A SEVERE SEXUAL INHIBITION IN THE COURSE OF THE PSYCHOANALYTIC TREATMENT OF A PATIENT WITH A NARCISSISTIC PERSONALITY DISORDER

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This case report illustrates how an analysis of oedipal conflicts gradually resolved a severe and extended inhibition of sexual desire that developed as a new symptom in the termination phase of psychoanalytic treatment. The enactment in the countertransference of castration anxiety, against which the patient was successfully defending himself by projective identification, produced an extended stalemate, which was resolved once the countertransference was transformed into transference interpretations. This treatment also illustrates the intimate connection between pre-oedipal and oedipal conflicts in the advanced stages of the treatment of narcissistic personalities, and the need for very careful assessment of the patient’s sexual functioning before deciding on terminating the psychoanalysis of a patient with a successfully resolved narcissistic personality structure.

While the emergence of oedipal conflicts may characterise any phase of the resolution of the pathological grandiose self of narcissistic personalities in psychoanalytic treatment, it is particularly in the advanced stages of resolution of narcissistic transferences that the intimate connection between oedipal and pre-oedipal conflicts, with a growing dominance of oedipal conflicts, tends to become noticeable in the sessions (Kernberg, 1984; Rosenfeld, 1987; Grunberger, 1989). The following case report illustrates how the analysis of oedipal conflicts gradually resolved a severe and extended inhibition of sexual desire that developed in the course of analytic treatment. The enactment in the countertransference of castration anxiety against which the patient was successfully defending himself by projective identification produced an extended stalemate, which was resolved once the countertransference was transformed into transference interpretations.

Mr F was a 45-year-old businessman, a European financial expert whose knowledge and experience in investment banking had proved of such value to several corporations that his financial success would have permitted him to retire comfortably at this time of his life. His aggressive, ironic, sharp and intense style of management were both feared and appreciated by his colleagues. He entered psychoanalytic treatment after the failures of two marriages, in which his complete emotional indifference to the women he had married and his corresponding lack of any sexual interest in them finally drove his marital partners into such despair that they demanded and obtained divorces from him.

His relatively brief periods of marriage were interspersed with a long-standing pattern of...
sexual promiscuity. He would become infatuated with a woman for a period of days to weeks, establish a sexual relationship that would last at most several months, and then drop her. Mr F had felt proud of his sexual exploits until his second divorce, when he began to recognise his inability to maintain any relationship as a serious threat. He presented a rather typical pathology of narcissistic love relations (Kernberg, 1995).

Mr F's social relations were characterised by superficial friendships with other men, business tycoons who were linked to him by their common interest in travel and action sports and in arrangements for get-togethers in which relationships with women could be established and exploited. He considered himself proudly as one of the leaders of this group of 'golden playboys'. What was striking was his inability to provide any differentiated descriptions of his male friends or of the many women with whom he established relationships. At a deeper level, it turned out that he was very suspicious of women that interested him financially, and prone to presenting himself dressed in casual and non-presidential ways, the impression of an ageing hippy rather than a successful and wealthy businessman. He would carefully hide his financial prominence from women he was involved with and enjoyed their surprise that he should appear in the presence of apparently powerful businessmen. He presented an engaging, superficially friendly and humorous façade, and only when frustrated in his demands would he show an abrupt, derogatory and occasionally arrogant behaviour.

He was the youngest of three brothers, respectively five and eight years older than him, and he obviously enjoyed describing them as relatively unsuccessful businessmen with whom he maintained very distant relationships, and towards whom he still harboured deep resentments because of what he had experienced as their hostile and dismissive behaviour towards him during their childhood. Living within the cramped quarters of a lower-middle-class household in a northern European city, predominant memories of his childhood included his resentment over the privileged position of his older brothers when it came to space and privacy in the home, freedom to do things as they wanted, and their early rebellion against what all of them experienced as the chronically irritated, scolding and nagging, suspicious and controlling attitude of both parents.

