

Kohut's Theory of Narcissism and Adolescent Drug Abuse Treatment

Gail F. Goldman and Charles J. Gelso
University of Maryland, College Park

In this study, we sought to determine whether changes in narcissism among adolescents occurred during a 6-month period of treatment for substance abuse and whether level of narcissism was related to progress in treatment and treatment persistence versus withdrawal. Participants were 95 adolescents ($M = 16$ years of age) entering or already in long-term treatment for drug abuse, surveyed three times over 6 months. Narcissism was measured by two instruments based on Kohut's theory of narcissistic development. Findings indicated that many, but not all, narcissistic characteristics did change during treatment. Theorized relations were found between narcissism scores and progress in treatment for most narcissistic manifestations. The ability to relinquish angry acting-out behavior distinguished dropouts from persisters.

It is believed by some that among the most costly and prevalent problems facing our society today are alcoholism and drug abuse (Butcher, 1988). In the realm of theory and research, personality structure has long been suspected as an influential factor in the development of addictive behaviors (e.g., Freud, 1898; Rado, 1933; Wurmser & Zients, 1982).

Within this literature on personality structure, there is a nascent body of psychoanalytic theory that links substance abuse and psychological structure (e.g., Frosch & Milkman, 1977; Krystal, 1977; Morgenstern & Leeds, 1993; Treece & Khantzian, 1986). A psychoanalytic theory that would appear to have considerable promise in explaining substance abuse and its treatment is Kohut's self psychology and its concept of narcissistic development (Levin, 1987; Wood, 1987).

In this article, we focus on Kohut's concept of narcissism and how narcissism may unfold over the course of substance abuse treatment. We also examine how narcissism may itself be related to indices of response to substance abuse treatment.

In summarizing Kohut's early and most influential theoretical writings, Kohut (1971, 1977) conceptualizes the emerging self as comprised of the *grandiose* and the *idealizing* lines of development. Minor phase-appropriate "failures" in empathy of "good-enough" parents lead to healthy narcissism. Disturbances in the self arise from severe, phase-inappropriate, and/or chronic frustration of the child's needs for mirroring (reflecting back) of his or her grandiosity and needs for models worthy of idealizing.

If the deprivation has been in the grandiose line of development, Kohut (1971) suggested that the primitive demandingness of these narcissistically injured individuals can be split off in two ways. Such demandingness can be either repressed (in a "horizontal split") or maintained in consciousness but separated from the "reality ego" (in a "vertical split"; p. 185). These splits are important theoretically because they explain seemingly contradictory behaviors (i.e., overt grandiosity coupled with a more covert shaky self-image). The splits are important empirically because, if combined, one could statistically cancel out the other when, in fact, they both actually might exist side by side. If the deprivation has been in the second line of development—the idealized parental image—the result may be a vulnerability to separations from others, the inability to soothe oneself, and empty depression.

Although narcissistic self-inflation shows up in the arrogance, rebelliousness, defiance of rules, and disobedience of parents' authority in many adolescents, Blos (1962) pointed out that the result should be the maintenance of self-esteem through realistic achievement. It can be argued that drug abuse severe enough to have one placed in treatment is not typical adolescent defiance, but a more pathological form of narcissism (Lapan & Patton, 1986) and an extreme defensive rather than compensatory strategy (Patton & Robbins, 1982), hindering growth.

Adolescence is a time when early narcissistic injury to psychic structure may manifest itself in addictive behaviors. Of course, psychic structure is but one facet in the development of substance abuse. Not all adolescents (not even all adolescents with an unstable psychological structure) develop addictive behaviors. Theorists such as Huba, Wingard, and Bentler (1980) developed interactive models. They take into account such factors as biological, intrapersonal, interpersonal, and sociocultural influences. However, adolescence (due to psychic instability, social expectations, and environmental stress) is still fertile ground, given exposure and availability of drugs, for the development of addictive dependencies.

We move to the point of this study: Based on Kohutian theory, Patton, Connor, and Scott (1982) suggested that by ingesting alcohol and drugs, the narcissistically injured person either is acquiring the confidence and self-esteem so painfully lacking (a defect in the grandiose self) or is using the substances to calm and protect himself or herself (a defect in the omnipotent, idealized parental image). In dealing specifically with adolescents, Wolf, Gedo, and Terman (1972) went on to say that a "loosening of structure" during adolescence may result in a regressive shift to an earlier narcissistic position, leading some adolescents to abuse drugs (p. 267).

