CHAPTER 10

Narcissistic Defenses in the Distortion of Free Association and Their Underlying Anxieties

In this chapter, I examine distortions in the characteristics of free associations of patients with narcissistic personality disorders. I propose that the dominant narcissistic transference developments typical of the early and middle phases of the analytic treatment of these patients are reflected in these distortions of free association and proposes technical interventions geared to deal with them.

A frequent finding in narcissistic personalities treated with standard psychoanalysis or transference-focused psychotherapy (TFP) is their persistent difficulty in carrying out free association. They may show a particular type of association that reflects an ongoing critical evaluation of what comes to mind, rather than any curiosity about what is un-

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known or not understood, or about the unexpected and surprisingly new ideas that may emerge. The prevalence of intellectual speculation over what does come to mind gives their associations an obsessive-compulsive quality. Although they may appear much freer than obsessive patients to engage in intense affective reactions, the matter-of-fact, nonreflective assertion of their feelings also indicates a great difficulty in exploring the unknown in their mind.

When the analyst draws these patients’ attention to peculiar ideas, behavioral reactions, or questions that arise during their apparent efforts to do free association, their reactions take the form of intellectual speculation, theoretical musings, or reflections about the analyst’s intentions. They present, in short, with what may be called an ongoing self-supervision of what emerges in their mind or in reaction to the analyst’s interpretive interventions.

This is the nature of the problem with free association that I wish to explore. It affects, particularly, the “thick-skinned” narcissistic patients (see Chapter 9, “An Overview of the Treatment of Severe Narcissistic Personality”), including those who represent the relatively less severe degree of pathology within the wide spectrum of narcissistic personality disorders (Kernberg 2014).

In earlier work (Kernberg 2007), I have stressed the dominant defensive operations geared to protect the narcissistic patient from any authentic dependency on the analyst as the most important expression of the activation of the patient’s pathological grandiose self. In a recent publication (Kernberg 2014), I have related my overall approach to those of other authors. Authentic dependency on the analyst would mean recognition of the importance of his or her capacity to provide the patient with psychological understanding and help. That, by the same token, would evoke intolerable envy and resentment, and feelings of inferiority and humiliation. As a result, it is as if the patient, while carrying out free association, seems to be talking to himself or herself in the presence of the analyst, or to the analyst in order to influence him or her. As a result, the analyst’s countertransference is as if he or she were alone in the room, with a painful lack of contact or meaningful interaction with the patient that, typically, may cause a sense of boredom and a chronic temptation to distraction. Although this development is present in all types of narcissistic personality, it is most clearly observable over an extended period in cases of the thick-skinned narcissistic personality (Rosenfeld 1987).

This defensive avoidance of true dependency is matched frequently by a complementary defense of omnipotent control, which is a conscious effort on the patient’s part to influence and control the analyst’s beh-

behavior to avoid both the emergence of feelings of inferiority (stemming from the newness or recognized importance of what the analyst is saying) and a complete devaluation of the analyst (as a consequence of the activation of the patient’s contemptuous grandiosity). If the analyst is completely devalued, there remains no possibility of receiving any help or any useful consequence of the treatment; if the analyst expresses anything potentially useful, however, this is intolerable and the resentment may be unavoidable.

The two mutually complementary operations—denial of dependency and omnipotent control—may evolve in several ways, expressed in the influence on the process of free association rather than in any specific fantasy or other material emerging concretely in the content of the sessions. It is on the effects of these defensive operations on free association that I wish to focus in this chapter.

The instructions given to the patient in explaining the fundamental rule of free association include the invitation to try to say whatever comes to mind, in whatever form that occurs (e.g., thoughts, fantasies, observations, relationships, fears, dreams, memories) without attempting to order all these contents in any way. The patient is instructed to try to verbalize what goes through his or her mind regardless of whether that seems easy or difficult, something to be proud or ashamed of, something important or trivial, and so on. The patient is often told that this may seem difficult at first but may gradually be learned, and that the analyst will be attempting to help the patient in this regard. Narcissistic patients quite frequently present what comes to mind in an organized way, similar to what would be typical for obsessive patients, but may “learn” to disperse such organized communications with some words, thoughts, feelings, or questions that convey a spontaneity that feels more uncontrolled but is then followed by an orderly communication of what the patient was trying to present in the first place.

