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A THEORETICAL AND TECHNICAL APPROACH TO NARCISSISTIC DISTURBANCE

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This paper illustrates and discusses a useful, and possibly necessary, technique for the handling of resistances due to disturbances in narcissism. The terminology for dealing with the issues surrounding narcissism is clarified and then clinical material is presented to show that the analyst can interpret unconscious states of being as well as unconscious wishes and object relationships. The analyst's prime task remains the elucidation of psychic reality. To describe the technique less accurately but more simply, we may say that the patient must be told who he is in addition to what he feels, wishes, thinks and does.

DEFINITIONS AND REVIEW OF THE LITERATURE

Self-concept

A person holds a consciously accessible, stable picture of himself which may be more or less realistic. This *self-concept* emerges from a mixture of perceptions arising from two sources: from perceptions of internal experiences including representations of self interacting with object and from perceptions of the person's body and external interactions with people and situations (according to Fenichel, 1945, with slight modification).

Self

Hartmann (1950) attempted to clarify Freud's definition of narcissism as the libidinal cathexis of the ego (Freud, 1914) by distinguishing between the *ego* (a structure within the mental apparatus) and the *self* (the whole person in external reality including both his physical and mental attributes). Jacobson (1964) followed Hartmann and added terms like 'mental self' and 'physical self'. I retain the words 'self', 'person', 'mind', and 'body' for descriptions of phenomenology.

Thus reference to the subject as agent, or as an object, of an activity would use 'self' rather than 'ego'. Compound words such as 'self-observation' and 'self-criticism' are straightforward and meaningful at the phenomenological level and need not, indeed should not, imply any particular intrapsychic state. For example in one instance self-observation may reflect a superego activity and in another an ego activity; similarly a self-criticism may be directed at a self-image or, as in melancholia, at an object representation. In each case, only psychoanalytic observation can determine the details of the psychic reality beneath the surface events.

Self-representation: Self-image

These two terms have been used interchangeably at times, and with different definitions. Here, *self-image* will be used to refer to unconscious, preconscious and conscious mental presentations (registrations, ideas) of the person. Self-images may be located in the id, ego and superego and there are many of them corresponding to the many and varied aspects and activities of the person which have become internalized as part of psychic development. The body-image, for example, is one which has been much investigated. During development, self-images become dynamically organized to form an intrapsychic structure. Spiegel (1966), Kohut (1971), Kernberg (1975) and others refer to this structure as the 'self'. However it is preferable to use an unequivocally technical term and *self-representation* is adopted here.

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Narcissism

The term 'narcissism' has been used in many ways (Pulver, 1970)—so many that Lichtenstein (1964) suggests that the word should be used 'not so much as an abstract concept but as a kind of ideogram, i.e. a pictorial symbol or a word in its visual not its auditory form, the mere tracing of which evokes the whole group of ideas or notions it connotes'. Retaining narcissism as such a global concept requires us to devise alternative terms for the more specific notions subsumed within it.

This paper called for the invention and definition of two terms. One is concerned with a mode of relating to others and the corresponding intrapsychic object relations, the other with a person's relationship to himself and the nature of his self-representation.

Rosenfeld (1964) and other Kleinian psychoanalysts use 'narcissism' to refer to a defensive mode of object relating. Although they regard it as extremely pathological, sometimes labelling it 'destructive narcissism', it is to be found during the analysis of patients over the whole range in severity of psychopathology. It is seen as isolating the needy-dependent-emotional part of the person from potentially meaningful and gratifying relationships. I shall refer to this as *object-narcissism.*

Jacobson (1954), Reich (1960), Sandler *et al.* (1963) and others more recently have used 'narcissism' to refer to a person's relationship with his 'self'. Their definition of narcissism as the 'libidinal cathexis of the self' has been expanded by Jacobson (1964) and Joffe & Sandler (1967) to include a consideration of the discrepancy between an 'actual state of the self' and an 'ideal self-representation'. The degree of this discrepancy is said to determine the person's sense of well-being and level of self-esteem. However self-esteem and its regulation are not the sum total of this area of psychic life. Kohut (1971) and Kernberg (1975) have emphasized cohesiveness and continuity as aspects of the self-representation, and Winnicott (1960) and Giovacchini (1975) have suggested that certain early experiences can prevent psychic existence.

