THEORY II: BEYOND WISH AND DEFENSE

CLASS 10

NARCISSISTIC TRANSFERENCES: THE ZWICKMÜHLE

Aim: The purpose of this class is to collate and integrate some of the implications of the material we have studied in this trimester. Implicit in Freud's concept of narcissism is the formation of an internalized self-self relationship which serves to ward off depressive affect (including inferiority and shame) by utilizing splitting, denial, idealization, and denigration to maintain a fantasized self that is adequately congruent with the ego ideals. From the resulting identifications, objects are sought *along the path of narcissism* in order to maintain the morale and therefore the functional integrity of the ego. Thus narcissistic transferences are narcissistic object relations are narcissistic defenses: the three terms are interchangeable.

Reading: Kris AO (1994): Freud's treatment of a narcissistic patient. IJP 75: 649 - 664.

Optional: Riviere J (1936) A contribution to the analysis of the negative therapeutic reaction. IJP 17: 304-320.

Discussion of paper by A. Kris

One of the more interesting passages in this paper, to a student in this class, must be the author's assertion that:

> Freud's formulation of the "narcissistic problem", and Jones's concurrence with it, surprised me, as Freud refers to matters that had until then only been adumbrated and never spelled out in his writings on narcissism. The last of these, *Group Psychology*, appears frequently in the correspondence at this time, in regard to its translation. I do not believe, however, that readers of those works could have made the link between unconscious guilt and narcissistic phenomena in the way that Freud does here.

This state of surprise points to the "undiscovered Freud" which we have commented on previously.

The relationship between the "narcissistic problem" and the concept of "narcissistic transference-like structures" is one that requires further elucidation. What seems apparent in the case of Mrs. Riviere is that she was convinced that Jones had become deeply attracted to her, had allowed his feelings to show and then (when she had begun to respond) had become frightened of his own attraction, had self-protectively married his first wife as a way of finding an exact opposite in a "substitute object", and that when this wife had died, had withdrawn into a "hard" and "brutal"

formality in which he refused to admit he had ever had any feelings for her. During all this time, he remained her analyst, asserting that all he wanted to do was to help her and cure her. From this point of view, it would be **Jones** whom she was describing when she stated (in her paper on the Negative Therapeutic Reaction) that the retreat to omnipotence and the attempt at inordinate and tyrannical control of people (covered over with a deceptive friendliness) was a protection against the inner sense of failure and despair arising from the inability to love because of the feeling of hatred and vindictiveness directed against the love object for disturbing the self-mastery of the reluctant lover. From the material that Kris provides, I conclude that it was some version of this story that she relayed to Freud, who more than half agreed with its accuracy. What Freud apparently failed at was getting her to see that the same story applied to her and that her picture of Jones, however accurate it might be, was also a projection onto him of that which she criticized in herself. It is my thought that it was her repudiation of this attempt to "turn the tables" and deprive her of her paranoid-masochistic vindication which led her rapidly to become harsh, unpleasant and critical with Freud and to say things about him which he found "provocative" and in the face of which he felt the need to "restrain [his] anger." So, at the same time, the state of mind she described was **her own** and her literary self-description a post-analytic gift to Freud to whom she could not make such an admission in person.

It is thus possible to estimate the *Zwickmühle* of which Freud complains. On the one hand, "paranoia is that which arises in place of a self-reproach" and "paranoids love their delusions as they love themselves" so that every interpretation of the material is perceived as a sadistic attack on the patient's love-object which is the patient's self-love and results in an ever-more-fierce clinging to the self-esteem maintaining story, with the analyst installed as the newest edition of the persecuting figure. On the other hand, extending to the patient the usual attitude of tactful understanding will be taken as "evidence" that the analyst agrees with the patient, that the patient is right, and probably, eventually, that the analyst cares deeply for the patient in ways that the analyst is afraid to admit. In either case, the analyst is confronted with an ego-syntonic or *erotized* transference. The dilemma is that the usual tools of the analyst: silence, sympathetic support, and interpretation are all rendered unusable by this kind of a transference.