However, Kohut (1984) left room in his theory for a healing of the core structure if the individual is later involved with healthier relationships.

Is it not possible then, given milieu and group treatment (as we utilize in this study), that the new, therapeutic group could take over the process of tightening the psychic structure in a more positive way? So that when Anna Freud (1958) spoke of adolescents being "in no hurry to close down on possibilities" (p. 275), perhaps those "possibilities" can entail a positive outcome for children who have developed substance abuse in part as a result of unempathic experiences in the formative years. This is the premise of the present study.

Surveys of adolescents have pointed to the role of personality factors both antecedent to and simultaneous with alcohol and drug use (e.g., Rydelius, 1983; Sutker & Allain, 1988). Many of these personality factors noted by Sutker and Allain (1988) as having been associated with substance abuse in adolescents have been explained theoretically as stemming from early narcissistic injury (Kohut, 1971, 1984, 1987). Therefore, it was believed that significant results in the present study would give a theoretical umbrella for seemingly disparate characteristics.

Our study was an attempt to empirically document changes in narcissism in adolescents being treated for substance abuse and to determine if and how narcissism might relate to progress and persistence in such treatment. Multidimensional measures of narcissism based on Kohut's psychoanalytic theory of self psychology were employed. As previously outlined, Kohut theorized two lines of narcissistic development: grandiosity and idealized parental image. It is important to note that each of these lines of development has defensive and healthy potentials.

In this study, both lines of development (grandiosity and idealized parental image), in their healthy and defensive forms, were examined in a sample of adolescents who were in long-term day treatment for problems with substance abuse. Because the existing research (Hubbard et al., 1989; McLellan, Luborsky, O'Brien, Woody, & Druley, 1982; Nicholson & Treece, 1981) has found that treatment ameliorates certain pathological characteristics in substance abusers (though none looked specifically at narcissism or adolescents), it was hypothesized that healthy narcissism (in both lines of development) would increase and defensive narcissism (in both lines) would decrease over time during treatment.

It was also hypothesized that healthy narcissism in both lines of development would be positively correlated, and defensive narcissism inversely correlated, with the assigned phase of treatment requested by the adolescents and agreed upon by the staff (higher phases reflecting progress in treatment). Blos (1962) stated that the narcissistic adolescent does not directly experience the nature of his or her conflict, but rather experiences rage and anger. Running through our hypotheses is the basic assumption that those high in defensive narcissism would have difficulties with the interpersonal relationships necessary for therapeutically beneficial results, thereby slowing their progress and hindering their assigned succession to the next treatment phase. Because, according to Lapan and Patton (1986), Kohut's ideas

about the self entail a wide range of potentially observable events, confirmation of this hypothesis might suggest that staff and the adolescents themselves may be responding to changes in overt indicators of narcissism, even though perhaps not aware of those characteristics as such.

Rosenthal (1984), DeLeon (1985), and Hubbard et al. (1989) stated that success in substance abuse treatments is determined in large measure by length of treatment. Therefore, indicators of retention are extremely important. Several studies have indicated that early dropouts from treatment exhibit higher levels of psychological dysfunction than do clients whose durations of stay are longer (DeLeon, Skodol, & Rosenthal, 1973; Sacks & Levy, 1979). In extrapolating from such literature, it was hypothesized that those who drop out of treatment would have lower healthy and higher defensive narcissism scores (in both lines of development) than those who remain.

METHOD

Participants and Setting

The study sample consisted of 95 adolescents entering or already in long-term day treatment for severe problems with chemical dependency at a nonprofit treatment center within the metropolitan Washington, DC area. Treatment was based on confrontation, Alcoholics Anonymous steps, and cognitive-behavioral approaches. Khantzian (1985), a noted writer on the psychodynamics of substance abuse, outlined the benefits of cognitive-behavioral techniques, self-help groups (such as Alcoholics Anonymous and Narcotics Anonymous), and group therapy for substance abusers in repairing self-care, self-regulating deficiencies, and some of the "compensatory attitudes of bravado and counterdependency" (p. 86). In this setting, "newcomers" are returned to a somewhat regressed state where they are led around, arm-in-arm, by patients who are in higher phases of treatment. But, these newcomers can progress through the system, gain some esteem, and become leaders themselves.

