# Chapter 10
# The search for a primary object: making and breaking in the treatment of narcissism

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## Introduction

It is well known that Freud was never very enthusiastic about the therapeutic effects of the analytic process. And in Freud's view the narcissistic patient could not really benefit from psychoanalytic treatment as it stood. Anna Freud (1976) was also basically sceptical about the widening therapeutic scope of psychoanalysis. She felt:

> . . . that classical analysis should remain within its original realm of the neurosis, except for exploratory excursions. In a 1976 paper, Anna Freud wrote along these lines: our psychoanalytic understanding of these severe disorders has far outstripped our capacity to help them by analytic therapy; what the ego has done to itself during development can be un-done by the ego in analysis – but what has been done to the ego by early deprivation or trauma can only be healed by a modified approach.
>
> *AS Couch (1987, unpublished paper, 'Anna Freud's adult psychoanalytic technique')*

Indeed, as Anna Freud remarks, there is a discrepancy between analytic theory and practice. Our theoretical understanding of infant development has grown tremendously and we now understand the nature of and reasons for severe disturbance, whereas clinical work is more arduous and random. As we know, these deeply disturbed patients do form a transference relationship both with the healthy and ill parts of themselves. However, Freud (1914) was all too aware of the narcissist's 'unconquerable resistance' which adds to the analyst's perseverant work undertaken with the psychoneurotic, because for the narcissist there is a constant need to attack the therapeutic relationship. For these patients, analysis can become a way of life, both for support and to attack: 'Such patients may need to go on in analysis partly in order to have a libidinal

relationship to attack' (Rosenfeld, 1987, p. 22). Attack can take any form: from utter contempt to complete withdrawal, and the analyst can be made to feel ignored or despised. In our view, the aim of analytic treatment for these patients should be to provide an unbreakable 'container': a link that is strong enough to survive the repeated attacks on it, thus providing an experience of primary attachment which can be internalised.

## The narcissistic patient

What demarcates this category of patient is their despair and sense of futility (Bollas, 1979). As they cannot internalise anything – nothing can feed, be digested or metabolised – their lives feel permanently empty. An example of this is a highly intelligent patient aged 52 years. He has spent his whole life feeling a sense of futility, unable to use his gifts or allow any of his therapies, over the years, to help him. As Glasser (1992) remarked: 'They cannot use reality.' This patient's isolated life shows clearly how this type of disturbance leads people into 'avoiding anxiety by avoiding contact with other people and with reality' (Steiner, 1993). One can feel this wholesale avoidance in the transference: 'the analyst has to carry the despair associated with the failure to make contact' (Steiner, 1993).

The personality of this type of patient is often marked by an extreme degree of splitting with fragmentation of affects, high expectations to receive, which explains their permanent feeling of disappointment, and a reluctance to give because they would feel depleted (Kernberg, 1977).

The narcissistic patient pushes ruthlessly in search of a primary object (Balint, 1968; Bollas, 1979). Hence the 'narcissistic transference' (Kohut, 1971) is different from the ordinary transference neurosis, because it involves a need for the revival of archaic objects rather than the instinctual investment of Oedipal conflicts. The fact that these patients are constantly on a search could explain why they change analysts, trainings, studies, jobs. These changes are often preceded by high achievement. They often display a sense of great urgency about their quest, and their frenzied search for an object can appear more in keeping with the behavioural profile of mania with its ingredients of triumph, control and contempt. To give an example, the patient we have already mentioned is always quoting his previous analysts. After almost 2 years of therapy he still reports his weekend happenings filled with destructive attacks on his treatment. This is a repeated behavioural theme of his; even in a 1-hour assessment with a consultant some years ago he managed to enrage him with his manic contempt for psychoanalysis.

It is not unusual for these patients to have come from another analysis and ours will not be their last stop. They feel as though they are in transit in the consulting room unless they find a perfect fit with their



analyst. It is as if they are on 'a somewhat manic search for health' (Bollas, 1979). Another trait of these patients is that they cannot tolerate any recognition of separateness between self and object. This would lead to feelings of intense anxiety about dependency (Rosenfeld, 1965). They feel most comfortable in a merged state. On the other hand, they are consumed with an intense, often unconscious hostility against the primary object, and this can lead them into a repeated cycle of destruction and search.