Typical “organizing” comments may include a clarification of what the patient is trying to communicate by enumerating it, or by commenting “I will clarify this later.” The result is a clearly ordered sequence of subjects repeatedly activated, with a focus on different angles from which the patient considers this material as part of his or her self-analysis. The total sequence results in an “imitation spontaneity” that makes it difficult for the analyst to perceive what, if anything, is emotionally relevant—other than the patient’s control of the process.

Some patients express concern over whether what comes to their mind will be helpful and question repeatedly if the analyst understands it. They may wonder, throughout the session, whether it is going to be a “good” or “bad” session, or initiate the session with such a comment.
Free association is accompanied by a continuous evaluation regarding the extent to which what is coming to their mind right now will foster the analytic process.

The patient's reaction to the analyst's interpretive comments may show some typical repetitive qualities. The patient seems to consider very thoughtfully what the analyst has said and may repeat it to assure himself or herself that he or she has understood it correctly and therefore is able to "work" with it. The patient may frequently express agreement or disagreement with what the analyst has said, or ask for further clarification. What seems to be missing is a spontaneous expression of the emotional response to what the analyst has said. The patient conveys an impression of being an attentive and interested participant in a dialogue, rather than open to an effort to experience anything new in himself or herself. It usually takes some time for the analyst to become aware of this subtle way of the patient's protecting himself or herself against any unexpected emotional impact of what the analyst is saying. Narcissistic patients have enormous difficulty understanding that the analyst's interpretations are hypotheses that only will be proven right or wrong from whatever they stimulate in the patient's awareness of his or her emotional reactions to them. Rather, the patient will treat them as theories or oracles.

Sometimes the analyst may have the experience of an important breakthrough or change, something unexpectedly understood by the patient that sheds new light on a particular problem. This new emotional understanding, however, disappears without leaving a trace in the days and weeks that follow. This development may be considered a form of negative therapeutic reaction or an unconscious devaluation, or may even reflect a silent, conscious dismissal of what the patient has received from the analyst. What is impressive, however, is the patient's reaction when the analyst returns to this event because it fits the material of a later session, and when the analyst wonders whether the patient remembers what occurred in that past session. Often a patient may respond "Yes, of course," and repeat almost verbatim the interaction, saying that he or she remembers it very well and that, in fact, it involves an issue that in different ways has been discussed a thousand times, with the implication that he or she has heard it, remembers it, and therefore has nothing else to say about it. This sequence of events clearly illustrates the intellectual "learning" of interpretations that do not really touch the patient. The patient incorporates the new knowledge and devalues it in the process.

Beneath this pattern lies the defensive constellation of omnipotent control and the need to avoid any authentic emotional dependency on the analyst, with the patient's ongoing monitoring of his or her free association and the analyst's comments to develop, on his or her own, an analytic understanding of what evolves in the sessions. What may be most helpful at this point is to focus the patient's attention on the risks involved in just listening to what the analyst is saying, with an open question as to whether that will bring about any reaction in the patient. Will the analyst's intervention foster his or her own superiority, putting the patient down, or will it confirm the patient's feared demolition of the analyst? One may point out to the patient his or her frequent concern as to whether the analyst's comment is "good" or "bad," "correct" or "not," whether it implies that the analyst is accepting or rejecting the patient. In other instances, it may help to focus on the patient's paranoid attitude regarding the analyst that emerges as a consequence of pointing to the patient's lack of spontaneity in his or her response to the analyst's comments.

The development of "filler" subjects in the patient's discourse also may alert the analyst to an underlying difficulty in free association. The patient comes back, again and again, to the same subject matter—for example, a detailed reference to the technical aspects of his profession, or some particular work project he or she needs to carry out at home, and similar repetitive contents—without any reference to any human interaction. This is in sharp contrast to the repetitive narrative about the dominant conflicts in the patient's life, which, even if repetitive on the surface, usually imply live transferential implications. Thus, repetitive discussion about, for example, the various concrete tasks involved in gardening may serve as a protective avoidance of uncontrolled emergence of new material. One patient returned, again and again, to technical details regarding his scientific research in an area totally unknown to the analyst. Eventually it became clear that his apparently obsessive concern served the function of asserting his superiority over the analyst.