Kris's own suggestion is for "a shift in the analyst's stance to one of *functional* neutrality." He recommends that the interpretation of the self-criticism be made from an "*affirmative*" stance. I am not sure if this means that the analyst should affirm the validity of the self-criticism or affirm that the patient is better than his self-criticism says he is (always remembering that Freud had noted that melancholic self-criticism tends to be quite accurate and would be hailed as insight if it were not pathology). His prescription is for "*support*" which, he claims, "frees up the interrupted associative processes and ultimately permits the analysis of narcissistic entitlement," thereby avoiding the sterility and therapeutic impotence of a "minimalist technique that [cannot] provide the support [Freud] had known was needed."

Before making any judgement on this recommendation, we would do well to inquire further into the subject of erotized transferences.

Narcissistic Transferences are Erotized Transferences

It is important to distinguish *erotized* from *erotic* transferences. The latter term relates to the *content* of the transference wish, the former to its *role* in the functioning of the personality. The neurotic transferences are all wishes that have emerged from repression by virtue of having become attached to the figure of the analyst. They are therefore, by definition, *ego-dystonic* for the same reasons that caused them to be repressed in the first place. Erotized transferences (i.e., narcissistic object relations with the analyst), in contrast, are part of the self-esteem maintaining functions: they make the patient feel *better* and their analysis threatens the patient with depression. They do not necessarily (although they may) involve demands for erotic satisfaction. They are sometimes called *perverse transferences* with reference to the ego-syntonicity of the perversions. Remembering McDougall's distinction between the libidinal search for the *forbidden* and the narcissistic search for the *unattainable*, it is easy to see that implicit in the erotized transferences is the demand that the analyst change to meet the expectations of the patient rather than vice versa. What keeps the erotized transferences out of the material is shame (the fear of being thought ill of by another) and fears of rejection, not self-disapproval. If the patient acquires sufficient comfort and self-justification in the analytic situation (perhaps through the accumulation of grievances), then the importunate demands of the erotized transference will emerge.

In 1919, Abraham[1] described a group of patients who

> tend to speak in a continuous and unbroken manner, and some of them refuse to be interrupted by a single remark on the part of the physician. But they do not give themselves up to free associations. They speak as though according to programme, and do not bring forward their material freely. Contrary to the fundamental rule of analysis they arrange what they say according to certain lines of thought and subject it to extensive criticism and modification on the part of the ego. The physician's admonition to keep strictly to the method has in itself no influence on their conduct.

Abraham describes this as a deceptive transference (cf. Joan Riviere's notion of the *false* transference):

> It is by no means easy to see through this form of behaviour. To the physician who is not experienced in recognizing this form of resistance the patients seem to show an extraordinarily eager, never-wearying readiness to be psychoanalyzed. Their resistance is hidden behind a show of willingness. I must admit that I myself needed long experience before I was able to avoid the danger of being deceived.

Noting that "under the apparent tractability of these patients lies concealed an unusual degree of defiance," Abraham goes on to describe them:

> They only say things which are 'ego-syntonic'. These patients are particularly sensitive to anything which injures their self-love. They are inclined to feel 'humiliated' by every fact that is established in their psycho-analysis, and they are continually on their guard against suffering such humiliations ... they not only persistently avoid every painful impression but at the same time endeavour to get

> the greatest amount of positive pleasure out of their analysis. This tendency to bring the analysis under the control of the pleasure principle is particularly evident in these patients and is, in common with a number of peculiarities, a clear expression of their narcissism. And it was in fact those among my patients who had the most pronounced narcissism who resisted the fundamental psycho-analytic rule in the way described.

