2

NARCISSISTIC PERSONALITY DISORDER

The problem of understanding narcissism holds considerable interest, particularly in psychoanalysis, although increasingly so in the field of personality disorder theory and research. It is a condition that Sigmund Freud struggled with and rethought at several stages of his career (Baudry, 1983). Like other psychoanalytic explanations of personality disorders, a complete understanding of narcissistic personality disorder remains unsettled, despite Kohut's (1971, 1977) and Kernberg's (1975) systematic formulations of narcissism. It is also a condition plagued by imprecise terminology, perhaps more so than other personality disorders.

I have reserved narcissistic personality disorder for a chapter by itself, not because it should be considered the paradigmatic or signature disorder of Kohut's self psychology, but rather because narcissistic personality disorder provides the clearest illustration of the fundamental premises of Kohut's ideas about the self. Consequently, this chapter serves both to introduce Kohut's concepts of the self and to apply these concepts to an understanding of narcissistic personality disorder.

As I will do for each of the Axis II disorders in forthcoming chapters, I begin by examining the current status of this disorder with respect to its

diagnostic validity, clinical phenomenology, and relationships with other personality disorders. I summarize personality theory viewpoints about narcissism and then psychoanalytic perspectives emphasizing developmental and object relations views. Next, I present an overview of narcissistic personality disorder and the main tenets of Kohut's self psychology. I will emphasize in this context an important though sometimes overlooked point: Kohut's viewpoint began as an attempt to understand narcissistic personality disorder as an expansion of drive theory and psychoanalytic ego psychological premises. An idea introduced in chapter 1 bears repeating: As Kohut extended his theory about narcissism to what was to become a broader psychology of the self, his observations and theories were no longer confined to this particular disorder. Indeed, it is the main purpose of this book to demonstrate how the broad scope of self psychological ideas may add to an understanding of the personality disorders of Axis II. I also include a discussion of related self psychological viewpoints (primarily intersubjectivity theory) that were influenced by Kohut's self psychology. Finally, I conclude (as I will in the chapters on other disorders) with a comprehensive discussion of a clinical case illustrating a self psychological approach to understanding narcissistic personality disorder.

CLINICAL CHARACTERISTICS AND PHENOMENOLOGY: DESCRIPTIVE PSYCHOPATHOLOGY

From a descriptive viewpoint, narcissistic personality disorder has a relatively low prevalence rate (Mattia & Zimmerman, 2001); however, its diagnostic overlap with other Axis II disorders is high, cutting across all three clusters described in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV*; American Psychiatric Association, 1994). Because diagnostic overlap varies considerably across studies, Gunderson, Ronningstam, and Smith (1995) suggested that idiosyncrasies of diagnostic criteria and their assessment may partially explain why narcissistic personality disorder is particularly difficult to define, sampling variations across studies notwithstanding. For example, problems concerning definitions of empathic failure and the nonspecificity of "excessive envy" are notable. However, grandiosity has been one of the better criteria for isolating narcissistic personality disorder. Paris (1995) observed that part of the difficulty results from having to rely on a substantial capacity for introspection on the part of patients. Diagnostic inconsistency also arises from variation in clinicians' judgments about the boundaries between normal and pathological dimensions (e.g., grandiosity, empathy, and hypersensitivity) on the one hand and boundaries between observable (behavioral) and nonobservable (inferred internal dynamics) characteristics on the other.

Gunderson, Ronningstam, and Smith (1995) also pointed out that validation studies are lacking or insufficient; thus, "the value of including this

diagnosis in *DSM* rests solely upon the attributions of clinical utility from a widely recognized, psychodynamically informed clinical literature and tradition" (p. 209). This statement about narcissistic personality disorder, a disturbance primarily of outpatients, raises a question about the validity of this condition, a question that is raised less often about other personality disorders: It suggests that narcissistic personality disorder is an important clinical entity for psychoanalytic clinicians but that it is of uncertain significance for nonpsychoanalytic clinicians, at least as a condition in its own right.

The concept of narcissism and its clinical variants has also been considered from nonpsychoanalytic frameworks. Bursten (1973) described four types of narcissistic disorders (craving, paranoid, manipulative, and phallic), which resemble a broad range of personality disorders similar to those described in the *DSM–IV* as dependent/histrionic, paranoid, antisocial, and narcissistic. Previously, Leary (1957), an early social–interpersonal theorist, described two broad forms of narcissism—one characterized by a cold exterior, interpersonal aversiveness, and heightened independence resulting from fearfulness of dependency and a second type characterized by depression, hypersensitivity, and preoccupation with diminished self-esteem. Beck and Freeman's (1990) cognitive viewpoint emphasized schemas directed toward perpetuating an aggrandized self-image coupled with disregard for others, leading to insensitivity to normal cooperativeness or reciprocity in social interactions. These characteristics described by Beck and Freeman predated Costa and Widiger's (1994) suggestion that narcissistic personality disorder patients are characterized chiefly by low agreeableness on the five-factor model.

Millon's (1969) biopsychosocial approach originally emphasized the grandiose, overvalued aspect of narcissistic personality disorder, noting its origins in an unsustainable parental aggrandizement of a child's qualities or abilities. His more recent emphasis on an evolutionary perspective (Millon, 1996) devoted attention to a passive pattern of accommodation in narcissism, where narcissistic individuals seek to have others acquiesce to their wishes. Millon also stressed such patients' self-interest orientation, characterized by diminished or indifferent interest in others. These patterns of individuation in such patients' adaptive styles could account for their arrogant or haughty demeanor, exploitative behavior, and expansive thinking patterns. Millon also observed that these patients' overconfidence can give way to depression and feelings of emptiness when defenses fail, causing them to turn to an inner life of rationalizations to satisfy needs external reality no longer can provide.

Millon (1996) described various prominent clinical manifestations, including an exaggerated exploitative nature centering exclusively on patients' needs. This form overlaps with several key features associated with antisocial personality behavior. Another manifestation is a seductive Don Juanism dominated by patients' grandiose fantasies about their abilities accompanied by indifference to their targeted objects' needs. A less overt aggrandized clinical

presentation is characterized chiefly by attempts to compensate for deficiencies by ever-constant aspirations for superior achievements; patients engage in an elitist way of life centered on markedly overvalued self-images and self-promoting behavior.

Millon (1996) attributed the development of narcissistic personality disorder to parental overindulgence, whereby parents imparted a sense of specialness that gave way to excessive expectations of praise or subservience from others. People who are raised with such expectations typically do not learn to consider the needs of other people; thus, they acquire a limited sense of interpersonal responsibility and poorly developed skills for reciprocal social interaction. Such individuals feel entitled to have their own needs recognized as the most important ones and think that nothing is wrong with exploiting others to get what they want. Once patterns like these are set in motion, a pathogenic character style is perpetuated, resulting in the relatively inflexible constellation of personality characteristics of most clinical definitions of narcissistic personality disorder. Turning inward for gratification, narcissistic (as well as antisocial) personality disorder patients strive more to enhance how they see themselves than to influence what others think of them, in part out of a fear of losing self-determination. Because they often devalue other people's points of view, narcissistic patients are more arrogant and entitled than antisocial patients, who are generally inclined to be more distrustful.

