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In whose mirror : a comparative analysis of the conceptualization and treatment of pathological narcissism, using modern analysis and self psychology

Heather Novack
Smith College

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and Self Psychology

ABSTRACT

Pathological narcissism is an emotional disorder clinical social workers are likely

to encounter. Psychodynamically oriented social workers have access to a variety of

models to structure the treatment of narcissistic individuals. Self-Psychology and

Modern Analysis are two analytic treatment models which serve to explain and treat this

exact clinical population. The two models define narcissism extremely differently which

ultimately impacts each theory's understanding of the developmental trajectory, treatment

implications, and the definition of a successful treatment experience. Ultimately, the two

models serve to treat two different clinical populations. The two theories are also not

equally applicable in social work settings.

IN WHOSE MIRROR: A COMPARATIVE ANALYSIS

OF THE CONCEPTUALIZATION AND TREATMENT OF PATHOLOGICAL

NARCICISSM, USING MODERN ANALYSIS AND SELF PSYCHOLOGY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

Heather Novack

Smith College School for Social Work
Northampton, Massachusetts 10160

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We say that the human being has originally two sexual objects:

himself and the woman who tends to him, and thereby we

postulate a primary narcissism in everyone, which may in

the long run manifests itself as dominating his object choice.

<div align="right">Sigmund Freud, 1914, p.45</div>

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CHAPTER I

INTRODUCTION

Clinical social workers often treat patients with very few financial and emotional

resources. In some cases, the emotional depravation clients experience as children, yields

long term characterological struggles in adulthood. Pathological narcissism is one such

condition clinical social workers are likely to encounter. *Narcissism*, as defined by the

American Psychiatric Association's Diagnostic and Statistic Manual of Mental Disorders

(DSM IV-TR) is type 3 personality disordered marked by "pervasive pattern of

grandiosity (in fantasy or behavior), need for admiration, and lack of empathy" (APA,

APA, 2000, p. 689)

Modern social workers are trained in a variety of models for the treatment of

narcissism and other clinical disorders. Historically, social work practice was profoundly

affected by psychoanalytic writings (Meyer, 2004). Both undergoing psychoanalysis

themselves and applying psychoanalytic principles to their clients, social workers utilized

a psychoanalytic lens as early as 1920. (Goldstein, 2001). As Freudian theory was

revised and built upon, some social workers followed the chronology of thought and

continued to incorporate psychoanalytic concepts in their practice throughout the 20th

century (Goldstein, 2001). Today, the field is split in its acceptance of the merger of

psychoanalytic thought and social work principles. (Horowitz 1998).

This study, which is theoretical in design, attempts to consider both the reality of

social worker's likelihood to encounter character disordered individuals, and the social

work legacy of incorporating psychoanalytic thought into practice. Social workers who

leverage psychoanalytic concepts for the treatment of narcissistic individuals have been

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exposed to a variety of ideas on the subject. Erickson and Kohut emphasized the importance of the deeply rooted subjective experience of the individual (Mitchell, 1995). Winicott, highlighted the ways in which a *good enough mother* nurtures the true self of an individual (Winicott, 1960). Hyman Spotnitz underscored the relevance of repressed aggressive drives in the development of pathological narcissism (Spotnitz, 1954). What these theorists have in common is their disagreement with Freud's notion of narcissism; and yet each provides a unique understanding of and treatment formulation for pathological narcissism.

By over viewing psychoanalytic thought on pathological narcissism, and ultimately comparing two varying psychoanalytic frames, this study serves to provide social workers an increased understanding of psychoanalytic approach to the treatment of pathological narcissism. The study assumes that social workers and others working with narcissistic clients would benefit from an in depth comparative analysis of two varying theoretical frames. The assumption is based on the notion that comparative analyses of different theories allows for a richer understanding of clinical phenomena. Self Psychology, developed by Heinz Kohut, and Modern Psychoanalysis founded by Hyman Spotnitz are two such frameworks. Both deal specifically with issues of pathological narcissism. An in depth understanding of these two seemingly divergent frames may allow clinicians to develop more inclusive model of treatment for pathological narcissism.