Ages of the participants ranged from 13 to 21 ($M = 16$ years). There were 58 male and 37 female participants; there were 82 Whites, 7 Blacks, and 6 participants of other races, fitting the pattern found in federally funded programs (Beschner & Friedman, 1985). Socioeconomic status ranged from upper-lower to middle class.

All patients who remain in treatment pass through five phases of treatment. Patients must apply for graduation to the next phase. The final decision for such movement is made by the staff who have daily contact with the patient. Higher phases reflect improvement in patient functioning, as judged by the staff, and are accompanied by increased freedoms and a change in focus of discussion. Patients must attend 6 days a week initially, which decreases to 3 in their final phase. A full course of treatment usually entails approximately 18 to 24 months.

Instruments

Narcissism was measured by two instruments, containing seven self-report subscales based on Kohut's theorized grandiose and idealized parental image lines of development. The Inventory of Self Psychology (ISP; Slyter, 1989) originally included two measures of defensive (Defensive Grandiosity and Defensive Idealized Parent of 15 items each) as well as two of healthy (Healthy Grandiosity and Healthy Idealized Parent of 15 items each) narcissism, and displayed satisfactory stability (all retest r s $> .8$) and internal consistency ($r > .79$). Regarding construct validity, significant differences were found on the scales between a normal sample (college students) and a client sample (counseling center clients). Considerable evidence was amassed by Slyter for convergent and discriminant validity in that the ISP was related in theoretically predictable ways to other measures of narcissism and unrelated to social desirability.

Slyter subsequently revised the Defensive Grandiosity subscale to reflect the horizontal (repressed grandiosity, 10 items) and vertical (conscious grandiosity, 10 items) splits theorized by Kohut and added five new items to each of the other subscales (for a total of 20 items each). The split in the Defensive Grandiosity scales resulted in five subscales instead of the previous four.

Because the ISP was not normed on adolescents, it was subjected to several processes by us. The scale was modified to change readability from 11th-grade to 5th-grade level (Fry, 1977). Judges (two social workers and one psychiatrist, all of whom worked exclusively with adolescents) rated whether they thought each rewritten sentence was applicable to adolescents and conveyed the same concept as the original statement. Likewise, six children (ages 13, 14, and 16) were then used to further check readability and pertinence. All rewritten items were deemed highly satisfactory.

This modified version demonstrated sound reliability. Cronbach's alphas at the first testing time were Healthy Idealized Parent = .84, Healthy Grandiosity = .91, Defensive Grandiosity–Horizontal = .71, Defensive Grandiosity–Vertical = .65, and Defensive Idealized Parent = .81.

The ISP subscales encompass the following characteristics:

1. Healthy Grandiose Self: self-assertive striving toward realistic goals, reactive activity, self-confidence, and self-enjoyment.
2. Defensive Grandiose Self–Horizontal split: repressed grandiosity as demonstrated by feelings of shame and embarrassment, deflated self-esteem, and work inhibitions.
3. Defensive Grandiose Self–Vertical split: conscious grandiosity as demonstrated by themes of superiority, domination, and perfection.
4. Healthy Idealized Parental Image: enthusiasm and admiration for the realistic qualities of others, the ability to soothe one's inner tension, productiv-

ity, empathy, a sense of humor, an acceptance of one's limitations, and internalized goals and values.

5. Defensive Idealized Parental Image: the need to look to and attach to important others, anxious excitement, an overly critical nature, reactive rage, depression when leaving or when disappointed by important others.

The other subscales utilized were Lapan and Patton's (1986) Pseudoautonomy and Peer Group Dependence scales, also measures of Kohut's two lines of narcissistic development (grandiosity and idealized parental image, respectively), which were normed on adolescents. Although Slyter's scales measure both healthy and defensive narcissism, Lapan and Patton's scales measure only defensive narcissism in the two lines of development. These two 8-item scales have demonstrated high reliability, independence from one another, and construct validity.

