superego figure at a later period, probably at the age of four or five. Some of the idealization of the breast and of the earlier relationship to the father was transferred and projected on to the real father with whom she identified as her ego-ideal. The real aspects of the superego father reinforced by the idealization were also used to deny and split off some of the persecutory qualities which were also projected into this relationship. This factor strengthened the later superego in its defensive function of preventing the persecutory aspects of the early superego from being reactivated.

There remains the question whether the superego development of this particular patient should be considered as a fairly typical one. I am suggesting that, while the degree of persecutory anxiety in the patient's early superego was unusually severe, the point that emerges is of general validity: that is, that there is a direct relationship between the intensity of the early persecutory superego and the patient's need to make absolute uncritical identifications with the real parents or parent substitutes as later superego figures. This factor I believe to be essential for the understanding of the later superego. Selective identification with the real objects and their qualities is an important factor of normal ego and superego development, and this is possible only if the early superego has overcome most of its persecutory quality. As the depressive position is a central factor in assisting the change from the persecutory to the more normal, ego-syntonic superego, we may say that normal superego development depends on the degree to which the depressive position has been worked through in infancy and later childhood.

9

NOTES ON THE PSYCHOPATHOLOGY AND PSYCHO-ANALYTIC TREATMENT OF SCHIZOPHRENIA[1] (1963)

My interest in the psychological approach to schizophrenia goes back more than twenty-five years. At that time I had the opportunity of interviewing a large number of schizophrenic patients in the Maudsley Hospital and I noticed that some of them regarded psychological problems as the cause of their illness. I remember a young catatonic schizophrenic girl of sixteen who explained to me that she became ill after she had discovered the facts of life. She found it unbearable to think about the details of her birth from the inside of her mother. She explained that this was the reason why she did not want to have anything to do with her mother or anybody else. She did not want to read any more because she was afraid of having to visualize again something which was similarly unbearable. In fact it seemed as if this girl had, as a result of this experience, turned away from the outer world and from all her interests which were related to it. My observations at that time had the effect of making me increasingly doubtful about the prevalent contemporary teaching, which suggested that schizophrenia should be regarded as an endogenous problem which became manifest completely uninfluenced by external circumstances. At a later time I had the opportunity of trying some psychotherapy with schizophrenics in various hospitals and was astonished that I succeeded in making good contact with some very ill schizophrenic patients and that they could be helped by simple psychotherapeutic talks. In other cases, however, I felt completely helpless, especially when I realized that, after some initial improvement, the patients became very much worse.

During my training as an analyst my second control case turned out to be a latent schizophrenic and my supervisor

[1] First published by the American Psychiatric Association (*Psychiatric Research Report* No. 17).

thought that an acute schizophrenic breakdown might occur if I continued the psycho-analytic approach. I was aware of this danger, but my interest in the analysis of schizophrenia was much too strong for me to follow this advice. I continued the analysis, though without understanding at first what was going on between the patient and myself. The material which the patient produced and the transference seemed to be very unusual and none of the analytic books helped me over it.

At this time Melanie Klein began to develop her own observations on schizoid mechanisms and object relations and published a paper on this subject (Klein, 1946). When I became convinced of the importance of Melanie Klein's work in my own analysis I found it possible to use my observations and counter-transference intuitively, and began to understand and to interpret the schizophrenic transference situation of my patient. She made slow but certain progress in her three years' analysis, which was interrupted by her marrying and joining her husband, who lived abroad. She had children and has apparently remained well. As a result of my experiences with this case, Mildred, I wrote in 1947 the paper 'Analysis of a Schizophrenic State with Depersonalization' (chap. 1 in this volume).

I will now try to give a brief picture of the difficulties which confronted me at that time and which at first left me completely helpless. I assume that many readers who have treated schizophrenic patients have probably met with similar problems.

