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Narcissistic Transference: The Product of Overlapping Self and Object Fields*

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The Concept

Freud (1905) regarded transference as one of the two pillars of psychoanalysis, the other being resistance. In his metaphor, transferences are "new editions or facsimiles" of old emotional experiences, and "they replace some earlier person by the person of the physician." In a similar vein, **Greenson (1967)** defines transference as "the experience of feelings to a person which do not befit that person and which actually apply to another. Essentially, a person in the present is reacted to as though he were a person in the past." Until recent times in clinical theory, "the past" was understood to refer to the patient's oedipal period and the "earlier person" to a significant object of that period whose characteristics the patient now attributes to the analyst.

The ego of the oedipal child is relatively advanced in terms of function and identity. Self and object, child and parent, are perceived by the child as separate entities. When this situation is later replicated in the transference, the patient who is fixated at the oedipal period sees the analyst as a clearly delineated object who represents an earlier well-defined parental figure, both differentiated from the patient's self, past and present. Thus, for example, when such a patient accuses the analyst of being sly and deceptive, he is displacing

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onto him his impression of an *imago* of his one-time oedipal period.

The narcissistic patient differs from this picture. The phase at which he is fixated marks a level of development in which self and object are commingled in varying degrees. *I* and *you* are not separate entities. It may fairly be said of this state that what is mine is yours and yours mine, including traits, attitudes and emotional dispositions. If we transpose this situation into the analytic framework and consider how this affects the transference, we are obliged to conclude that the transference of the preoedipal patient differs radically from that of the oedipal patient. When the preoedipal patient ascribes to his analyst an attitude which he is transferring from a figure in early life, e.g., "You are hostile," several possible meanings present themselves. 1) He experienced his mother as hostile, introjected her hostility and made it his own, and now reprojects it on the analyst. 2) He was himself hostile and projected the hostility first on his mother and now on the analyst. 3) It was an attitude ascribed to the patient by objects in his early life and accepted by him about himself. The mother regarded the patient as being hostile, a judgment about himself which he introjected and made his own. He now reprojects onto the analyst the trait of hostility, which he has always accepted as characteristic of himself. The potential for transference meanings is limitless, fostered by the vicissitudes of early maturational history.

We distinguish the transference of the preoedipal patient from that of the oedipal patient by calling the former narcissistic transference and the letter object transference. In operational terms, this means that the oedipal patient transfers the images of distinctive objects of his oedipal period onto the analyst, whereas the preoedipal patient transfers onto the analyst the fuzzy and ambiguous images of his narcissistic period. These latter images may represent assorted pcrsonac of that period, such as the patient himself as a young child, various objects (mainly parental) in his environment, and confused self-object configurations. The blurring of boundaries between self and object at that early time and their consequent overlap results in the child's embodying in his own psyche the attitudes of the ministering parental figures. The child's ego may therefore be said to encompass the internalized representations of all the personac of his narcissistic period. Later on in the analysis, when the patient speaks about the analyst, he may be transferring onto him the attributes

and attitudes of any number of these figures, but he ultimately speaks of himself. In building the narcissistic transference and cliciting the patient's picture of the analyst, we are actually cliciting his picture of himself. Thus, for example, should the preoedipal patient, like his oedipal counterpart described above, see the analyst as sly and deceptive, he is expressing an attitude about himself. In standard

analytic parlance, this is called a projected image, which may serve as a shorthand reference to it. It is therapeutically useful, however, to conceive of the narcissistic transference less as the function of operant defensive mechanisms, such as projection, and more as the product of overlapping self and object fields.