Reich (1960) pointed out that narcissistic pathology became noticeable in the methods used for self-esteem regulation. A functional approach such as this is very useful but is more adequate if the frame of reference is expanded to the regulation of the self-representation, of which self-esteem is only one aspect. Activity, mental or physical, can then be defined as narcissistic in so far as it serves to maintain a self-representation which is integrated, has continuity over time and can be given a positive (affective) value (Stolorow, 1975). As would be expected, such activity is to be seen in all analyses. I shall refer to this as *self-narcissism.*

It should be noted that self-narcissism refers to the self-representation and not to the self-concept. This clarifies very simply some forms of self-defeating activity: the individual will tolerate considerable injury to his conscious idea of himself when it preserves his (unconscious) self-representation. The clinical material to follow will illustrate this.

By using object-narcissism and self-narcissism as metapsychological viewpoints, we can minimize controversy and permit investigation. We also obviate judgemental dichotomies such as healthy/pathological, normal/abnormal, benign/malignant or constructive/destructive which have been used to differentiate types of narcissism. Activity in either area, object-narcissism or self-narcissism, can be judged along a continuum as more or less constructive or destructive, more or less benign or malignant, etc. in relation to the person's particular constitution, intrapsychic state and environmental context.

Self-Narcissism

There appear to be three attitudes towards the phenomena of self-narcissism. Kleinian workers regard it as important but rarely discuss it. For example neither 'shame' nor 'self-esteem' appears in the index to Segal's (1973) introduction to Kleinian theory, and the terms 'ego' and 'self' are not clearly defined or carefully distinguished. Rangell (1963) represents a second view by arguing that concepts such as *self* and *self-representation* are of too high order and should not be used as ultimate explanatory concepts for a multiplicity of clinical states. He suggests that the use of these concepts implies a superficiality in analytic technique and an avoidance of the detailed analysis of intrapsychic conflict. Jacob-

son (1964) also doubts the importance of these concepts in the analysis of neurotic disturbance.

The third position, held to in this paper, is that disturbances in self-narcissism are inevitable in neurotic (as well as in narcissistic, borderline and psychotic) patients as a consequence of the particular nature of human development (Lichtenstein, 1961). Kernberg (1966, 1970), following Jacobson (1964), claims that the integration of 'all good' and 'all bad' self-images (similar to integration of object-images) occurs in healthy psychic development and that failure of this integration leads to disturbances in self-feeling and defects in psychic structure. He asserts that even mild neurotic conflicts are inevitably associated with imbalances in the realm of self-narcissism due to internal and external factors: internal from the id, ego and superego and external from the responses of others to his behavioural disturbances (Kernberg, 1975).

Jacobson (1964) claims that self-images are even more under the influence of subjective emotional experiences than object-representations; and Van der Waals (1965) writes that 'the trouble with many neurotic characters is that they often do not have the slightest insight into what kind of self comes to the fore in their behaviour in a given situation'. If these views are correct, analysis of the self-representation would appear to be essential. However in comparison to descriptions of the analysis of intrapsychic conflicts and object-narcissism, little clinical material has been presented to enable discussion of the technical problems.

A TECHNIQUE OF INTERPRETATION

All technique inevitably involves emphasis at any one moment on one aspect of the psychic life of the patient to the relative neglect of others; the psychoanalyst makes his choices as best he may. Almost any phenomenon can be interpreted within the framework of object relations, object-narcissism or self-narcissism.For example withdrawal from the analyst may reflect a defence against sexuality, or may be part of a denial of any connexion with the analyst or may aim to produce a feeling of safety, or some combination. Ignoring the disturbance in self-narcissism may prevent progress with certain patients, and result in an unnecessarily incomplete analysis with others. This paper examines only a limited aspect of technique.

Self-images are at least as susceptible as object-images to emotional influences and defensive manoeuvres including repression and splitting-cum-projection. The analysis of unwanted self-images, i.e. self-images that deviate too far from some ideal shape of the self, is necessary for the resolution of narcissistic disturbance. In making interpretations, the phrase 'You feel ...' is only valuable in describing the affective colouring of an already integrated self-representation. The phrasing of an interpretation to promote an understanding of an unconscious or split-off self-image takes the form 'You are ...', e.g. 'you are incompetent'. Alternatively the interpretation given leads the patient to be able to make a statement in his own mind of the form 'I am ...' referring to some self-image he was previously unaware of and found unacceptable, e.g. 'I am nothing'. The form of interpretation has some of the quality of a reconstruction: the analyst makes it clear that he is referring to an idea in the patient's mind which has come from the past and which has all the force and conviction of material reality for the patient. When the interpretation is given skilfully, the patient does not feel labelled or intruded upon.