The patient came to the analysis as if she was an automaton and communicated the impression that the uncertain relationship with me could be broken off at any moment. She often told me she had nothing to say and actually she talked very little. When she spoke, she described certain phenomena with great clarity. She felt bored and without any interest; she felt there was something like a blanket separating her from the world so that she felt dead and cut off from herself. She was afraid that her thinking might come to a standstill, and that she might drift into an unconscious state. She tried constantly to force herself to resist this tendency, but she was also afraid that if she tried to join up with herself she might force her mind completely out of joint, an anxiety which created an inhibition of all her activities. Gradually the difficulties of the patient concentrated not only on talking in the analysis but on coming to her sessions. At times she was forty to forty-five minutes late and so arrived just before

the end of her session. She felt it was a hopeless fight to get up in the morning; it seemed like a fight against the Devil but there was no point in fighting this Devil because he was stronger than everybody. The patient's mother tried, as always, to help her. The patient welcomed this, but she complained that her mother's help was senseless because as soon as somebody told her what to do or asked her what she wanted to do she felt trapped and blocked. Afterwards she always became very tired and unable to do anything. I want to emphasize here that the mother of this patient was generally understanding, affectionate, and not dominating. For example, she allowed the patient to stay in bed in the morning and served her with breakfast herself.

It seemed to me at this time that I represented in the analytic transference-situation the patient's mother, and the patient expressed by her attitude the wish that I should, both in the analysis and in the outside world, be a mother who would do for her everything that she needed without her having to say or ask for anything. I interpreted the negative transference at first as her reaction against my not being this ideal mother; in other words, my being experienced as a useless and bad mother. I had often observed that the patient felt criticized and dominated by me in the same way that she had described herself as being in her relation to her mother. However, interpretations of this type appeared to make no impression. Very much later I discovered that from the beginning of the analysis a very particular transference situation had developed. On the first day of the analysis I had explained to her that she should tell me in the analysis everything she was thinking or feeling. She, however, was convinced, though without mentioning it for the first one and a half years, that I had told her that she should push everything that she was thinking and feeling aside and think of something completely different. So from the start she had formed a delusional transference to me in which I was not only experienced by her as a criticizing and dominating figure but in which she was convinced that I demanded that she should give up her own thinking and her own self in order to become somebody completely different.

I have explained that I had observed that the patient felt that having to come for treatment and to talk meant being criticized and dominated by me. It was never possible to ask her to repeat anything she was saying when she spoke indistinctly because she

immediately fell into a silence which lasted until the end of the hour. The exact nature of her anxiety became clear when acute fears appeared that she might one day find herself talking in a strange voice or accent. I was then able to diagnose the patient's fear that I would force myself into her in order to dominate her so that she would lose her own thoughts and feelings and her own self. This transference anxiety, or transference psychosis, dominated her so severely that she was not only unable to show any feelings towards me but had continuously to fight against tendencies to withdraw entirely from me. Further analysis showed that the basis of this transference situation was not derived directly from the real mother but from a dominating fantasy-image whom the patient had projected on to the mother and the analyst, based on the patient's impulses to force herself omnipotently into the analyst and mother to dominate and control them. A very important cause of her lack of feelings seemed to be the necessity to get rid of her negative and positive feelings, as most of her feelings were experienced as intruding, or dominating, and consequently dangerous. As a result of the understanding and the interpretation of the problems in the transference situation real contact with the patient was established, the analysis became alive, and the patient was able to improve. Since this first successful analysis of schizophrenia I discovered in all my schizophrenic patients transference relations which were either a direct expression or a defence against the primitive object relation where the patient intruded with positive or negative parts of his personality into his objects and as a result felt treated in a similar way by his internal and external objects. These primitive object relations often lead either to the psychotic identification of the schizophrenic when he assumes a different identity or to a confusional state. Melanie Klein described these primitive object relations and the ego disturbances related to them under the collective name 'projective identification'. She stressed the splitting off and the projection of parts of the infantile self and the identification of these parts with the mother and other objects. Analysts such as Mahler, Jacobson and others have acknowledged the importance of these early object relations which lead to a fusion with the mother, but without recognizing the importance of the persecutory anxieties and the splitting processes which are part of this situation. Bion, and others besides myself, have applied the concept of projective identification to the treatment of schizophrenia and have enlarged it through a number of observations.