Negative Transference and Implications for Therapy

Understanding the difference between narcissistic and object transference provides us with a valuable insight into the treatment of the narcissistic as distinguished from the ocdipal patient. When the ocdipal patient ascribes an attitude to the analyst, the latter may make an interpretation based on object transference, e.g., "This is how your father appeared to you and how you felt about him." The patient had experienced the oedipal situation as a relatively mature person, with a command of language and secondary process thinking. The interpretation now offers him an insight into his unresolved ocdipal conflicts and how they affect his relationship with the environment. It makes a connection in his mind between his current transference feelings and the original ocdipal feelings by means of the spoken word, which is present in both situations. As a result, it enables him to evoke from the unconscious the hostile thoughts and feelings about his father and to liberate himself from the conflicts associated with them.

The therapy of the preoedipal disorders, on the other hand, differs from that of ocdipal disorders expressly with regard to the use of interpretation. Language skills had not yet evolved to any appreciable degree in the early stages of development at which the preoedipal patient is fixated, nor had thoughts, feelings, and memories become associated with verbal expression. Events and feelings of that

period are therefore largely inaccessible to secondary process thinking and verbalizing. Interpretations, offering intellectual explanations of the connection between the patient's transference feelings and his early childhood experiences, will only fall on deaf ears. They will evoke no countervailing memories of the past. To tell a restless, demanding, discontented preoedipal patient: "You were a colicky, distraught infant who remained inconsolable no matter how your mother tried to ease your distress," will have no constructive effect. It may even worsen the patient's condition and generate greater resistance since, unable to place the statement in any meaningful context, his immature ego may experience it as an attack.

The give and take between mother and child in the narcissistic phase is essentially emotional, and the patient-analyst transactions can have meaning for the patient only if they likewise take the form of emotional interchanges. The development of the narcissistic transference is thus an emotional process, not dependent on insight. The narcissistic transference is, in Spotnitz's **(1969)** words, "the patient's attempt to reveal the basic maturational needs for objects that were not met in the course of his development." The attachment of the impulses arising from these needs "to the present transference … makes it possible to liberate [the patient] from their pathological influence" (p. 139).

We are dealing with an individual who has remained maturationally stranded by virtue of his self-destructive narcissistic defense patterns. This entailed repressing his negative feelings against the mothering object and deploying them against his own ego, with unfavorable consequences for emotional growth. The narcissistic transference affords the patient an opportunity to reexperience those old feelings in the presence of an accepting object and provides the occasion for duplicating the struggle for survival that the patient conducted in the first years of life. It helps the patient throw off the conflicts and fixations of the narcissistic period by mobilizing his feelings, particularly his angry feelings, and releasing them verbally toward the analyst, who stands surrogate to early objects. The release of feelings thus helps promote emotional growth. That is why the development of the narcissistic transference is heavily weighted on the side of negative transference, since that gives the patient latitude to verbalize such feelings. The successful mobilization and

verbal release of aggression constitutes the key to the maturational unfolding of the narcissistic ego.

What keeps the patient's mobilized rage from spilling over and destroying the analyst? The analyst's technical skill is, of course, of utmost importance in maintaining control of the process and channeling the aggression into acceptable verbal expression. The analyst would be unable to accomplish this, however, were it not for the patient's libidinal drive which allies itself with the analyst, paradoxically in the form of resistance. When the analyst, in the interest of mobilizing the patient's aggression, makes a frustrating intervention, the patient becomes enraged and impelled to attack him. But his libidinal impulses intervene. In actuality, the patient craves closeness and affection from the analyst, akin to the way he once felt toward his mother. This libidinal investment in the analyst prompts the patient to shield him from the destructiveness of the patient's aggressive drive, as he once shielded the frustrating mother. Instead of turning his anger on the analyst, the patient protects the analyst and attacks himself. This is the narcissistic defense, which functions as the chief impediment in the analysis to the patient's expression of his aggressive feelings. It protects the analyst from attack by the patient, but it accomplishes this at the expense of offering overall resistance to the patient's expression of his aggressive feelings.

From this point of view, the narcissistic transference may be conceived as a reexperiencing by the patient of the patterning of the narcissistic defense, as well as its gradual loosening and fading away. The patient starts by protecting the analyst and attacking himself.