Inevitably, the "narcissistic attitude such patients adopt towards the method of treatment also characterizes their relations to the analyst himself:"

> Their transference onto him is an imperfect one ... If signs of transference do appear, the wishes directed on to the physician will be of a particularly exacting nature; thus they will be very easily disappointed precisely in those wishes, and they will then quickly react with a complete withdrawal of their libido. They are constantly on the look-out for signs of personal interest on the part of the physician, and want to feel that he is treating them with affection. Since the physician cannot satisfy the claims of their narcissistic need for love, a true positive transference does not take place.
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> In place of making a transference the patients tend to identify themselves with the physician. Instead of coming into closer relation to him they put themselves in his place ... They instruct the physician by giving him their opinion of their own neurosis ... they desire to surpass their physician, and to depreciate his psycho-analytical talents and achievements. They claim to be able to 'do it better' ... They are given to contradicting everything, and they know how to turn the psycho-analysis into a discussion with the physician as to who is 'in the right' ...
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> The presence of an element of *envy* is unmistakable in all this. Neurotics of the type under consideration grudge the physician any remark that refers to the external progress of their psycho-analysis or to its data. In their opinion he ought not to have supplied any contribution to the treatment; they want to do everything by themselves ... The patients actually see in [the analyst] a hindrance to progress during the hours of treatment, and are exceedingly proud of what they imagine they have achieved without his assistance ...
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> The analysis of patients of this description presents considerable difficulties. These difficulties reside in part in the pretended compliance with which the patients cloak their resistance. For analysis is an attack on the patient's narcissism, that is, on that instinctual force upon which our therapeutic endeavors are most easily wrecked.

Ernest Rappaport[2] quoted Blitzstein in describing these transferences as *erotized*, that is, the transference itself is libidinized or hypercathected. He stressed that, "this is not a transference neurosis." It is, rather, a demand to be loved in the absence of a capacity to love. He noted that in the object relation with the analyst, the quality of *as if* is missing. These patients do not feel embarrassed by and ashamed of their demands on the analyst. They insist unequivocally on the ways in which they want to be treated and are angry (and not reticent to express this anger openly) when the analyst does not immediately comply with their demands. They do not feel this situation to be unpleasant, they take it for granted that it is the analyst's task to provide them with the responses that they want. Otherwise, they regard the analyst as stubborn and inconsiderate. They do not expect to change for the analyst, they expect the analyst to change out of love for them. To this end they are alternately ingratiating and obnoxious. They are persistent in provoking, annoying, and antagonizing the analyst, they wish to turn the analysis into a row or a

brawl. All the while they are fearful that they will lose contact with the analyst and therefore try to maintain a continuous atmosphere of tension with occasional flare-ups. They have intense feelings of worthlessness and lack of self-respect and try to overcome these feelings by stirring up the analyst to prove they have the power to arouse anger. When their provocations are not responded to, they feel neglected. In cross-gender analyses this easily translates into a demand for conventional genital contact, which when rejected causes the patient to claim to be deeply hurt and humiliated. What is too intense here is not the dependency, the hostility, nor the erotic wishes, it is the desire to make the analysis pleasurable and to deprive it of the character of a learning experience. Rappaport stressed the omnipotent strivings of these patients and their intolerance of nongratification of their wishes. They act as if their cooperation would serve not their own needs but the needs of the therapist. They display an arrogant behavior based on the "megalomanic" delusion that the analyst ought to be grateful to them for their participation in the treatment. They will persist in teasing him with only a trickle of free associations or with regular silent intervals between each communication. Their insistence on transforming the analyst into a real object is meant to achieve control of the analytic interchange and enslavement of the analyst.

That it occasionally succeeds in doing so (particularly when the *erotized* transference is also an *erotic* one) is attested to by Glen Gabbard[3] who notes that:

> Many of the key figures in the history of psychoanalysis became sexually involved with patients they were analyzing. Carl Jung maintained a long-standing relationship with his patient Sabina Spielrein. Otto Rank and Anaïs Nin became lovers after beginning their relationship as analyst and patient. August Aichhorn became sexually involved with Margaret Mahler when she was in analysis with him. When Karen Horney was middle-aged, she embarked on a love affair with a much younger male candidate she was treating. Frieda Fromm-Reichmann openly acknowledged that she stopped analyzing her patient to marry him.

To this list might be added Harry Stack Sullivan who began a homosexual affair with a catatonic adolescent boy he was treating, David Rubinfine who became sexually involved with his patient Elaine May, and Victor Rosen who began an affair with, and then married, a former patient for whom he had been the training analyst.