The study of projective identification and its relation to ego-splitting has helped us to a better understanding of certain typical schizophrenic difficulties of thought and language. For example, the splitting and projection of parts of the self leads not only to a confusion of ego and objects, but to interference with such functions of the ego as abstract thinking and the use and understanding of words, so that patients may lose the capacity to speak or may become unable to understand correctly what is being said.

I shall now examine briefly the question of the connexion between the understanding of the psychopathology and its relation to the technique of analysing schizophrenics and shall make use of Mildred's analysis again. It seemed at first that the interpretations of the positive or negative transference were quite useless; the analysis was very near breaking point, and one had to consider seriously whether analytic interpretations and the technique used so far should be continued, or whether the technique should be changed completely. Perhaps some therapists might be of the opinion that instead of interpreting that Mildred wanted an ideal relationship to me as the mother, I should have shown by action that I *was* now this ideal mother, allowing her to stay in bed, and starting to visit her at home. I shall not examine how Mildred might have reacted to such actions of the analyst, but it is important to emphasize that I myself attempt to adhere to the principle that, when my interpretations do not meet with success, my understanding and my interpretations must be at fault and need revision. Under such circumstances I do not think it useful to change my technique, but attempt to understand the analytic material and the transference better so as to reach the patient with my interpretations. With Mildred the interpretations did not help because they were only partially correct, as I had not recognized the main problem of her specific delusional negative transference. Psychotic patients, whether they are manic depressives or schizophrenics, exert on the analyst a very strong pressure to act out. It needs courage and understanding and also some certainty in one's understanding of the psychopathology to resist this pressure in order not to relinquish the analytic situation. In Mildred's analysis it was important to understand and interpret the demand for an ideal

relationship as a defence against the negative transference which was a specifically paranoid one. When this hidden paranoid transference was interpreted, the relationship to the analyst became more real and a relationship between patient and analyst began to develop where besides the psychotic transference a certain non-psychotic transference appeared. This non-psychotic transference can be observed in the analysis of both acute and chronic schizophrenic patients. It is at first weak and uncertain and tends to disappear again for long periods, but it is developed and strengthened by the use of transference interpretations which have a meaning for the patient: I regard this factor as of central importance for the analysis of schizophrenia.

I have often stressed that in the analysis of schizophrenia I retain the basic principles of the classic analytic technique and compare the analysis of schizophrenia with the classical analysis of children which was developed by Melanie Klein. In the analysis of schizophrenia, as in the analysis of children, one does not insist on free association or on the patient lying on the couch. Instead one uses the words and the whole behaviour of the patient, for example his gestures and actions, as analytic material. I suggested calling the transference which develops with schizophrenics and other psychotics 'transference psychosis', and it is the task of the analyst to follow this transference psychosis in all its positive and negative details and to convey this understanding to the patient in interpretations. I observed that even in the acute states the patients are able to understand the interpretations and to respond to them, a factor which cannot only be deduced from the patient's direct confirmation, but from the change in the analytic material.

I shall now bring material from the analysis of an acute schizophrenic patient and shall attempt to show the strong positive and negative impulses related to the transference psychosis and the response to transference interpretations. In such cases the negative impulses are usually not just a direct expression of disappointment, jealousy, envy, and something similar but also usually have a paranoid character. The genital and oral transference impulses are often completely confused, and although this transference is partially derived from the later oedipal complex, certain elements of a much earlier phase of ego development, such as splitting of the ego, splitting of objects, confusion