Modern Psychoanalysis and Self Psychology are two major psychodynamic frameworks which, at their core, serve to explain and provide a treatment base for pathological narcissism. This study is an attempt to highlight the major concepts of each

theory while also providing historical contexts for each theory, and points of overlap

between the two. Hopefully, this theoretical analysis will provide social workers with

insight into the understanding and treatment of pathological narcissism.

CHAPTER II

METHODOLOGY AND CONCEPTUALIZATION

"Psychotics are a nuisance to psychoanalysis"-Sigmund Freud

(as cited by Federn, 1952, p.136)

In his 1914 paper, "On Narcissism: An Introduction" Freud defined *narcissism* as

the "labidinal cathexis of the ego directed at oneself"(Freud, 1914, p.32). From Freud's

perspective, narcissism is an emotional state in which sexual energy is directed toward

the self rather than to an external object. Freud elaborated on this point, making a

distinction between *primary* or normative narcissism, and *secondary* or pathological

narcissism. Freud asserted that narcissism is, in infancy, a normative developmental state

which in time usually lessens, but in some individuals develops into a pathological

narcissistic state. According to Freud *secondary narcissism* is exhibited in individuals

such as paraphrenics (schizophrenics) whose libido has almost entirely withdrawn from

the world, existing in a state of megalomania. (Freud, 1914)

Freud determined that this sort of pathology exists in contrast to *transference*

neurosis. In treating transference neurosis, the analyst considers that childhood dynamic

issues are worked through by the process of becoming reanimated in the treatment

relationship as the central problem plaguing the patient (Black & Mitchell, 1995).

Because Freud thought narcissistic patients were unable to develop a transference

relationship with the analysts, he also considered these patients untreatable. This

dichotomy between narcissistic disorders and transference neuroses remains essential in

understanding the impetus for the development of both Modern Psychoanalysis and Self

Psychology. Both Hyman Spotnitz, the founder of Modern Psychoanalysis, and Heinz

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Kohut, the founder of Self Psychology, developed treatment models to treat the exact population Freud considered "untreatable". Spotnitz and Kohut believed that narcissistic disorders were indeed curable yet required an expanded version of Freud's notion of pathology and more importantly cure (Spotnitz, 1954; Strozier, 2001).

This study presents a comparative analysis of two major theoretical frameworks which were developed in opposition to the classical analytic notion that narcissistic disorders are untreatable. By examining Modern Psychoanalysis and Self Psychology a richer understanding of the essential concepts in each theory may become accessible.

Research Question

The research question guiding this study is: How do Modern Psychoanalysis and Self Psychology define pathology, treatment, and cure as they relate to the concept of pathological narcissism? The purpose of this study is to identify the strengths and weaknesses of each theory while also considering areas of overlap in hopes to provide a more comprehensive understanding of pathological narcissism.

Sequence of Chapters

In this study, the phenomenon of pathological narcissism, the theory of Modern Psychoanalysis and the theory of Self Psychology will each be considered in separate chapters, consecutively. A discussion chapter will conclude the study. The following is a brief description of each chapter in this study.

Narcissism

Freud's initial paper on narcissism postulated that patients dealing with narcissistic issues were not suitable candidates for treatment through psychoanalysis. Throughout the history of psychoanalytic and psychological thoughts this view has both been expanded upon and rebutted. Chapter III will provide an overview of the chronology of psychoanalytic thought as it relates to the concept of pathological narcissism, beginning with Freud and ending with the current DSM IV (2000) classification and treatment recommendations. Special attention will be provided to the relationship between these theories and social work practice, including any sociological factors which may have influenced the social work field to support any particular theoretical frame.

Modern Psychoanalysis

Although Freud believed the impenetrable wall of narcissism prohibited some clients from benefiting from analysis, Hyman Spotnitz, the founder of Modern Psychoanalysis, used this same narcissistic wall to form a treatment alliance. By highlighting the concept of the *narcissistic defense,* Spotnitz explains how during the early stages of treatment clients do indeed develop a transference relationship with their analyst (Margolis, 1987). Rather than becoming frustrated with the narcissism, the analyst takes advantage of the client's propensity to assume the analyst is like herself, and nurtures the narcissistic transference (Margolis, 1987). This strategy is the first of many involved in the treatment of pathological disorders through Modern Psychoanalysis.

