CHAPTER 10

SOME REACTIONS OF THE ANALYST TO THE IDEALIZING TRANSFERRENCE

As may be expected, the analyst’s major reactions (including his countertransferences) in the analysis of narcissistic disorders are rooted in the analyst’s own narcissism and, especially, in the area of his own, unresolved narcissistic disturbances. These phenomena do not, in essence, differ from those which occur in the analysand, and they will here be considered only in so far as they are mobilized in the analyst in response to the circumscribed transference constellations of the narcissistic patient. The examination of the various reactions manifested by the analyst when he is predominantly confronted by the mobilization of the patient’s idealized parent imago in the idealizing transference will, therefore, be separated from the examination of those which occur when the patient’s grandiose self has come into the focus of the analytic work in the mirror transference (see Chapter 11).

I shall introduce the discussion of the analyst’s reactions to the analysand’s idealizing transference with a concrete example.

Some time ago I was consulted by a colleague concerning a prolonged stalemate in the analysis of a young woman (Miss L.) which seemed to have been present from the beginning of the treatment and to have persisted through two years of work. Despite the fact that he gave me an informative review of the patient’s history and of the analysis, I was at first unable to determine the cause of the stalemate; and since the patient, an emotionally shallow, shiftless, and promiscuous woman, showed a severe disturbance of her ability to establish meaningful object relationships, and presented a history of severe childhood traumas, I tended initially to agree with the analyst that the extent of the narcissistic fixations prevented the establishment of that minimum of transferences without which analysis cannot proceed. Evidence of some warmth toward the analyst and of interest in the treatment, however, spoke against the espousal of an altogether pessimistic outlook; yet, the stalemate seemed in essence to have been present from the beginning of therapy. I therefore asked the analyst to give me an account of the early hours of the analysis, with particular attention to possible activities on his part which the patient might have experienced as a rebuff.

Among the earliest transference manifestations several dreams of this Catholic patient had contained the figure of an inspired, idealistic priest. While these early dreams had remained uninterpreted, the analyst remembered—clearly against some resistance—that he had subsequently mentioned to the patient that he was not a Catholic. He had seemingly not given her this information in response to the dreams, but had justified the move by her supposed need to be acquainted with a minimum of the actual situation since in his view the patient’s hold on reality was tenuous. This event must have been very significant for the patient. We later understood that, as an initial, tentative transference step, she had reinstated an attitude of idealizing religious devotion from the beginning of adolescence, an attitude which in turn appeared to have been the revival of vague awe and admiration which she had experienced in early childhood. Later material from the analysis of this patient led to the conclusion that these earliest idealizations had been an attempt to escape from the threat of bizarre tensions and fantasies caused by traumatic
stimulations and frustrations from the side of her severely pathological parents. The analyst’s misguided remark, however, that he was not a Catholic—i.e., not like the priest of her dreams, not an idealized good and healthy version of the patient—was taken as a rebuff by the patient and led to the analytic stalemate which the analyst, with the aid of a number of consultations concerning this patient and his response to her, was later largely able to break.

I am focusing neither on the specific significance of the incipient (idealizing) transference, nor on the specific effect of the analyst’s mistake—in this instance, it may have been partly provoked by the patient—on the course of the analysis; I am interested in the elucidation of a countertransference symptom. A single observation would not allow a valid conclusion; but a combination of factors (among them the fact that I observed similar incidents; one, occurring in a student whom I supervised, was almost identical) allows me to offer the following explanation with a high degree of conviction. The analytically unwarranted rejection of the patient’s idealizing attitudes is usually motivated by a defensive fending off of painful narcissistic tensions (experienced as embarrassment, self-consciousness, and shame, and leading even to hypochondriacal preoccupations) which are generated in the analyst when the repressed fantasies of his grandiose self become stimulated by the patient’s idealization.

The analyst’s uneasiness at being idealized by the patient is especially likely to occur when the idealization takes place early and at a rapid pace, i.e., when the analyst is caught by surprise and has no time to prepare himself emotionally for his own reactions to being suddenly invested by an outrush of the patient’s narcissistic-idealizing libido. Some discomfort, of course, when one is exposed to open and intense adulation is ubiquitous (and proverbial: “Praise to the face is a disgrace!”), and thus even analysts whose personalities have no undue narcissistic vulnerability may have to resist the temptation to fend off their patients’ admiration. Unless there are unusual vulnerabilities in this respect, however, these reactions will be controlled and will be replaced by responses and attitudes which are more in keeping with the proper unfolding of the idealizing transference (and with the patient’s internal resistances against it) and with the development of the analytic process. If the analyst, however, is not sufficiently aware of his intolerance for narcissistic tensions and, especially, if he has (via identifications and imitations, or on his own) formed a stable countertransference attitude either of quasi-theoretical convictions or of specific character defenses or (as is frequently the case) of both, then his effectiveness with certain groups of narcissistic personality disturbances is impaired.

It makes little difference whether the rejection of the patient’s idealization is blunt, which is rare; or subtle (as in the instance reported), which is common; or, which is most frequent, almost concealed by correct, but prematurely given, genetic or dynamic interpretations (such as the analyst’s quickly calling the patient’s attention to idealized figures in his past or pointing out hostile impulses and contemptuous thoughts which supposedly underlie the idealizing ones). The rejection may express itself through no more than a slight overobjectivity of the analyst’s attitude or a coolness in the analyst’s voice; or it may reveal itself in the tendency to be jocular with the admiring patient or to disparage the narcissistic idealization in a humorous and kindly way. (In this context, see Kubie, 1971.)

It may be added here that it is their narcissistic vulnerability which motivates many excessively jocular people to employ these specific characterological defenses; i.e., they are continuously driven to deal with their narcissistic tensions (including the pressure of narcissistic rage) by belittling and self-belittling jokes. (For the differentiation, within the framework of the metapsychology of narcissism, of jocularity and sarcasm, on the one hand, from a genuine sense of humor, on the other hand, see Kohut, 1966a.)
Finally, to round out the account of the various ways by which the analyst, when he feels oppressed by his own narcissistic tensions, may attempt to fend off the patient's overt idealization (or by which he is led to overlook the defenses by which the patient disguises the manifestations of the therapeutic reactivation of the idealized parent imago), it is even deleterious to emphasize the patient's assets at a time when he attempts the idealizing expansion of the ingrained narcissistic positions and fels humble and insignificant by comparison with the therapist—appealing though it may seem when the analyst expresses respect for his patient. In short, during those phases of the analysis of narcissistic character disturbance when an idealizing transference begins to germinate, there is only one correct analytic attitude: to accept the admiration.