of ego and objects or projective identification, can be clearly observed. Of the family history of the patient I need only mention that Anne saw very little of her father in early infancy as he was away in the war for five years. The mother tried to continue the father's business and left the child and the older brother to a Nanny who was deeply loved and idealized by the patient. When Anne was twelve years old she had her first severe schizophrenic breakdown. She refused all food and felt persecuted by auditory and visual hallucinations. She became completely negativistic and had to be tube-fed. After about one year the patient had a remission but later she suffered further schizophrenic episodes which each time lasted about one year. I saw her in her fourth episode and after two months' analysis in the acute state she improved so much that she was able to come to my consulting-room by herself for two years. She gradually made progress but defended herself against her sexual impulses in the transference situation and acted out with a great number of men, which often caused her considerable difficulties. The danger of a new acute state was foreshadowed by a strong tendency to make herself independent of me and to deny all her problems. She was obviously terrified of bringing her sexual problems into the transference situation. I tried to prepare Anne's parents for the return of the acute condition which I expected to become manifest after the analysis had broken through the defensive state. However, when the acute state returned the parents looked upon this as a great calamity, but with some reservations they allowed me to continue the treatment in a nursing home. In the earlier (third) acute schizophrenic state the patient's sexual genital impulses had been greatly suppressed and displaced to various parts of her body. She often complained of heat or smoked a cigarette in an excited way. In contrast to this the fourth acute schizophrenic episode was characterized by sexual genital excitement and wishes which were *openly* expressed. One might therefore regard the fourth episode not so much as a relapse as an attempt to progress. As is usual in the acute phase of schizophrenia the splitting and repression diminished and her ego was temporarily overwhelmed by the strong libidinal and aggressive impulses.

In the acute state I saw the patient for one hour six times a week. In the first consultation in the clinic the patient, who was acutely excited and hallucinated, came towards me, shook my

hand, and said, 'I had almost forgotten you.' After this she turned away from me quickly and paced the room from one side to the other. She kept her eyes tightly shut and sometimes knocked against the chairs and other furniture; sometimes she suddenly jumped into the air. The pacing of the patient gave the impression that she was driven simultaneously by panic and despair. One felt that she did not know where she wanted to go; sometimes one felt that she wanted to run in many different directions at the same time. From time to time she exclaimed, 'Get out, get out, don't talk to me!' In between she looked in the mirror and said, 'The face is the only thing I have left. I am a cannibal, I am falling to bits, I had a haemorrhage, I am shot through the brain.' Suddenly she took a bottle which stood on the shelf and threw it out of the window as if she wanted to emphasize that she felt persecuted by me and therefore tried to throw me out. As soon as I started to talk to her she shouted at me again to stop me. I tried to show her that she was terrified of me because she believed that I had changed into somebody very dangerous. In the second consultation the patient at first continued her pacing up and down and avoided looking at me. I interpreted that she was afraid to look at me because she had turned away from me in hate and she believed now that I had become hostile and extremely dangerous. She immediately stood still, looked me full in the face and said, 'You are dead; are you going to kill me?' Then she came very close to me and said, 'I shall not turn away from you now.' She became very affectionate and put her arms around me and wanted to be kissed by me. In such a situation I would not push the patient away but control the sexual approaches by not reacting to them. After some time she put her hands round my throat and said, 'Now I will kill you.' In between she talked about her father, explaining that he was absent in the war. She asked, 'Where is my Daddy?' and stroked my face. I interpreted that she had gone right back to her childhood when her father was away in the war and she wanted him. She believed that I was her father and wanted to possess me completely. I showed her too that her love quickly changed into hate when I did not react exactly in the way she wanted. In fact her feelings changed frequently and quickly during the session. She asked me whether I came from Russia, whether I was a Nazi or a cannibal. At one moment she seemed afraid that I would kiss her and struck me hard across my face