PSYCHOANALYTIC VIEWPOINTS

Freud (1910/1957e) considered narcissism to be a stage of development that led eventually to libidinal involvement (cathexis) of others and object love. He considered psychoanalysis to be unsuitable as a treatment method for narcissism for the same reason it was unsuitable for the psychoses—there was a failure in both kinds of patients to develop an object (libidinal) transference. Regarding narcissism at times as a perversion and at other times as a form of severe psychopathology, Freud returned at various times to the problem without reaching a satisfactory resolution. His writings on the subject addressed the matter of narcissism as a developmental process (primary narcissism) progressing to object love (Freud, 1910/1957e) and at other times as a withdrawal of narcissistic libido from object cathexes back into the ego (secondary narcissism; Freud, 1914/1957b). This conceptualization of narcissism became the basis for the ego ideal, which Freud recognized as the repository of remnants of infantile narcissism. Freud's (1931/1961c) evolving ideas about narcissism continued with his later description of a narcissistic libidinal type characterized by self-confidence and, at an extreme, grandiosity. Narcissistic libido thus became the foundation of self-esteem. Freud's (1914/1957b) recognition of this connection influenced

Kohut's (1966, 1968, 1971) early formulation of narcissism and later views about the self as well.

Freud's contributions to understanding narcissism thus were an important starting point for Kohut's viewpoint. It was through Freud's recognition of the relationship between the ego and external objects that he introduced the concept of the ego ideal and its self-observing capacity (Freud, 1914/1957b). In this respect, the ego ideal became the forerunner of the superego.

W. Reich (1933/1949), in his expansion of psychoanalysis beyond symptom neuroses to characterology, continued Freud's (1914/1957b) and Andreas-Salome's (1921) attempts to understand the balance between narcissism as a normal developmental pattern and as a pathological disorder. Reich likened the developmental level of such patients to character formations based on erogenous zones. Thus, Reich's description of the narcissistic character was referred to as *phallic narcissism*; for the same reason, he characterized oral–dependent and anal–compulsive character types. Fenichel (1945) was one of the earliest analytic writers to emphasize prominent feelings of emptiness or diminishment in patients with narcissistic disorders, in contrast to the overvaluing of the self and disdain for others Reich and Freud had previously emphasized.

Other psychoanalytic thinkers called attention to various associated qualities such as exhibitionism as a defense against inferiority (A. Reich, 1960) and self-idealization and omnipotent denial (Rosenfeld, 1964). Hartmann (1964) proposed a formulation of narcissism as a hypercathexis of self rather than as ego representations. Jacobson (1964) added an emphasis on superego functions in narcissism to explanations of identity development and self-esteem regulation. She also viewed psychosis largely as a product of narcissistic identifications, representing the breakdown or dedifferentiation of internalizations of ego and superego identifications.

The sections that follow provide an overview of subsequent psychoanalytic viewpoints about narcissism, some of which were formulated specifically as theories of narcissistic pathology and some of which represented developments in ego psychology or object relations theory. My discussion of these views will center on their similarities to and differences from Kohut's self psychology.

Developmental Viewpoints

Spitz (1965) and Mahler, Pine, and Bergman (1975) contributed a developmental perspective on narcissism, emphasizing good and bad representations of the self and objects. They considered magical omnipotence, mastery, and self-love to represent steps toward the development of the self and the attainment of self-esteem. Interruptions or arrests of normal narcissism in the developmental progression to object love set the stage for various forms of narcissistic pathology. Remaining within an ego psychological framework

in which the object world was made up of good and bad part objects, "Mahler's baby" (M. Tolpin, 1980) was continually trapped in intrapsychic conflict where individuation requires renunciation of objects.

Psychoanalytic views of early infant development began to shift, however, from an emphasis on conflict toward an emphasis on deficiency (Kohut, 1971; M. Tolpin & Kohut, 1980) as a more important influence on narcissism. Taking a different view from Mahler et al. (1975), M. Tolpin (1980) referred to "Kohut's baby" as "a baby which 'every mother knows' although heretofore this baby has not been integrated into a tenable clinical theory" (p. 54). M. Tolpin emphasized how young children's early development is characterized less by splitting defenses and curbing aggressive drives—which are among the fundamental dynamics of classical drive theory in psychoanalysis—than by vigorous, developmentally in-phase needs that lead to competence and pride in their attainments. Normal development, therefore, involves a progressive unfolding of infants' pride and vitality "to announce his legitimate developmental needs" (p. 55). For this and other reasons, D. N. Stern's (1985) detailed videotaped recordings of mothers interacting with their infants, and more recently Beebe and Lachmann's (2002) extension of infant–mother observation to adult treatment, may also be thought of as important self psychologically informed reformulations of the conflict model of psychoanalytic ego psychology. Further, Teicholz's (1999, p. 172) reconciliation of Kohut's views with ego psychological and postmodern viewpoints considered D. N. Stern's observations of infants as "a meeting place" for these and similar views.

In considering the matter of development of the self as terminating in a state of individuation, as Mahler et al. (1975) maintained, Kohut (1977, 1984) instead considered needs for self-cohesion as continuing throughout life. Thus, for example, the need for cohesiveness of the self does not disappear; ongoing sources of responsiveness or vitalization are required for shoring up the self. Although he noted differences between his ideas and Mahler et al.'s, Kohut (1980) also saw similarities, commenting in a letter to Mahler that he believed they "were digging tunnels from different directions into the same area of the mountain" (p. 477).

Kernberg's Viewpoint

Kernberg (1975) proposed a view of narcissistic psychopathology that represented aspects of both ego psychology and object relations theory. His clearly specified descriptions of narcissistic personalities were important for establishing the clinical criteria of recent editions of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980, 1987, 1994). Kernberg highlighted the clinical importance of narcissistic patients' unusual degree of self-reference, noting also the contradiction between their inflated self-image and their heightened needs for love

and admiration. He called attention to frequently associated features, such as their shallow emotional lives, diminished empathy, and limited enjoyment of life beyond narcissistic gratifications. He described how narcissistic patients

> feel restless and bored when external glitter wears off and no new sources feed their self-regard. They envy others, tend to idealize some people from whom they expect narcissistic supplies and to depreciate and treat with contempt those from whom they do not expect anything (often their former idols). (p. 228)

Kernberg (1975) went on to describe narcissistic patients' undifferentiated affect states and their frequent emotional flare-ups. Such patients lack genuine feelings of sadness, despite their propensity for depressive reactions, which he explained as the resentful sadness of feeling abandoned or disappointed rather than the sorrow of mournful longing. Kernberg considered the essential psychological structure of narcissism to closely parallel that of borderline personality organization. Thus, he regarded narcissistic patients' smooth social capacities coexisting with omnipotence and grandiosity as surface manifestations of pronounced ego and superego defects. Consequently, Kernberg considered narcissism to be characterized by defenses of splitting, projective identification, and primitive idealization in a personality structure otherwise prone to intense oral–aggressive conflicts, not unlike those seen in borderline personality organization.

Kernberg (1975) observed that narcissistic patients often fail to develop a capacity to depend on and trust others, despite overt indications of dependency. If rejected, these patients feel hate as they drop and devalue their former idols. They may also lose interest in people who looked up to them, even becoming offended if people who no longer interest them move on to develop other interests or sources of admiration. Thus, the essential nature of their object relationships is narcissistic exploitation based on the need to be admired. They are also prone to experience emptiness as a defensive minimization of the anger or envy that Kernberg regarded as regularly associated with object relationships.