Chapter IV explores the theory of Hyman Spotnitz' technique of Modern

Psychoanalysis.By exploring concepts such as narcissistic defense, narcissistic

transference, mirroring and joining, we will visit Spotnitz' unorthodox method for

"curing schizophrenia" and other narcissistic disorders. The chapter also provides the

historical context for his ideas, and briefly explore the ways in which the personal life of

Hyman Spotnitz may have influenced the development of his ideas.

Self Psychology

Much like Spotnitz, Heinz Kohut also developed a theory that works with the

characterlogical traits of the clients being treated. Self Psychology postulates that as

infants we all have archaic *self-object* needs which through the processing of being met,

unable both psychological and physiological functions (Goldstein, 2001). Kohut believed

that even in the healthiest of environments, these needs are retained through adulthood

but become more mature and flexible throughout the lifecycle. However, in cases where

self-object needs are not met, the rigidity of the initial self-object endures and may result

in pathological narcissism (Berzoff, Melano Flanagan, & Hertz, 2002).

Chapter V explores the three major self-object needs that Kohut identified as

being central to the development of a healthy self including mirroring, idealizing, and

twinship. The chapter will visit the chronology of Kohut's ideas regarding these self-

object needs and provide insight into the ways in which he came to develop his theory of

self. Finally, The chapter will also explore the ways in which Kohut's personal life

influenced the progression of his ideas.

Discussion

Chapter VI concludes the research with a discussion regarding the findings of the previous chapters on Narcissism, Modern Psychoanalysis, and Self Psychology. The key aspects of each chapter are revisited. Areas of overlap and compatibility between the theories ware identified while also highlighting theoretical incompatibility as well. Special attention is also paid to the level of cultural appropriateness of each theory for the client. For instance, do the theories address issues of race, class and gender? If not, do these theories leave room to broach these issues with clients?

Finally, the chapter discusses the implication of the findings for clinical social workers. In light of the research question: *How do Modern Psychoanalysis and Self Psychology define pathology, treatment and cure as they relate to the concept of pathological narcissism?* Additionally, the conclusion will touch upon ways in which clinical social workers could use this comparative theoretical analysis to enrich their work.

CHAPTER III

NARCISSISM

According to the American Psychiatric Association's Diagnostic and Statistic Manual of Mental Disorders (2000) (DSM IV-TR), narcissism falls under the category of *personality disorder*. The APA defines personality disorders as characterized by "an enduring pattern of inner experience and behavior that deviates markedly from the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (APA, 2000, p. 685). According to the DSM, *personality traits* refer to the manner in which an individual perceives and relates to her environment; this manner tends to be particularly rigid and maladaptive for personality disordered individuals (p. 686). However, the hallmark feature of a personality disorder is an inner experience which deviates from what is culturally accepted and expected. The diagnosis of personality disorder requires a longer term evaluation of the individual's functioning, in part due to this focus on the inner experience of the individual. Clinicians may also hesitate to diagnose a patient as being personality disordered due to strong cultural stigmas surrounding this diagnosis.

Narcissistic Personality Disorder specifically, is grouped in the DSM as a Cluster B personality disorder. The clusters denote personality disorders believed to have overlapping features and symptoms or "descriptive similarities" (APA, 2000, p. 685). Cluster B personality disorders are characterized by "dramatic, emotional or erratic" behavior (APA, 2000, p. 695). Included in the Cluster B with Narcissistic Personality

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Disorder are also Borderline Personality Disorder, Antisocial Personality Disorder, and Histrionic Personality Disorder.