Mr F's mother had been, by far, the dominant person in his childhood. What he described as her overpowering, suspicious, manipulative and hypochondriacal attitude, her unrealistic and constant concerns regarding real and imaginary illnesses in herself and the rest of the family conveyed an almost psychotic picture of his mother. He described his father as chronically dissatisfied, in an ongoing struggle with his wife, resisting her efforts to control the family at every step, taking refuge in his rather unsuccessful small business, and apparently having a very distant relationship with his children. Mr F said that he had never experienced any moment when his parents would appear to be in harmony with each other, and over the years he had come to depreciate the ineffectual way in which his father would attempt to stand up to the powerful mother.

Most remarkable in Mr F's references to his childhood were severe and extended memory gaps, which meant that my early knowledge of his childhood experiences did not extend much beyond the actual summary that I have provided here. He remembered that his sexual development was relatively late, that he started masturbating in his adolescence only after learning that all his schoolmates had been masturbating for years, and that his relatively small stature and frail aspect gave him a sense of being less masculine than his friends, a sense that only disappeared after his early relationships with women that rapidly turned into the promiscuous pattern outlined before. The first five years of the analysis were characterised by a slow but successful working through of the severely narcissistic character structure of Mr F. At the beginning of the treat-
ment, he was quite ambivalent about whether he needed psychoanalysis. He oscillated between concerns over his difficulty in maintaining a relationship with a woman beyond a few weeks, and over the shock of his total failure to maintain any emotional or sexual relationship with the two women whom he had married after a few weeks of infatuated involvements, and an emotional reaction strikingly contradictory to those concerns that emerged in his early relationship with me. In this opposite state of mind, he considered his behaviour with women to be perfectly normal, and regarded men who maintained long-term relationships with women as 'squares, bourgeois types'; he felt himself to be in danger of being brainwashed by the questionable wisdom of a conventional psychoanalyst presumably identified with such values.

Mr F was so impatient with the slow course of psychoanalytic treatment that he offered to pay for his entire treatment at its initiation if I committed myself to reduce it by at least one-third of its usual time: in other words, he wanted to tempt me, quite seriously, with an 'incentive/award' if I did my work faster, and proudly told me how his paying high incentive awards had permitted him to triumph over business competitors in the past.

His initial surface friendliness towards me rapidly turned into an ironic expression of superiority as he found himself uncovering various ridiculous peculiarities in my behaviour. He had noticed, for instance, a 'panic button' at one place in my office (corresponding to a general physical arrangement of the hospital setting within which my private office functions took place), and speculated on the absurd location of that panic button in terms of the location of the couch and my chair. He also thought that, because he could occasionally hear the voice of my secretary in spite of the double doors separating our rooms, she must be hearing his voice, and therefore, that privacy was not assured. Because I did not take any actions to correct what he considered as obvious shortcomings in my physical arrangements, he oscillated between considering me stupid in not realising that these were absurd conditions, or extremely stubborn because, silently recognising that he was right, I persisted in my behaviour rather than giving into him.

These initial unimportant 'foibles' of mine gradually turned into frightening experiences for him, as he realised that he really was attributing to me the bizarre, rigid and controlling behaviours that he associated with his mother. The gradual shift from a view of me as a weak, somewhat pathetic and rigid person who reminded him of his father to the dangerously manipulative and almost 'crazy' replica of his mother signalled a transformation of his narcissistic superiority into paranoid fearfulness as a dominant transference development.

At the same time, he became increasingly aware of intense envy of me. He started to consider the possibility that I might not be imprisoned as he was by the incapacity for a relationship in depth with a woman. His initial devaluation of my wife, whom he had seen accidentally on a few occasions in casual encounters at cultural events, and whom he compared triumphantly with the young beautiful women that he considered his 'specialty', gradually turned into painful feelings of envy and resentment over what he thought my possible enjoyment of my wife and of our life might be. Carefully exploring the chaotic relationships with women characterising my patient's daily life, it also became evident that he was studiously staying away from women whom he might have appreciated and admired for their intelligence, integrity, sensitivity, interests and achievements. He was carefully selecting women who, with all their physical attractiveness, he could depreciate for their inferiority, as he saw it, in comparison with him. The unconscious envy of women, in short, became a major issue to be explored in the transference and in his acting-out behaviour.

This state of affairs shifted rather abruptly after several years, when he established a lengthy relationship with a woman who seemed to be a severe and chronic liar. Information he had about her indicated a pattern of exploita-
tiveness and irresponsibility that raised serious questions in my mind. It turned out that, while Mr F was superficially denying his awareness of all these issues, projecting his fear and con-cerns on to me, at a deeper level he was fasci-nated by this sexual involvement with a woman who seemed closely to resemble his mother.