A frequent—and, for the analyst, quite disturbing—development may be the patient's appropriation of the analyst's language or theory when reporting emotional reactions or conflicts, so that analytic explanations may be included in the patient's discourse without reflecting any authentic emotional learning. Obviously, the analyst should attempt to talk in concrete, ordinary language rather than introducing technical terminology reflecting his or her own theories. However, even if interpretive comments are presented in very simple language, the analyst's underlying theoretical orientation may be perceived clearly by the patient and be reflected in the content of his or her associations. In peer supervision, this development in the patient's discourse may lead to amusing identification by the group of the analyst's theoretical preferences.
The ongoing effort to monitor, absorb, and store the analyst's comments in a continuous learning process also reflects the narcissistic patient's need to be admired, rather than any authentically loving or dependent relationship. Where does the patient stand regarding the analyst's interest in him or her? Does the analyst appreciate and feel impressed by the patient's communications? Is the analyst bored, distanced, indifferent, or angry, resentful, or dismissive and contentious? The patient may be projecting aspects of his or her own pathological grandiose self onto the analyst, including the need for admiring confirmation from the patient, as well as devastating hostility or humiliating contempt. At the same time, the patient cannot build up an awareness of those aspects of the analyst's personality that ordinarily would come through in any long-standing therapeutic relationship, in terms of the analyst's concern, empathy, and interest and his or her emotional sensitivity to the patient's needs. All this may be unavailable to the narcissistic patient. Under the dominance of the pathological grandiose self, the patient is reduced to evaluating how the analyst's behavior affects him or her, rather than being capable of an authentic interest in the analyst as a person, an interest that would grow and develop in consonance with a developing dependent relationship, and the development of appreciation and gratitude for what he or she receives from the analyst. By the same token, the patient cannot believe in the analyst's authentic interest and concern for him or her.

This same difficulty to empathize with the personality of the analyst shows, of course, in the relation between the patient and all other people in his or her life. It leads to the stereotyped description of the most important persons in his or her life and the persistence of these stereotypes throughout lengthy periods of the analysis. Typically, these patients present a fixed, rigid view of their family and of their own past, with an impressive lack of curiosity or reflection on the wishes, experiences, and motivation of significant others. This conveys to the analyst the painful experience of emptiness that these patients must contend with in all their interactions, and against which fantasies of grandiosity and superiority and self-sufficiency provide an illusory protection. The stereotyped panorama of the patient's life combines with the rigid cognitive control in the patient's free associations to convey an arid emotional experience that can only be penetrated by the analysis of its replication in the transference. The analysis of the patient's fear of listening without his or her controlling safeguards opens up the analysis of his or her difficulty to listen to others as well, and the consequent ignoring or misunderstanding of communications, an emotional ignorance caused by the underlying paranoid stance to protect the patient against threats to the pathological grandiose self.

Under these conditions, the patient brings narratives about brilliant, exuberant, exciting, overwhelming experiences that may have a dramatic or exhilarating quality. These reports, in which the patient experiences himself or herself as the center of attention, have a grandiose quality and serve to reassure the patient and impress the analyst, but they have a strangely empty quality. The patient may enthusiastically communicate an experience that, however, leaves no trace of permanence in terms of some emotional relationship and, in the analyst's countertransference, leaves him or her cold or uninvolved despite all efforts to empathize with the patient. Narcissistic patients, however, may find an escape from emptiness in such experiences of exuberance, as they do in unusual sexual involvements, drug-induced emotional states, or dangerous sports.

The lifeless quality of communication conveyed by the repetitive descriptions of interactions that show very little or no change throughout time is reinforced by the patient's reaction to the very comments of the analyst indicating that what is being referred to now seems to be a replica of what has been discussed before, but with no reference to the contribution made by the analyst in previous discussions of the same material. It is as though these, or similar matters, have never been previously discussed. A confrontation with this fact may trigger the patient's sense of being attacked or, to the contrary, professed agreement with the analyst, with the implication that the patient is communicating precisely the understanding that was reached in the previous discussion. The naturalness with which the patient may assert the latter may dovetail with another aspect of the communication that reflects the omnipotent control of the interaction. Some narcissistic patients are prone to the repetitive use of semiautomatic statements such as "as you know," "that we have discussed before," or "that we have seen before," implying a harmonious bit of work with the analyst in terms of the confirmation of the patient's view or interpretation of an experience. In essence, the unchanging repetition of an experience that had been explored earlier in some depth expresses the patient's stress on maintaining his independence from the analyst's interference.

