On Working with Narcissistic Patients

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When working with narcissistic patients, we are faced with an enormously complex task. Before these highly disturbed patients, countertransference becomes especially important. This subject may be among my longest-standing interests. In line with this inquiry, I have often found myself wondering: what do these patients demand from us, and why do we often find ourselves unable to respond to that demand?

I will elaborate on certain features of the analyst-patient relationship to then propose some ideas about the conditions that, in my opinion, determine whether a problem in the countertransference will arise, a phenomenon that I call countertransference pathology. I use the term to refer to countertransferential features that lead the analyst into either a paralysis or an “enactment,” and which may complicate his task.

These patients’ extreme projections generally tend to confuse and overpower the analyst. They may elicit exhaustion and discouragement, or else evoke countertransference reactions in which the analyst’s repressed aggression prevails, thereby giving rise to fear that the patient might react violently. Bion and others refer to such conduct from the patient as an attack on linking.

In his brief 1957 article “On Arrogance,” Bion begins to develop the idea that normal employment of projective identification represents an important factor in the creation of the link. To this end, the analyst must tolerate the stress involved in containing the patient’s projective identification. What I am interested in analyzing here is what happens when the intensity of the patient’s projections gives rise to countertransference in which the analyst's own unconscious content heightens the intensity of his reaction, paralyzing him. On such occasions, there may be feelings of guilt and defenselessness that surface within him, which may lead to an enactment.

In our acting as analysts, the quest for evenly suspended attention, patience, and neutrality is constant. Such an effort constitutes a real load on our psychic functioning, which, in turn, is subjected to the pressures exerted by every patient. Nonetheless, we demand excellence of ourselves, in part due to the unconscious narcissistic fantasy to be perfect that exists in us all. This fantasy is also associated with another, in which we believe that our personal analyses have liberated us and equipped us with the tools necessary to circumvent the appearance of traits from our childhood conflicts.

Joel Zac informs us that some parts of the analyst’s real self that are not always visible may sometimes break through. Although certain structures reliably correlate to analytic functioning, others are fluctuating and may not always be manageable. When circumstantial factors suddenly break through, they may be difficult to control because we cannot quickly determine the correlations. Sometimes, we perceive them only through their disturbing our ability to interpret.

León Grinberg (1962), in turn, defined a new concept, projective counter-identification, to refer to a reaction of the therapist that is not due simply to his own conflicts but rather is almost entirely a response to the projective identification from the patient, seeking to influence the analyst. Subsequently, Grinberg describes it as an interaction in which the analyst is no longer a passive recipient of the patient’s projections.

Joseph Sandler (1976) described a similar phenomenon. The author uses the verb “to enact” and the noun “actualization,” and adds a note emphasizing the meaning of the latter “as an enactment.” In his opinion, “very often the irrational response of the analyst, which his professional conscience leads him to see entirely as a blind spot of his own, may sometimes be usefully regarded as a compromise-formation between his own tendencies and his reflexive acceptance of the role which the patient is forcing on him.”

Unlike Grinberg and Sandler, who focus on the effect of the patient’s conscious and unconscious behaviors on the analyst, my main interest is in the reactions elicited by such behavior in the analyst that are due to his own conflicts. We might consider that the feelings in the analyst that stem from those conflicts (and lead to blind spots or distorted perceptions) form part of the countertransference. Therefore, it is important to differentiate the responses in the analyst that activate and involve his own emotional conflicts – and may affect his understanding and technique – from the responses that reflect something that occurs in the patient and that directly serve our task. In my opinion, it is this predicament of failing to properly differentiate between transference, per se, and countertransference, which responds to the patient’s transference reactions, that precipitates our paralysis.

Thus, it seems fitting to ask ourselves which elements of the patient tend to bring to the fore the analyst’s own world rather than patient’s in the analyst’s mind. I contend that countertransference comprises the totality of the feelings generated by the patient in the analyst and is clearly related both to the patient’s projective identifications and to analyst’s inner world. When we treat patients with this kind of pathology, they unleash a chaotic, powerful, and aggressive transference that quickly produces intense emotional reactions in the analyst. These transference reactions make it difficult to withstand the stress and anxiety that pile onto one’s own problems. Projective identifications parasitize the object (in this case, the analyst) (Maldonado), depriving him of his identity: the patient believes the analyst to have become part of himself.