Lapan and Patton (1986) characterized the Pseudoautonomy scale as rebellious nonconformity, perhaps reflecting hurt and anger that gets managed by withdrawal, which helps preserve self-esteem. Peer Group Dependence encompasses the adolescent's defensive attachment to others as a substitute for his or her own internal ideals or goals and the adolescent's need for reassurance from others and the fear that it might not be available.

Interscale correlations between Slyter's and Lapan and Patton's subscales demonstrated significant correlations in theoretically expected directions (e.g., all subscales based on Kohut's grandiose line of development were significantly correlated; all $ps < .01$).

Procedure

All measures were administered three times by Gail Goldman at 3-month intervals. Eighty percent of the parents of potential participants (99% of the adolescents consented) gave permission. Testing took place during routinely held group meetings. Anonymity was protected.

A testing period of 6 months was chosen. This 6-month time frame seems to be a crucial one within which to work (see Feigelman, 1987; Kennard & Wilson, 1979). Although testing occurred over 6 months, participants could have been in treatment over a wide range of time.

Design and Analysis

Participants were initially divided into one of four groups reflecting their length of time in treatment at the point of the *first* testing. Group 1 ($n = 50$; those whose first testing occurred within the first 6 months of their admission to the program); Group

2 ($n = 24$; first testing at 7–12 months of admission); Group 3 ($n = 10$; first testing at 13–18 months); and Group 4 ($n = 11$; first testing 19–24 months). As expected, the change rates were not found to differ statistically for Groups 1 or 2. Thus, both groups are combined in subsequent analyses of narcissism change scores (note that participants in Groups 3 and 4 were eliminated for change analyses because of insufficient sample sizes over time).

The first independent variable comprised the three testing sessions (giving rise to the repeated measures), with an initial testing and the following two testings separated by 3 months (hereafter, labeled *testing time*). The second independent variable utilized was the phase of treatment (hereafter, labeled *phase*) assigned to the adolescent subsequent to the adolescent's request and staff evaluation. The staff members were blind to all independent and dependent variables being studied in the present research.

RESULTS

Changes in Narcissism Over Time

In order to test Hypothesis A (changes in narcissism over the 6-month time frame), a repeated measures multivariate analysis of variance (MANOVA) was conducted, comparing differences between first and the last (third) testings on measures of narcissism. As can be seen in Table 1, an overall significant multivariate effect was obtained for time of testing (first vs. third) on the five measures of defensive narcissism as well as the two measures of healthy narcissism. As also can be seen in Table 1, univariate analyses of variance (ANOVAs) on all but one measure of defensive narcissism demonstrated significant differences between Testing Time 1 and 3. Defensive Grandiosity–Vertical scores did not change. In sum, these results represent decreases in defensive independence (Pseudoautonomy); defensive attachment to others (Peer Group Dependence); repressed grandiosity, shame, and embarrassment (Defensive Grandiosity–Horizontal); and inappropriate attachment and depression when leaving or disappointed by others (Defensive Idealized Parental Image), but with no significant change in conscious grandiosity (Defensive Grandiosity–Vertical).

Significant changes were found in Healthy Grandiosity, which is characterized by self-assertive striving toward realistic goals, creative activity, self-confidence, and self-enjoyment. Changes were not found, however, in Healthy Idealized Parent (involving enthusiasm and admiration for the realistic qualities of others, the ability to soothe inner tension, productivity, empathy, and internalized goals). In summary, five measures of defensive and healthy narcissism showed significant change over time, whereas two did not.

TABLE 1
Changes in Defensive and Healthy Narcissism

	<i>Time 1</i>		<i>Time 3</i>		<i>F</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Defensive Narcissism					
Within subjects (Time 1 vs. 3)					4.00**
Pseudoautonomy	2.59	2.29	1.48	1.39	14.81***
Peer Group Dependence	5.59	1.82	4.48	2.39	7.14**
Defensive Grandiosity-H	41.59	5.85	39.05	7.18	4.84*
Defensive Grandiosity-V	35.23	7.40	35.48	7.49	0.06
Defensive Idealized Parent	76.48	10.88	72.05	11.85	7.39**
Healthy Narcissism					
Within subjects (Time 1 vs. 3)					7.42**
Healthy Grandiosity	77.55	15.02	83.77	13.09	9.93**
Healthy Idealized Parent	83.89	11.60	85.05	9.36	0.56