and said she would kill me. She also said, 'My mother is a man.' I interpreted that she was not sure whether I was the father or the mother and that she was also not sure whether I came as friend or enemy. She was afraid that I would eat her up in revenge, which was one of the reasons for striking me in the face. I had the impression that the patient at this time completely confused eating and sexual intercourse. To possess her father and mother sexually meant for her to eat the parents and to be eaten by them. As long as she was in the acute state I made no attempt to interpret all the material but only what was characteristic and important for the present transference situation. The patient often showed a distinct response to my interpretations. For example, when I interpreted that I had changed into somebody hostile and dangerous her anxiety lessened and in her reply, 'You are dead; will you kill me?' she not only showed her understanding of my interpretation but elaborated it further by telling me that I was persecuting because she felt I *was dead*. During the next session the patient talked about her mother as a murderess from Russia who had killed many people. She herself was also a murderer. She said she was very clever and I was stupid and empty-headed. She stressed again that her mother was a man. I said that she wanted to show me that she now was a man herself and had a penis. She responded very quickly 'Yes, I had one until I was twelve years old and then I had a haemorrhage. Harold shot me and pushed my teeth in. She immediately asked me whether I was Harold. I said she believed that Harold had taken away her penis and made her ill and she felt now that I was Harold and had taken away her penis and her mind. I also interpreted that she was envious of me and my mind and that was the reason why she wanted to enter my head and wanted to take away my penis. In this session she shouted at me several times that I was mad and prevented me from talking. It seemed to mean that she felt she had castrated me and driven me mad and was therefore afraid that I would retaliate in similar fashion. Because of the strength of her anxiety, I believe that in this situation some projective identification played an important part, namely that she feared that she had put her madness into me so that I had become a mad person. Therefore I interpreted that she knew that the thoughts which she had about Harold and me were mad ones, that she wanted to get rid of them and pushed them into me. I explained that

she was envious of my sanity which caused her to attack me and that she was afraid that I would put her mad thoughts and ideas back into her through my talking. That was the reason why she felt my words as an attack and why she could not bear my speaking. In this session the patient brought her castration anxieties and wishes very clearly into the analysis. Madness, her first schizophrenic illness when she was twelve years old, and castration are very closely related for her. Harold is no real acquaintance or relative; he is a fantasy-image of an extremely rich and omnipotent father-figure who is generally experienced as persecuting. Apart from the persecuting castration problem the aggressive projection of anxiety situations and bad parts of the ego into the analyst play an important part. Whenever the patient projected the bad parts of herself–for example, her illness or other unpleasant parts of her personality–into me, her fear of my talking became very acute. The projection of the mad or bad part of the patient plays an important part in the analysis of most acute or chronic schizophrenic patients. It is often accompanied by an acute negative transference caused by the patient's fear of retaliation following the attack by projection.

The reason for the projection relates not simply to the wish of the patient to get rid of her illness, but also to the patient's envy of the analyst, standing for the superior healthy adult; it is an expression of the infantile omnipotent wish to reverse the infant-parent position.

During the next session the patient was at first manically excited and danced round the room. She declared she wanted to marry me, examined my hand, saw my ring, became furious and shouted that she hated me and my wife. Then she became manic again and very superior and said she was now a doctor of medicine and a man. In her manic excitement she had reversed the situation, in an omnipotent way; however, the manic state did not last long. She quickly became aware of her dependence on me, was overwhelmed by fury, and attempted to destroy the furniture in the room. At the same time she shouted that she wanted to break up marriages. Then she talked again about me as Harold and as a relative and about marriage. When I interpreted that she wanted to marry me as her father she replied immediately 'obscene' and seemed disgusted. She talked about me and my wife and said 'I want to kill you both' and then she

screamed again 'Get out, get out of here!' as on the first day of her analysis, in the acute state.

During the next day she at first did not want to look at me. She said, 'I don't love you, I myself am married and I love somebody else, I am Hitler and hate the Jews.' In one moment she said she wanted to break in my face; afterwards she tried to tear her own dress. Later on she said, 'Kill me and rape me; I do not want to live any more.' Here it is clear that the oedipal situation is experienced by the patient with great intensity; it is related to murderous fantasies which are directed against the parents and against the analyst. In this session she was much less persecuted and more aggressive and afterwards deeply depressed.