I believe that, in analyzing countertransference, we should include the feelings belonging to what Zac refers to as the “real person of the analyst.” In my opinion, identification with the patient tends to be paralyzing and to produce a generalized feeling of dissatisfaction. This is because such identification leads to the analyst’s being invaded by the patient’s rage and violence and, consequently, his experiencing a feeling of emptiness induced by a sense of uselessness, a sense of internal depletion that, perhaps, also stems from the narcissism we share as analysts. The devaluation that appears in the analyst, and that contributes to the patient’s self-adoration, is sustained, I believe, by the analyst’s own need to avoid projecting his own destructive impulses.

I contend that the patient experiences the same paralysis as the analyst, and, as its mirror image, this paralysis may cause us to fear our aggression towards the patient. A fear of loss also becomes engendered in these patients, for they believe that they have depleted the object and that it will abandon them as a result. Fear of our own natural reactions tends to still the situation further and may prevent us from noticing the appearance of fear and the enormous anxiety it produces in the patient. For this reason, it may be useful to analyze the paradox of the patient, who wants help and simultaneously rejects it. This fear-based rejection gives rise to the enactment. From time to time, the analyst recognizes the need and the implicit request behind the patient’s actions. When this happens, revealing this paradox to the patient partially resolves the analyst’s own paradox by avoiding entering into a counter-identification with him.

In addition to paralysis, frightening fantasies may appear in the patient’s dreams precisely because

he has introjected an authoritarian object – the analyst, with whom he identifies – in order to control it, and yet he feels subjugated to it. I believe that the depth of feeling of privation and dearth in narcissistic patients gives rise to fear of dependent love. This profound experience manifests in the mechanism they use to omnipotently deny a frustrating reality, which, paradoxically, tests their very fear.

The analyst risks not perceiving a mutual idealization – which, should it be noted, would not only facilitate recognition of the patient's aggression but also of the analyst's own aggression – perpetuating their mutual idealization, and, thereby, paralyzing the process. Thus, "prohibitions" on interpretation require the limit given by an interpretation. The analyst's explanation of the implicit limits of an interpretation, which he gives when his fear of aggression disappears, not only gives the patient relief but also conveys the presence of an object that does not break or submit. That is, it resolves a double paradox, the patient's and the analyst's own.

At times, there may be conflict between sustaining the fusion with the idealized object and protecting oneself through discernment of one's own identity. The analyst, then, must undo the countertransference fusion that these patients have created to limit their offensive functioning; this strengthens the analytic space. It seems to me that some features of the analyst's manner of containment come to play here – how he formulates an interpretation, i.e., his tone and speech, which may either serve as a container or reflect the analyst's fears.

Jorge Maldonado, citing Baranger, tells us that the choice of what to interpret is connected with the analyst's theories themselves. It is evident that there is a close relationship between what and how something is heard and the content and mode of interpretation. How something is heard causes various kinds of problems. Often, theoretical assumptions condition our interpretation of the patient's material and of our countertransference. Broadly speaking, there is an unconscious mechanism that causes us to look to theory for support when something impacts our unconscious and impedes our understanding each patient's own language. This language has to do not with what patients say, but rather with what they mean to say and, as a result, with what we mean to tell them when we intervene.

The issue of "emptiness" or of "nothingness" has been studied by various philosophical schools. These schools point out differences between thinking that develops from being and thought that arises from nothing. However, the feeling of nothingness that manifests in the analyst arises through action. The analyst's privateness is the set of factors that influence the selection of the patient's material on which the interpretation is formulated. The selection is influenced by these very structures – the personal history that we theoretically suppress – and the pressure exerted by the patient. These factors are not always controllable, and even less so with patients with narcissistic pathology.

When our ability to tolerate the frustration produced by the patient's enactment is adequate, inner emptiness or nothingness transforms into thought and allows us to think and interpret. It is only when the analyst can transcend the immobility generated by the feeling of nothingness that he can become the proclaimer of his interpretation. When the analyst is able to reflect and recognize the need and the request implicit in the patient's actions – who presses and tries, through his projections, to test whether the analyst will react aggressively – and can show the patient how he paradoxically wants to receive help and also does not, the paradox itself partially resolves. In such a way, he avoids becoming counter-identified with the patient and, thus, discovers a way out of this seemingly inescapable infinite loop.

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