Over several months he developed a sado-masochistic relationship with her, in the con-text of which he asserted his triumph at being able to achieve a long-standing, highly gratify-ing sexual relationship that included the enact-ment of sado-masochistic scenarios, meanwhile proclaiming his total emotional indifference towards the woman. This period coincided with a remarkable distancing in the transference, which was eventually revealed as a complex combination of strong homosexual impulses towards me as a concerned, warm, caring father, and fear over the development of the negative oedipal transference, while he vengefully tried to destroy the sadistically per-ceived pre-oedipal/oedipal mother. At one point, fantasies of a ménage à trois involving him and myself and a woman whom I would 'generously' cede to him reflected a condensa-tion of his wishes for a sexual submission to me as a price to pay for his access to women, and his reliance on my sexual strength to be able to subjugate and sexually attack a feared and hated woman.

The sexual relationship ended when his mistress's behaviour finally convinced him that she was indeed setting out to exploit him financially, and when her dishonesty and devi-ousness became well known and documented in their social circle. At the same time, he began to recognise one of his 'temporary' girl-friends as a gifted professional as well as a very attractive and loving companion who had maintained her interest in him in spite of his erratic behaviour towards her. For the first time in his life, Mr F fell in love, and was able to combine a tender and sexual relationship with this young woman that evolved into a decision to marry her.

This third marriage turned out to be very satisfactory in an emotional and sexual sense. They decided to have children (a decision that Mr F had strenuously resisted in his earlier marriages), and they had three children during the following three years. It was at a point when we were beginning to consider the possibility of ending his psychoanalysis that he developed an extreme sexual inhibition, to the extent that he lost all desire for sexual intercourse; in fact he could not be excited by any sexual stimuli. For a period of almost six months he had no mas-turbatory or other sexual activity. It is this epi-sode of his psychoanalysis that I wish to focus upon in what follows.

It was when we were beginning to discuss the potential date for the end of his analysis that Mr F started to report a loss of interest in having sex with his wife. In the past, he had been erotically stimulated by a multitude of erotic material as well as in his social interac-tions with women, but now a total lack of interest in and capacity for sexual arousal set in, while what he described as a warm committed relationship with his wife continued. Mr F sounded genuinely concerned about this development, and attempted to overcome it by cre-ating 'artificial' romantic scenarios, smoking marijuana, which in the past had intensified his sexual desire, and he developed fantasies of imitating the sexual attitudes and prowess of conventional movie heroes, such as '007'. At first, I thought that anxiety about his capacity to achieve an erection in relating to his wife might reflect the upsurge of deeper leveis of oedipal anxieties and guilt over the successful establishment of his marriage and his father-hood, and there was some material indicating his fear of losing the protection of a benign and powerful father image in connection with the planned termination of his treatment. I also explored with him the possibility that, rather than tolerating a full-fledged mourning reac-tion in connection with the projected termination of his treatment, he might be regressing to a display of symptoms as an unconscious plea for me not to abandon him. These develop-ments in the transference, however, remained feeble, and there was a lack of development of
new elements in the sessions that I found disconcerting.

As the patient’s anxiety about this remarkable, unprecedented loss of his sexual interest increased, he started reading the literature about impotence and wondering whether there might be organic factors determining this development. Mr F’s high intelligence deployed in his capacity to absorb specialised medical literature about this problem was impressive. I raised the question of to what extent he might be competing with me regarding the understanding of the origin and meanings of his difficulty, and to what extent a split-off fear of competing with me might be expressed in his sexual inhibition.

This did not lead anywhere, and in the course of several months, he reported not only a total disappearance of all sexual fantasy and arousal, but of all morning erections, as well as a disquieting inability to masturbate in his effort to generate sexual arousal. He raised the question of the advisability of a medical consultation, and during several weeks of discussion I made it clear that he was, of course, free to decide whether he wished to carry out such a medical consultation, while he expressed his reluctance to do so without my explicit ‘authorisation’. I eventually expressed my agreement: he had in fact gradually managed to convince me that some organic condition might be determining his impotence and that medical exploration was indicated. Beyond this ‘rational conviction of mine, however, I developed an uneasy sense of hopelessness about his impotence, vaguely related to an image in my mind of his wife as totally unattractive, and a feeling of impotence on my part—as if there were no feasible further psychoanalytic exploration of this symptom. At times, I found myself imagining my own erotic responses to hypothetical situations similar to those reported by my patient in relating to his wife, as if to reassure myself against the ‘hopelessness’ of the patient’s condition.