During the next few months many fantasies and situations were repeated in the transference. Sometimes she complained that I visited her during the night. These nightly hallucinations often had a sadistic and persecuting character. She sometimes expressed delusions of being split into a masculine and feminine self. She called her masculine part after the musical play 'Annie Get Your Gun'. Her omnipotent manic impulses and fantasies were often related to this masculine self as an expression of her independence and denial of needs. When she was in the feminine role she often said she was full of blood and spiders and attacked her abdomen in order to press all the bad things out. Sometimes she tried to cut off her breasts or to damage them. She said they were full of blood and I should suck the blood out of them. The bad things which she experienced inside herself were, among others, a stolen penis, blood, children, and the breasts of her mother, which she felt she had stolen and spoilt in her fantasies. This made it impossible for her to identify with her good mother and to accept her own femininity. As I explained before, the patient was unable in the chronic mute state of the illness to bear a strong sexual transference to me and acted it out. In the acute state it became apparent why her sexual impulses and fantasies were so unbearable: they were accompanied by overwhelmingly strong murderous sadistic fantasies.

During the acute schizophrenic state the splitting of the ego lessens. This leads to states of confusion but there are also attempts to reconstruct the ego and the object relations in a better way. In Anne the drive for integration often became clear even during the acute state, and I was able to observe attempts to regain her normal self and her normal thinking. The patient

sometimes asked me 'Why don't you help me to bring everything together?' or she looked questioningly at me saying 'Where has your common sense gone?' Simultaneously she talked about reflections in the mirror. Here I became by projection the mirror image of the patient, namely somebody who has lost his mind; at the same time the patient felt that she had lost the capacity to regain her own ego and her femininity. The main dynamic importance of such transference situations is the use of the analyst as the functioning integrating ego in whom the patient has not only projected her madness but whom she also suspects of containing the sane part of herself, which she attempts to regain with the help of the analyst. During the next three or four months, while still in an acute state, the patient made good progress and became much quieter and clearer. The parents were very enthusiastic and insisted, against my advice, on taking her home. This was too early, because she was not well enough, as we soon saw, to come from her house to my consulting-room. On the other hand, her parents could not bring themselves to send her back again to the nursing home. I was forced to see the patient in her own house, but this brought the progress of the analysis almost to a standstill. As a consequence of various difficulties, among which a short illness of mine played an important part, the analysis was interrupted. This shows how extremely important it is to have the complete cooperation of the parents in the analysis of a psychotic patient. Despite the interruption of the analysis, I heard that the patient has improved further and has married.

At the end of this paper I would like to say a few words about the aetiology of schizophrenia. In investigating a number of schizophrenic patients it was apparent that psychogenic trauma in infancy played an important part. Anne, apparently because of the absence of her father during the war, had been deprived of the opportunity to work through the oedipal situation with her real parents. This contributed to the fact that the oedipal fantasies remained omnipotent and unreal. The preoccupation with incest was perhaps increased through the fact that the parents were first cousins. In the case of Mildred the trauma appeared to be the birth of her brother when she was one and a half years old. In another case an early weaning situation when the patient was ten days old seemed to be an insuperable obstacle. As far as the parents of schizophrenic patients are

concerned, we hear that Mildred's mother was particularly affectionate and motherly; her father however was egotistical and dominating. In the case of Anne, both parents were very neurotic and it seemed that they used the illness of their daughter to deny and split off their own problems. The mother always wanted to have Anne around when she was ill and she felt extremely guilty when she had to be sent to a nursing home during the acute episodes. Anne herself was quite aware how strongly she was able by her illness and her difficulties to influence and dominate her parents. On the other hand, it was very obvious how much she was herself influenced and dominated by them. But similar traumas and problems related to the parents of our patients are known to us from our experiences with neurotic patients and are not typical for schizophrenia. The examinations of a large number of parents and families of schizophrenic patients have shown that the parents of schizophrenics have no character traits which can be regarded as typical and the existence of a schizophrenogenic mother has been disproved by many investigators.