In this psychoanalytic model, the task of the analysis is the description of the patient's internal reality currently alive in the psychoanalytic relationship. The unsympathetic reader may not reach the *Clinical Example* or *Discussion* so some of his reactions are best met briefly now. First, it is abhorrent to say such things to a patient. This is irrelevant: sexual interpretations were equally abhorrent 75 years ago. Second, such an interpretation is an opinion or confrontation and is non-analytic as the analyst has no mandate to describe external reality. This is a misunderstanding: the comment 'You are ...' is useful only if it reaches the patient as a description of internal reality; if it fails to do so there will be a variety of unfavourable consequences. Third, the author is rationalizing a sadistic superego-like attack on a trusting suggestible person. This is important: any technique can be abused due to ignorance or countertransference blind-spots, so an unthought-out confrontation of an unprepared patient with a

bald negatively-toned statement would fit such a criticism. However, the suggested interpretations require the same checks and balances characteristic of good analytic practice as other interventions. In fact, ignoring narcissistic material or opportunities to interpret within the narcissistic frame of reference would conventionally be regarded as evidence of countertransference problems. Using 'you feel' when 'you are' is necessary is not a solution: the patient will be left believing the analyst is supportive but does not know him and he will continue in his confusion between psychic and external reality in relation to his self-images.

The technique will be clearer via the following detailed example taken from the 39th month of a five times per week case.

Clinical illustration

Background

Mr X was referred for analysis after several years of other psychological treatments for his obsessional neurosis and perversion. The obsessions had become insignificant but the associated character problems were little improved and the perversion remained. This included masturbation in baby pants with simultaneous defecation and urination, attending prostitutes and a preoccupation with pornography. His request for analysis was not for this—he hoped his perverse sexuality would be gratified in an ideal relationship—but for his isolation. He was able to maintain superficial contacts but had never sustained a relationship or had sexual intercourse.

At 30 years of age, Mr X was unwilling and unable to grow up; he was an only child living at home with his parents whom he controlled tyrannically. The family seems never to have functioned well: father was weak and ineffective and mother infantile. At the age of 4, Mr X had been sent away for a year and there has never been an adequate explanation from his parents. He went for psychiatric treatment following the collapse of his hopes at University. After failing matriculation exams once, he had attended a University away from home. However, he found himself so overwhelmed by feelings of being uncared for that he was barely able to leave his room and was unable to study. He failed repeatedly and, to his great humiliation, was subsequently barely able to hold down a poorly paid clerical position in a large firm. His personality difficulties resulted in two changes in department with only slight upgrading. He complained incessantly about not being given responsibility and yet persistently behaved in ways such that no reasonable person could regard him as responsible. He would then complain that people destroyed his self-confidence. His offensive behaviour seemed, both to himself and to others, to be deliberate.

Aspects of the analysis

Mr X's appearance and behaviour was repulsive and peculiar. The first years of the analysis centred on his object-narcissism activated by separation anxieties and expressed in masturbation fantasies. He was convinced that he would be rapidly rejected by me and used his perversion to deal with the terror. The perversion served to attack and destroy the humanness in himself and others; during sessions erections and masturbatory states of mind were used to blot out his emotional self with its needs.

The disturbance in self-narcissism manifested initially with a countertransference experience of extreme awkwardness and self-consciousness, worse at the beginning and end of the session. Mr X would send me into the consulting room ahead of him, or hide in the hall and make me come to find him, or turn off the lights and sit in darkness or play games in the toilet while I saw the next patient. These behaviours were infiltrated with intense hostility and a crude sexuality and were, of course, overdetermined. In the context of his unpleasant body odour, his peculiar gait and posturing, his odd speech and his falsity, they resulted in a grotesque hateful image in my mind. The analysis of underlying object-relationships and the object-narcissism had partly dealt with the need to externalize his self-hatred so violently and reduced his outbursts of narcissistic rage. As he got more in touch with his emotional self, he had transient experiences of it as sordid and disgusting.

Before presenting two sessions in detail, it is necessary to describe the atmosphere and content of the analysis at this period. Mr X had

shown only minimal changes in his life and still lacked a sense of autonomy. The practice of his perversion was rare, but the pathological mental organization which it reflected was still operating against his emotional self and the value of analysis. Mr X did seem to be less paranoid and less provocative of humiliation at work but this was probably due to containment within the analysis where he continually made paranoid-aggressive and contemptuous attacks on the analyst and on his self.