I need to clarify that, on general principle, I would refer a patient to a urologist or a medical specialist in disturbances of sexual functions when, in fact, the patient develops symptoms that seem indicative of an organically caused impotence, or when there are concurrent medical treatments with known sexual side-effects. I also should mention that I saw this patient before the availability of Viagra, and the related culture of self-medication by men with feelings of insecurity over their sexual functioning.

I referred Mr F to a urologist with a specialised expertise in the diagnosis and treatment of impotence. The patient underwent a complete medical and neurological check-up, with an exhaustive endocrinological study as well as an examination in the sleep laboratory, and was found to be functioning perfectly normally from a medical viewpoint. The urologist recommended that he continue his psychoanalytic treatment!

When Mr F informed me about these developments, what struck me as particularly significant was his sense of satisfaction and relaxation. Indicating that his impotence and lack of sexual desire had now become my problem, not his, he wondered whether I would be able to live up to this challenge, or whether he would have to accept that he might have resolved his difficulties with women, but at the cost of giving up his sexual life.

It was at that point that I realised—with a shock—that I had been imprisoned for the past six months in a chronic countertransference fixation, in the sense of defending myself against a profound feeling of insecurity and impotence with regard to Mr F’s analysis. I could now see how I had been utilising my increasing concern over a medical illness that might be underlying his sexual inhibition as a defence against my identification with the patient’s sense of impotence and castration anxiety. Freed internally to resume thinking analytically, I found it easier to realise that the patient was split between a rational and urgent wish to resolve his loss of sexual desire and total indifference to this problem: he had projected his insecurity and anxiety on to me. I also realised, almost with a shock, that the patient had successfully communicated to me an image of his wife as having become utterly
uninteresting from a sexual viewpoint, a warm, nice but unfeminine and sexually boring companion, in total contrast with the previous image of her as an exciting, highly sexual, responsive partner with whom Mr F had had a highly gratifying sexual relationship. In fact, he had communicated to me over an extended period of time how his future wife was ‘coming on like a sex bomb’, triumphantly implying that his sexual experiences surely exceeded mine.

I now gave an interpretation of his deep-seated indifference towards resolving the sexual inhibition with his wife except by magical, ‘as-if’ means that would bypass the emotional relationship with her, such as his identification with a ‘007’ personage. I suggested that he was attempting to protect himself against a deep-seated insecurity about his sexual power, a fear of failure and impotence, by attempting to make these my problems, perceiving himself in a position of an interested bystander, observing my efforts and wondering whether I would be successful or fail in my task to restore his sexual power. In short, a reactivation of his narcissistic defences had occurred, within the context of projecting on to me his sexual inhibition and anxiety.

In response to this approach, Mr F’s relaxation shifted into a growing sense of anxiety along with a reactivation in the transference of an ambivalently admiring and yet helplessly doubtful relation to a warm but weak father image. Memories from his childhood emerged, in which, because of his mother’s hypochondriacal concerns over his health, he had been ‘dragged’ to doctors because she was preoccupied with the underdevelopment of his genitals. There were painful recollections of being shamefully exhibited before doctors who repeatedly reassured his mother that his penis was not deformed or twisted towards one side, that the size of his testicles was normal, and that they were definitely descended. He remembered now that he was smaller than most of his classmates, that he had experienced a relatively late development of his pubic hair and other secondary sexual characteristics, and, with great shame and resentment, Mr F mentioned that his mother used to call him a ‘shrimp’. He gradually became aware of the frightening fantasy that it was inconceivable that he, a little ‘shrimp’ boy with a ‘shrimp’ penis would be able to penetrate his wife, an attractive, adult woman and mother of his children.