With some frequency, after an extended narrative of what the patient wishes to communicate to the analyst and often expressing an unconscious effort to influence the analyst in some specific way, the patient may remain silent and then make a statement such as "I've said all I've had to say. Now it's your turn." Such a statement perhaps reflects, better than anything else, the subtle transformation of free association into a shared, alternating communication of the respective thinking of patient and analyst, or the patient's implicit reminder to the analyst that it is now his or her task to make sense of what the patient has been saying.
and to add something new to it. Questions directed to the analyst regarding his or her agreement or disagreement with what the patient is saying may disrupt the patient's free association from time to time, with the implication of assuring himself or herself that there is no disagreement or implicit critique, or any negative reaction of the analyst that may have threatening implications for the patient. Or, the patient wonders, is there in the analyst's contribution something new, not already known to the patient, which could be a source of humiliation?

Obviously, these efforts to maintain control to defend against dependency or any real influence from the analyst affect long-term countertransference developments with narcissistic patients who show a strong combination of these defenses. The analyst's very commitment to the patient may suffer by the patient's unconsciously undermining everything that comes from the analyst and the chronic absence of an authentic connection with the patient.

The intensity of negative countertransference under those circumstances may take many forms. One analyst, with very good understanding of her patient although still somewhat limited clinical experience, found herself frequently contrasting, with a revengeful enjoyment, her own satisfactory love life with the emptiness of the patient's sexual exploits. It was as if she obtained a particular satisfaction with this comparison, and the analyst clearly recognized this as an expression of her hostile, resentful feelings in the countertransference.

The artificial, manipulated quality of the patient's communications tends to evoke a sense of meaningless triviality and monotony, and may induce boredom in the analyst that requires an ongoing attention to the subtle, transitory shifts in the interaction that may become noticeable in response to the analyst's interventions. As mentioned previously, the patient's experience of the analyst's comments may be that of an assertion of the analyst's superiority and dominance over the patient or of an expression of hostile indifference. At other moments, the patient may experience the analyst as ignorant, incompetent, or helpless, with a sense of superior security that then turns into worry that the patient is wasting his or her own time, given the uselessness of this treatment.

Pointing to this rapid, and at first relatively subtle but gradually more obvious, oscillation between the patient's sense of triumphant superiority and humiliating inferiority in his or her relation to the analyst may help the patient to become aware of projecting the activation of his or her pathological grandiose self and identifying himself or herself with devalued aspects of the self when confirmation of his or her omnipotence fails. This is an important step in the exploration of the narcissistic transference. It opens the patient's awareness to his or her deeper sense of total ignorance regarding the realistic attitude he or she encounters on the part of the analyst and of the patient's deep conviction that the best that can be expected is an analyst who is basically indifferent, thus confirming the patient's aloneness in the world.

At this middle stage of the treatment, the patient's heightened interest in the analyst's relationship to him or her may clarify the correspondent identifications with the pathogenic experiences from the past, the gradual attributing to the analyst of features that replicate aspects of parental figures that reflected the sources of the conflicts with, and the power of, the parental couple. By the same token, the patient now enacts his or her identification with such parental imagos while projecting his or her corresponding self experience onto the analyst. In the countertransference, moments of relatively quiet interest in pursuing the development of the patient's experience in the hour may be followed by a sense of sudden openness to an authentic emotional experience, a live intensification of an internal relationship with the patient, that may then be almost brutally dismantled by a subsequent expression of disdainful disqualification of everything that has been evolving in this relationship. Against the background of consistent efforts to deepen transference analysis over a long period, months of hopefulness and occasional experiences of emotional closeness may shift again into disappointing disengagement by the patient, and the analyst is faced with a new wave of empty trivialities filling the sessions. Here, the dynamics of disappointment, disillusionment, and despair in the countertransference described by Lucy LaFarge (2015) may enter the picture.

The patient's incapacity to experience himself or herself in any relationship where he or she is being loved may become an important issue at this point: the patient may feel that any positive interest and commitment to him or her on the part of the analyst is the product of the patient's seductive efforts and the analyst's weakness and naivety, and therefore justifies the patient's contemptuous devaluation. The unconscious efforts to provoke the analyst into a consequent counter-disqualification of the patient may help the patient to reconfirm the lack of trust in the analyst and the worthless quality of that apparent emotional investment in him or her by the analyst. The clarification of this issue may highlight the patient's unconscious envy of the analyst's capacity to love, and that resonates with the patient's unconscious envy and resentment of those in his or her early life who might have become a source of ordinary and trustworthy love and commitment.