## Theories of primary attachment: proximity and connectedness

> . . . when for any reason mother fails to be a steady source of satisfaction the transformation of narcissistic libido into object-libido is carried out inadequately
>
> *A Freud (1954)*

These sorts of disturbances are built over a long time: 'when object relationships continue to be unsatisfactory during the succeeding years of early childhood' (Fairbairn, 1956). Khan's (1963) concept of 'cumulative trauma' refers to this fact. Along this line of explanation, the vulnerability to traumatisation is also mentioned as important (Kohut, 1971). Winnicott spoke in terms of environmental failure or impingement and the different kinds of response to impingement.

Environmental failure can take many different forms: obviously there can be the reality of an actual loss of mother's presence; then there can be the complete lack of empathy (a neglectful, remote or abandoning mother); defective empathy (seducing mothers who lead a child into believing that he or she is mother's special object); or the over-empathic mother (intrusive and controlling). This last category has been stressed by Glasser (1992) in his concept of the 'colonising pre-Oedipal mother' who allows no space for father. Even if one admits that the actual external situation is irretrievable, through direct observation of children and through the analysis of adults, we find that there is some common agreement as to the importance of how the environment works on intrapsychic life.

Perhaps the oral component of attachment has been over-emphasised in theories such as Melanie Klein's. Bowlby (1971) says that to equate good breast and good mother could be somewhat limiting. Bowlby studied mother–child proximity in terms of an infant seeking attachment and he observed that proximity often takes precedence over feeding, even in states of hunger. Winnicott (1953, 1958), when he refers to mother's breast, includes the whole technique of mothering as well as the actual flesh: it is possible for a mother to be a good-enough mother using a bottle for the actual feeding. Vitally important conditions of motherhood are for Winnicott (1948) that 'she exists, continues to exist . . . is *there* to

be sensed in all possible ways' and that 'she loves in a physical way, provides contact, a body temperature, movement and quiet according to the baby's needs'. The fact that she also provides food is placed fourth. Thus, it would seem that the presence and continuity of the mother, and the provision of contact and warmth, are previous to oral needs and their satisfaction. The infant is born with nutritional provision for a few hours. We can say that placenta resources last on the nutritional level more than, for example, on the thermic level. Indeed, as Kohut (1971) points out, in relation to the need for warmth, narcissistic individuals have an enduring difficulty with regard to self-regulating their temperatures, and they depend largely on others for this function.

So what is the experience that this sort of patient lacks? What are they longing to receive? The answer would seem to be just the right degree of connectedness. The fact is that the mothers of these very disturbed patients have generally been there, but without providing contact: they were not responsive.

The concept of connectedness refers to the essential fact which guarantees life preservation after birth. After birth, it is essential to restore human proximity. The human infant needs connectedness to maintain the interuterine set of resources, both biological and psychological, in the outer world. Proximity to mother or her substitutes becomes gradually less urgent as the child grows.

The narcissist's need for a point of anchor to take him back to a time before the primary catastrophe happened is clear, that is, to a time before there was any question of loss or environmental failure where needs were not met. The need for constant change represents another unconscious hope of retrieving the original safety, however fleeting that was. Sometimes this place of safe attachment seems to have been before birth, in the womb when the baby was connected to the placenta. Or, it could come from the time when mother was active in the infant's caretaking as a 'transformational object': 'able to metamorphose his entire internal and external world' (Bollas, 1979). So, the feeling of connectedness is like being able to have both a good internal object and a good external reference point.

The external anchor point is represented by the stability and regularity of the treatment and any small shift of progress is noteworthy. For example, the aforementioned patient managed to get his rent reduced and also to go for some musical weekends which provided a break from his uneventful, monotonous, predictable, lonely existence. These small positive movements, away from the aridity of his usual life, allow us to hypothesise that something in his inner world was being repaired.

## Analytic provision

As these patients are looking for ideal containment and an absolutely perfect fit of understanding, they are highly intolerant of any frustration.



The provision of an 'intermediate space' (Winnicott, 1971; Nissim Momigliano and Robutti, 1992) where experience can be shared and the analyst can offer the patient the possibility of a link with a primary object is of utmost importance to the treatment.