Narcissistic patients may have better impulse control and social functioning (which Kernberg [1975] termed *pseudosublimatory potential*) than patients with borderline personality organization. Narcissistic personalities may therefore be seen as leaders in their work and professional activities or in creative fields, although

> careful observation . . . of their productivity over a long period of time will give evidence of superficiality and flightiness in their work, of a lack of depth which eventually reveals the emptiness behind the glitter. Quite frequently, these are the "promising geniuses" who then surprise other people by the banality of their development. (Kernberg, 1975, pp. 229–230)

Kernberg (1975) observed that such patients often had mothers who exploited special qualities in them while simultaneously showing callous indifference and spiteful aggression. This pattern exposed such children to revengeful envy or hatred by others. A cold rather than a comforting maternal relationship would likely set in motion a search for compensatory admiration, although such children simultaneously developed a characterological devaluation of others. Kernberg considered his narcissistic patients to have more stable ego boundaries than did Jacobson (1964) and A. Reich (1960), who described their patients as being more vulnerable to ego regressions. Kernberg called attention to the pathological fusion among ideal self and object representations and actual self-images. He thought this interfered with normal differentiation of the superego, leading to primitive and aggressive superego pathology. As Kernberg (1975) wrote, "It is the image of a hungry, enraged, empty self, full of impotent anger at being frustrated, and fearful of a world which seems as hateful and revengeful as the patient himself" (p. 233). Narcissistic patients' defensive organization, like that of borderline patients, is dominated by splitting or primitive dissociation of split-off ego states. This personality organization can account for the coexistence of grandiosity and inferiority, not unlike the vertical split Kohut (1971) proposed to describe how contradictory self states might appear simultaneously as conscious phenomena.

Kernberg (1975) considered his view of the pathological structural deficit in narcissistic personality disorder to be fundamentally different than Kohut's (1971), which I will describe more fully in a separate section. Kernberg placed particular emphasis on rage and the relationship between libidinal and aggressive drives. He regarded this dynamic feature to be a fundamental one, whereas Kohut viewed narcissistic pathology as an interruption of the development of a normal albeit archaic self. Kernberg's position did not emphasize a continuity between normal and pathological narcissism.

Their theoretical differences may reflect differences in the types of patients Kernberg and Kohut saw in treatment while formulating their views. For example, Kernberg (1975) recognized that narcissistic patients often functioned in life at a higher level of competence than did borderline patients, at least when judged by overt indications. But as Kernberg came to understand narcissistic patients in greater depth, their structural deficits and degree of pathology became more apparent, and they began to resemble patients with borderline personality disorder.

Kohut (1966, 1968, 1971), however, formulated his ideas by studying patients in psychoanalytic treatment who did not necessarily show the propensity for regression, splitting, and archaic pathology resulting from poorly integrated rage of the type Kernberg treated and thus emphasized. Kohut considered the patients he treated to have achieved a more stable, intact degree of self-cohesion than those with borderline disorders, despite their propensity for self-esteem dysregulation producing excessive grandiosity or

inferiority and vulnerability to disappointment. Kohut also called attention to such patients' depletion depression or anxiety, diminished zest or enthusiasm, and in some cases hypochondriacal preoccupations.

Whereas Kernberg (1975) conceptualized narcissism from the framework of pathological internalized object relations, Kohut's (1966, 1971) approach was derived from his discovery of specific transferences. Kohut did not, however, delineate clinical characteristics of narcissism as clearly as Kernberg did. Kohut also regarded narcissism as a line of normal development much like but different from object love. He thus considered pathological narcissism to be a derailment of normal narcissism, whereas Kernberg emphasized its inherently pathological structure and regarded it as being clearly different from normal narcissism. Thus, Kernberg saw a closer relationship between narcissistic and borderline personality disorders than Kohut did.

Other Object Relations Viewpoints

Kernberg's (1975) integration of ego psychology and object relations theory was influenced in part by M. Klein's (1930, 1935) view of narcissism as a defense against envy. The so-called middle or independent school of object relations also proposed views about narcissism and the self that were influenced by Klein, though these views departed from some of Klein's more extreme views. Whereas Kernberg proposed a view of narcissism, object relations theories such as Winnicott's (1965) and Fairbairn's (1954) were about the self and its development.

Winnicott (1965) in particular considered early development largely as an existence in which a "good enough" mother provides a holding environment that facilitates infants' and young children's growth and development. His concept of a maternal *subjective object* comprises the nearly indivisible unit formed by mother and infant that gave rise to his well-known comment, "There is no such thing as a baby" (p. 39), by which he meant that infants could not be understood in the absence of mothers' maternal care. This concept has a close but not identical correspondence with Kohut's (1977, 1984) concept of selfobject functions and the self–selfobject unit described later in this section. However, Bacal (1989) regarded Winnicott's concept of a subjective object as being nearly synonymous with Kohut's original idea of the selfobject operating as an extension of the self—that is, the psychological or internal experience of an object that provides functions that sustain and strengthen the self. Notwithstanding this similarity, Winnicott's (1971) reference to the mirroring function of a mother's face, for example, does not indicate that Kohut borrowed Winnicott's idea of mirroring to express Kohut's own concept of mirroring; Kohut's concept of the mirroring selfobject function is more nuanced than Winnicott's use of the idea of a mirror, which Winnicott intended mostly as an analogy.

Winnicott (1965) also distinguished between true and false selves; the false self is a defensive presentation patients use to protect themselves from an authentic but fragile true self. Consequently, the authentic or true self becomes undermined by the absence of a sufficiently caring holding environment, resulting in the prominent appearance of a false self. Winnicott's true self and Kohut's (1971) cohesive self are similar in that they both represent favorable outcomes of maternal responsiveness in normal development. Winnicott's false self parallels Kohut's (1971) vertical split (described in chap. 11), in which pseudo-omnipotent grandiosity conceals a simultaneously experienced but split-off enfeebled self.

Although Bacal (1989) understood Kohut (1971) to intend mirroring to refer to archaic grandiosity, Kohut, like Winnicott (1965, 1971), had in mind the idea that mirroring represented confirmation of one's unique or creative capacities. Bacal also pointed out that both Winnicott and Kohut commented on the capacity to be alone. For Winnicott, this represented an internalized psychological experience of an adequate holding environment; for Kohut, it represented the psychological experience of a cohesive self derived from the experienced sense of there being available a sustaining selfobject surround.

Bacal and Newman (1990) and Summers (1994) considered that Fairbairn (1954), Winnicott (1965), Balint (1968), and Guntrip (1969, 1971) developed object relations formulations of several phenomena Kohut (1971) would later emphasize, anticipating positions that Kohut brought together in a more crystallized form. For this reason, Bacal and Newman (1990) and Summers (1994) regarded Kohut's self psychology as a further step within object relations theory rather than as the paradigmatic advance that Kohut and several of his followers considered it to be. In any case, Kohut, as well as all of these object relations theorists, had in mind a concept of infants as engaging in object seeking from birth or shortly thereafter. *Selfobject* was Kohut's particular term for denoting the idea of the self's object.