Note. $n = 44$, which is the number of participants in Groups 1 and 2 who were still in treatment at Testing Time 3. The between- and within-subjects analyses are multivariate, and the subscale analyses are univariate. Range of scores for Pseudoautonomy and Peer Group Dependence are 0-8; Defensive Grandiosity-Vertical (V) and Horizontal (H) are 0-60; Defensive Idealized Parent, Healthy Grandiosity, and Healthy Idealized Parent are 0-120.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Narcissism and Assigned Phase of Treatment

It was hypothesized that the level of defensive narcissism would be inversely correlated, and the level of healthy narcissism positively correlated, with attained phase of treatment as assigned by agency professional and paraprofessional staff. Because length of time in treatment is highly correlated with assigned phase of treatment (as reported earlier), length of time in treatment was partialled out of the analyses. As can be seen in Table 2, Defensive Idealized Parent, Defensive Grandiosity-Horizontal, and Healthy Grandiosity demonstrated significant partial correlations with the participants' phase at all three testing times. Pseudoautonomy and Peer Group Dependence showed significant partial correlations at two out of three testings. Healthy Idealized Parent demonstrated a significant partial correlation at one and Defensive Grandiosity-Vertical at no time. It should be noted that these latter two scales, which showed nonsignificance on these correlations, also demonstrated a lack of improvement in the previous hypothesis.

Differences in Narcissism Between Dropouts and Retainees

It was hypothesized that those who drop out of treatment will have higher scores on defensive narcissism and lower scores on healthy narcissism at the time of

TABLE 2
Correlation Between Defensive and Healthy Narcissism and Phase of Treatment
(Partialing Out Length of Time in Treatment)

<i>Subscale</i>	<i>Testing 1^a</i>	<i>Testing 2^b</i>	<i>Testing 3^c</i>
Pseudoautonomy	-.30**	-.53***	-.02
Peer Group Dependence	-.14	-.32**	-.27*
Defensive Grandiosity–Horizontal	-.37***	-.40***	-.28*
Defensive Grandiosity–Vertical	-.10	-.14	-.03
Defensive Idealized Parent	-.42***	-.35**	-.31**
Healthy Grandiosity	.30**	.38***	.38***
Healthy Idealized Parent	.19*	.07	.05

^a*n* = 92. ^b*n* = 59. ^c*n* = 48.

p* < .05. *p* < .01. ****p* < .001.

withdrawal than those who remain. A multivariate procedure was utilized, employing Hotelling's T^2 comparing dropouts to retainees for each testing time. Changes in healthy and defensive narcissism were analyzed separately. Although no MANOVA demonstrated significance, the MANOVA for defensive narcissism after Testing Time 2 approached significance, $F(1, 32) = 1.59, p = .1$. A closer look at the ANOVAs for defensive narcissism at Testing Time 2 revealed that Pseudoautonomy was able to significantly differentiate those who withdrew from the program from those who remained, $F(1, 32) = 6.42, p < .01$.

DISCUSSION

The data indicate that many narcissistic characteristics do improve over time for adolescents in treatment for substance abuse. These results support the clinical findings of others who view adolescence as a time of change and possible healing of narcissistic injury (Blos, 1962; A. Freud, 1958; Kohut, 1966, 1971; Wolf, 1988) and add the dimension of narcissism to the literature that looks at characteristics which change over the course of treatment for substance abuse.

There was a dramatic decline in scores, over time, from the responses of the participants to the Pseudoautonomy scale, meaning that participants' self-reported defensive withdrawal and rebellious nonconformity, and displays of anger and cheating, made impressive improvements. In addition, Pseudoautonomy was the only characteristic able to discern dropouts from retainees. It seems that the ability to control these particular defensive characteristics is necessary for adjusting to day treatment for substance abuse. Khantzian (1985) noted that group therapy for substance abuse allows a focused examination of self-defeating behaviors and some of the "compensatory attitudes of bravado and counterdependence" (p. 86). This seems to correspond to the characteristics found on the Pseudoautonomy scale.