These sorry episodes underline Coen's observation[4] that "patients who use sexualization extensively will tend to reassure themselves that they can transform themselves by seduction into an idealized, omnipotent ... object. This illusion reassures the patient against the risk of being left alone with a dangerous ... introject."

Narcissistic Transference as Defense Against Depressive Affect

Joan Riviere[5] agreed with Abraham on the characteristics of the narcissistic transference, but she added, "Observations have led me to conclude that where narcissistic resistances are very pronounced, resulting in the characteristic lack of insight and absence of therapeutic results under discussion, these resistances are in fact part of a highly organized system of defence against a more or less unconscious depressive condition in the patient and are operating as a mask and

disguise to conceal the latter." She described the narcissistic defenses as being centered in the denial of the dependence on objects through assertions of omnipotence which led to contempt, depreciation and attempts at "inordinate and tyrannical control and mastery." All of this is motivated by the fear of the transference proper which, by dissolving the defensive fusion with the ego ideal, would render the patient vulnerable to states of depression. To avoid this, they cling to an attitude of self-satisfaction, megalomanic claims, and egotism. They are fearful that the analyst will gain power over them and that they will develop love for the analyst and so they resort to deceptiveness, a mask which conceals their reservation of power to themselves under a guise of feigned politeness and superficial compliance. This tendency to control the analysis is more widespread than most analysts believe because it is largely masked and disguised. The patient does not wish to get well since the first step towards that is the dissolution of the attitude of omnipotent pretension and control and this will leave him vulnerable to a depression which he fears. The patient struggles to maintain the equilibrium that he has established because he feels that what is coming is a change for the worse, that any lessening of control on his part will bring about a disaster. At times these patients will implore the analyst to leave the grandiosity untouched, not to take it away, because its removal will mean chaos, ruin, and impulses of murder and suicide which the patient fears he cannot control. Every abandonment of grandiosity leaves the patient in a state of desolation. For these patients, the sense of failure, of the inability to remedy matters is so great, the belief in better things is so weak, that despair is always near. The patient's inaccessibility, his megalomania, his lack of adaptation to real life and to the analysis are all denials of his internal reality: his greediness, his selfishness, his lack of generosity, his inability to love. He feels a need to cure and make well and happy his objects rather than again put himself first and thereby abandon them. The analytical offer of help is like a betrayal of those objects in the name of the self and therefore only increases his sense of guilt: he feels he is betraying the only good side of him in accepting analysis. The analysis hangs on the patient's hope that he will be cured in order at last to be capable of fulfilling his task to others. The feeling that the patient deserves no help until his loved ones have received full measure corresponds to Freud's unconscious sense of guilt. These patients resist the positive transference above all: they parade a substitute friendliness which they declare to be normal and appropriate, but what is underneath is *love*, a craving for absolute bliss in complete union with a perfect object for ever and ever. Riviere closes by stressing that, "the most important feature to be emphasized in these cases is the degree of unconscious falseness and deceit in them ... the *false* transference when the patient's feelings for us are all insincere and are no feelings at all ... seems to be something the analyst can see through only with difficulty. A false and treacherous transference in our patients is such a blow to our narcissism, and so poisons and paralyzes our instrument for good (our understanding of the patient's unconscious mind), that it tends to rouse strong depressive anxieties in ourselves. So the patient's falseness often enough meets with denial by us and remains unseen and unanalyzed by us too".

Narcissistic Relations to the Analyst at the Beginning of Treatment

With regard to many of these phenomena: the desire to say what is "ego-syntonic", extreme