Narcissistic patients' typical incapacity to commit themselves emotionally to a loving partner is reflected in these complex dynamics in the transference, and highlighting them in working through these issues
would seem essential for changing this fundamental aspect of their pathology. The analyst’s tolerance of the patient’s expression of arrogance and consistent devaluation precisely at points at which the analyst has given evidence of his or her deep wish to understand and help and his or her emotional commitment to the patient may be crucial to avoid falling into the trap of a reactive devaluation of the patient in response to his or her contempt. In short, the patient’s rejection of moments of the analyst’s intense investment in him or her and the reinforcement of the patient’s distancing himself or herself emotionally in a grandiose way from the analyst may be a crucial precondition for the discovery of those hidden moments of recognition of the analyst’s authentic interest, which, however, the patient cannot tolerate. Boredom in the countertransference may represent a defensive smokescreen against the resentment following an active effort on the patient’s part to destroy the analyst’s recognized interest and commitment to him or her.

I have found it helpful, at times, to share with the patient my thoughts about what is going on in the patient at this point in his or her relationship with me, or what I think might have been going on in relation with someone else as an expression of the displacement of the envious devaluation in the transference. I might communicate these thoughts to the patient even though I am quite certain they will be depreciated or incorporated intellectually in a destructive way. In doing this, I am treating the patient “as if” he or she were a “normal” person who would be able to be interested in listening to me and imagining what goes into my saying what I said. And yet, I would be open to expect the forthcoming devaluation of what I have to contribute. I might be right or wrong in what I am saying, but that would only emerge in the patient’s reaction: if what I am saying were to be taken seriously, this would reflect at least the patient’s momentary awareness of a concerned expression of my interest in him or her.

The patient may surprise me by reacting to what I am saying without immediately “analyzing” it or qualifying it for its value or uselessness, and may experience an emotional reaction that he or she now communicates to me. That would indicate a “normal” attitude that we expect from free association and would indicate that I was wrong in my pessimistic assessment of the patient. More frequently, the patient indeed will react in the disqualifying manner described. I would then interpret this as the patient’s way of avoiding reflecting on what I have just been saying, but rather assessing my comments in terms of whether I have said anything new, therefore confirming my superiority or uselessness.

As an indication of the working through of a prevalent narcissistic transference, the patient’s increased capacity to depend on the analyst will emerge. Patients now may evince reactions to separation over week-ends or other extended absences. These reactions may have a predominantly paranoid quality but may also coincide with the beginning of awareness of the aggressive, devaluing behavior as an issue to be examined. They give hope of some potential for feelings of concern for the analyst. There may be times when a patient provocatively insists that nothing has changed, stating that he or she is worse than ever, and flaunts the repetition of old symptoms as an indication of the incompetence of the analyst while also beginning to be aware that such repetitive provocation also has the function of testing the extent to which the analyst is still available to him or her and has not given up. Fear that he or she has exhausted the therapist may be another expression of concern and tolerance of a dependent relationship.

Naturally, parallel behavior in relation to others in the patient’s life may provide further evidence of some change in his or her capacity to love and to be authentically interested in what happens inside other people, and change in his or her concern over other people’s reaction to the patient. The patient’s developing fantasy life regarding the experiences of the analyst may reflect a deepening of the activation of specific object relations in the transference, in contrast to the long-standing, fixed nature of the relationship between the grandiose self and the devalued aspect of the self. The analysis of dreams will reflect a broader and deeper space of associations that creates a new dimension of dialectic tension between manifest and latent dream content not available in early analytic stages, in which the patient’s associations to elements of the dream were simply new versions of intellectualized interpretations of his or her experiences.