Are these failings of the analyst vis-à-vis the manifestation of an idealizing transference due to endopsychic constellations in the psychic apparatus of the analyst to which we should refer as countertransferences? This question which, it may be added here, can also be raised with regard to the analogous phenomena which occur during the analysis of the remobilized grandiose self in the mirror transference, leads us to a complex but by now familiar set of problems. I shall not address myself again to those aspects of the problem which hinge on the meaning of the term transference, i.e., whether we accept it as referring to a clinical phenomenon which is understood in its dynamic and genetic dimensions or whether, in addition to the above, we insist on a more rigorous metapsychological definition from the topographic-structural and psychoeconomic points of view (Chapters 8 and 9). Here I shall consider only the limited question whether the analyst's reactions are in the main motivated by current stress, or whether his faulty responses are due to specific long-term vulnerabilities which are related to the dangerous mobilization of specific repressed unconscious constellations. Since I feel certain that either one of the aforementioned causative factors may be responsible, the answer to this ques-

tion cannot be given in general terms but must be derived from the analytic investigation of individual instances.

Material obtained from the analysis of colleagues while they were engaged in the psychoanalytic treatment of narcissistic personalities as well as analogous self-analytic experiences have convinced me that these faulty reactions may relate to any point within a broad spectrum, i.e., from (a) simple defensive responses in a situation of momentary current stress to (b) responses which are part of ingrained countertransference attitudes. In the first case, the supervisor's or consultant's explanation, or the analyst's own rapid self-scrutiny, will usually remedy the situation if the significance of the idealizing transference is understood by the analyst and if he is willing to permit the spontaneous unfolding of the analytic situation. Brief interferences with the analyst's optimal functioning stem in these instances from the fact that, as stated before, a degree of narcissistic vulnerability is ubiquitous and that open praise and glorification (and, especially, the anticipatory tensions when narcissistic stimulation is expected) tend to make most civilized people uncomfortable and thus defensive. Specific ingrained resistances to allowing the unfolding of a cohesive idealizing attitude, however, can be recognized not only by the fact that simple explanations do not suffice in changing the analyst's deleterious attitude, but often also by a characteristic specificity and rigidity of the analyst's responses. He may be convinced, for example, that hostility always lies behind the patient's wish to admire the analyst; he is certain that the maintenance of a friendly rapport with the patient requires that the analyst respond with modest realism, etc. Since either one of these two assumptions may indeed be correct if the analyst is not dealing with an idealizing transference, his error cannot be demonstrated without reference to the fact that it has been committed on the basis of a blunting of his usual professional perceptive and empathic sensitivity. These feelings usually become especially blatant when the analyst fails to grasp the
unmistakable significance of the patient's expression of the fact that the analyst had misunderstood him. Clearly, there must be disturbing (unconscious) factors at work when an experienced analyst confuses the exaggerated praise of a patient which is accompanied by allusions to unconscious hostility with the shyly germinating tendrils of idealization which an analysand may extend (in his dreams, for example) while an idealizing transference begins to establish itself. And equally clearly, the automatic emphasis at the beginning of an analysis on the analyst's realism vis-à-vis a patient's idealization is no more justified than would be an analyst's protestation that he is not his patient's parent in response to the first hint of the patient's oedipal strivings.

In a letter toBinswanger (February 20, 1913) Freud expressed himself as follows about the problem of counter-transference which he considered "one of the most difficult ones technically in psychoanalysis." "What is given to the patient," Freud said, must be "consciously allotted, and then more or less of it as the need may arise. Occasionally a great deal. . . ." And later Freud sets down the crucial maxim: "To give someone too little because one loves him too much is being unjust to the patient and a technical error" (Binswanger, 1956, p. 50).

The present considerations constitute the analogue in the realm of the analysis of narcissistic personality disturbances to Freud's preceding statement about the counter-transferences in the analysis of the transference neuroses. If, in the analysis of a transference neurosis, the patient's remobilized incestuous object-libidinal demands elicit an intense unconscious response in the analyst which the analyst does not understand, he may become cold and overly technical vis-à-vis the patient's wishes, he may reject them in some other way, or will not even recognize them. At any rate, his ego will not have the freedom to choose the response that is in harmony with the requirement of the analysis and he will not be able, as Freud expressed it, to allot consciously what he gives to the patient "more or less . . . as the need may arise." A parallel situation may occur in the analysis of a narcissistic personality disturbance when the remobilization of the idealized parent imago prompts the analysand to see the analyst as the embodiment of idealized perfection. If the analyst has not come to terms with his own grandiose self, he may respond to the idealization with an intense stimulation of his unconscious grandiose fantasies. These pressures will call forth an intensification of defenses and lead, in an elaboration and buttressing of the defenses, bring about the analyst's rejection of the patient's idealizing transference. If the analyst's defensive attitude becomes chronic, the establishment of a workable idealizing transference is interfered with and the gradual working-through processes and concomitant transmuting internalizations in the realm of the idealized parent imago are prevented. The curtailment of the freedom of the analyst's "work ego" (Fliess, 1942) is due to his intolerance for a specific narcissistic demand of the patient. Paraphrasing Freud, he was unable to allow himself to be idealized "more or less . . . as the need may arise."

The slow analytic dissolution of the idealizing transference which occurs during extended working-through periods, usually late in the analysis, exposes the analyst to another emotional test in this area. In the initial phase, as described before, the analyst may feel oppressed by the stimulation of his narcissistic fantasies; in the late stage, he may resent being belittled by the very patients who had formerly idealized him.

Exaggerated fault-finding and belittling commonly also occur as defenses against the establishment of a comparatively uncomplicated idealizing transference, early in some analyses. The perceptive analyst will usually have no trouble recognizing the thinly disguised admiration which hides behind the patient's critical attitudes in these instances. These defenses require, of course, a different technical approach, and they call forth different reactions in the analyst than the
attacks on him that precede and accompany the withdrawal of the idealizing libido. The knowledge that he is dealing with the patient's defense against the establishment of an idealizing transference will, in general, protect the analyst against the development of untoward reactions that might disturb his analytic posture.