The content of the analytic work just preceding the sessions had focused on Mr X's use of the perversion as a solution to the disturbance in his self-narcissism. He had repeatedly claimed to be 'the sickest person ever to be treated by psychoanalysis' and said that his perverse sexuality made him 'special', 'extraordinary' and 'exceptional'. He spoke about his perversion with pleasure and glee, insisting that the idea of 'being ordinary—like everyone else' was almost unbearable and totally unacceptable. He linked his lack of achievements to his belief that he was a 'potential genius'. However, his envy of others was overt and he admitted freely that he wanted to do things and have things like other people.

Session 1[1]

Mr X was still complaining about his problem in greeting me. In the previous two sessions he had lain down awkwardly and reflected on his difficulty in a way that was humiliating to himself and contemptuously aggressive to me. The important current event in his life was the marriage of a female cousin approximately his age, Julia. He had often compared himself to her and used her in his externalizations. He was uncertain as to how he wanted to fit into the celebrations as he felt so jealous and humiliated. Julia's family had asked him to give one of the speeches.

Mr X entered the room, walked to a corner and stood with his back to me while I walked between him and the couch to my chair. He then moved to the couch and lay down.

I thought to myself that this behaviour, which had often appeared before with various meanings, was an extension of his awkwardness of the previous days.

Mr X began nastily; 'I'm resentful of you—you're right—that's why I have to express it—you want me to express my resentment, don't you?' He paused, presumably for a response from me, and when none came he began describing his visit to Julia's on the previous evening. He had taken his speech which, he said, was not very good as it was just a collection of jokes which he had copied out of a book. When the speech had been criticized, however, he had felt very attacked. This puzzled him as it was not even his speech; this awareness did not diminish his anger. They told him what he needed to say and he could see that they were right. He had had fantasies of secretly turning up at the party and giving the speech; and he realized that this would have been disastrous. At one moment at Julia's he had almost thrown a scene and walked off in a huff. However, he controlled himself. Then they asked him to come back the following week with the rewritten speech to practise it on their tape-recorder. He asserted that this meant they did not trust him and launched into a tirade about the fact that they had not made him 'the best man' at the wedding. He complained bitterly that they wanted him to make an 'ordinary speech'.

I thought that if Mr X made an ordinary speech that would be acceptable and liked by everyone, he would feel sordid and humiliated as these were the self-feelings that characterized his emotional 'true' self. He obviously wished to avoid this. I believed that interpretation of this once again would not reach him due to resistance stemming from his self-narcissism. So I proceeded as follows.

Dr K: If you give the speech you planned, then you will make a mess of things. But at the same time, the statement, 'You're inadequate and incapable', will be in the minds of others and not your own. It won't be in your mind because you will be thinking two things: first, 'it wasn't really my speech', and second, 'I could have acted differently if I'd chosen and so it's not really true—I'm not really incapable'. But the point is that you can't act differently. You say to yourself that if you wanted you could give a proper speech but you can't. Just like you can't come into the room and you can't get on to the couch. You feel you ought to be able to do things, but you can't.

[1] Session 1 was reconstructed from memory immediately after the session. Notes were taken during Session 2 to assist recall.

Mr X: No, I can't ... that's right.
Dr. K: We've talked about your feeling special as a compensation—and how the compensation is for a sense of being defective. Now the defect is clearer. You are a person incapable of functioning, incapable of doing anything. That is you.
Mr X: Yes, that's why I can't leave home ... I can't do the cooking, I can't do the washing. Even when I was in a flat for a short time I went home for these things.
Dr K: Your problem has been what to do with this defective you. You try to tell yourself that you are not defective—you even assert the opposite, that you are a genius. Or you enact and get other people to see that you are defective rather than seeing it yourself.

Mr X then described his problem at Julia's at the end of the evening. Other relatives had been there and he wanted them to drive him home. They were not agreeable to this but asked him if he would accept a lift to the nearby bus-stop. He did but felt very angry about it; and a terrible atmosphere developed in the car. To his surprise, however, he suddenly found that they had driven him right home. He thanked them and felt really appreciative.

I took this as a transference expression of his gratitude that I had made contact with him and his problems despite the early bad atmosphere in the session. Metaphorically, my interpretations went home. However, I thought that an interpretation about this was unnecessary, even wasteful of the rapport which could be used for integration of further insight.

I explained that his perpetual resentment had two sources linked to this issue. On the one hand he had a need for others and wished that they do things for him—if they did not he felt resentful. On the other hand, he suffered from his idea that he was incapable and this flooded back if anyone did anything for him—naturally he was resentful of such affirmation of his inadequacy.
Mr X: My mother washed my hair until I was 17. Then I wouldn't have it anymore, but I still didn't wash it myself unless I went to have it cut. Only in the last few months have I been able to wash my hair.
Dr K: Yes. Psychically your identity is that of a person unable to care for yourself. Your mother could not care for you and meet your needs and this deficiency in meeting your needs has become part of you.
Mr X: I feel alien ... strange ... I don't know what to do.