Although Fairbairn (1954) and Guntrip (1969, 1971) used the term *ego* much as Kohut used the term *self*, their concepts of the object differed from the drive theory and ego psychological views of an object as an embodiment of libidinal or aggressive drives. All three theorists considered libidinal and aggressive experiences as being satisfying when early relationships were adequate. They spoke of libidinal and aggressive experiences as representing drive discharges or pathological breakdowns when early relationships were frustrating. Moreover, Fairbairn's view of the outcome of successful development was a mature dependence on objects based on differentiation between self and object. Fairbairn's and Guntrip's views were considerably different from Kohut's emphasis on the predominant role of empathic failures in self–selfobject relationships. Fairbairn and Guntrip emphasized instead the ever-constant struggles between the longing to be in relationships and the fearful distrust that intimacy leads to feeling devoured.

A SELF PSYCHOLOGICAL VIEWPOINT

The Self and Its Basic Constituents

Kohut's (1966, 1968, 1971) seminal works on narcissistic personality disorder opened up a new period of psychoanalytic theory formation. They represented a different way for clinicians to understand and treat a type of patient that stymied them by defying treatment attempts based on classical drive theory and ego psychology. As I noted earlier in this chapter, narcissism had presented an explanatory problem for Freud and for psychoanalysis since its beginnings. Although Kohut has been criticized for seeming to ignore important views in psychoanalysis that could legitimately be seen as forerunners of his own viewpoint (Bacal & Newman, 1990; Summers, 1994), the innovations he introduced nevertheless formed the basis for a new psychoanalytic view of psychopathology, one that despite criticism called for a substantial revision of psychoanalytic theory and treatment.

Although Kohut distinguished between narcissistic personality disorders and narcissistic behavior disorders, he sometimes used these terms interchangeably because their main dynamics were similar. *Narcissistic personality disorder* encompassed disturbances where the primary symptomatic presentation included depression, purposelessness, chronic boredom or disappointment, or related aspects of depletion and generalized experiences of diminished self-esteem. The *narcissistic behavior disorders* were disturbances in which most of these same phenomena were manifested as behavior disorders rather than as psychological experiences. Such behavior disorders included sexualizations (e.g., perversions), addictions, or delinquent (antisocial) acts.

Kohut (1959, 1966, 1971) identified empathy as a primary method of clinical investigation. Empathic listening was a way of understanding patients' verbalized and nonverbalized experiences and their clinical histories. Understanding such experiences and what gave rise to them thus enables clinicians to reconstruct patients' lives as their struggles to sustain self-esteem and cohesiveness of the self. Considered in this way, empathy has little (if anything) to do with sympathetic expressions of understanding or tenderheartedness. It is instead the way a clinician gathers information and then attempts to comprehend clinical data.

Kohut (1971, 1977) also introduced the term *selfobject* to refer to the internal psychological experience of an object that provides functions necessary for self-regulation. In self psychology, as in psychoanalysis more generally, the term *object* often refers to an actual person (such as a mother or other person sought for his or her maternal functions). Its accurate definition is the psychological function such a person has come to provide or represent (mental representation). Thus, a mother or a maternal object in the sense of an object relation is really that person's maternal capacity. From the self psychological viewpoint, therefore, a selfobject is an object needed by the

self for its cohesion or vitalization. That is, the meaning of a person as a selfobject is understood from the vantage point of how that person promotes (or fails to promote) self-cohesion. Further, selfobjects need not be persons; they may be ideals or values, such as political or philosophical beliefs that are bound up with the core of a person's existence. As such, abstract representations would have to be sufficiently embedded in a person's psychological structure that it could be said that they provide important self-regulatory functions.

Self psychology stresses that it is the self, an agency of mental life, and not drives or the ego that is the fundamental clinical problem in narcissistic disorders. Ornstein (1978, p. 98) observed that Kohut (1971) initially regarded the self as an "adjacent territory"—that is, as an extension of drive theory and ego psychology. However, Kohut never clearly articulated what he meant by the self as clearly as the concepts of drives and ego had been defined. Kohut referred to the self in an ill-defined, vague way as a content of mental life or experience; he did not consider the self to be a mental structure like the ego or superego. Although this description of the self remained unacceptably nonspecific, Kohut did specify its attributes as providing cohesion, vigor, and harmony. Many of the central concepts of Kohut's self psychology emerged from a further delineation of these attributes of the self.

The attribute Kohut (1971) characterized as *cohesion* refers to experiencing the self as either intact or fragmented. Self-cohesion is the relatively enduring experience of the self either as integrated when it is intact or as breaking apart when it is vulnerable to fragmentation. The *vigor* or vitality of the self is an attribute best described as one's feeling of being assured or strong, not necessarily in the sense of confidence about one's abilities but rather of a firmed-up capacity to stand up to the world without sinking or caving in. Finally, *harmony of the self* is the way Kohut referred to a capacity for feeling calmed or soothed, a quality that is itself related to how cohesive or invigorated people experience themselves to be.

These constituents of inner experience were what Kohut (1966, 1971) emphasized in attempting to understand narcissism. It was as close as he came to providing a definition of the self. Narcissistic personality disorder was thus in his view a disturbance of the regulation of self-experience rather than an imbalance among the structures of id, ego, and superego (Freud, 1926/1959b). Its symptoms or clinical manifestations might take the form of grandiosity or an exaggerated sense of one's importance, self-centeredness to the extent that other people's needs barely exist or matter, pronounced entitlement, or envy. These, of course, are the familiar manifestations that form the basis of most diagnostic criterion sets. But Kohut, like Fenichel (1945) before him, observed that narcissistic personality disorders may also assume a form in which the opposites to grandiosity or entitlement are seen. These include, for example, self-depreciation, denigration of one's abilities, excessive shame or modesty, or deep-rooted feelings of not belonging or of not being able to

hold one's own, sometimes masquerading as excessive shyness or unassertiveness. Paradoxical reactions such as these may comprise the main clinical presentation for some patients, or these reactions may first emerge after an initial burst of superficial, grandiose bravado gives way and a fundamentally injured self appears. The most crucial considerations in Kohut's understanding of narcissistic personality disorders were the characteristic deficiencies in cohesion, vitality, or harmony of the self.

Selfobject Functions

Kohut's (1966, 1971) early descriptions of narcissistic personality disorder emphasized how the three attributes of the self—cohesion, vigor, and harmony—operate to produce the clinical forms of the disorder. He explained that the self requires attuned responsiveness from the external world to sustain its cohesiveness. By *attuned responsiveness* Kohut meant empathic selfobject experience. (As I noted earlier in this chapter, clinicians apprehend the psychological significance of attuned or failed selfobject experience through empathy as a mode of investigation.) Kohut at first identified two primary kinds of selfobject experience—mirroring and idealization, representing sectors or poles of a bipolar self (Kohut, 1971, 1977). He later added a third, twinship, which previously was included in mirroring and was subsequently differentiated as a selfobject function in its own right (Kohut, 1984).

Mirroring

Mirroring is the "echoing presence" Kohut regarded as the means by which others' affirming responsiveness strengthens the self. It is one route for firming up a sense of being valued. Mirroring is built up from experiences in normal development in which young children expect that their accomplishments will be recognized and met with prideful satisfaction. Kohut (1971) conceptualized mirroring needs as arising from what he termed the *grandiose–exhibitionistic self*, comprising three forms. The most psychologically archaic form is a fusion of self and other (the self and its selfobjects), which is detected in treatment by a merger transference. A second, healthier manifestation is, as Kohut phrased it, a *mirror transference* in the narrow sense, which is the familiar seeking of an affirming or admiring presence without compromising the boundary between self and mirroring selfobject. The third form of mirroring is the *twinship* or *alter ego transference*, representing a need for another to be a faithful replica of the patient. Kohut (1984) subsequently reformulated the twinship transference as a distinct selfobject function, one that was separate from mirroring, which I discuss in a separate section.