The patient's attacks on the analyst which occur during the working-through periods of the later stages of the analysis, however, may indeed impose an emotional hardship on the analyst since most patients (in the context of their angry disappointment during the work of reality testing which precedes the waves of withdrawal of idealizing libido from the analyst) are able to fasten on some of the analyst's actual emotional, intellectual, physical, and social shortcomings. Still, serious difficulties in this area (i.e., reactions of the analyst which imperil the success of the analysis) are, according to my experience, not frequent. There are a number of reasons for the relative harmlessness of the reactions which occur when the analyst is under attack as the patient is working through his idealizations. If the analyst's narcissistic vulnerability is great (and especially if, in addition, his skill and experience with the analytic treatment of narcissistic disorders are insufficient), his patients are not likely to reach a stage in which the idealizing transference will be worked through systematically, and thus a phase in which the narcissistic libido is gradually withdrawn from the analyst does not occur. If, however, a systematic working-through process in this area is established, two factors combine to mitigate the harmful effect of the analyst's impeditive reactions: (a) the patient's by now lessened propensity to respond to the analyst's errors with more than fleeting narcissistic and pre-narcissistic withdrawal and retreat; and (b) the analyst's greater capacity to regain his balance after he has acted out through anger, emotional coolness, or misplaced interpretations. The patient's withdrawal, furthermore, of idealizing cathexes does not take place as rapidly as did the establish-
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As was true for the analyst’s experiences and his behavior during the remobilization of the idealized parent imago, so also for his emotional responses to the demands of the patient’s therapeutically mobilized grandiose self: these reactions are determined not only by the analyst’s level of professional experience with the analysis of narcissistic disorders but also, and often decisively, by his own personality and by his current state of mind. In addition, however, we must not disregard the fact that the therapeutic mobilization of the grandiose self occurs in different forms and that the corresponding transfereelike conditions present different clinical pictures which expose the analyst to different emotional tasks.

Thus in the mirror transference in the narrower sense of the term the analyst is the well-delimited target of the patient’s demands that he reflect, echo, approve, and admire his exhibitionism and greatness. When the therapeutic remobilization of the patient’s grandiose self, however, leads the analysand to perceive the analyst as an alter-ego or twin, and even more so when the analysand’s expanded grandiose self begins to experience the representation of the analyst as a part of itself (merger), then the emotional demands on the analyst are of a different nature. In the mirror transference in the narrower sense of the word the patient does acknowledge the presence of the analyst to a limited extent: he is aware of the analyst insofar as the latter fulfills his functions with regard to the patient’s narcissistic needs; the patient insists that the analyst’s activities become focused entirely on these needs, and he responds with various emotions to the ebb and flow of the analyst’s empathy with his demands. In the twinship (alter-ego) and merger varieties of the remobilization of the grandiose self, however, the analyst as an independent individual tends to be blotted out altogether from the patient’s associations and he is then deprived of that very minimum of narcissistic gratification that is still offered to him in the mirror transference: the patient’s acknowledgment of his separate existence. 1

Even the patient’s demands in the mirror transference in the narrower sense of the term, however, impose a number of emotional hardships on the analyst and may call forth reactions which may interfere with the development and maintenance of the transference and with the process of working through. For prolonged periods while the analysand begins to remobilize old narcissistic needs and, often struggling against strong inner resistances, begins to deploy his exhibitionism and grandiosity in the treatment situation, the patient assigns to the analyst the role of being the echo and mirror of his reluctantly disclosed infantile narcissism. Apart from his tactful acceptance of the patient’s exhibitionistic grandiosity, the analyst’s contributions to the establishment and unfolding of the mirror transference are restricted to two

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1 See in this context the remarks about the specific applicability of the analogy between the adult’s experience of his own body and mind, and of their functions, and the experience of the narcissistic object in the merger variety of the mirror transference (Chapter 8). It might be added here that just as one is in general not specifically aware of one’s body and mind, but takes their presence and functioning for granted, so also with the patient’s perception of the analyst in the merger transference. It is in general only when a disturbance in one’s bodily and mental functioning occurs (or, by analogy, when the analyst in the merger transference goes away or is unempathic) that one becomes angrily aware of the fact that something which should function without question is refusing to do so.
cautiously employed sets of activities: he interprets the patient's resistances against the revelation of his grandiosity; and he demonstrates to the patient not only that his grandiosity and exhibitionism once played a phase-appropriate role but that they must now be allowed access to consciousness. For a long period of the analysis, however, it is almost always deleterious for the analyst to emphasize the irrationality of the patient's grandiose fantasies or to stress that it is realistically necessary that he curb his exhibitionistic demands. The realistic integration of the patient's infantile grandiosity and exhibitionism will in fact take place quietly and spontaneously (though very slowly) if the patient is able, with the aid of the analyst's empathic understanding for the mirror transference, to maintain the mobilization of the grandiose self and to expose his ego to its demands (see the discussion of the working-through process in the mirror transference in Chapter 7).

The analyst's own narcissistic needs, however, may make it difficult for him to tolerate a situation in which he is reduced to the seemingly passive role of being the mirror of the patient's infantile narcissism, and he may, therefore, subtly or openly, through gross paraphrases and symptomatic acts or through rationalized and theoretically buttressed behavior, interfere with the establishment or the maintenance of the mirror transference.

Most of the considerations concerning the analyst's reactions and countertransferences presented earlier with regard to the idealizing transference apply also with regard to the mirror transference and many of the results of the earlier reflections can be easily applied to the present situation. In particular, we will again remember Freud's dictum that the analyst, aware of the patient's needs and of his own reactions, must be able to control how much he gives to the patient, even "occasionally a great deal." On the road toward the analysis of the patient's infantile grandiosity and exhibitionism it is not only necessary that the analyst demonstrate for a long time his sympathetic understanding for the patient's demands that he be the reflector of the patient's cautious attempts at remobilizing early forms of self love, but he must indeed serve as an amplifying mirror of these needs through his nonrejectingly expressed interpretations of the—frequently only subtly alluded to—manifestations of the patient's remobilized infantile narcissism. The analyst, however, will be able to perform this task only if he can without resentment tolerate the fact that the patient sees him in essence as occupying a quite humble position and that he demands of him the fulfillment of a rather modest set of functions.

The analyst's problems, and thus his potential interference with the analytic remobilization of the grandiose self, are different when he becomes involved in the twinship (alter-ego) and the merger varieties of the therapeutic remobilization of the grandiose self. Exposed to a mirror transference, the analyst may become incapable of comprehending the patient's narcissistic needs and of responding to them by appropriate interpretations. The most common dangers to which the analyst is exposed vis-à-vis the twinship and merger are boredom, lack of emotional involvement with the patient, and precarious maintenance of attention (including such secondary reactions as overt anger, exhortations, and forced interpretation of resistances, as well as other forms of the rationalized acting out of tensions and impatience).