I thought this alteration in his self-feeling was an expression of the effect my interpretations were having on his self-concept as a framework for stabilizing his experience of the world. In particular the previous interpretation probably resulted in the return of a projection, i.e. it was not the analyst who was deficient but himself and his maternal introject. However, I treated his comments as an association and pressed on with provision of insight.

Dr K: I'm giving you something and you don't have a way of responding.
Mr X: At parties I always feel that I don't know what to do.
Dr K: If you were actually functioning properly and with ease, it would produce a dissonance. You are not a person who can function properly. The idea of functioning here is weird for you. It's not that you can't do things in external reality—it's just that it's not you—not the true psychic you.

It was the end of the session and Mr X left thoughtfully.

Session 2

The next day Mr X entered naturally and lay down on the couch. The initial associations dealt with his conflict over expressing his appreciation for the previous session as it was not *him* to do such a thing.

He continued:
Mr X: Yesterday after I left here and got to work, I found that my boss wasn't there and there was a whole string of tenants coming into my office and I had to deal with them. Then when finally it was over I put my head in my hands ... I don't know how I felt ... unhappy. Then there was another knock and I was angry, but it wasn't a tenant. It was a girl I know who also works in the office and she came in and looked at me and she seemed to see right through me. She said: 'You look sad'. I tried to push it away and said: 'No, I'm just fed up'. But I couldn't hide it and she said: 'You're thin. You've got to face it'. Eventually I got her out. Then a man came in who wanted me to help him put someone in the shit, and that buoyed me up. But after he went I felt down again, and then Julia phoned. The conversation got round to my leaving home and she was asking me why I didn't do it. And it left me feeling depressed, because although at first I said I couldn't, I realized that it

wasn't between her and me whether I left home, it was my conflict. And I said that to her and then she said that it really was hard to find a good place. And all this conflict about leaving home and not leaving home—you proved to me at the beginning of the session that that is just a cover.

Dr K: You know that you can't do it. That is the psychic truth and your awareness of this being a part of your self left you sad and depressed. Putting yourself in the shit is at best only a temporary solution for you.

Mr X: I came to analysis because I felt I couldn't do anything and now I learn that I can't do anything. I came here to change. I want to get away from the idea of myself as a person who can't do things. Now you are telling me that I will do things, that I can do things, but I'm going to remain a person who can't do things.

Dr K: Yes.

Mr X: I can't escape from myself. I'm lumbered with me.

Dr K: You've wanted to be someone else—to be not yourself—for a long time.

(Long silence.)

Mr X: I feel comfortable. Is that possible? At least I don't have to be always escaping and hiding. I'm stuck with it. (Long silence.) I used to say that I can't do anything on the outside but inside I really can. Now I'm learning it's upside down. On the inside I can't do anything, but on the outside I can.

Mr X then became resentful about the loss of his defensive fantasy. His material contained sadistic impulses (e.g. he complained that I had broken the back of his defences) but he communicated them without the usual enactment and remained in a thoughtful frame of mind.

Following this he spoke about a girl with whom he was trying to have a relationship and complained of not knowing what to do. He said that she had put off going with him to a poetry evening but had suggested a visit to a discotheque; but when he tried to make a time she said she was busy all week. He went through all the different things that this interaction could mean in terms of whether she liked him or not and described how he felt. He ended by saying: 'Other people would know what to do ... I don't'.

Dr K: I'm like this woman ... and the question is not what to do with her or what to do with me, but what to do with the feelings and thoughts which you have when you are with us.

Mr X: While you were talking to me I didn't hear you. I was thinking it was the end of the session. Was that to blank out what you were saying, or was it because I have such a fantastically acute sense of time?

Dr K: The end of the session comes and you have feelings about it: they just come to you like the tenants walking into your office. And they involve doing some work. But you're incapable of doing any work with feelings.

Mr X: I hate it. I feel angry about the end of the session. Why does it have to come? Feeling angry makes me humiliated.

Dr K: To be yourself, whether it is angry or affectionate or whatever is associated with feeling humiliated.

It was the end of the session and as Mr X left, he awkwardly wished me a good weekend.