sensitivity to whatever injures the self-love, absence of an *as if* element in the relation to the analyst, the desire to be loved without loving in return, *etc*., these patients present a continuing picture that we would take for granted in a patient just beginning analysis. If the emergence of the transference means that the patient has "found" the analyst as an object, the period before that emergence must be one in which the analyst has not yet become a conventional object. Tarachow[6] insisted that it was only transference interpretation that created the *as if* quality of the analytic relationship and that until then, the relation to the analyst was merely another real relationship. Gitelson[7], writing thirty-four years before Kris, insisted that humanistic curative factors are intrinsic to the classical psychoanalytic situation "without benefit of the corrections and additions which it has received in recent years." He pointed out that the early phase of analysis recapitulates a developmental sequence which culminates in the finding of an object and that, prior to this, there is a free use of projection and introjection in both patient and analyst, introducing a factor of reassurance through rapport "which may be decisive." The analyst's intention to maintain and support his patient converges with the patient's need for this support and makes the analyst into an auxiliary ego providing the form for the patient's emerging developmental drives. It is the analyst's empathic imbrication with the patient's emotions that provides a sustaining grid of understanding and resonance which lays the groundwork for the therapeutic alliance. Transference grows out of rapport. "The patient starts out in an interpersonal situation and the analyst cannot prevent it."

> From the standpoint of the patient "rapport' may be considered to be the *optimistic* feeling that the 'hope' for, or 'expectation' of the diatrophic response, with which he comes to the analyst, can be fulfilled. He comes so to speak with the wish that he and the analyst will be 'tuned in'. Rapport is the first presentation of the 'floating transference'. In this state hypercathexis of the analyst-object pervades the attitude of the patient, no matter what the interfering state of his anxiety and defences. Absorbed in this feeling-idea of the analyst, reality-testing is reduced; the operation of the superego as a factor in this is diminished; the patient finds himself in a position comparable to the state of 'object-finding' before primary narcissism is resolved. We see in this situation essentially a libidinal process which unifies the various forms and derivatives of narcissism and focuses them on the analyst ... In the light of what I have already said, the curative factor is found in the analyst's professional commitment with its diatrophic intent. He does not 'offer' himself as an object, or, as has been suggested, as a replacement for the superego. The point is that the first analytic contact, if successful, sets up the anaclitic-diatrophic equation. This results in the 'rapport' which is the harbinger of the transference. The patient presents himself in the 'floating transference' with the wish to be loved for himself alone. His 'rapport' is in part a projection of the attitude: 'the analyst loves me as I love myself'. The analyst's participation is his diatrophic presence in which the patient discovers the availability of a 'new beginning' and thus of a new development ... I am trying to say that the *techniques which establish the psycho-analytic situation induce an infantile dyadic condition having the qualities of transition from narcissism to object love.*

If the analytic relationship begins as a real relationship and that real relationship is a narcissistic one, it is expectable that any residues of that real relationship would continue to bear the stamp of their origin.

The Real Relationship as Narcissistic Transference

Loewald[8], like Gitelson, explicitly denies any desire to suggest changes in the way the analyst ought to behave, being interested instead in the ways that analysts do behave, necessarily. He points out that a non-negotiable minimum necessity for any successful treatment is the capacity of the analyst to see his patient as functioning better than he currently does. It is this tension between the actual patient and the possible patient that informs every intervention and is mediated in every interpretation. This vision of the future patient is identical in its dynamics to the parent's vision of what his child will become and is subject to the same *caveats*. If the vision derives too exclusively from the analyst's ideal-systems ("therapeutic perfectionism") it will serve to crush the development of the patient by making every achievement inadequate. If the vision is "short", the patient will always feel that his analyst has not "recognized" him. What is required is an ability to empathize with the patient, not only as he is, but also as he is capable of being; to hold in front of the patient the extrapolation of old possibilities that have become blocked in the course of traumatic development. Loewald insists that the finding of a new self is always a re-finding of an old self that never developed and that such a catalysis of personal development always and exclusively occurs only in the context of a new object relationship. From this point of view, he describes the transference as an assimilative procedure, an attempt to evade the new relationship that the analyst offers by recourse to already-established patterns. Transference interpretation is always an insistence on the reality of the analytic interpersonal relationship and a simultaneous insistence on the patient's accommodation to that reality.

The "real" relationship of Loewald is, of course the same thing as Gitelson's "diatrophic" relationship. In both usages it means finding a new object who cares intensely about and for the patient without any trace of "selfishness", who has no ambitions for the patient that do not emerge out of the patient's own aspirations and capabilities, and who mediates his vison of the patient skillfully to help the patient realize his own developmental potentialities. In turn, both of these terms seem to me to describe the same behavior of the analyst as that which Kohut (who published eight years after Loewald) felt was necessary to maintain a "mirror" transference-like structure. If the "real" relationship between analyst and patient has the form of a "mirror transference", then the issue of narcissistic transferences cannot be limited to the treatment of "narcissistic patients" but is an integral part of every analysis.