The achievement of the depressive position—the patient’s capacity to realize that the intense hatred and resentment of his or her objects have been preventing the patient from perceiving any valuable and loving engagements that he or she had received in life, and what the patient might have received from those who loved him or her if the patient had not been so resentfully envious of their capacity to love him or her—may become a very painful experience. Mourning over the rejection and squandering of potentially good relationships, over the mistreatment of those who love him or her, and the realization of time lost indicate the tolerance of the depressive position. As the patient can increasingly tolerate the exploration of his own mind and feelings, he or she now becomes aware of and interested in the feelings and intentions of others. The experience of guilt over the aggression toward those who love him more and more now motivates impulses to repair relationships and to salvage what is good, and a new capacity to experience gratitude for the good in life may emerge.
Success or failure in the treatment of narcissistic pathology can be most clearly assessed in these patients' capacity to love, to be committed to life-enriching interests and commitments that are not bound to their narcissistic self-assurance or grandiosity, and the capacity to identify with a value system that transcends their own existence. Regarding the degree to which patients are able to achieve such a development, we have been reviewing the case material of the Weill Cornell Medical College Personality Disorders Institute faculty. The range of outcomes makes it clear that there are differences in the nature of the analytic experience of these patients based on their personality and life situation that affect the treatment and that remain to be clarified. To say the least, it seems that the extended experience in the earliest year of life of at least one stable relationship with a parental object that provided a consistent source of love, care, and concern is a prognostically important positive indicator. A person having achieved, throughout life, some understanding and enjoyment of the emotional values of art, literature, or science; a value system not centered in personal triumph or based on a rationalized system of hatred; and the availability, at some time, of a love object that did not have to be devalued and rejected seem to be significant positive features. Sometimes the emergence of the wish to be taken care of, the experience of being taken care of by the analyst without the analyst's expressing his or her superiority or making any demands on the patient, may indicate the potential for dependency that, dissociated from severely destructive tendencies, might imply a positive potential in extremely lonely patients. At the end, the achievement of the capacity to love without experiencing this development as a potential source of weakness or inferiority, and without basic self-regard being affected by the painful possibility that this love will not be reciprocated, indicates the transformation of pathological narcissism into the achievement of a normal capacity for object relations in the context of normal narcissistic development.

Perhaps the most significant issue regarding free association of these patients is the analyst's recognition that the patient's capacity to free associate has been distorted by the narcissistic pathology to the extent that suggesting to the patient to associate to any apparently significant subject matter will not lead to deepening awareness of emotionally significant material. The nature of the transference must be clarified and worked through systematically before the deeper functions of free association may emerge in treatment. Such extreme cases of narcissism illustrate the importance of the analysis of the process of the analytic relationship rather than assumed repressed contents, without losing sight of the eventual emergence of those contents once a more normal object relation evolves in the transference.

In short, all the defenses against the exploration of the pathological grandiose self and, particularly, against the development of a dependent transference relationship protect the patient against the anxieties of underlying conflicts between the pathological grandiose self and the projected devalued aspects of the self in the transference relationship. In essence, this is the conflict between a grandiose, self-sufficient, arrogant, and devaluing representation of an omnipotent self relating to a projected, devalued, depreciated, inferior, aspect of self—each, in essence, reflecting condensations of more primitive internalized object relations under the dominance of early aggressive conflicts.

The defenses operating through distortion of free association are not the only ones that protect the patient from the activation of these conflicts in the transference. Split-off acting out of these conflicts in extratransferential relations and subtle expression of these conflicts in the fantasy material produced by the patient during the sessions, as well as dreams and somatization, may reflect deeper aspects of these problems that have not reached the patient's preconscious and conscious awareness.

The systematic analysis of all these defensive operations tends to activate intense negative affects, including nonspecific anxiety, paranoid fears, experiences of humiliation and shame, and, at the end, the emergence of the potential for authentic feelings of guilt and concern as the patient recognizes the nature of his or her involvement in these transferential developments.

The nature of the anxieties that emerge in the transference reveals the degree to which the activation of the pathological self and the defenses against a dependent relationship in the transference are being worked through and resolved. To begin with, what usually predominates in the early stages of psychoanalytic treatment of narcissistic patients are paranoid anxieties linked to the projection of the grandiose self onto the analyst, a sense that the analyst is a cold, rigid, harshly critical authority who loathes and despises the patient, or is sadistically provocative. These early experiences rapidly turn into fantasies that the analyst is trying to put the patient down or humiliate him or her, with the surface rationale of confronting the patient with his or her difficulties disguising the analyst's true intent of asserting superiority and enjoying the humiliation of the patient, whose inferiority confirms the mighty position of the analyst. Defenses against experiences of humiliation may dominate the analytic situation for a significant period, together with the patient's defensive efforts to ignore and devalue the analyst's interventions. On the surface, fears of being humiliated and the reactive reinforcement of the distortions in free association may predominate at that point.
As the treatment progresses, and the patient is able to tolerate the realization that part of his or her fantasies and behavior reflect a problematic exaggeration of his or her importance and superiority, feelings of shame may replace those of being humiliated and put down. The patient may begin to realize that his or her efforts to assert superiority represent attempts to protect himself or herself again the experience of envy of competitors or rivals, who represent threats to the patient’s assumed greatness. The activation of intense conflicts around envy in the transference, usually at first displaced onto extratransferential objects—in the middle of enormous resistances to acknowledge envious feelings toward the analyst—may dominate the treatment situation. As the patient begins to realize how the unrealistic nature of his or her grandiose fantasies and aspirations negatively affects his or her daily life, causing chronic suffering and feelings of failure, shame may become painfully prevalent.