Subsequent sessions and longer term

In the next two sessions, Mr X produced a massive negative therapeutic reaction based on his guilt and envy. Then he had his first period of genuine silence in the analysis. Following this we could analyse his failures in terms of his guilt and aggressive wishes. He spoke of his relationships and work more realistically and began improving his lot. A little later, for the first time, he referred to his perverse activities with a reaction of disgust rather than glee.

The longer term development of the analysis has only served to confirm the importance of the insights of the sessions presented. Mr X never again acted with such oddness, nor did his extreme awkwardness return. About six months later he was promoted two grades and given a junior assistant, and six months after that embarked on his first serious relationship. At this time his inability to function was much more deeply analysed in terms of revengeful rage at the loss of the maternal union, anxiety about his intense sadism, his superego disorder and his castration anxieties.

Summary of the clinical evidence

It may help to summarize the clinical evidence for the effectiveness and psychic truth of the interpretation of the unconscious self-image which served as a narcissistic resistance.

1. The line of interpretation felt right clinically to the analyst.

2. The line of interpretation felt right to the patient.

3. The interpretations had a sense of immediacy and used material provided by the patient during the sessions reported.

4. There was not an excessive reliance on subtle shades of the analyst's private countertransference.

5. The interpretations had a marked dynamic effect during the sessions.

6. The interpretations affected the patient's self-narcissism.

7. Movement occurred in the analysis over subsequent sessions: in particular the interpretations both solidified the working alliance and facilitated the emergence of previously unavailable instinctual wishes and object relationships.

The interpretations moved Mr X from a paranoid state to a depressive stance, encouraged a shift away from his solution of conflict by perversion or manic defence, and allowed him to be less gauche. The grandiose and grotesque interaction had much diminished since analysis began but prior to the sessions reported, meaningful interchange and shifts to a state of mind in which psychic reality was accepted lasted only a few sentences. He would rapidly become remote, enter an altered state of consciousness, produce bizarre fantasies or start attacking the analyst. The second session shows him capable of integrating rather than reacting to analytic comments. Mr X's narcissism was too disturbed for him to experience usual forms of self-esteem: previously, meaningful interpretations produced an upsurge of euphoria but here this response is replaced by a moderate and real sense of well-being, what he called 'comfort'. Such an affective state had never been mentioned or seen to occur before this. It reflected an appreciation of his new situation with hope that self-esteem would be possible in the future. It is worth noting, finally, that the comment on his shame, withheld at the beginning of *Session 1* and replaced by the self-image interpretation, is given at the end of *Session 2*.

Discussion

The view presented is that disturbances in self-narcissism are associated with the presence of unwished-for self-images and that emotional acceptance—'owning', 'insight', 'integration'—of these self-images is necessary for a meaningful object relationship in the transference. Clinical evidence has been produced to support these contentions and indicate a useful technique.

The psychoanalytic method requires that self-images be interpreted with statements which describe who or what the patient is. The analyst conveys, mainly non-verbally, that self-images need to be understood and acknowledged in the same way as any other aspect of psychic life. He does not endorse the patient's futile wish that analysis will 'cure' by ridding him of the defective image; that way lies interminability. The interpretations of self-image must aim to reveal what lies under the patient's manifest behaviour and what contributes unconsciously to his state of mind; they must give meaning to his actions, fantasies and feelings.

Activities that are repetitive, stereotyped, obligatory or deliberate may be part of a narcissistic disturbance and require interpretation in terms of the patient's attempt to stabilize his self-feeling by acting on his self-concept. Spiegel (1959) claims that the self-concept acts as a framework for the experience of self-feeling with regard to one or a few self-images. He argues that the individual acts, internally and externally, so as to maintain a compatibility and consonance between his identifications and all the concrete and abstract objects in his life. Behaving in a particular way produces an external perception and this can correspond to whatever the patient's thoughts centre on. This approach takes note of the paradox that an unsatisfactory pattern of functioning persists and does not deny or obviate the need for interpretations of anxieties, wishes, and intrapsychic conflict.

In the analysis of narcissism, the analyst must distinguish between the patient's convictions about himself, his self-feelings (including shame) and other relevant affects (such as helplessness). Such patients suffer from recurrent intense experiences of shame and humiliation which require interpretation. However, only specific and detailed interpretations of the object of the shame, the self, can allow the patient's convictions about himself to come under his control, i.e. to become a part or possession of his ego. It is noteworthy that the interpretations given to Mr X did not produce an intensification of shame or help-

lessness despite his belief that his real self was being exposed.