As Kohut (1977, 1984) further developed the psychology of the self, he de-emphasized the idea of a grandiose–exhibitionistic sector of the self as a pathological formation. He shifted his emphasis, therefore, from a theory of psychopathology to a view of infants' and young children's exhibitionistic

displays of their abilities—exaggerated and overestimated though they may be—as normal developmental strivings. Consequently, the appropriate parental response to mirroring needs (and their grandiose–exhibitionistic manifestations) is simply an admiring recognition of this aspect of children's experience in a timely, developmentally in-phase way. This type of acknowledgement serves to instill normal pride and feelings of well-being. It becomes the echoing presence of empathic attunement to young children's native talents and skills that emerge normally during development. Thus, Kohut no longer regarded this prideful boasting as pathologically grandiose or exhibitionistic strivings. Rather, he understood it as a product of vitality resulting from caregivers' empathic responsiveness to their accomplishments in the form of proud encouragement.

Idealization

Before Kohut (1984) differentiated twinship from mirroring as a distinct selfobject function, he described another sector (pole) of the self (Kohut, 1966, 1971)—the *idealized parental imago.* Idealization as a selfobject function is mobilized when a sustained impetus emerges in young children to turn to others as all-powerful in order to feel calmed by their strong or steadying presence; in this way, the others become idealized selfobjects. Like mirroring and twinship, idealization is a product of a normal developmental thrust. It becomes apparent when children experience their caregivers as providing a soothing function when their own capacity to calm themselves is incompletely strengthened from within, thus compromising self-cohesion. Children idealize selfobjects whom they can look up to in this way for their all-knowing or all-powerful vigor. Children's longings to merge with idealized selfobjects' strength foster the restoration of equilibrium when the self is experienced as weakened. Bacal and Newman (1990) aptly expressed this idea in their description of the self as "walking proudly in the shadow" (p. 232) of its admired object; they thus captured the essential quality of the idealization selfobject experience as consolidating self-cohesion.

Selfobject failures may occur when idealized selfobjects no longer can provide this function. Idealized selfobjects may lose interest or prematurely withdraw their availability and in so doing interrupt a normal, developmentally in-phase process. A child or a patient with a prominent idealization selfobject need may experience such disruptions as abandonment if they occur before the person has internalized enough of what he or she needs to sustain self-cohesion.

Idealization selfobject disturbances may compel the patient to perpetually seek perfection in selfobjects who offer the promise of fulfilling his or her thwarted idealization longings. Patients with such idealization needs may thus attempt to merge with omnipotent selfobjects, sometimes successfully revitalizing self-esteem. However, such mergers are often short-lived and thus futile, because they typically do not lead to a dependable structure that

strengthens self-cohesion. Many patients with such thwarted idealization longings are frequently left feeling disappointed in once-idealized selfobjects. Attempts to secure self-cohesion through repeated idealizations often fail to restart a developmental process of internalizing self-cohesion that had been interrupted. Kohut (1971) referred to this developmental process as *transmuting internalization*. In its absence, chronically disappointing or unavailable idealized selfobjects reexpose such patients to injuries that can overwhelm an infirm self (M. Tolpin, 1971).

Relatively healthy sublimations may also occur, such as the acquisition of deeply felt convictions or principles. In general, though, many patients with idealization deficits remain vulnerable to feeling disappointed in idealized selfobjects. They are frequently unable to gradually let go of their need for omnipotence in idealized selfobjects. Others cling to idealized selfobjects long past the point when holding onto this possibility is viable. Further, it is not uncommon to reconstruct histories of parents' failures to recognize their children's idealization needs or of a parent, uncomfortable being idealized, who unwittingly fails to welcome or prematurely dismisses the child's normal idealized selfobject longings. Such parents may seem surprised to find that their children feel rejected by them, having misinterpreted their children's need for idealizing selfobject functions as clinging dependency. Deficits arising from rebuffed idealization needs may also result in the child's inability to calm or soothe him- or herself.

Idealization may represent another opportunity in early development to repair the injuries to the self if mirroring needs were thwarted. A sufficiently robust idealization selfobject relationship that solidifies self-cohesion in the face of mirroring deficiencies can provide a compensatory structure (Kohut, 1977; M. Tolpin, 1997). In this way, if mirroring has been irreparably damaged as an avenue for strengthening the self, it may be possible to achieve a reasonably robust and enduring degree of self-cohesion if another route (such as idealization or twinship) is available to sustain a damaged self. A compensatory structure established in this manner may permit development to proceed on course instead of leading to an inevitable state of chronic devitalization from which recovery cannot be expected.

Twinship

The third primary selfobject function Kohut identified was the twinship or alter ego transference. He originally identified this selfobject function as a manifestation of mirroring (Kohut, 1971), but he later became convinced of its significance as an independent selfobject function (Kohut, 1984). Like mirroring and idealization selfobject needs, twinship also represents a normal developmental striving. Kohut (1984) characterized it as a longing for an intimate experience in which a selfobject is perceived as a faithful replica of oneself, capable of matching one's psychological states as if self and selfobject were one and the same. It is not a merger, in which the sense of an

autonomous self is submerged, although in archaic forms it may manifest in this way. More typically, twinship selfobject needs spur people to turn to their selfobjects and experience them as a part of the self. The twinship or alter ego selfobject function, like those of mirroring and idealization, exists to provide calming of a vulnerable self. It operates as a silent presence to keep one company when self-cohesion requires bolstering. Corresponding in some ways to the colloquial term *soulmate*, the twinship selfobject function refers to the experience of a companionate presence that feels and thinks just like oneself. It is akin to the feeling of a special connection with someone who uncannily finishes one's sentences, although this sense of connection goes far deeper to sustain self-cohesion when the self is experienced as being devitalized.

Disorders of the Self: Narcissistic Personality and Behavior Disorders

As noted earlier in this chapter, the symptomatic manifestations of self disorders centering on mirroring, idealization, or twinship selfobject failures are often indistinguishable on clinical presentation. Therefore, one must determine the predominant selfobject disruption that is compromising self-cohesion. Moreover, admixtures of selfobject deficits are not uncommon. Selfobject needs may also shift in prominence as a result of time, stressors, and progress of treatment and over the course of life. Although the narcissistic personality and behavior disorders need not reflect one selfobject deficit alone (indeed, manifestations of more than one selfobject failure may very likely appear), one sector of the self is usually more prominently injured. Compensatory structures (Kohut, 1977; M. Tolpin, 1997) may sometimes become established and relatively firmed up as reparative—although still imperfect—attempts to substitute one selfobject function (typically idealization) for another (usually mirroring).

Finally, the selfobject functions of mirroring, idealization, and twinship may not represent a complete complement of such functions; these are only the ones Kohut himself addressed. Kohut and Wolf (1978) and Wolf (1988) outlined other possibilities, such as adversarial and efficacy selfobject functions; however, these and other potential selfobject functions have not been sufficiently studied.