Perhaps it was the absence of this relationship that Mrs. Riviere noted when she complained that Freud "used" her as a translator before he had established a relation with her as a patient. If this is so, it raises questions in my mind when Kris lauds Freud's behavior as giving her the necessary "support."

A Sequence of Narcissistic Transferences

Lester Schwartz[9] presents material from an analysis that illuminates more conventionally "narcissistic" issues. The patient was a 33 year-old businessman. In analysis,

> the patient was extraordinarily dependent for cues about how to impress me. His

"image" depended on his trying to please me. My not providing cues led to a mounting sense of disorientation, confusion, and panic ... He considered that I was in an ideal, emotionless state, and had fantasies that we thought of each other simultaneously throughout the day; he expected that the analysis would provide him with "an ultimate magical mechanism." After six months, he could reveal that he had wished for me to be the ideal of his adolescence - "like a computer, it would know all the actions in the world and could predict everything." As it became clear to him that analysis could not supply this, he became increasingly desperate.

A scene in a play in which a woman made a man grovel fascinated him. Gradually, wishes to be a girl filled the sessions. At the same time, he thought of me as a woman; he heard me walk in with high heels. Exciting, crazy fantasies occurred of how a powerful woman would take him over - he would become mindless, and she would whip him. Now mounting rages began to appear openly. He feared that without direction he would become berserk and murder someone ... For the next two years in the analysis, his wish to be an omnipotent "supergirl" preoccupied him ... He would see sexy, "fierce looking" girls on the street and become flooded with a combination of sexual tension and rage. These girls had breasts that drove men crazy, but they also had penises ... [later, these girls were acknowledged to be representations of himself] ... Over many months, he spun out fantasies in which he and I moved in and out of this magic role. He often feared that he would go crazy ... he would vacillate between states of sadistically tinged activity, as this omnipotent-omnisexual being, and others when he felt like a toy, a cute jack-in-the-box, there only to bob up and down on command. In the active role his wish was to get me to confirm his magical attractiveness, to fall in love with him, and then for him to torment and leave me; in the passive role [he wished] to be my abject creature ...

Over long periods of time, these omnipotent fantasies took such hold of him that they seemed utterly ego-syntonic, verging on the delusional. He gradually became aware that he had never questioned his underlying assumption that women (and he as a "supergirl") possessed some fantastic, irresistible power. He did not want to be aware that this was a fantasy - "I don't want to analyze it; I want to have fun." In retrospect, he could see that this had been there all along, but he never knew it was the most important, the only important thing in his life. For some time he couldn't imagine living without this idea; it became clear how much it protected him from ... states of overwhelming rage and of terrible helplessness. Periods of mourning then alternated with fresh expressions of the wish to be a "supergirl." However, as the months and years went by, he turned more and more to real relationships. His parents, who had been unidimensional cardboard figures, began to flesh out. He now had friends and a girl friend toward whom his tender feelings deepened, and gradually he was able to express feeling of appreciation and

> gratitude to me. As he began to act in an openly masculine way, he expressed fears that this would mean getting the father's penis, destroying the father, and being destroyed.

This vignette illustrates a common sequence in the evolution of the transference: 1) a phase of idealization ("you are like the omniscient ideal of my adolescence"), 2) a phase of grandiosity ("I am a supergirl with breasts that drive men crazy - I want you to fall in love with me"), and 3) the emergence of œdipal issues ("I want to steal my father's penis and destroy him but I am afraid of being destroyed") and, with them, the possibility of a transference neurosis. The phase of erotized transference ("I don't want to analyze it; I want to have fun") is clearly an attempt to seduce the analyst into a relation that will protect against the risk of being left alone with a dangerous introject ("My father will destroy me for my wishes to steal his penis"). Between the grandiosity and the œdipal issues lie necessary "periods of mourning."

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