These findings involving the Pseudoautonomy scale underscore Lapan and Patton's (1986) statements concerning the vulnerability of adolescents in their attempts at consolidating an adult self. They pointed out that the job of adolescents is to set aside patterns of childhood grandiosity often characterized by self-centered and noisy assertiveness and replace that with attempts to obtain recognition for competent performances in academic, vocational, athletic, musical, and similar domains. Helping to rein in impulsivity and toughness by providing trustworthy, responsive peers and adults and fewer opportunities for acting-out behaviors in those children prone to defensive independence could be a key to success in various forms of therapy.

The absence of change in defensive superiority (Defensive Grandiosity–Vertical) may be protective, possibly demonstrating that as adolescents find themselves having less control over their own behavior (as they do in treatment), they hold onto their cognitive sense of superiority as a compensation. As pointed out by Patton et al. (1982), “the proneness of clients to be overcome by shame, embarrassment, over-stimulation, or rage works against establishing a firm therapeutic alliance” (p. 273). From this, one could extrapolate that certain defensive stances are to be expected. Alternatively, it might be that conscious grandiosity is quite difficult to treat, or that the scale itself has some weaknesses, or both.

The Defensive Grandiosity–Horizontal subscale, which dealt with the more internalized psychic pain of shame and embarrassment, was noteworthy. These particular manifestations of narcissistic injury made modest, but significant, changes over time and were associated with assigned phase of treatment (improvement as viewed by the staff). The finding that this and most other scales were significantly correlated with phase of treatment suggests that staff and the adolescents themselves (because they have to apply for the next phase) are responding (perhaps without clear awareness), at least in part, to narcissistic progress. In other words, they may be responding to behavioral, or at least detectable, manifestations of narcissistic development, perhaps without an awareness that some of these manifestations are tied to narcissism.

While in treatment for substance abuse, adolescents seem likely to demonstrate increases in self-assertive striving toward realistic goals, creative activity, self-confidence, and self-enjoyment. Participants showed less reliance on the opinions of others and less of a need for an idealized other. This is especially meaningful given the opportunity for these adolescents to become overly dependent on others while in treatment.

All ISP defensive subscales in this study (at the time of the initial testing) were at least one standard deviation above Slyter's (1989) means, the caveat being that Slyter's populations were slightly older ($M = 20$ years for normal and $M = 24$ years for clinical). This lends some support to empirical (Sutker & Allain, 1988) and theoretical writings (Kohut, 1971, 1984, 1987; Miller, 1981, 1983; Wood, 1987), which find associations between psychological dysfunction and substance abuse.

This is noteworthy, especially in combination with the results demonstrating that change can occur, at least in the self-report of these pathological characteristics. Results support findings by Marlatt and Donovan (1982) and McAuliffe and Gordon (1980), who found cognitive-behavioral techniques to be helpful in repairing self-care and self-regulatory deficiencies in substance abusers. Findings also underscore the relevance of looking at narcissistic issues when discussing substance abuse and its treatment.

Some limitations of our research should be noted. Control or comparison groups were not ethically or practically feasible because all clients at the agency studied automatically received the treatment described. If possible, future designs incorporating nontreated groups would be methodologically desirable. A second limitation pertains to the measures used. Although both measures of narcissism have obtained preliminary reliability and validity data (including the construct validity inherent in our findings), these are relatively new measures, and continued validation efforts would be desirable. Furthermore, although Gelso and Fassinger (1992) described such theoretically based self-report measures of narcissism as especially significant, measurement of narcissism through means other than or in addition to self-report might be useful in the future. Finally, follow-up procedures were not incorporated into the current design and would be useful in the future as a way of determining if the changes uncovered in this study are maintained or deepened over time.

Despite the study's limitations, the changes and associations that were uncovered do further our knowledge of adolescents' sense of self, especially the sense of self of substance abusers in treatment. In addition, the findings point to the usefulness of Kohut's theory in relation to adolescent substance abusers and to the amenability of narcissism to at least some preliminary change during a relatively short time period in which substance abuse treatment is occurring.