A comparatively simple set of causal factors is responsible for most instances of the analyst's tendency toward boredom with, and withdrawal of attention from, his patients during the alter-ego (twinship) and merger varieties of the transference. A brief look at the metapsychology of attention will direct us toward the comprehension of the analyst's specific tendency to become inattentive when he is confronted with the merger transference or the twinship.
True alertness and concentration during prolonged periods of observation can be maintained only when the observer's psyche is engaged in depth. Manifestations of object-directed strivings always tend to evoke emotional responses in those toward whom they are directed. Thus, even while the analyst is still at sea about the specific meaning of his patient's communications, the observation of (object-instinctual) transference manifestations is not usually boring to him.

The situation is, of course, different in the case of the analyst's defensive boredom. Although in these instances the analyst understands the transference meaning of the patient's communications only too well, he does not want to understand it. He may, for example, be unconsciously stimulated by libidinal transference appeals and therefore defend himself, by an attitude of disinterest, against the patient's attempt to seduce him. In all these instances we are dealing not with genuine boredom but with the rejection of an emotional involvement (including preconscious attention) which is currently present below the surface layer of the analyst's personality.

In instances of defensive boredom the deeper layers of the analyst's psychic apparatus are thus walled off by the defensive activity of the surface layer. During periods of unopposed even-hovering attention, however, i.e., when the analyst's basic observational attitude is not disturbed, the deeper layers of the analyst's psyche are open to the stimuli which emanate from the patient's communications while the intellectual activities of the higher layers of cognition are temporarily largely—but selectively!—suspended. Unless the analyst's unresolved conflicts concerning his own unconscious libidinal and aggressive responses interfere with his receptiveness to the patient's (object-instinctual) transference messages, the analyst will be able to remain an attentive listener for prolonged periods and will escape neither through an attitude of disinterested emotional withdrawal nor through the premature formulation of (pre)conscious closures.

The verbal and nonverbal behavior of analysands who suffer from narcissistic personality disorders, however, does not engage the analyst's unconscious responsiveness and attention in the same way as the associative material of the transference neuroses, which consists of object-directed instinctual strivings. True, the idealizing transference may deal with the analyst as a transitional object of a somewhat higher order, and thus, as described earlier, the analyst's own narcissism is either stimulated or disappointed and his attention therefore becomes more easily engaged.

The same also holds true in the mirror transference in the narrower sense of the term, though for somewhat different reasons. Despite the fact that the analyst is here of importance to the patient only as a mirror for and echo of his remobilized grandiose self, he is still appealed to, defended against, or withdrawn from in the context of the patient's activated narcissistic demands. A variety of emotional responses to these appeals are thus stimulated in the analyst, and they arouse his attention and maintain it.

When the activation of the grandiose self, however, occurs in the form of its merger with the psychic representations of the analyst (or, to a lesser extent, in an alter-ego transference), then there is no object investment and the patient's attachment to the analyst is of a specific archaic type. Thus, while the analyst's attention is aroused by the cognitive task of comprehending the puzzling manifestations of the archaic narcissistic relationship—and while he may feel oppressed by the patient's unqualified yet silent demands which, from the point of view of the target of the merger transference, are tantamount to total enslavement—the absence of object-instinctual cathexes often makes it difficult for him to remain reliably attentive during prolonged periods.

Although the preceding considerations refer to a human reaction propensity which is probably ubiquitous, it may well be demanded of a trained psychoanalyst that he should be able to master the tendency to withdraw his attention from a
patient who does not stimulate him through the extension of object cathexes. In other words, the analyst should be able to mobilize and maintain his empathy and his cognitive involvement with the therapeutically activated narcissistic configurations of his narcissistic analysands. Still, in view of the frequency with which failures of this kind occur, it is unlikely that they are due to specific unconscious conflicts and fixations of the analyst and they should, therefore, not be classified as countertransferences. This contention is supported by the fact, furthermore, that the analyst's difficulties in this respect tend to diminish considerably when he acquires a deeper and more comprehensive understanding of this area of psychopathology, and when he becomes more clearly aware of the nature of the specific psychological tasks which are imposed on him.

There are, however, some instances when explanations (e.g., as given by a teacher, supervisor, or consultant; or as acquired in other ways), and the resulting expansion of the analyst's (pre)conscious comprehension concerning the specific psychological hardships in the treatment of narcissistic personality disorders, do not suffice and when the analyst's tendency toward inattentiveness, boredom, and defensive activity remains resistant to the consultant's or supervisor's comments and even to the analyst's own conscientious and persistent efforts at self-scrutiny. In such instances in which the analyst's unconscious fixations (generally in the realm of his own narcissism) appear to be responsible for his chronic inability to mobilize and maintain his attention, empathy, and comprehension, the term countertransference may indeed be appropriately employed. Here the analyst's need to evade the stress imposed by the chronic involvement in a complex interpersonal relationship which is devoid of significant object-instinctual cathexes appears to be due to the specifically frightening implication of feeling drawn into an anonymous existence in the narcissistic web of another person's psychological organization.

It is difficult to estimate the frequency of these specific fixation points in the personality makeup of analysts, especially in view of the fact that even if they are present they might not interfere with the analyst's professional activities in areas other than the analysis of narcissistic personality disturbance. They may thus escape detection since the analyst will usually avoid the treatment of such cases. I believe, however, that a modicum of vulnerability in this area is rather frequent among analysts since the specific development of empathic sensitivity often contributes to the motivation to become an analyst and remains indeed a professional asset so long as it is kept under the domination of the ego. While it must be admitted that the conscious ego does not play an active role in the psychological performance that leads to empathic perception, it controls it in a variety of ways: it decides whether or not to initiate the empathic mode of perception; it controls the depth of the regression during the state of even-hovers attention; and it replaces the empathic attitude with appropriate secondary process activities in order to assess the empathically perceived psychological data which have to be fitted into a realistic and logical context, and to which an appropriate response has to be chosen, be that silence, interpretation, or broad analytic constructions.

The potential for the acquisition of a special talent for empathic perception, however, as well as the propensity for the enjoyment of exercising this psychological function, is largely acquired early in life. And both the potential talent and the pleasure in exercising the function arise in the very situations which also form the nucleus for the vulnerabilities vis-à-vis the fear of archaic enmeshment which we are discussing here. If, for example, a narcissistic parent—in most, but not in all, cases it is the mother's personality whose influence is predominant in this respect—considers the child as the extension of herself, beyond the period in which such an attitude is appropriate, or more intensively than is optimal, or with a distorted selectivity of her relevant responses,
then the child’s immature psychic organization will become excessively attuned to the mother’s (or father’s) psychological organization. The long-term results of the psychological influence of such an early environment may differ widely. It may lead to the development of a sensitive psychological superstructure with unusually great ability for the perception and elaboration of psychological processes in others. Or the early excessive exposure to psychological overconstriction may, on the contrary, lead to a defensive hardening or blunting of the perceptive surfaces in order to protect the psyche from being traumatized by a pathogenic parent’s anxiety-provoking responses.