The DSM details nine diagnostic criteria for Narcissistic Personality Disorder, of which patients must exhibit at least five to qualify for this diagnosis. Each criterion is considered to be an indication of a "pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy" and must have presented initially in early adulthood. The diagnostic criteria for Narcissistic Personality Disorder are:

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements
(2) is preoccupied with fantasies of unlimited success, power brilliance, beauty or ideal love
(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
(4) requires excessive admiration
(5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
(6) is interpersonally exploitative, i.e. take advantage of others to achieve his or her own ends
(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
(8) is often envious of others or believes that others are envious of him or her
(9) shows arrogant, haughty behaviors or attitudes (APA, 2001 pp. 661)

The DSM also specifies that many successful individuals may exhibit these exact characteristics. However, they are only considered pathological in individuals in where these traits are inflexible, maladaptive, and cause significant functional impairment (APA, 2000).

Historical Roots

However, DSM conceptualization of pathological narcissism is strikingly different than the initial description of this condition. Prior to its appearance in DSM or even the psychoanalytic literature, the term *narcissism* was first used by physicians in the

late 1800's to denote a particular type of sexual perversion (Pulver, 1970). Although

many doctors were familiar with patients who seemed to derive sexual pleasure from

their own bodies, Havelock Ellis, a British doctor and self-proclaimed "expert on sex"

was the first to connect this concept with the term, *narcissism* (Pulver, 1970). Narcissism

in its initial conceptualization referred specifically to the practice of becoming sexually

aroused by one's own body; a practice of treating oneself as a sexual object. Yet in his

1898 paper, "Affirmations", Ellis stretched the application of the term narcissism to

depict behavior which is not overtly sexual as well. "That tendency which is sometimes

found more especially perhaps in women, for the sexual emotions to be absorbed and

often entirely lost, in self-admiration" (Ellis, 1898 as cited in Pulver, 1970, p.93). This

extension of the concept to non-sexual behaviors provided an essential foundation for

later psychoanalytic writings on the subject. The concept was first referenced in a

psychoanalytic paper in 1908, by Isidor Sadker, with the first paper entirely devoted to

narcissism written several years later by Otto Rank in 1911 (Pulver, 1970). Later,

Sigmund Freud wrote about the clinical phenomena in 1913, and was his first and only

clinical paper devoted to the subject "On Narcissism", was published in 1914.

Sigmund Freud

Unlike Spotnitz and Kohut, narcissism was not an area of particular interest to

Freud. More consumed with transference neurosis, Freud wrote only one major paper

dealing with this diagnostic category. Freud's (1914) paper, "On Narcissism", directly

addressed the difficulty in treating this population analytically. In fact, Freud believed

that successful analytic treatment could not be completed due to these patients' inability

to develop a transference neurosis (Freud, 1914). Some critics suggest that Freud never

further developed his thinking about narcissism, as he had difficulty incorporating his initial formulation of the narcissism into his later structural model of the mind (Pulver, 1970). In fact, we know that his inability to do so was a particular area of dissatisfaction for Freud, as he wrote to a colleague, "The narcissism was a difficult labor and bears all the marks of a corresponding deformation...that you accept what I wrote about touches me deeply and binds us even closer together. I have a very strong feeling of vexation at its inadequacy." (Pulver, 1970 as cited in Jones, 1955. P. 304). Freud's inability to incorporate his theory of narcissism into his later writings, paired with the rambling nature of his own paper on the phenomenon, leave Freudian ideas on narcissism vulnerable to much scrutiny. However, Freud's ideas provide the necessary context for understanding later psychoanalytical thought that deals more directly with the treatment and resolution of narcissistic disorders.

"On Narcissism" begins with Freud's suggestion that a *primary narcissism* exists in all individuals from birth. Freud suggested that "loving oneself" is a natural impulse to nourish and protect ourselves, and that this natural impulse for self-protection is bound up with sexual feelings and desires. Freud calls this phenomenon "primary narcissism" and contrasts this construct with "secondary narcissism" (Freud, 1914). In pathological or *secondary narcissism*, the libido is directed at the self at the expense of libido directed at the object, such as exists in paraphrenics (schizophrenics). Freud considered secondary narcissism to be the extreme manifestation of primary narcissism (Freud, 1914).