Experiences of empty depression and lack of purpose or enthusiasm may ensue when normal mirroring, idealization, or twinship selfobject needs become mobilized and then are thwarted. Empathic failures of normal selfobject responsiveness typically imply that a caregiver providing selfobject functions failed to recognize and appreciate that a normal need had emerged, one that could not be overlooked or ignored but that instead needed to be accepted enthusiastically (M. Tolpin, 1978; M. Tolpin & Kohut, 1980). Frequently, narcissistic manifestations (as well as self disorders in general) become expressed as depletion or fragmentation phenomena accompanied by tension states that are incompletely relieved and chronic affect experiences of being

adrift in life or lacking purpose or goals. Some people feel chronically underpowered or devitalized. Others perpetually seek out intense idealization selfobject relationships and often feel let down or dropped when their need to perceive greatness or vigor in such selfobjects is met with the disappointments that inevitably ensue. Such patients struggle hard to feel enthusiastic about themselves, the people they love, their work, and the people or values that would normally enhance self-esteem and make them feel their lives are worthwhile.

Regardless of how prominently the surface manifestations of grandiosity or entitlement may initially appear in narcissistic personality disorders, eventually weaknesses or deficits such as those just described will become evident, especially in treatment. Just as therapists need to recognize such patients' defensive bravado and loud, angry clamorings as their way of protecting themselves, they must understand the depression, ennui, and diminished zest that emerge alongside such defenses as the outcome of devitalized strivings to sustain a robust, assured self.

Selfobject deficits may be noted clinically as chronic empty depression or as a cold or arrogant demeanor. Manifestations such as these indicate that the patient is defensively sequestering feelings of shame and self-depreciation that are not far from the surface presentation. Heightened sensitivity to slights and criticisms also is common. Rageful reactions (narcissistic rage) are often apparent that represent the anger resulting from rebuffed expectations of affirming selfobject responsiveness from others. Narcissistic rage, if pronounced and widespread, may signal fragmenting self-cohesion, here understood as the breakdown (disintegration products) of a devitalized, underpowered self. Disintegration products may also take the form of addictions or perversions, which function to momentarily shore up the self.

When insufficient mirroring is prolonged during early development, the ensuing injuries to young children's normal prideful strivings derail their hopes for themselves, frequently leading to devitalization. In adult treatment, establishing empathic therapeutic understanding requires the therapist to reconstruct how his or her own misunderstandings from time to time repeat caregivers' chronic empathic failures. The diminished self-esteem that ensues in treatment is thus a repetition of childhood reactions to thwarted needs for selfobject responsiveness. By understanding how therapy reexposes patients to caregivers' empathic breaches, the psychotherapist is able to see how deficient mirroring responsiveness created the condition for a core experience to take root in which the patient came to perceive him- or herself as inadequate or devalued, concealed though it may be behind a veneer of defensive bravado. This veneer of grandiosity or exhibitionism may recede when patients come up against uncertainty about their abilities. They come to feel that their accomplishments do not matter, predisposing them to feelings of empty depression, disappointment in themselves as well as others, and a generalized sense of ennui about their lives.

Thus, narcissistic personality disorder typically results from failures of the echoing, affirming responsiveness of mirroring selfobjects or from failures of potentially idealizable selfobjects to provide a dependably sustaining presence. Sometimes both mirroring and idealization selfobject failures may be detected, particularly when a stable compensatory structure could not be established. So injured as young children, patients with a disorder of the self move into adolescence and then adulthood, repeatedly failing to realize their goals. They frequently achieve far less in life than the promise they once may have shown. Ambition is often stifled; initiative is manifested clinically as lethargic indifference associated with depression, affective constriction, or blunting. Hypochondriacal concerns may occur, in which somatization overlies an ever-present sense of a weakened, devitalized self. A propensity to shame is also common, coexisting with rage reactions when shortcomings are exposed.

Such disturbances do not preclude other forms of psychopathology, including comorbid Axis I syndromes and Axis II personality disorders. Comorbid disorders may represent depressive, anxious, impulsive, aggressive, or other symptomatic perturbations of an underlying self disorder. The narcissistic behavior disorders in particular may resemble Axis I and Axis II disorders characterized by perversions (sexualizations) of painful affect states, addictions, delinquency, or propensity for intense outbursts of helpless anger (narcissistic rage). These behavioral dysfunctions typically achieve only momentary soothing; they replace the internalizations of selfobject functions that failed to develop, thus impeding a capacity to calm or soothe the self.

Maturation of Narcissism in Normal Development With Treatment

Kohut (1966, 1977, 1984) frequently observed that there is no self without a selfobject, which was how he expressed the idea that throughout life the self requires persons, ideals, or sustaining goals from which it can derive vitality and cohesion. Selfobjects never become completely unnecessary; instead, they always remain important to fuel or sustain self-cohesion, which Kohut likened to a kind of psychological oxygen. A selfobject surround may consist of parents or other caregivers (including grandparents, other close relatives, or sometimes beloved nannies); love objects; intimate friends; teachers, mentors, or similar admired or beloved figures; or even profoundly meaningful values, principles, or institutions. The selfobject environment functions to affirm one's attributes or qualities to ensure a sense of initiative, efficacy, and well-being. Selfobject needs in normal development, therefore, are not thought of as inherently pathological; rather, they represent a baseline of legitimate expectations. One turns to the people or other selfobjects who are important in one's life, it is hoped with confidence, expecting to be responded to in a way that invigorates the self.

Cohesiveness of the self comes about through internalization, which is how selfobject functions become firmed up as a mental structure. In keeping with drive theory, Kohut (1971) regarded frustration to be the basis for strengthening the self, but only if frustration was optimal (i.e., not prolonged or intense). Optimal frustration strengthens self-cohesion by firming up the self as a stable mental structure. Kohut's term for this process of gradual strengthening of self-cohesion was *transmuting internalization*. This concept of Kohut's may be considered a specific form of internalization, which is itself a broad concept in psychoanalysis. For example, internalization has been described as a defense whose distortions influence various forms of psychopathology. Internalization is also the mechanism by which psychological growth achieved through treatment becomes consolidated. It is in this latter sense that transmuting internalization is thought to promote cohesiveness of the self. However, Kohut believed that growth-fostering internalizations occurred mainly as a result of optimal frustration.

Failures of internalization lead to disorders of the self. A chronically unresponsive selfobject environment that produces mirroring or idealization failures creates frustration, but not of the kind that promotes internalization and self-cohesion. Transmuting internalizations during normal development may be impeded by untimely interruptions such as early parental loss or illness or a pronounced and abrupt (i.e., traumatic) withdrawal of responsiveness from needed selfobjects. Several of Kohut's followers objected to his insistence that frustration was necessary to establish internalizations of selfobject experience to build self-cohesion. Bacal (1985) and Terman (1988) considered optimal responsiveness, rather than optimal frustration, to be a more decisive influence for promoting self-cohesion.

Kohut (1971) thus did not view selfobject needs as drive states that required being rechanneled as sublimations; instead, he viewed deficits of selfobject functions as representing derailments of normal development. In self psychologically informed treatment, the therapist understands patients' clamoring for attention or their angry disillusionment not primarily as derivatives of drives but rather as rebuffed legitimate needs for selfobject responsiveness. The therapist sees ignored selfobject needs as reactivations of empathic selfobject failures to meet normal developmental needs. Thus, self psychology provides a way of viewing and successfully treating patients' problems that previously were subject to long, unproductive treatments. In many such instances, treatment remained at an impasse because legitimate needs for selfobject responsiveness were misinterpreted as drive states in traditional psychoanalytic treatment.