At the same time, behind the helpful and idealised but also competitively devalued image of me as warm and friendly, yet impotent in solving his sexual difficulty, emerged, in a series of dreams, an image of me as dangerous and threatening. In that image, my face changed to a mysterious figure with a moustache that he could trace back to nightmares in his childhood, and that he associated to the murderous enemies of ‘007’.

Mr F then became aware of once again being aroused by his wife, but at such moments he developed intense anxiety, fearful of being unable to achieve or maintain an erection, and of her making fun of him or depreciating him. These developments occurred against the background of significant victories over competitors in his business, and renewed efforts to deny the importance of his sexual difficulties by focusing on his professional and social triumphs. His behaviour towards his wife became quite domineering and controlling, and, for the first time, conflicts developed because she resented his authoritarian attitude and confronted him with his aggressive demands. This increased Mr F’s anxiety and he found himself relating to his wife in the resentful and grudging manner that had typified his father’s behaviour towards his mother. He also experienced me, once again, as irrationally controlling him, disturbing his well-being by confronting him with his sexual difficulties. It is in this context that the following session took place, illustrating, I believe, the intensity of oedipal rivalry and castration anxiety underlying his lack of sexual desire, and illuminating the transference/countertransference enactment related to the urological consultation.

As Mr F came into my office, he looked at a wire connected with a television set in a corner
of the room. He was accustomed to seeing this equipment (utilised for research purposes) from time to time, and knew it was turned off. He then commented that this wire was dangerous because people could trip on it and I should arrange it differently, for example, along the wall or under the carpet. Mr F became quite angry, remarking that he knew from past experience that it was useless to give me good advice. I would stubbornly do what I wanted, even if it was obvious that this wire could really be dangerous for patients. While telling himself that it was ridiculous to get upset over all this, he was getting increasingly angry with me. I pointed out that he was afraid of the intensity of his anger at what he perceived as my arbitrary, stubbornly provocative attitude towards him.

He then remained silent, and after a few minutes said, 'I now have the image of your balis, just your balis, no penis there. Not even a small one', he added, 'not even a shrivelled one'. I said that, in this image, I shifted from being dangerous and provocative to being a sexless shrimp, and the patient said, 'I knew you were going to say that'. He added that, while he was silent, he had actually also had the fantasy that I might have laid down that wire specifically to make him trip, and he had imagined an electrical discharge if that happened.

He then went on to describe a successful meeting in which his side had effectively dismantled the efforts of the lawyers of the other side to change the nature of a highly lucrative contract that he had engineered. He mentioned proudly that he had outsmarted those lawyers in their own area of competence. This had given him a sense of well-being and power. He commented derisively on the uncertainty of the business partners on the adversary side. Earlier, he had referred to them with a sense of resentment and envy because of their freely making sexual jokes during an informal party on another occasion, indicating their sexual security while he had to struggle with all these problems in his life.

He then returned to the wire across my room, and said that there was no reason to get irritated; it probably only indicated my bumbling way of arranging things in my office, and he added some comments regarding the disorderly state in which my books had been stacked along some bookshelves. I said that the triumph over his adversaries and the thought that my wire-laying reflected a bumbling attitude on my part reassured him against a sense that he could not compete sexually with them nor with me, and that, in this regard, my not having a penis, my being castrated, was part of this effort to reassure himself against the fantasy that he possessed a small, deficient penis.

The patient then said that he felt very tired, all of a sudden, and in fact, while taking up once more the successful business deal that he had completed in recent days, he sounded more and more monotonous and sleepy. I should mention that, in recent weeks, as we were exploring his intense fears over sexual engagements with his wife, on several occasions he had fallen asleep precisely following moments at which intense anxiety had been stirred up in him: in fact, during one period when I simply drew his attention to his anxiety in the relationship with his wife, Mr F would actually fall asleep for a few moments in the session.

I said that he seemed to me to be falling asleep, and that if that were so, I would think that thoughts about the relationship with his wife had come into his mind together with an effort to avoid exploring this issue in the session. Mr F said that he had just remembered looking at his wife that morning, from the back, and finding her very attractive, and that was painful. He said he didn't know why it was painful but she looked very beautiful and he tried to dismiss this image from his mind.