Integration of self-images not only reduced unpleasant affects and atmosphere in Mr X's analysis, but also allowed him to recreate a self-object relationship in the transference and then accept as useful more conventional analytic insights. These findings are in accord with Kernberg's (1975) views that an integrated self is necessary for an authentic personal relationship.

Countertransference

Analysis requires that a patient bring his self to the analyst and remember early experiences by reliving. Doing this with his narcissistic disturbance may not be easy; his unwanted self-concept and self-images are 'his self' and so are the particular psychic contents that need reliving and analysing. The re-creation of early states of the self, and defences against these, requires unusual and sometimes bizarre, self-destructive or sadistic efforts which may escalate if the patient's communication is not responded to with interpretive understanding. Mr X revealed his problems very early with his games, however, for details of his disturbance to come alive and be available for analytic work, he had to operate on the analyst in a complicated and determined way.

In the countertransference the analyst believes that he possesses an 'objective' opinion of the sort of person his patient is. The analyst notes a pattern of functioning in the patient's mind or his life which appears to be resistant to analysis of its component parts. The production of this pattern in the analysis will have allowed analytic interpretations but at a certain point the analyst becomes aware that these are neither producing psychic change, nor facilitating the analytic process, nor deepening the relationship between patient and analyst.

Bach (1977) pointed out that narcissistic fantasies are by their nature static. Mr X used to complain of the static quality of his life and the analysis. The maintenance of sameness produces a sense of continuity and so becomes an important activity in the service of self-narcissism. As the sameness (the self) is sterile and unsatisfactory, the patient's wish will be to be someone else. The analyst's countertransference complements this with a desire to be analysing someone else.

The hazard is the usual one of loss of distance. For example the analyst may make comments which sound like the expression of an opinion and this may confuse, burden or anger the patient.

Alternative views of the material

The use of clinical material to demonstrate a point automatically raises two different questions. The first, a basic objection, is that the material cited is not derived from properly applied psychoanalysis and hence the technical points, even if interesting, are essentially irrelevant to psychoanalysis. The second question allows that we are discussing psychoanalytic treatment but asks whether alternative explanations and alternative handling of the material are preferable.

The basic objection does not, of course, concern itself with externals such as the use of the couch or five-times-per-week attendance. It would probably take the form that this patient was unsuited for psychoanalysis, and/or the intervention was not an interpretation in the psychoanalytic sense but rather an opinion, manipulation or confrontation. According to Rycroft (1972), 'correct interpretations' are 'those which both (a) explain adequately the material being interpreted and (b) are formulated in such a way and communicated at such a time that they have actuality for (make sense to) the patient'. If this semantic view of interpretation is accepted then the evidence presented can stand as psychoanalysis. All interpretations confront the patient but I do not believe the analytic attitude in these sessions was confrontational.

The material suggests that the line of interpretation carried immediacy and intensity of experience and was 'mutative' in its own right. It was made in an analysis which, following contemporary fashion, placed high value on numerous transference interpretations in the context of historical reconstructions. One could view the interpretations as disguised transference interpretations. When the patient relates to the analyst as an extension of his self or as a mirroring parent, the only here-and-now comments which can reach the patient may be those concerning his relationship to himself.

A final major objection to this paper might be that it places an undue emphasis on the self and represents the trend which Khan (1972) criticized in Guntrip (1971), namely the roman-

ticization or idealization of a pure self-system. It has been emphasized throughout that this paper is not a comprehensive account of psychoanalytic technique, but that it aims to highlight a particular phenomenon of psychic life. The author regards the analysis of self-other relationships in the transference as one essential feature of treatment but has found that such relationships depend on the presence of sufficiently stable integrated self-representations.

We now move to the second group of objections which centre on a preference for alternative explanation and therefore different handling of the material.

Some analysts might consider the interpretations to be rejecting, attacking or denigrating. It might be that the patient-analyst relationship had been inadequately explored and that the analyst lacked awareness of the active conflicts and anxieties. For example it could be argued that faulty technique had produced the poor atmosphere in the analysis until the analyst lost control of his hostility and made a disguised sadistic attack matching the masochism of the patient: subsequent improvement occurred due to the relief at discharge of these wishes and the patient's pleasure in submission. The author does not claim control over his unconscious experiences but believes that close scrutiny of the material does not lend much support to this form of criticism. The emergence of a workable negative transference, the increased sense of genuineness and external improvement all argue against it.