Kohut (1971, 1977) stressed not only the importance of interpreting defenses, which occupies the typical ongoing work in treatment, but also the need to interpret them as expressions of thwarted but still hoped-for strivings for empathic selfobject responsiveness. Kohut considered such strivings to be the leading edge of treatment, which he contrasted with a so-called "trailing

edge" (Miller, 1985) of conflicts, defenses, and symptoms. M. Tolpin (2002) recently revived this concept, which Kohut spoke about informally (Miller, 1985) but did not write about. Tolpin described "forward edge" transferences that coexist with a self disorder; these transferences frequently are silent and difficult to recognize because they may be deeply submerged. Nonetheless, searching for and integrating forward edge transferences can represent an important mutative factor, because such transferences reach the potentially revivable tendrils of selfobject longings that have been driven underground. The remobilization of such buried (but not entirely abandoned) efforts may allow previously interrupted development to continue, thus restarting a process of securing more advantageous empathic selfobject responsiveness. These transferences represent patients' hopeful anticipation that something that had gone awry in their development will be recognized and responded to as a reasonable, normal need rather than as a pathological need state.

Thus, Kohut and his colleagues considered the emergence in treatment of patients' mirroring, idealization, and twinship selfobject needs as both reactivations of earlier injuries and as attempts to convey to others what they require to promote repair of the self. This understanding of selfobject transferences was not technically different from the way other transferences were approached in treatment. Thus, selfobject transferences were amenable to interpretation using essentially the same technical approach as that of other well-understood transference configurations. Further, Kohut did not discard drives as important psychological mechanisms, but he increasingly regarded them as requiring a different way of being understood without delegating them to a position of secondary importance (Kohut, 1977, 1984). He understood sexual and aggressive drives as vitalizing functions to enhance well-being and self-cohesion (M. Tolpin, 1986). This understanding of drives became a part of how self psychologically informed treatment facilitated reviving patients' initiative to pursue goals with enthusiasm and to take pride in their abilities and accomplishments.

Kohut (1971, 1977) also was not convinced of the primacy of an aggressive drive, certainly not in the way Kernberg (1975) and other followers of Melanie Klein's (1935) work had emphasized. Kohut considered Klein's "essential attitude that the baby is evil" and "a powder keg of envy, rage, and destructiveness" (Kohut, 1996, p. 104) to be misguided. Kohut (1972) instead considered narcissistic rage reactions to arise from selfobject failures when caregivers did not respond to phase-appropriate needs—the relatively normal, expectable developmental needs of childhood. He explained narcissistic rage as excessive or severe frustration and not as primary or archaic residuals of an aggressive drive. Though Kohut considered frustration to be optimal when it promoted firmed-up self-cohesion through internalization, he regarded excessive frustration as producing a breakup or fragmentation of self experience. Kohut called fragmentations of the self *disintegration products*, and narcissistic rage is one example. Kohut (1996) also observed in this

context that "the baby cries, and then the baby cries *angrily* when whatever needs to be done is not done immediately. But there is no original need to destroy; the original need is to establish an equilibrium" (p. 199).

Other Self Psychological Viewpoints

Although I have emphasized Kohut's psychology of the self, other self psychological perspectives also exist that were influenced by and extend Kohut's views. These viewpoints were not concerned specifically with narcissism, and even Kohut's later formulations emphasized self disorders rather than narcissistic disorders. Nonetheless, the other self psychological views I outline in this section all have implications for understanding narcissistic personality disorder.

Stolorow and his colleagues' intersubjectivity theory was one of the earliest to have evolved (Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1987). Lichtenberg's (1989) concept of motivational systems and Shane, Shane, and Gales's (1998) integrative viewpoint based on Thelen and Smith's (1994) nonlinear dynamic systems theory are also closely allied with psychoanalytic approaches to disorders of the self. Lichtenberg's and Shane et al.'s emphases on development and the self incorporated aspects of attachment theory as well.

Intersubjectivity Theory

Stolorow and Atwood (1992) considered their intersubjective viewpoint to be closely allied with Kohut's self psychology insofar as both viewpoints regarded selfobject experience as a primary aspect of mental life. Like Kohut, intersubjectivity theorists emphasized empathic understanding as a method for therapists to use in obtaining the subjective data needed to apprehend patients' experience of the self and its constituents. Stolorow and colleagues' (Stolorow & Atwood, 1992; Stolorow et al., 1987) intersubjective viewpoint is perhaps more closely related to (but not necessarily derived from) Kohut's concept of the self and selfobject functions than are other viewpoints based on intersubjectivity, such as Ogden's (1994). Stolorow and Atwood commented that they arrived at their point of view independently of Kohut and that their view emerged from a different frame of reference, one that was influenced appreciably by Tomkins's (1963) theory of affect regulation. Further, intersubjectivity theory expanded self psychology's understanding of borderline and psychotic disorders (Brandchaft & Stolorow, 1984; Stolorow et al., 1987).

Stolorow and his colleagues (Stolorow & Atwood, 1992; Stolorow et al., 1987) stressed the primary importance of *intersubjective contexts*, which they defined as an intersection of two subjectively true realities, such as that between a child and its caregivers or that between a patient and his or her therapist. This intersection is thought to construct (their term for this, like

that of many relational theorists, is *coconstruct*) a new or different reality than that of either party alone. By contrast, Kohut and his colleagues regarded others as independent persons who provide selfobject functions to shore up the self. Intersubjectivity theory advocates that psychological experience cannot be understood without considering the intersubjective field. Thus, other persons' motivations and perceptions (i.e., subjectivities) are believed to equally influence the perception of one's own sense of psychological reality. The perceptions and beliefs resulting from such a newly created intersubjectivity, whether accurate or faulty, represent what Stolorow and his colleagues termed *invariant organizing principles*. Their view has been criticized, however, for conflating experience with social determinism (Summers, 1994), perhaps even with an extreme form of it.

A crucial concept in intersubjectivity theory concerns the central role of affects rather than drives as primary organizers of experience. Affect states that are inevitably embedded in intersubjective fields are themselves regulated by the reciprocal influence that occurs in dyads. Psychopathology, therefore, represents failures to integrate affective experience (Socarides & Stolorow, 1984–1985) because the early child–caregiver system of reciprocal mutual influence that normally promotes affective integration has broken down. Under more optimal conditions, the child–caregiver mutual influence system ensures that affect states become integrated with ongoing experience. Affects can thus be tolerated and differentiated to signal what people experience at any given moment. Disturbed affect articulation results therefore from intersubjective contexts in early development where affects were walled off or inhibited, usually because caregivers remained unattuned to their children's affect states.