I wondered whether it was painful to tell me that his wife was attractive to him because this would mean that he would want to have sex with her and would become afraid that he would not be able to function sexually with her, and he would experience it as humiliating to share that fear with me. I added that, perhaps, his protest about the wire in my office and my incompetence, and his excited triumph over his rivals, were efforts to avoid a very shameful and humil-
iating sense of fear over not being able to function sexually because it confirmed in his mind his being a 'shrimp', and my thinking he was a shrimp. Mr F remained silent for a while, and I had a sense that there was a shift in his altitude, such that I no longer experienced him as being in the competitive or fearful relation with me that had seemed dominant earlier in the session.

Mr F then said, 'It is true that I have to struggle with this image of myself. But then you confirmed it; because, after all, you sent me to the doctor, the same as my mother'. I was impressed by what seemed to me Mr F's genuine reflection about that difficult period in our work, and, after a silent moment, I said that I understood that he had felt that I had been contaminated by his uncertainty over his sexual functioning, and that I had reacted with the same behaviour as his mother, thus reconfirming his view that I saw him as sexually inferior.

Mr F then mentioned that he had had sex with his wife the night before the session. At first, he wanted to have sex but didn't have an erection, and then she caressed him and they were talking, and she smiled at him in a loving way, and he realised that she loved him, and that he did not have to present himself as a big businessman to be accepted by her, and all of a sudden he was able to respond and to have sex with her. He added that he didn't fear the intensity of her movements and reaction before she reached orgasm, while previously at such moments he had doubted he was enough of a man to respond to such an adult woman's behaviour.

Now I had a brief experience of confusion: a significant shift seemed to occur in the transference. Mr F conveyed the impression of having been able both to tolerate his insecurity in relating to his wife and to accept her love without being overwhelmed by his fantasies that she must be depreciating him, or that he was not an adult man but only a small child in relating to her. I would have expected him to be very pleased to tell me about this, but instead his derogatory comments and ironic teasing earlier in the session had seemed to reflect a defensive competitiveness with me. I wondered whether he might have told me this experience expecting me to feel relieved, thus reconfirming my anxiety over his sexual performance. I also wondered whether, at a still deeper level, castration fears, in which I would be a dangerous father image, might have something to do with his underplaying his satisfaction over a good sexual relation with his wife. I said nothing at this point.

Mr F remained silent for some time, and then said that he was thinking of his wife, that he liked her body after she had recovered her shape following the birth of their third child, but that he found it difficult to talk about that for some reason. She also had fuller breasts now, and that was very attractive, and then he went back to the painful feeling when she had seemed so extremely desirable that morning. He looked increasingly uneasy as he was talking about his wife's attractiveness and I pointed this out to him. He said he didn't know what this was about, and I suggested that, for some reason, talking about his sexual excitement as well as his sexual interactions with his wife was difficult for him, perhaps because of fears about how I would react to his telling me about this. In fact, I had experienced a sense of satisfaction with the good sexual experience my patient had communicated to me, in a transient and mild but definite identification with his erotic interest in his wife.

Mr F said that there was no reason to feel uncomfortable; he had talked to me about his sexual feelings and experiences many times, so this was strange. And then, with a laugh: 'You wouldn't get sexually excited with what I am telling you here, would you?' I said that it sounded as if he was trying to protect himself against fears that I might get sexually excited, and fantasies about what that would mean. Mr F said the thought had never occurred to him before, and in fact, he considered me an analyst with so much experience that I wouldn't react to patients' telling me about their sexual life.

I reminded Mr F that, early in his treatment, he had experienced himself as an expert on women while I appeared to him as a 'square', a conventional bourgeois. Later on, in fact, very recently, he had experienced me as a very secure and effective man with women
who would depreciate him because of his insecurity with his wife. Mr F then said, 'Well, perhaps you might become envious of me if things go well with my wife; after all, you know that I am much more successful than you when it comes to business and earning money, and that I probably earn more in a month than you earn in a year'. He then remained silent again, and then thought of his father, his father's failing health, and the fact that he was ever more dependent on the care of the patient's mother, which Mr F thought was pathetic, given the constant fights that his parents engaged in. And he became very angry with the doctors who were seeing his father, and were not being as effective as they should be in the management of his medical problems.

I thought that this reflected his guilt feelings about the triumph over me as father image, displaced on to his father, but it was towards the end of the session, and I decided not to say anything at that point. The patient then went on to talk about how difficult it was to find good doctors, making fun of a local medical doctor who was giving his father contradictory information. I still had time to wonder whether that was a displacement of a reaction towards me, but that was the end of the session.