He slowly learns to redirect the destructive impulsivity and give up his resistance to attacking the analyst. The narcissistic transference thus first highlights the pathological process of internalizing aggression, then reverses the process by helping the patient give up old pathways of discharge and externalize his destructive impulse, all in the minimally stimulative, non-threatening environment of the analysis. The spoken word serves as the unique vehicle for this purpose. The patient learns to say everything, to speak all his feelings without fear of acting on them or regressing out of control into psychosis. With the development of the narcissistic transference and the gradual release of aggression, the erotic drive, hitherto consumed in the struggle to check the aggressive drive, now becomes liberated

and directs its energies toward objects. The patient grows increasingly cooperative, more freely expressing his feelings, thoughts, fantasies, and memories. The working alliance and object transference begin to take shape.

Building the Narcissistic Transference

With the beginning of therapy, the analyst strives to create a comfortable emotional climate, so that the patient will feel safe and wish to stay on in treatment. This is particularly crucial for the deeply narcissistic patient, who is often in treatment against his inclination. The analyst listens quietly, speaking only in response to the patient's contact. “By not providing the patient with excessive communication, the analyst can maintain the ego-syntonic environment necessary to master the patient's destructive impulses” **(Spotnitz and Meadow, 1976)**.

The patient at first experiences the analyst as he experienced the object in the period in which he is fixated. This may be a very early objectless period, and the analyst does not exist emotionally at all for the patient. Strictly speaking, since no object existed for the patient in that period, we cannot speak of the transference at this point as related to objects. What is transferred is an original non-relatedness. The transference is not of an attitude *toward* the object but *about* the object, viz., that it does not exist. In this state, the patient remains enclosed in a shell of his own. Though he speaks, he makes no effort to establish contact with the analyst. Here is his initial resistance. The analyst soon recognizes that the patient will not make contact spontaneously. Having established this, the analyst's first steps are directed toward resolving the resistance by getting the patient to “see” him, to recognize his emotional presence. He does this by asking object-oriented questions at intervals and later on by asking the patient what he wants the analyst to do with the material he has been presenting. When the patient begins to manifest awareness of the analyst by addressing him spontaneously, the development of the narcissist transference may be said to be under way. The analyst, we observe, does not go about building the narcissistic transference directly. Instead, he helps the patient develop the ego function of

making contact, which by its nature implies an object. With the analyst serving as object, contact functioning and narcissistic transference develop conjointly.

The foregoing description of the emergence of narcissistic transference through the resolution of resistance suggests one model (of several) of the process of transference building. 1. The patient is self-absorbed (resistance). 2. The analyst asks object-oriented questions (interventions). 3. The patient begins to manifest an awareness of the analyst by addressing him directly (resolution of resistance as evidenced by contact functioning). 4. This signals the beginning of the development of the narcissistic transference. As the analysis proceeds, other forms of resistance appear which require other types of intervention, notably, joining and mirroring. The aim, however, remains the same: to help the patient develop the narcissistic transference through the resolution of resistance, contact functioning and verbal communication.

It may be useful at this point to remind ourselves that the narcissistic transference serves only as a key—a vital one, to be sure—to the maturational unfolding of the preoedipal ego. The verbal interchanges of patient and analyst alternatively pose and resolve the patient's resistance to talking. This process is accompanied not only by the release of aggressive and positive feelings toward the analyst but also by the patient's burgeoning capacity to “say everything,” to recount his life story, emotional, intellectual, circumstantial, past and present. The detailed accretion and sifting through, in this narrative, of fact and fantasy, of thought, dream, memory and striving that we call progressive communication, underwrites a parallel quickening of the long dormant potential for emotional growth. As the narcissistic transference develops, in brief, so does the patient's capacity to speak freely and in that way to accommodate ever larger segments of inner and outer reality.