The intersubjectivity perspective is integrally anchored in the self psychological point of view in which the self is the center of psychological experience. Stolorow and colleagues (Stolorow & Atwood, 1992; Stolorow et al., 1987) have consistently stressed the importance of affects as organizers of the experience of the self. They also emphasized the mutual (bidirectional) influence of dyads as the basis for self regulation and selfobject experience. This emphasis is congruent with studies of observations of infants and mothers in interaction (Beebe & Lachmann, 2002; D. N. Stern, 1985); these studies also highlight the importance of the mother–infant dyad as a mutually influencing system that is important for self regulation. In recent years, Stolorow and colleagues have increasingly taken the position that Kohut's so-called traditional self psychology remained too wedded to the one-person psychology of drive theory and ego psychology. Consequently, intersubjectivity theorists have criticized important self psychological concepts such as transmuting internalization, because they consider its view of selfobject experience to be too closely anchored in a Cartesian isolated-mind tradition of conceptualizing internal experience. These theorists have argued that self psychology does not sufficiently emphasize what Stolorow and Atwood (1992) considered to be of crucial importance—dyadic systems and the intersubjective

context. However, self psychologists consider Stolorow and colleagues' distinction to be of limited importance. They instead have emphasized that the central feature of both views—one that differentiates them from early psychoanalytic positions—is a fundamental concern about the interdependency between self and others, regardless of whether this is conceptualized as selfobject experience or as an intersubjective field.

Motivational Systems and Development

Lichtenberg's (1989) view of the self is derived partly from Kohut's emphasis on the self–selfobject unit and partly from assumptions of intersubjectivity theory and the mother–infant observation literature. His particular emphasis rests on motivational systems that underlie self-regulation, a concept Lichtenberg introduced to expand the scope of self psychology beyond the empathically observed data of clinical psychoanalysis. His is a theory of the self, because it considers experiences of optimally attuned selfobjects to be affectively invigorating when needs are met, thus strengthening the self. (Lichtenberg's term *self-righting* approximates Kohut's concept of repair or restoration of the self.) The motivational systems Lichtenberg outlined included a description of their precursors in infancy based on attachment patterns. Thus, he linked motivation with development as crucial influences on self-integration. Lichtenberg also attempted to integrate intersubjectivity theory's emphasis on child–caregiver interactions as serving mutually affect-regulating functions for both children and their caregivers. His concept of the self emphasizes motivation more as a sense of initiative than as drive states. Motivations thus serve to organize and integrate experience, specifically selfobject experiences, which Lichtenberg defined as the mutual or reciprocal regulatory relationship of the self and its objects.

Like Lichtenberg, Shane et al. (1998) also integrated a literature beyond the data of the consulting room, building on Kohut's views by incorporating recent knowledge from contemporary attachment theory, mother–infant observation research, developmental psychology, neurobiology, and studies of trauma. Their integration of these areas with self psychology formed the basis for what they termed *nonlinear dynamic systems*, based on a perspective first proposed by Thelen and Smith (1994). According to Shane et al.'s adaptation of this model, development represents a consolidation of the self and of the self with the world outside it. They viewed trauma as interfering with consolidation of the self, broadly defining it as including neglect and loss in addition to overt abuse. Such disruptions of normal development lead to self-protective coping mechanisms that do not promote consolidation of the self. Shane et al. did not consider these self-protective adaptations to be fundamentally pathological defenses, but rather survival strategies of vulnerable children. They also considered this view from an attachment theory perspective, observing that such adaptations attempted to preserve an attachment to needed others.

Like Kohut (1971, 1977), Shane et al. (1998) considered that treatment could possibly mobilize a reactivation of normal developmental strivings that had been interrupted. Treatment should be conducted with the goal of fostering consolidation of the self, which is the same process Kohut called *self-cohesion*. Shane et al. regarded the work of repair in treatment as *self-with-other consolidation*, in which patients turn to others for security and self-regulation. They considered this concept to be one that was implied but not specifically articulated by Kohut's concept of selfobject functions. Shane et al. thus reformulated Kohut's view of selfobjects as relational configurations for promoting a new experience of the "self-transforming other." Shane et al. discussed several specific configurations representing trajectories of developmental progressions to achieve the self and self-with-other consolidations they emphasized.

Current Status of Self Psychological Viewpoints

As I noted earlier in this chapter, these and other theories recently allied with a self psychological viewpoint do not explicitly formulate views about narcissism or narcissistic personality disorder. They can, however, readily be applied to an understanding of narcissism. My main intent in including other self psychological theories in this discussion of Kohut's self psychology is not to argue for their specific relevance to narcissism but rather to show how they have provided a context for understanding ongoing developments in the psychology of the self since Kohut formulated his ideas.

I will not characterize most of these views or their differences from Kohut's self psychology beyond the general descriptions presented in the preceding sections, although readers should note that good comparative reviews of the various self psychologies are available by Goldberg (1998), Shane and Shane (1993), and Wallerstein (1983). In this and succeeding chapters, I make note of complementary or alternative viewpoints such as those outlined above alongside Kohut's when such concepts offer related perspectives for understanding a self psychological point of view. In regard to whether one or several self psychologies may be said to have existed since Kohut's formulations, suffice it to say that Goldberg regarded the primary concepts that Kohut first articulated as having led to "separate tributaries, each of which lays some claim to serve as the major voice in the field" (p. 254). Shane and Shane considered Kohut to have "clearly shaped the advances in self psychology" during his lifetime; however, further developments, although "dedicated to his vision," also were "not limited by it" (p. 779).

CLINICAL ILLUSTRATION

The clinical history and course of treatment presented in this section illustrate a self psychological approach to conceptualizing narcissistic per-

sonality disorder. The patient, Mr. A., presented with a mixed anxiety–depressive syndrome with features of hypomania and somatic symptoms. My discussion will demonstrate how these comorbid conditions may be conceptualized within a self psychological framework. This case is of interest because the characteristic Axis II narcissistic personality disorder features of grandiosity and entitlement were not initially prominent, although they became more apparent in his treatment with me shortly after he was clinically stabilized.

Mr. A. was a 27-year-old single White man, a college graduate who worked as an occupational therapist. He was admitted by his internist to a general hospital with a specialized medical service for treating illnesses with a prominent psychiatric overlay or medical management problems. Mr. A. had developed chest pains and dizziness complicated by an 8-month period of heavy drinking that he had terminated on his own before admission. Medical workups were negative. He presented with depression and agitation, and he showed a histrionic preoccupation with somatic functions and was fearful that he was dying. His history revealed that he had had a similar but less severe and protracted reaction at age 18, during his 1st year at college. Mr. A.'s current somatic complaints had begun about 1 year before the episode under discussion, and he had attempted to subdue them with alcohol use. His somatic symptoms had intensified during the 3 months preceding admission, perhaps associated with his self-imposed termination of alcohol abuse.

Several events during the previous year contributed appreciably to the onset of the present illness. First, Mr. A.'s father, who had a 20-year history of heart disease, had suffered another heart attack 18 months previously, and he had died 9 months before the patient's hospital admission. The patient felt that his father was particularly weakened several months before he died, but Mr. A. had little overt emotional reaction to his father's decline and eventual death. However, once he had begun treatment in the hospital, Mr. A. became more overtly depressed and agitated, mainly out of concern for himself and how he would manage without his father.

For 4 years, Mr. A. had been living in an apartment in the home of married friends. He felt needed there, because this married couple argued frequently, and he had become a source of emotional support for both of them, sometimes acting as a go-between. About 1 year previously, he had moved out of this apartment, even though he did not feel secure enough to live alone. His decision to try living on his own coincided with his father's weakening condition and Mr. A.'s feeling that his father would soon die. His chest pains began around that time. The patient ended up sharing an apartment with a friend he knew casually. Mr. A. was unhappy in this situation; he felt that his roommate was irresponsible and worried that his new living arrangement was unstable, a worry that coincided with his worsening somatic symptoms and the onset of alcohol abuse.