Some (Levin, 1987; Patton & Robbins, 1982) have felt that Kohut's theory would bring together disparate bits of research and theoretical formulations into a more cohesive and understandable explanation of results. This study was an attempt to do that. Characteristics associated with adolescent substance abuse found by others (as well as some unique to this study) were also found in this population of adolescents, but were held together in a Kohutian theoretical orientation.

Whether any of the assessed characteristics change more as a result of this specific treatment program or whether scores are reflecting a more generalized change that one could come to expect from diverse forms of substance abuse treatment is an empirical question that can only be answered with further research. Future research efforts may usefully study treatment programs fashioned to more directly address narcissistic issues, perhaps comparing these to different types of programs and doing follow-up studies.

Further research regarding the validation of these instruments based on Kohut's concepts could make an integral contribution to studying narcissistic development

validation of these measures of narcissism found in this study, therapists and researchers in the field interested in quantifying change in therapy might find these measures to be of value in many settings, including and in addition to treatment for substance abuse.

ACKNOWLEDGMENTS

We gratefully acknowledge the administration, adolescents, and their parents at Straight, Inc., Springfield, VA, for their participation and Peter Cohen, MD, for his support and interest in this study. Appreciation goes to Michael Patton and Mary Ann Hoffman for commenting on an earlier version of this article.

REFERENCES

- Beschner, G. M., & Friedman, A. S. (1985). Treatment of adolescent drug abusers. *International Journal of the Addictions, 20*, 971–993.
- Blos, P. (1962). *On adolescence: A psychoanalytic interpretation*. New York: Free Press.
- Butcher, J. N. (1988). Introduction to the special series. *Journal of Consulting and Clinical Psychology, 56*, 171.
- DeLeon, G. (1985). The therapeutic community: Status and evolution. *International Journal of the Addictions, 20*, 823–844.
- DeLeon, G., Skodol, A., & Rosenthal, M. S. (1973). The Phoenix therapeutic community for drug addicts: Changes in psychopathological signs. *Archives of General Psychiatry, 28*, 131–135.
- Feigelman, W. (1987). Day-care treatment for multiple drug abusing adolescents: Social factors linked with completing treatment. *Journal of Psychoactive Drugs, 19*, 335–344.
- Freud, A. (1958). Adolescence. *Psychoanalytic Study of the Child, 13*, 255–278.
- Freud, S. (1898). Sexuality in the aetiology of the neuroses. *S.E., 3*, 263–285.
- Frosch, W. A., & Milkman, H. (1977). Ego functions in drug users. In J. D. Blaine & D. A. Julius (Eds.), *Psychodynamics of drug dependence* (National Institute on Drug Abuse Research Monograph #12). Rockville, MD: National Institute on Drug Abuse.
- Fry, E. (1977). Fry's readability graph: Clarifications, validity, and extension to level 17. *Journal of Reading, 21*, 242–252.
- Gelso, C. J., & Fassinger, R. E. (1992). Personality, development, and counseling psychology: Depth, ambivalence, and actualization. *Journal of Counseling Psychology, 39*, 275–298.
- Huba, G. J., Wingard, J. A., & Bentler, P. M. (1980). Framework for an interactive theory of drug use. In D. J. Lettieri, M. Sayers, & H. W. Pearson (Eds.), *Theories on drug abuse* (pp. 95–101). Rockville, MD: National Institute on Drug Abuse.
- Hubbard, R. L., Marsden, M. E., Rachal, J. V., Harwood, H. J., Cavanaugh, E. R., & Ginzburg, H. M. (1989). *Drug abuse treatment: A national study of effectiveness*. Chapel Hill: University of North Carolina Press.
- Kennard, D., & Wilson, S. (1979). The modification of personality disturbance in a therapeutic community for drug abusers. *British Journal of Medical Psychology, 52*, 215–221.
- Khantzian, E. J. (1985). Psychotherapeutic interventions with substance abusers—The clinical context. *Journal of Substance Abuse Treatment, 2*, 83–88.