Shame as a normal, quite prevalent early experience is related to the small child’s gradual realization that some spontaneous, naïve interests, habits, and behaviors—particularly, exhibitionistic and self-affirmative behaviors—may be rejected and powerfully suppressed by those whom he or she loves. This includes the early enjoyment of oral incorporation of “dirty” objects, and the enjoyment of anal play and fecal deployment, and, later on, of infantile masturbation as well as polymorphous sexual impulses. Critique and rejection of these behaviors lead to conflicts between the ideal representation of the self, loved by an ideal object, and a shamefully devalued, criticized self, cognizant of the discrepancies between this new, unexpected reality and the ideal representation of self (Lansky 1994; Wurmser 1981, 2004). In this regard, shame is an early affect activated in negatively valenced interactions with infantile objects, which then determines powerful efforts to live up to the critical, newly incorporated aspects of the ego ideal. Under ordinary circumstances, shame is gradually replaced by the development of guilt over unacceptable behavior. This includes the painful recognition that one has failed in one’s own responsibility in maintaining the relationship with the ego ideal and with ideal objects, the recognition of unacceptable sexual and aggressive impulses that are part of normal ambivalence in relations with significant others. The development of guilt feelings reflects the integration between the prohibitive aspects of the superego and the ego ideal, a reflection of the integration of the superego and a key aspect of the integration of the self in the development of normal identity.

Shame normally acquires a particular, specialized function to protect the privacy and secrecy of infantile sexuality, of sexual desire and activity, the infantile reaction to, and replication of, the secretive life of the parental couple. This secretive internal sexual life increases the intensity of erotic impulses in the later achievement of an intimate sexual relation with a realistically available object, the erotically exciting “shamelessness” of the intimate sexual encounter (Kernberg 1995).

In the case of the narcissistic personality, however, shame acquires a particularly important function as an expression of discrepancy between ideal self and real self. Here, what evolves is a discrepancy between the pathological grandiose self and the gradual acceptance of emotional reality, the previously denied, projected, and unacceptable aspects of the self geared to protect the totally idealized nature of the pathological grandiose self. Thus, in early and middle stages of psychoanalysis or TFP with narcissistic personalities, shame may become prevalent, gradually replacing feelings of humiliation as an intermediate stage between the paranoid nature of early anxiety and the beginning of the capacity to tolerate guilt, concern, and depressive anxieties and defenses. Shame, in short, stands between paranoid fears and painful humiliation, on the one side, and development of recognition and guilt over one’s own aggressive impulses, on the other.

Obviously, given progressive and regressive moments of analytic treatment, these sequences are not that clear in individual cases, and these affects may appear in combination or apparently reversed sequences. Their differentiation, however, is helpful in leading to a clearer picture of the nature of working through of the pathological grandiose self in the transference, and the gradual transformation of the grandiose self—devalued self relationship into the more specific object relations that characterize the general transference developments of borderline personality organization. At this point, the treatment begins to reveal the history of the patient’s internalized object relations, the conflictual and traumatic nature of which originated the pressures in the direction of the establishment of a pathological grandiose self in the first place.

References

LaFarge I: Disappointment, disillusionment, and despair in the analytic situation. Presentation at the Midwinter Meeting of the American Psychoanalytic Association, January 2015
The Differential Diagnosis of Antisocial Behavior

A Clinical Approach

The Spectrum of Antisocial Behavior

What follows is a clinical approach to the differential diagnosis of antisocial behavior as a significant symptom in a patient’s psychopathology. Antisocial behavior may be defined as actively damaging or aggressive behavior directed against other individuals or society at large, typically expressed without guilt feelings and classifiable as either passive-parasitic type (e.g., lying, stealing, irresponsibility regarding money, exploitation of others) or aggressive type (e.g., destruction of objects, physical assault, armed robbery, sadistic sexual behavior, murder). While both types of antisocial behavior may be combined, most frequently patients are involved mainly in one or the other. The practical importance of making this differential diagnosis resides first in the assessment of the...