I selected this session as a rather typical one during this stage of my patient's treatment, a fundamental phase in the treatment that evolved into a gradual resolution of Mr F's inhibition of sexual desire and impotence, as his castration anxiety, his profound guilt over competing successfully with his father, and his feelings of inferiority towards the oedipal mother emerged in the context of a defensive reactivation of past narcissistic resistances. In the weeks following this session, Mr F remembered childhood fantasies about the inordinate size of his mother's hairy genitals, in the context of both excitement and fear over his wife's genitals. Dreams in which he was being attacked by underwater predators signalled the intensity of his fear of potential damage during sexual intercourse.

In conclusion, what I have been highlighting is an extended stalemate of the treatment over several months as a consequence of a counter-transference enactment derived from my defensive rejection of the patient's projective identification of his sexual fears on to me (Kernberg, 1993). This development led to the symbolic repetition of a childhood experience, the patient's mother taking him to a doctor because of an assumed sexual inferiority. It illustrates Sandler's concept of the role-responsiveness of the analyst, particularly the case of the enactment of this responsiveness in actual behaviour of the analyst rather than his utilising his internal reaction as a countertransference source for the integration of projective identification on the patient's part (Sandler & Sandler, 1998). This treatment also illustrates the intimate connection between pre-oedipal and oedipal conflicts in the advanced stages of the treatment of narcissistic personalities, and the need to assess very carefully the patient's sexual functioning before deciding on terminating the psychoanalysis of a patient with a successfully resolved narcissistic personality structure. As Green (1997) has stressed, the focus on pre-oedipal pathology in recent times has often coincided with a neglect of the fundamental conflicts around sexuality that mark human development in normality and pathology from the beginning of life. The threat of separation from the analyst reactivated, I think, the threat of becoming the 'third excluded other' linked with the separation from the early (symbiotic?) mother. This expression of the early or archaic oedipal situation had remained latent under the dominance of the severe, pathological narcissistic conflicts of Mr F, only to be triggered by the conflict around termination.

Finally, this case also illustrates how a symptom, emerging in the advanced or final stage of an analysis, may recapitulate an earlier symptom not fully explored previously in all its unconscious determinants. At the same time, this symptom may enter naturally into the transference, the systematic analysis of which may facilitate completing earlier analytic work related to this symptom as well as exploring new transference developments connected with termination.
Ce cas clinique met en lumière la façon dont une analyse dès conflits oedipiens permet de résoudre graduellement une inhibition sévère et étendue de désir sexuel qui se développe en tant que nouveau symptôme dans la phase terminale d’un traitement analytique. L’événement de l’angoisse de castration dans le contre-transfert, contre lequel le patient s’est défendu avec succès au moyen de l’identification projective, produisit une stagnation étendue qui ne put se résoudre qu’une fois que le contre-transfert fut transformé en interprétations de transfert. Ce traitement illustre aussi la connexion inlême qui existe entre ces conflits oedipiens et préoedipiens dans les phases avancées du traitement des personnalités narcissiques, ainsi que la nécessité d’évaluer avec précaution le fonctionnement sexuel du patient avant de prendre la décision de terminer la psychoanalyse d’un patient dont la structure de la personnalité narcissique est résolue avec succès.


Este caso ilustra como un análisis de los conflictos edípicos fue resolviendo, gradualmente, una grave y amplia inhibición del deseo sexual que se desarrolló como un síntoma nuevo en la fase de terminación de un tratamiento psicoanalítico. La puesta en escena, en la contra-transferencia, de la ansiedad de castración, contra la cual el paciente se había ido defendiendo con éxito por medio de la identificación proyectiva, dio lugar a una paralización extendida que se resolvió una vez que la contra-transferencia se transformó en interpretaciones transferenciales. Este tratamiento ilustra también la íntima conexión entre conflictos preödipicos y edípicos en los estádios avanzados del tratamiento de las personalidades narcisistas y la necesidad de evaluar con mucho cuidado el funcionamiento sexual del paciente, antes de decidir la terminación del análisis, si ese paciente tiene una estructura de personalidad narcisista resuelta exitosamente.

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