- Kohut, H. (1966). Forms and transformations of narcissism. *Journal of the American Psychoanalytic Association, 14*, 243–272.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Kohut, H. (1984). *How does analysis cure?* (A. Goldberg, Ed., with P. E. Stepansky). Chicago: University of Chicago Press.
- Kohut, H. (1987). *The Kohut seminars on self psychology and psychotherapy with adolescents and young adults* (M. Elson, Ed.). New York: Norton.
- Krystal, H. (1977). Self- and object-representation in alcoholism and other drug dependence: Implications for therapy. In J. D. Blaine & D. A. Julius (Eds.), *Psychodynamics of drug dependence* (pp. 88–100). Rockville, MD: National Institute on Drug Abuse.
- Lapan, R., & Patton, M. J. (1986). Self-psychology and the adolescent process: Measures of pseudoautonomy and peer-group dependence. *Journal of Counseling Psychology, 33*, 136–142.
- Levin, J. D. (1987). *Treatment of alcoholism and other addictions: A self-psychology approach*. Northvale, NJ: Aronson.
- Marlatt, G. A., & Donovan, D. M. (1982). Behavioral psychology approaches to alcoholism. In E. M. Parrison & E. Kaufman (Eds.), *Encyclopedic handbook of alcoholism*. New York: Gardner.
- McAuliffe, W. E., & Gordon, R. A. (1980). Reinforcement and the combination of effects: Summary of a theory of opiate addiction. In D. J. Lettieri, M. Sayers, & H. W. Wallenstein (Eds.), *Theories of addiction* (pp. 137–141). Rockville, MD: National Institute on Drug Abuse.
- McLellan, A. T., Luborsky, L., O'Brien, C. P., Woody, G. E., & Druley, K. A. (1982). Is treatment for substance abuse effective? *Journal of the American Medical Association, 247*, 1423–1428.
- Miller, A. (1981). *The drama of the gifted child—The search for the true self*. New York: Basic Books.
- Miller, A. (1983). *For your own good—Hidden cruelty in child-rearing and the roots of violence*. New York: Farrar, Strauss & Giroux.
- Morgenstern, J., & Leeds, J. (1993). Contemporary psychoanalytic theories of substance abuse: A disorder in search of a paradigm. *Psychotherapy, 30*, 194–206.
- Nicholson, B., & Treece, C. (1981). Object relations and differential treatment response to methadone maintenance. *The Journal of Nervous and Mental Disease, 169*, 424–429.
- Patton, M. J., Connor, G. E., & Scott, K. J. (1982). Kohut's psychology of the self: Theory and measures of counseling outcome. *Journal of Counseling Psychology, 29*, 268–282.
- Patton, M. J., & Robbins, S. B. (1982). Kohut's self-psychology as a model for college-student counseling. *Professional Psychology, 13*, 876–887.
- Rado, S. (1933). Psychoanalysis of pharmacohymia (drug addiction). *Psychoanalytic Quarterly, 2*, 1–23.
- Rosenthal, M. S. (1984). Therapeutic communities: A treatment alternative for many but not all. *Journal of Substance Abuse Treatment, 1*, 55–58.
- Rydelius, P. A. (1983). Alcohol-abusing teenage boys: Testing a hypothesis on alcohol abuse and personality factors using a personality inventory. *Acta Psychiatrica Scandinavica, 68*, 381–385.
- Sacks, J. G., & Levy, N. (1979). Objective personality changes in residents of a therapeutic community. *American Journal of Psychiatry, 136*, 796–799.
- Slyter, S. L. (1989). *Kohut's psychology of the self: Measures of healthy and defensive narcissism*. Unpublished doctoral dissertation, University of Maryland, College Park.
- Sutker, P. B., & Allain, A. N. (1988). Issues in personality conceptualizations of addictive behaviors. *Journal of Consulting and Clinical Psychology, 56*, 172–182.
- Treece, C., & Khantzian, E. J. (1986). Psychodynamic factors in the development of drug dependence. *Substance Abuse, 9*, 399–412.
- Wolf, E. S. (1988). *Treating the self*. New York: Guilford.
- Wolf, E. S., Gedo, J. E., & Terman, D. M. (1972). On the adolescent process as a transformation of the self. *Journal of Youth and Adolescence, 1*, 257–272.

Wood, B. L. (1987). *Children of alcoholism—The struggle for self and intimacy in adult life*. New York: New York University Press.

Wurmser, L., & Zients, A. (1982). The return of the denied superego. *Psychoanalytic Inquiry*, 2, 539–580.