Under optimal circumstances the grownup who is empathically merged with a small child will perceive the child’s anxiety and will respond appropriately to the child’s tensions. A child’s severe anxiety tension, for example, will elicit an immediate empathic signal anxiety in the adult. After an assessment of the reality situation, however, the adult may recognize that no danger is present and he will become anxiety-free. He will then include the child in his own calmness by phase-appropriate actions which emphasize the empathic merger-transmission of the emotional state, by picking the child up, for example, and holding him close and the like. Such interactions encourage the development of a wholesome and balanced empathic capacity in the child. If, however, the mother, instead of serving as a buffer for the child’s tension experiences, tends to respond to a child’s beginning, mild anxiety diffusely or selectively with the hypochondriacal magnification and elaboration of the painful emotion and threatens to infect the child with her own panic, then the child will attempt to protect himself against the development of a traumatic state through distancing and premature aut-

3 Replicas of such beneficial merger situations occur, of course, also between adults. When a person puts his arm around the shoulders of a friend who is upset, he not only dramatizes protection but also allows him, in voluntary regression, to merge temporarily with his own calmness.

tonomy, or, what is most important in this context, through the phase-inappropriate (i.e., premature) replacement of empathic perception by other modes of reality assessment.

Under specific, selectively favorable circumstances, even such early traumatization may not exclude later talent in the psychological field and, although encountered rarely, there are indeed some prominent psychoanalysts whose mastery of and scientific contributions to the field of analysis appear to be the result of a stunted empathic capacity that was replaced by an early capacity for assessing psychological reality through the secondary process. While most analysts collect their data through the empathic perception of large units of complex configurations in others (analogous to the recognition of a face through a single cognitive act), this group of psychologists does not similarly recognize the complex psychological state in one cognitive stroke, but they collect and fit together simple psychological details until they are able, in this way, to arrive at the grasp of a complex psychological configuration in others. In the process they achieve conscious awareness of many details which escape the empathic observer; on the other hand, however, they often waste a great deal of time perceiving what is plainly open to view, they are occasionally victims of grotesque misunderstandings, and they are frequently boring in their communications since they tend to belabor the obvious.

The aforementioned classification of personality types of psychoanalysts on the basis of the scrutiny of their attitudes and developmental responses in the realm of empathic sensitivity is, of course, oversimplified. These pure forms are in reality encountered less frequently than mixed forms, and thus no simple typology of the personality makeup of depth psychologists can be established. Experience does teach us, however, that many of those who choose a career in which the empathic preoccupation with others forms the center of the professional activity are persons who have suffered traumas (of tolerable proportions) in early phases of empathy
development and who have secondarily responded to the apprehensiveness concerning the danger of retraumatization with two complementary reactions: (a) they developed a hypersensitivity of the perceptive surfaces; and (b) they responded to the need to master the threatening influx of stimuli with an unusual growth of secondary processes aimed at understanding the psychological data and bringing order to the psychological material.

The investigation of the varieties of specific gifts and specific disturbances in the area of empathy is beyond the scope of the present work. Suffice it to repeat, in regard to specific countertransferences during the analysis of narcissistic personality disturbances, that analysts with a good and even outstanding capacity for the empathic perception of the structural conflicts of the transference neuroses may nevertheless be selectively and specifically incapacitated with regard to the empathic perception of the structural defects, the traumatic states, and the narcissistic fixations which are encountered during the analysis of narcissistic personality disturbances.

The archaic fear of being defenselessly flooded by the mother's overwhelming anxiety responses (or by other irrational or exaggerated emotional reactions) may lead certain analysts to an inhibition of their empathy because they fear that they might not be able to resist the merging needs of their analyses and because they have to defend themselves against the image of the intrusion of an archaic mother who will overwhelm the child with her own anxiety. Analysts with such personality makeups will therefore be selectively unable to relate empathically to patients who threaten them with an archaic narcissistic enmeshment. Hiding their specific inability through rationalizing statements expressing general therapeutic pessimism concerning such cases, they will defensively withdraw from the specific task of comprehending the mobilization of the patient's grandiose self in the twosome or, especially, in the merger transference.

I do not know how frequently such deep fears of merger interfere specifically with the work which the analyst has to carry out in the analytic treatment of narcissistic personalities, but I would estimate that the occurrence of permanently and seriously crippling merger apprehensions is not common. But if the analyst's lack of comprehension, boredom, withdrawal, or his defensive therapeutic activism will not yield to his increasing conscious grasp of the nature of his task: if explanations and conscious reflection will not produce any change; and if the cause of the inhibition is connected with old fears of traumatic overstimulation through loss of boundaries and uncontrollable flooding emanating from the mother's excitement—then such reactions should be classified as countertransferences in the broader, clinical meaning of the term.

Schools of psychoanalysis which give a prominent or even exclusive place in neurogenesis to the earliest developmental stages and to primitive mental organizations tend to see as ubiquitous occurrences the specific phenomena discussed in this monograph. Since the explanatory concepts employed by these schools of thought—e.g., the "interpersonal" school of H. S. Sullivan (1940)—stem from their characteristic single-axis approach, they understand, from their point of view, the various forms and varieties of psychopathology as degrees and nuances of psychosis or as defenses against it.

It is against this background that one must view some of the similarities and differences in the approaches of various schools of psychoanalytic thought to the narcissistic disorders. Leon Grinberg (1956), for example, describes technical difficulties which have certain similarities to those described in the present work. But Grinberg's theoretical framework—the theoretical system which is the prevalent one in South America; it is strongly influenced by the Kleinian outlook—does not appear to provide for the distinction between a narcissistically cathexed object and an object invested with object-instinctual cathexes; and projection and introjection are
regarded as the dominant psychic mechanisms which the analysand mobilizes vis-à-vis the object. The result is the obliteration of the crucial difference between those forms of psychopathology which are based on the structural conflicts of the differentiated psychic apparatus (the transference neuroses) and those psychic disorders in which the merging with and the detaching from an archaic self-object play the central role (the narcissistic personality disorders). As a consequence of this theoretical stance the transference neuroses are explained on the basis of archaic conflicts between mother and infant, while to the narcissistic disorders are imputed mechanisms—secondary projection and introjection—which come into being only after full structuralization of the psychic apparatus has been established and after the differentiation between self and object (including the investment of the latter with object-instinctual cathexes) has been accomplished. It is in harmony with the preceding considerations concerning Grinberg’s theoretical approach that he sees the countertransferences which are mobilized on the basis of merger fears as ubiquitous phenomena. In reality, however, these phenomena are not frequent. They appear in consequence of specific vulnerabilities of specific analysts vis-à-vis a specific psychological task. They appear, in other words, when the intensely mobilized, specifically narcissistic, demands of patients with narcissistic personality disorders impinge on the psyche of an analyst whose own tendency toward self-object dedifferentiation has not been fully or reliably transformed into the capacity toward the extension of trial-mergers in the form of a controlled empathy.