Even if such a criticism is not made, some analysts might prefer an interpretation of the form, 'Part of yourself is ...'. Such an interpretation may suffice, but *not* if it is chiefly motivated by the analyst's anxiety about being rejecting. There are two issues. Firstly psychic reality has an absolute quality because in the primary process the part is equal to the whole. The analyst may speak (and usually does) without qualification, because the context of his utterances should remove ambiguity. Secondly mitigation of the message may play into the patient's dishonesty: having lied to himself for years he can superficially agree but continue to believe 'the central me is not really like that'.

It could be argued, following Kohut (1971), that the crucial dynamic in the transference is the patient's fear of the analyst's rejection of the archaic grandiosity. This, however, implies a patient in active authentic relationship with the analyst. When the patient has obliterated the analyst or is in a state of falsity, such interpretations are simply unnoticed. Following the sessions reported, Mr X became able to listen to and respond to interpretations concerning his grandiosity.

Analysts subscribing to the central importance of the analysis of intrapsychic conflict as described earlier by Rangell (1963) may, after exhausting a repertoire of interpretations, deal with repetitive patterns of self-defeating behaviour by telling the patient that he has a not-yet-understood need or wish for matters to turn out as they do. (Mr X's bizarre escapades invited and were partly helped by such declarations because of his penchant for dynamic notions.) As an act of clarification and an encouragement to the working alliance, this approach may serve some purpose, but the analyst may be unwittingly and unhelpfully communicating two messages. First, he may be locating the patient's behaviour within an analytic scheme when it should be located within the patient's psychic reality. Second, the message may suggest 'this pattern is a result of a neurotic compulsion and you will do well without it'. Such a suggestion, often appropriate in reference to a symptom, may be out of order for character traits which are part of the self; and it may imply, anti-analytically, that it is feasible and desirable to rid the psyche of unwanted contents.

Finally, it might be claimed that the use of the analyst as part of the patient's self, obliterates the analyst's own self and is therefore a manifestation of object narcissism and omnipotence. In this way of thinking, disturbances of self-narcissism mainly reflect the effects of object narcissism. Such a formulation is not excluded by the material presented but it does not necessarily make work on Mr X's relation to his self redundant. Kernberg (1975) warns that a patient like Mr X whose self is not integrated may have insight into the primitive processes of object-narcissism but remain unable to use this effectively in the interpersonal realm.

In my next paper the relationship between self-narcissism and object-narcissism will be further investigated.

Summary

This paper makes a limited contribution to the theoretical problem of narcissism and offers a possibly useful technical approach. Terminology is clarified and two concepts are introduced: self-narcissism and object-narcissism. Detailed clinical material illustrates the presence of an unwished-for self-image acting as a resistance. Interpretation leading to integration of the self-image into the self-representation results in an increase in authenticity on which conventional interpretative activity depends. Objections and alternative views of the material are briefly discussed.

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Translations of Summary

Cet exposé contribue peu au problème théorique du Narcicism, mais sans doute offre un abord technique utile. La terminologie est clarifiée et deux nouveaux concepts y sont introduits: narcicism-du-soi, et l' objet—narcicism. Le matériel clinique illustre la présence d'une image du soi non desirée agissant comme résistance. L'Interprétation conduisant à l'intégration de l'image du soi vers la représentation du soi aboutit à un agrandissement de l'authenticité sur laquelle dépend l'activité conventionnelle interprétative. Toute objection et tout point de vue alternatif sont brièvement discutés.

Dieser Artikel enthält einen begrenzten Beitrag zum theoretischen Problem des Narzissmus und bietet einen möglicherweise brauchbaren technischen Zugang an. Die Terminologie wird abgeklärt und es werden zwei Begriffe eingeführt: Selbstnarzissmus und Objektnarzissmus. Ausführliches klinisches Material illustriert die Existenz eines unerwünschten Selbstbildnisses, welches sich als Widerstand zeigt. Die Deutung, die zu einer Integrierung des Selbstbildnisses in die Selbstvorstellung führt, hat eine Erweiterung der Authentität zur Folge, von der die konventionelle deutende Tätigkeit abhängig ist. Einsprüche und andere Ansichten über das Material werden kurz diskutiert.

Esta comunicación hace una pequeña aportación al problema teórico del narcisismo y ofrece un enfoque técnico de posible utilidad. Aclaramos la terminologia e introducimos dos conceptos nuevos: el narcisismo del yo y el narcisismo del objeto. Ilustramos la presencia de una imagen del yo no deseada y que actúa como resistencia, con material clinico detallado. La interpretación que conduzca a la integración de la imagen del yo en la representación del yo, resultará en un aumento de la autenticidad de que depende la actividad interpretativa convencional. Discutimos brevemente objecciones y puntos de vista alternos.

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