The analysis of schizophrenic patients again and again illustrates that disturbances and problems of earliest infancy continue, influence, and hinder later developmental phases. In discussing these disturbances I have concentrated especially on the splitting of the ego and projective identification. Even in the case of Anne, who was completely dominated by her sexual fantasies, it was possible to observe the splitting of the ego and the projection of parts of the self. In Anne's case one could also illustrate the importance of the problem of confusion which, as Melanie Klein has shown, can also be traced back to disturbances in the first year of life. The case histories of many schizophrenics emphasize that the patients had shown some signs of peculiarity from early on in life and were never able to express strong feelings. There had been a tendency to turn away from the outside world at the least provocation. However, there are other cases in which the development seemed to be comparatively normal until suddenly, for example after childbirth, a severe schizophrenia becomes manifest. I am of the opinion that psychotic parts of the personality may be split off in very earliest infancy while other parts of the self may develop apparently normally. Under certain circumstances the *split-off psychotic parts* may break through to the surface, often producing an acute

psychosis, for example a schizophrenia. One has to assume that a certain predisposition to the psychosis exists from birth. In such cases the destructive instinct seems constitutionally stronger and dominates the rudimentary ego, which as a consequence develops a tendency to fragmentation and splitting. Under such circumstances the paranoid-schizoid mechanisms such as projective identification become greatly reinforced.

When we consider the question of a disturbed mother-infant relationship in the first year of life it is important to consider not only the influence of the mother on the child but the reaction of the mother to a particularly difficult schizoid infant. As Bion has often suggested, and I myself believe, some mothers of children who have a tendency to schizophrenia show a diminished tolerance towards the projections of the infant. They feel disturbed and persecuted and withdraw their feelings from the child. One has the impression that the infant not only notices the responses of the mother but actually feels responsible for it, which increases the infant's omnipotent belief that his intruding into his mother has actually changed her. This may be one of the reasons why, during the analysis, the patient's omnipotent fantasies of intrusion into the analyst play such an important part. The capacity of the analyst to bear this relation, to understand and to interpret it, makes it possible to work through and correct in the analysis the disturbed mother-infant relationship and so help the patient to find a basis for a more normal development.

10

ON THE PSYCHOPATHOLOGY OF NARCISSISM: A CLINICAL APPROACH[1]

(1964)

FREUD was pessimistic about the psycho-analytic approach to the narcissistic neuroses. He felt that people suffering from these diseases had no capacity for transference, or only insufficient remnants of one. He described the resistance of these patients as a stone wall which cannot be got over, and said that they turn from the physician not in hostility but in indifference. Many analysts have tried to develop methods of analysis which would deal with narcissistic patients–I am thinking of Waelder (1925), Clark (1933), and later Fromm-Reichmann (1943, 1947), Bion (1962), Rosenfeld, and others. The majority of analysts who have treated narcissistic patients have disagreed with Freud's view that there was no transference. As the transference is the main vehicle for any analytic investigation, it seems essential for the understanding of narcissism that the behaviour of the narcissist in the analytic transference situation should be minutely observed.

Franz Cohn (1940) suggested that the sharp distinction between transference neurosis and narcissistic neurosis should be disregarded. He felt that the transference in the narcissistic neurosis is of a primitive or rudimentary type–for example, there are often serious difficulties in distinguishing between subject and object–and he stresses the introjection and projection of destructive tendencies in oral and anal terms in relation to the analyst. Stone (1954) described transferences which are 'literally narcissistic', where the analyst is confused with the self or is like the self in all respects: the therapist and the patient alternately seem to be parts of each other. He stresses both the primitive destructiveness and the need to experience the analyst as an omnipotent, godlike figure, and suggests that, in the patient's

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