Complex as the subject matter of the analyst's reactions during the therapeutic mobilization of the analysand's grandiose self might be, at times it may prove easier to outline the various forms metapsychologically than to comprehend and classify an analyst's relevant failure in a concrete clinical instance. The following description of a temporary empathic failure of the analyst during the analysis of a specific case involving the mobilization of the analysand's infantile grandiose self may help to illuminate the subject matter from a clinical viewpoint.

Miss F., age twenty-five, had sought analysis because of a number of diffuse dissatisfactions. Despite the fact that she was active in her profession, and had numerous social contacts and a series of love relationships, she felt that she was different from other people and isolated from them. Although she had many friends, she thought that she was not intimate with anyone; and, despite the fact that she had had several love relationships and some serious suitors, she had rejected marriage because she knew that such a step would be a sham. In the course of the analysis it gradually became evident that she suffered from sudden changes in her mood which were associated with a pervasive uncertainty about the reality of her feelings and thoughts. In metapsychological terms, her disturbance was due to a faulty integration of the grandiose self into the total psychic apparatus, with the resulting tendency toward swings between (1) states of anxious excitement and elation over a secret "preciousness" which made her vastly better than anyone else (during times when the ego came close to giving way to the grandiose substructure, i.e., the strongly cathexed grandiose self); and (2) states of emotional depletion, blandness, and immobility (which reflected the ego's periodic enfeeblement when it used all its strength to wall itself off from its unrealistic, grandiose substructure). The patient established object relations not primarily because she was attracted to people but rather as an attempt to escape from the painful narcissistic tensions. Yet, while in later childhood as well as in adult life her social relations were, on the surface, comparatively undisturbed, they did little to mitigate the pain caused by the underlying narcissistic disturbance.

Genetically, as we could reconstruct with great certainty,
the fact that the mother had been depressed during several periods early in the child’s life had prevented the gradual integration of the narcissistic-exhibitionistic cathexes of the grandiose self. During decisive periods of her childhood, the girl’s presence and activities had not called forth maternal pleasure and approval. On the contrary, whenever she tried to speak about herself, the mother deflected, imperceptibly, the focus of attention to her own depressive self-preoccupations, and thus the child was deprived of that optimal maternal acceptance which transforms crude exhibitionism and grandiosity into adaptably useful self-esteem and self-enjoyment. Although the traumatic fixation on the infantile form of the grandiose self was not complete since the mother’s depressive state had not been unmitigated, the pathological condition had later become reinforced by Miss F.’s relationship with her only sibling, a brother three years older than she, who (himself lacking in reliable parental approval) treated the sister sadistically, pushed himself into the limelight on all possible occasions, and used his superior intelligence to deflect parental attention from what the sister proudly said or did, thus interfering again with the realistic gratification of her narcissistic needs.

In the following I shall focus on that part of the clinical material which illustrates the analyst’s specific problems during the analysis of the therapeutically activated grandiose self. During extended phases of the analysis, beginning at a time when I did not yet understand the genetic background of the patient’s personality disturbance and still had only an unclear notion of the essential nature of the patient’s psychopathology, the following progression of events frequently occurred during analytic sessions. The patient would arrive in a friendly mood, would settle down quietly, and begin to communicate her thoughts and feelings about a variety of subjects: interactions at work, with her family, or with the man with whom she was currently on friendly terms; dreams and relevant associations, including tentative but genuine references to the transference; and a variety of insights (arrived at against what seemed like appropriate resistances) concerning the connection between present and past, and between transferences upon the analyst and analogous strivings channeled toward others. In brief, in the first part of the analytic sessions during this phase, the process of therapy had the appearance of a well-moving self-analysis.

Three features, however, differentiated this stage of the patient’s analysis from phases of genuine self-analysis when the analyst is, indeed, little else than an interested observer who holds himself in readiness for the next wave of resistances. (1) The stage in question lasted much longer than the periods of self-analysis encountered in other analyses. (2) I noted, furthermore, that I was not able to maintain the attitude of interested attention which normally establishes itself effortlessly and spontaneously when one listens to an analyst’s work of free associations during periods of relatively unimpeded self-analysis: my attention would often lag, my thoughts began to drift, and a deliberate effort was required to keep my attention focused on the patient’s communications. This tendency toward inattention was puzzling since the patient dealt with object-directed preoccupations, inside and outside the analytic situation, and present as well as past. Yet, while she spoke about currently invested objects, including fantasies about me, I recognized gradually that my inattentiveness was due to the fact that the communications themselves did not seem to be directed toward me and that my object-libidinal attention responses were, therefore, not spontaneously mobilized. (3) After a prolonged period of ignorance and misunderstanding during which I was often not only struggling with boredom and inattentiveness but was also inclined to argue with the patient about the correctness of my interpretations and to suspect the presence of stubborn, hidden resistances, I came to the crucial recognition that the patient demanded a specific response to her communications, and that she completely rejected any other.
Unlike the analysand during periods of genuine self-analysis, Miss F. could not tolerate my silence, nor would she be satisfied with noncommittal remarks; but, at approximately the midpoint of the sessions, she would suddenly get violently angry at me for being silent and would reproach me for not giving her any support. (The archaic nature of her need, it may be added, was betrayed by the suddenness with which it appeared—like the sudden transition from satiation to hunger or from hunger to satiation in very young children.) I gradually learned, however, that she would become immediately calm and content when I, at these moments, simply summarized or repeated what she had in essence already said (such as, "You are again struggling to free yourself from becoming embroiled in your mother's suspiciousness against men." Or, "You have worked your way through to the understanding that the fantasies about the visiting Englishman are reflections of fantasies about me"). But if I went beyond what the patient herself had already said or discovered, even by a single step only (such as: "The fantasies about the visiting foreigner are reflections of fantasies about me and, in addition, I think that they are a revival of the dangerous stimulation to which you felt exposed by your father's fantasy stories about you"), she would again get violently angry (regardless of the fact that what I had added might be known to her, too), and would furiously accuse me, in a tense, high-pitched voice, of undermining her; that with my remark I had destroyed everything she had built up; and that I was wrecking the analysis.