The Analyst's Role

Who is the analyst? What role is assigned to him by the patient? The latter sees the analyst as he once saw his mother, so that the figure of the analyst is at first fleshed out as the bad mother representations.

The patient had often experienced his mother as hostile, neglectful or indifferent. He had introjected into his own ego the parent representation with all its hostility, whereupon he came to view himself as equally hostile and to hate himself as his mother had hated him. If the narcissistic transference proceeds successfully, he now reprojects onto the analyst those same baleful parental feelings and his feelings about himself. It is the analyst who is now bad, as the parent was and as the patient is. The patient not only sees the analyst as hostile toward him, he actually strives to arouse in the analyst the same active hatred for the patient as the patient feels himself. From the early narcissistic configuration, in which the young child saw both parent and himself as hateful, the transference rearranges matters so that the patient and the analyst are now both perceived as hateful. Thus, when the narcissistic patient says to the analyst, "You despise me," he is saying, "You and I share an identical feeling of contempt, primarily for me, but also for you." The analyst abets the process by interventions that the patient experiences as frustrating, modified by occasional interventions experienced as gratifying, thereby replicating the emotional deprivation suffered by the patient in his narcissistic period. By analogy, the patient receives as meager an emotional "feeding" from the analyst as he did from his mother, while he develops the "bad mother" transference.

This is the genius of the narcissistic transference. It can reproduce within the analytic framework the overlapping self-object state that obtained in the period of early narcissism. In the person of the analyst, it provides the patient at one and the same time with a double of his own self-image and a replica of his bad mother figure. The patient can reexperience and work through with the analyst the emotional traumas of his first years of life, freeing himself of the conflicts associated with them and proceeding with his psychological growth.

With the complete evolution of the narcissistic transference, equivalent to a fully developed symbiosis, the process of separation of self and object begins. The analyst gradually takes on for the patient the characteristics of the good (as well as, at times, bad) mother, and the patient, in transforming the analyst, transforms himself.

In schematic outline, the patient is helped to forsake his self-absorbed

state and to permit the analyst to partner a common universe with him. The patient now sees the analyst as at once separate and part of himself, thus reenacting in the transference the symbiotic phase of his narcissistic development. All of the beginning and much of the middle phases of treatment are engaged in facilitating the evolution of an emotionally complete symbiotic union of patient and analyst, represented in the flowering of the narcissistic transference. From there, the patient proceeds in slow stages with the dissolution of the symbiotic bond and with emotional separation from the analyst, an enactment in the transference of unfinished business from early life. The process culminates in the fading of the narcissistic transference and the emergence of the object transference. Successful development of the narcissistic transference therefore carries within itself the logic of its own passing and its metamorphosis into object transference.

In view of the patient's fragile ego, his incapacity for verbal communication of feelings and his desperate clinging to the narcissistic defense, the burden of building the narcissistic transference falls upon the analyst. This differs from the analysis of the oedipal patient, where, with the preliminaries over and the analysis under way, the cooperative patient is expected to assume responsibility for developing the transference and establishing and maintaining the working alliance **(Greenson, 1967)**. The narcissistic patient is, of course, far from cooperative, and the task of converting him into a stalwart of the working alliance is exactly what the building of the narcissistic transference concerns itself with. Since he is from the outset incapable of, and even resistant to, this undertaking, it falls to the analyst to assume the responsibility for building the narcissistic transference. This is consistent with the general therapeutic approach of letting the patient feel accepted with all his ambivalences and resistances. His task, he is told, is merely to talk; everything else is left to the analyst. Should obstacles arise to impede the course of the analysis, the analyst takes the blame: "Why am I letting you feel so anxious and depressed?" "Why am I not helping you come on time?" "How come I'm doing such a poor job that you're getting colds and headaches?" This procedure not only spares the patient any tension over his resistance, simultaneously it draws the patient's attention

to the analyst and in that way helps build the narcissistic transference.

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