which leads to the building up of narcissistic structures.

Integral to the process of transmuting internalization is the patient's increasing ability to perceive the analyst's empathic and nonjudgmental attitude—a capacity that is dependent on the working through of those character features which had established themselves in relation to early narcissistic traumata and which can constitute important resistances against the perception of the analyst's empathy.

Summary

An attempt was made to demonstrate the participation of defense organizations in the process of working through in the analysis of the narcissistic personality disorders. By briefly examining the nature of defenses and their organization into hierarchical structures, I have tried to show that pathognomonic regressions contain defense structures from different layers of the mind and with different degrees of neutralization. Defenses were considered part of the transference, rather than mere resistances against the discovery of particular contents in the unconscious.

Because of the participation of defense structures in the transference, the analyst can attempt to reconstruct those intrapsychic experiences which best explain the patient's unique and specific mode of dealing with pathogenic and developmental issues. Such emphasis on the endopsychic structures in the process of interpretation appears to bring greater inner conviction to the patient than when the emphasis is placed primarily on the reconstruction of environmental etiological influences. This is particularly true when the most important etiological considerations have to be given to parental psychopathology.

With the help of a brief segment of a five-year analysis, I have described the manner in which a transference symptom...
made itself evident in the second year of the analysis. Pathological archaic patterns (like the need to project badness onto the analyst) conflicted with the patient's increasing ability to perceive and to utilize the analyst's empathy. This conflict led to a compromise formation, consisting of prolonged silences aimed at reducing the interaction between analyst and patient in order not to disturb the precariously established narcissistic equilibrium. The analysis of the transference symptom proved productive, for it not only dealt with the derivatives of the repetition compulsion but also gave recognition to those new developments in the analysis to which Balint (1968) aptly referred as a new beginning.

References


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