Certain convictions can be achieved only firsthand and I am thus not able to demonstrate in detail the correctness of my conclusions about the meaning of the patient's behavior and about the significance of the typical impasse (including specific aspects of the countertransference) which developed during these sessions. During this phase of the analysis the patient attempted, with the aid of my confirming, approving, and echoing presence (mirror transference), to integrate an archaic, narcissistically hypercathexed self into the rest of her personality. This process began with a cautious reinstatement of a sense of the reality of her thoughts and feelings, and then moved gradually toward the transformation of her intense exhibitionistic needs into an ego-syntonic sense of her own value and an enjoyment of her activities. As a significant transitional undertaking (which was, however, carried on only temporarily) she began to take dancing lessons. These lessons (and her participation in various public performances) provided an important buffer for that excess of her narcissistic exhibitionistic needs that could not find satisfaction in the analytic situation and that she could not sublimate through any of her customary activities.

As I gradually began to realize, the analysand assigned to me a specific role within the framework of the world view of a very young child. During this phase of the analysis the patient had begun to remobilize an archaic, intensely cathexed image of the self which had heretofore been kept in insecure repression. Concomitant with the remobilization of the grandiose self, on which she had remained fixated, there also arose the renewed need for an archaic object (a precursor of psychological structure) that would be nothing more than the embodiment of a psychological function which the patient's psyche could not yet perform for itself: to respond empathically to her narcissistic display and to provide her with narcissistic sustenance through approval, mirroring, and echoing.

Due to the fact that I was at that time not sufficiently alert to the pitfalls of such transference demands, many of my interventions interfered with the work of structure formation. But I know that the obstacles that stood in the way of my understanding lay not only in the cognitive area; and I can affirm, without transgressing the rules of decorum and without indulging in the kind of immodest self-revelation which ultimately hides more than it admits, that there were specific hindrances in my own personality which stood in the way.
There was a residual insistence, related to deep and old fixation points, on seeing myself in the narcissistic center of the stage; and, although I had of course for a long time struggled with the relevant childhood delusions and thought that I had, on the whole, achieved dominance over them, I was temporarily unable to cope with the cognitive task posed by the confrontation with the reactivated grandiose self of my patient. Thus I refused to entertain the possibility that I was not an object for the patient, not an amalgam with the patient’s childhood loves and hatreds, but only, as I reluctantly came to see, an impersonal function, without significance except insofar as it related to the kingdom of her own remobilized narcissistic grandeur and exhibitionism.

For a long time I insisted, therefore, that the patient’s reproaches related to specific transference fantasies and wishes on the oedipal level—but I could make no headway in this direction. It was ultimately, I believe, the high-pitched tone of her voice which led me on the right track. I realized that it expressed an utter conviction of being right—the conviction of a very young child—which had heretofore never found expression. Whenever I did more (or less) than provide simple approval or confirmation in response to the patient’s reports of her own discoveries, I became for her the depressive mother who (sadistically, as the patient experienced it) deflected the narcissistic cathexes from the child upon herself, or who did not provide the needed narcissistic echo. Or, I became the brother who, as she felt, twisted her thoughts and put himself into the limelight.

The answer to the question whether the mother (or the brother, who in this context was seen by the patient as in a team with the mother, i.e., as an extension of or a substitute for her) had actually been consciously, preconsciously, or unconsciously sadistic, as the patient insisted for long periods of her analysis, is of small importance at this point. The archaic object is experienced as all-powerful and all-knowing, and thus the consequences of its actions and omissions are always viewed by the child’s psyche as having been brought about intentionally. The patient therefore assumed—correctly within the framework of her mental organization—that the initial lack of my understanding of her was not due to my intellectual and emotional limitations but that it was the result of sadistic intentions. I do not believe that this misperception should simply be ascribed to a transference confusion. It must rather be understood as being due to the therapeutic regression to the level of the essential pathogenic fixation, i.e., to a narcissistic conception of the object and thus to an animistic confusion between effect and cause on the one hand, and between deed and intention on the other.

Whatever the mother’s (and brother’s) own conscious or unconscious motivation may have been, however, from the point of view of the metapsychological assessment of the patient’s psychological development, their behavior had contributed to driving an archaic, highly cathexed grandiose self into repression where it was not accessible to modification by reality and could not become available to the ego as a source of acceptable narcissistic motivations. Her father, to whom, it may be added here, the patient had turned more in search of a substitute for the narcissistic approval which she had not obtained from her mother than as an oedipal love object, had further traumatized the child by vacillating between attitudes of fantastic love for the girl and emotional disinterest and withdrawal over long stretches. His behavior stimulated the child’s old narcissistic preoccupations without helping her to integrate them with a realistic conception of the self by an optimal selectivity of his responses in a setting of reliably maintained interest. He thus interfered with the establishment of a solid repression barrier and, through his inconsistent and seductive behavior, he reinforced the trend toward the resexualization of her needs, somewhat similar to the circumstances that brought about the resexualization of the need for narcissistic homeostasis in the case of Mr. A.

The clinical situation described in the preceding pages
and, especially, the analyst's therapeutic responses to it require further elucidation, even though the following discussion of the analytic process does not directly belong to the present specific subject matter, the countertransference in the mirror transference.

At first hearing it might seem to be stating that, in instances of this type, the analyst must indulge a transference wish of the analysand; specifically, that the patient had not received the necessary emotional echo or approval from the depressive mother, and that the analyst must now give it to her in order to provide a "corrective emotional experience" (Alexander, French, et al., 1946).

There are indeed patients for whom this type of indulgence is not only a temporary tactical requirement during certain stressful phases of analysis but who cannot ever undertake the steps which lead to that increased ego dominance over the childhood wish which is the specific aim of psychoanalytic work. And there is, furthermore, no doubt that, occasionally, the indulgence of an important childhood wish—especially if it is provided with an air of conviction and in a therapeutic atmosphere that carries a quasi-religious, magical connotation of the efficacy of love—can have lasting beneficial effects with regard to the relief of symptoms and behavioral change in the patient. Having received the bishop's handshake like Jean Valjean of Hugo's Les Misérables, the patient walks away from the therapeutic session as a changed person. (For a striking incident of a sudden cure following a wholesome experience outside of planned psychotherapy see the vignette adduced by K. R. Eissler [1965, p. 357ff.] from Justin [1960].)