The analyst should, however, be wary of falling into the trap of pursuing the quest for a symbiotic object which this type of patient is so adept at presenting. For females, this longing for merger often takes the shape of wanting to identify with mother through marriage and babies whereas the male may not want this as he perceives it as engulfment. Although increasingly encouraged culturally to do so, his biological endowment does not allow merger except in a more sexualised form. For women, pregnancy and babies, especially in the first year, allows them to re-live the symbiotic experience. The dangers of living out this symbiosis for both sexes can be very damaging (perpetuating the cycle of inadequate parenting) and, in fact, Grunberger (1989) is explicit in his summing up that for this band of patients, both male and female, the principle of parenting in its reality is just not active.

It would seem that these patients require an openly warm attitude from the analyst with a reasonable degree of involvement, rather than a more neutral medical model. This attitude has to include the uncompromising provision of goods, freely given and with no expectations in return. These patients are in the position of children forever. Hence some gratification through shared experience is very relevant for them. And alongside this a careful dosage of interpretations. The main point of interpretations, quite often, is to show a patient that he has made contact with us and been understood. The right blend of these components would seem to facilitate some progress. Even the expectation of recovery could become viewed as the analyst's wish imposed, as a burden, on the patient. As these patients have the ability to provoke strong emotions in the analyst – they involve one – the analyst should be alert to this unconscious longing for merger which is always present.

As this group of patients has had such early environmental disturbances, they constantly need to re-enact the scenario of merging and breaking. Thus, if for any reason analysts fail to maintain their patients' feeling of connectedness with them, patients will almost certainly react by going into a 'malignant regression' (Balint, 1968), or with some other form of omnipotent narcissistic attack. This pattern can be extremely exhausting for the analyst.

The analyst's willingness to be found and used as an archaic object has been associated with his degree of expertise. Lomas (1987) suggests at least 10 years of clinical experience. However, this also depends on the availability of the analyst's time and energy: Little (1985) had to wait her turn to regress with Winnicott. Perhaps an analyst can only cope with one or two patients of this sort at a time.

Exhaustion is a normal component of early infant holding, but gradually the infant's satisfied needs lead to a decrease in their demands. However, with this sort of patient the analyst must be ready for a taxing and exhausting time, with very meagre results. A different scale of measurement is required – one's mental microscope has to be adjusted. Neurotics may feel a sense of fear and concern that they have exhausted their analysts, although often this is a correct perception in narcissistic patients because of their incessant and excessive demands (Rosenfeld, 1987).

Altogether these tremendous pressures and demands on analysts could lead them to act out in terms of their giving real provision to their patients (money, food, etc.) which could aggravate the symptoms (Freud, 1909; Rosenfeld, 1987). Sechehaye (1951, p. 140) makes this precise point calling it 'symbolic realisation' when she offers her disturbed patient the apples: '. . . it is not the apples themselves which count but the fact that it is the mother or her substitute who furnishes them'. However, Sechehaye emphasises that the pre-condition for this to take place is that: '. . . the patient had to be connected emotionally to the being who gives' (Sechehaye, 1951, p. 140). It is in the maintaining of this connectedness that some of the main problems arise.

## Impasse

One of an analyst's main tasks is to realise when the patient is stuck. Impasse is usually an indication that something in the analytic situation needs to be changed. Different authors emphasise different things, but on the whole there is consensus that the analyst must re-examine his or her view. In fact, although, previously, breakdown in the treatment of narcissistic patients was thought to be inherent in treating such disturbed people, today there is a growing trend which explains impasse in terms of treatment error and puts the responsibility on the analyst (Nissim Momigliano and Robutti, 1992).

Impasse can show itself in so many ways. The most extreme manifestation is in premature termination of treatment. However, it can show itself in other difficult ways such as negative therapeutic reaction, transference psychosis and symptoms such as hypochondria. Beneath these different expressions of impasse lies the compulsion to revisit the original environmental void which has left its scar. Indeed, this is exactly what Kohut meant by 'narcissistic injury', Winnicott by 'environmental failure', Balint by 'basic fault', Khan by 'lack of mother as a protective shield', Bion by 'unreliable container' and Rosenfeld by his description of 'the infant turning away from the breast with hostility'. In all these various conceptualisations, there is a difference in emphasis between the Independents who stress the importance of the environment, and the Kleinians who concentrate on the infant's role. Thus, the Independents feel that it is the failing environment that leaves its destructive mark, whereas the Kleinians believe it is the infant's 'destructive envy' that wreaks its own havoc. Both schools would agree that the patient resists exploration and rejects recognition of the original fault in order to uphold his idealisation of his primary object. As Rosenfeld points out:



> When a containing relationship breaks down . . . the patient feels that the container for his feelings has been destroyed, and therefore has himself to build up a very strong container. He needs a kind of wall or castle in order to keep the pressure from getting out of control.
>
> *Rosenfeld (1987, p. 215)*

## The concept of failure

With narcissistic patients there is a constant demand for provision of one sort or another. Balint has contained this idea of the different sorts of demands that can be made of the analyst in his concepts of 'benign' regression which desires 'recognition' and 'malignant' regression which demands 'gratification'. Analysts fear that this demand from the patient is going to be insatiable and that they will be seduced/manipulated into responding sexually or with retaliatory aggression.

With these patients failure can come from any source – either from the analyst's fear of his or her own sexual or aggressive response or from the patient's need to demand from and attack the holding containment of the analytic provision. According to Sechehaye (1951), once the patient's deep need has been understood, there is no question of insatiability. Going along with this framework a patient would be seen as needy and not greedy. Nevertheless, failure is all too easy if we do not manage to reach the patient through the narrow range of his possibilities.

## Conclusion

In treating this kind of patient by ordinary analysis one learns an enormous amount about narcissism, but how far do we actually succeed in helping them (Pierce Clark, 1933)? The old question does not seem to have changed much. An increasing number of theorists, including Balint and Winnicott, Bion (1962), and Nissim Momigliano and Robutti (1992), all propose that a patient of this sort gains more through emotional experience that is shared, than merely through interpretations from the analyst which could become persecutory. Shared experience includes the mirroring experience where the demand for a certain symmetry in the analyst–patient relationship is respected without the analyst losing his or her boundaries or letting the sharing deteriorate into a *folie-à-deux*. In this sense Resnik's (1995) concept of 'double transference' rather

than transference and countertransference is pertinent.

In any event the prognosis of these patients is poor. If it does come, change comes about very slowly. Freud (1914) was not wrong when he claimed that their resistance was 'unconquerable'. Whether they clamour for insight or not, the 'how', 'what' and 'why' is rarely understood by them (Bion, 1967) given that the idealised primary object is untouchable. The analyst may invest a lot of energy over a long period of time, but he or she has to be prepared for the fact that it may well turn out to be an analysis that goes nowhere as a result of the patient's early childhood experience of non-containment. The desire for change is frequently put into the analyst who can feel a lot of irritation and guilt, whereas the patient him- or herself periodically accepts grains of truth.

However, it is imperative not to lose sight of these patients' search for connection, even through their destructive attacks, because we must remember that, however vicious their behaviour, they are trying to re-experience the missing connectedness of their primary attachment. If the analyst does lose sight of the narcissist's urgent desire for connection, he or she (the analyst) may well experience a more intensive onslaught of attacks.

Thus the idea of the search for connectedness may give us a more relevant lead into the treatment than one of regression. It is not our idea to underestimate the importance of regression in the treatment of this sort of patient. Regression may signal either a hope of 'recognition' or a compulsive drive towards 'gratification' (Balint, 1968; Khan, 1969). For example, with the same patient whom we have previously mentioned, when there is any hint of separateness between us (i.e. a need for clarification or a disagreement), the patient shows the most extreme distress and aggression. I insist on relating his rage to his disbelief that we can be separate and both survive: connected without being merged.

However, underlying any sort of regression is the unconscious notion of primitive contact. This is phantasised as either broken or sustained. The analyst should always be aware that, in the repetition of earlier 'smashings', the patient is trying to find the original unbroken contact with his primary object (Little, 1985).

## Summary

To summarise the relevant points:

- The narcissistic transference is different from the ordinary transference neurosis because it involves the revival of archaic objects rather than the instinctual investment of Oedipal conflicts.
- These patients are trying to re-experience the missing connectedness of their primary attachment.
- The experience that they lack and the one that they are longing to find is one that we define as *the right degree of connectedness*.
- Once these patients' deep need has been understood (although we all know this is no easy matter), there is no question of insatiability. Going along with this framework a patient would be seen as needy and not greedy.
- This feeling of connectedness, when re-established, enables the patient to have both a good internal object and a good external reference point.
- In the repetition of earlier 'smashings', the patient is trying to find the original unbroken contact. Therefore, the importance for the analyst/therapist with this type of patient is to keep the treatment going in spite of the exhaustion and projected hopelessness involved.



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