The analytic process in analyzable cases, however, as in the case of Miss F., develops in a different way. After overcoming certain cognitive and emotional obstacles I recognized that the essential transference manifestation lay not in the content of the material (which related to later developmental phases and referred to the patient's defensively used, emotionally shallow interpersonal relations) but in the interactions which were taking place during the analytic session itself. Specifically, I recognized that the patient had reinstated me as the depressive, hypochondriacal mother of her early childhood who had deprived her of the narcissistic nutriment which she had been in need of. Although, for tactical reasons (e.g., in order to insure the cooperation of a segment of the patient's ego), the analyst might in such instances transitorily have to provide what one might call a reluctant compliance with the childhood wish, the true analytic aim is not indulgence but mastery based on insight, achieved in a setting of (tolerable) analytic abstinence.

As is the case in the transference neuroses with regard to object-instinctual drives, so also with regard to the narcissistically invested object in the analysis of narcissistic personality disturbances: the analyst does not interfere (either by premature interpretations or by other means) with the spontaneous mobilization of the transference wishes. In general, he begins his interpretative work concerning the transference only at the point when, because of the nonfulfillment of the transference wishes, the patient's cooperation ceases, i.e., when the transference has become a resistance. And again, as in the case of the transference neuroses, so also—and even more—with the narcissistic personality disturbances: once the interpretative work has begun, the analyst will not expect that ego mastery over intense childhood desires can be achieved at the very moment when the patient is making the first steps toward allowing them access into consciousness. On the contrary, the analyst knows that a prolonged period of working through lies ahead in which the patient will, initially at least, put up resistances not so much by insisting on

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5 Interpretative references to the transference, especially early in the course of the analysis, which are not aimed at remobilizing the lost momentum of an analytic process that has become obstructed by transference resistances, will be correctly understood by the patient as prohibitions. No matter how friendly and kindly the analyst expresses himself, the analysand will hear him say: "Don’t be that way—it's unrealistic, childish!” or the like.
the fulfillment of the infantile wishes but rather by renewed attempts at retreating from them, usually by expressing noisy claims concerning the satisfaction of demands in a split-off sector of the psyche while the central needs and wishes are again going into hiding. Neither the analyst’s noninterference with the establishment of the transference wish, however, nor his sober-minded acceptance of the gradualness and complexity of the working-through process must be confused with that abrogation of analytic work implied in the notion of a "correctional emotional experience" or with that replacement of it by educational measures (and by other activities from the side of the analyst) which might be advocated as justified in the service of a need for the establishment and maintenance of the therapeutic alliance.

In the case of Miss F., my recognition that a specific childhood demand was being re-enacted constituted only the beginning of the working-through process concerning the grandiose self. After I had gained mastery over my own countertransference resistance which for a while made me insist that the patient was struggling with object-instinctual transferences, I was finally able to tell her that her anger at me was based on narcissistic processes, specifically on a transference confusion with the depressed mother who had deflected the child’s narcissistic needs onto herself. These interpretations were followed by the recall of clusters of analogous memories concerning her mother’s entering a phase of depressive self-preoccupation during later periods of the patient’s life. Finally, the patient vividly recalled a central set of poignant memories, upon which a series of earlier and later ones seemed to be telescoped. They referred specifically to episodes when she came home from kindergarten and early elementary school. At such times she would rush home as fast as she could, joyfully anticipating telling her mother about her successes in school. She recalled then how her mother opened the door, but, instead of the mother’s face lighting up, her expression remained blank; and how, when

the patient began to talk about school and play and about her achievements and successes during the preceding hours, the mother appeared to listen and participate, but imperceptibly the topic of the conversation shifted and the mother began to talk about herself, her headache and her tiredness and her other physical self-preoccupations. All that the patient could directly recall about her own reactions was that she felt suddenly drained of energy and empty; she was for a long time unable to remember feeling any rage at her mother on such occasions. It was only after a prolonged period of working through that she could gradually establish connections between the rage which she experienced against me when I did not understand her demands and the feelings she had experienced in reaction to the narcissistic frustration which she had suffered as a child.

My interpretations thus led the patient to a gradually increasing awareness of the intensity of her demands and of her need for their fulfillment, a recognition which she resisted vigorously because she now could no longer deny the presence of an extreme neediness in this area which had been covered for a long time by a display of independence and self-sufficiency. This phase—to outline the sequence in rough approximation—was then followed by a slow, shame-provoking, and anxious revelation of her persistent infantile grandiosity and exhibitionism. The working through which was accomplished during this period led ultimately to increased ego dominance over the old grandiosity and exhibitionism, and thus to greater self-confidence and to other favorable transformations of her narcissism in this segment of her personality.

Leaving the specific clinical illustration, however, I will now summarize the analyst’s cognitive and emotional tasks during analyses in which the vicissitudes of early stages of the patient’s grandiose self are therapeutically remobilized in the various forms of the mirror transference. In order to function properly during the analysis of such personality disorders the
The analyst must be capable of remaining interested in and attentive to the remobilized psychological structures despite the absence of significant object-instinctual cathexes. Furthermore, he must be capable of accepting the fact that his position (which is in harmony with the specific level of the major fixation) within the patient’s therapeutically reactivated narcissistic world view is that of an archaic prestructural object, i.e., specifically, that of a function in the service of the maintenance of the patient’s narcissistic equilibrium. Not only must the analyst be capable of a passive tolerance of these aforementioned psychological facts (i.e., he must neither become impatient; nor must he interfere with the establishment of the narcissistic transference through premature interpretations; nor must he withdraw his attention and empathy), but he must remain positively involved with the patient’s narcissistic world in creative perpectivity since many of the patient’s experiences, because of their preverbal nature, must be empathically grasped by the analyst and their meaning must be reconstructed, at least in approximation, before the patient is able to recall analogous later memories (through “telescopy”) and can connect the current experiences with those of the past.

In performing the tasks which are imposed on him during the analysis of the remobilized grandiose self, the analyst is greatly aided by the theoretical grasp of the conditions with which he is dealing. He must, furthermore, be aware of the potential interference of his own narcissistic demands which rebel against a chronic situation in which he is neither experienced as himself by the patient nor even confused with an object of the patient’s past. And, finally, in specific instances, the analyst must be free of the active interference by archaic fears of dissolution through merger. He must not wall himself off against the merger needs of certain patients but must tolerate their activation without undue anxiety and must himself remain capable of trial-mergers and signal penetrability in the form of the controlled empathic grasp of the patient’s narcissistic demands and of the requisite responses to them, i.e., the interpretations and reconstructions which lead to the gradual integration of the patient’s narcissistic structures into the mature, reality-oriented personality. It bears repeating, however, as we are here once more surveying the analytic process in the treatment of these disturbances, that the analysand tends initially and for an extended period to have insufficient tolerance for his own narcissistic demands, and that he must first learn to accept and to understand them before his ego will gradually attempt to achieve further dominance over them.