As suggested by his notion that pathological narcissism exists in individuals who withdraw too much libidinal energy from objects in order to nurture the self, Freud believed that each of us has a finite amount of libidinal energy. In other words, object

libido and ego-libido exists in an inverse relationship in where an increase in one would necessitate a decrease in the other. "We perceive also, broadly speaking, a certain reciprocity between ego-libido and object-libido. The more that is absorbed by the one, the more impoverished does the other become" (Freud, 1914 p.33). If a continuum of libidinal energy exists, Freud would consider being in love to be an example of object-love while conversely, paranoid schizophrenia an extreme example of ego-libido (Freud, 1914). In this model, it would be impossible for a paranoid schizophrenic to be "in love". Freud's line of thinking suggests that the experience of being in love and the experience of being schizophrenic are exact opposites.

It is the inability to relate to others that Freud deemed problematic in treating this population. Freud's model centered on encouraging clients to free-associate in order to uncover unconscious conflict, the source of a patient's symptoms. However, Freud also believed that through this process a patient would develop a transference relationship with the analyst (Mitchell and Black, 1995). In other words, internal conflicts would be projected onto the analyst, thus allowing the analyst and patient to work through these conflicts in session. However, Freud held that excess libido directed inward (rather than toward objects) would prohibit a narcissistic patient from developing a transference relationship with the analyst (Freud, 1914). Thus, an essential component of treatment could not happen, deeming effective treatment an impossibility for this population.

Freud cited several less extreme clinical examples in which people withdraw libido from objects and direct it internally. He suggested that those with physical illnesses or "organic disease" tend to withdraw their attention and interest from the outside world and direct it internally (Freud, 1914). Freud understood this behavior as

their investing libidinal energy in the ego as a way of nurturing it through a compromising situation. A further discussion yields a description of *erotogenicity*, or the capacity of any part of the body to provide sexual stimulation if the ego invests that particular part with libidinal energy. "We can make up our minds to regard erotogenicity as a property common to all organs and are then justified in speaking of an increase or decrease in the degree of it in any give part of the body. It is possible that for every such change in the erotogenicity of the organs, there is a parallel change in the libidinal cathexis in the ego" (Freud, 1914 p. 41). Consequently, Freud believed that hypochondria is an example of erotogenicity in which too much libido has been directed toward a particular body part, thus creating the internal perception that this body part is diseased. The resolution of hypochondria occurs when, through psychoanalysis, the patient is able to work through the conflict which has encouraged her to withdraw libido from objects and invest it internally.

Freud also spent time explaining the phenomenon of auto-eroticism. He suggested that a relationship exists between auto-eroticism and narcissism, yet it remains important to distinguish between the two. *Auto-eroticism* or the capacity to gain sexual pleasure from one's own body, Freud argued, pre-exists the formation of the ego (Freud, 1914). The pleasure seeking infant, has the capacity to seek and out and experience sexual stimulation, yet is not born with a developed ego. Thus, narcissism is not experienced until the ego is further developed, because narcissism is defined as libidinal investment in the ego.

Freud's ideas on narcissism, although underdeveloped, serve as the necessary foundation for later conceptualizations of the condition. His understanding of narcissism

as a result of undue amounts of libido turned inward offered access to a more sophisticated lens through which to view narcissistic symptoms. In later years, we see more sophisticated conceptualizations of the disorder. Yet, all of the new ideas have significant links to Freud's initial formulation.

Annie Reich

Annie Reich was a theorist who expanded upon Freud's original conception of narcissism. And like Freud, Reich ascribed to the classical or "drive" perspective on narcissism which considers a finite amount of libidinal energy to exist in each person. Followers of this perspective, like Freud and Reich, understand narcissism as a condition which occurs when too much libido is directed inward, thus resulting in profound symptoms. However, Reich placed particular emphasis on the distinction between *normative* and *pathological* narcissism. According to Reich, narcissism only becomes pathological under two conditions: (1)When an imbalance between object cathexis and self-cathexis exists. In other words, pathological narcissism exists in patients who direct libidinal energy at themselves at the expense of investing this energy in outside relationships. (2) In individuals whose ego boundaries are compromised and are therefore unable to differentiate between objects and self. This is often accompanied by an inability to distinguish wish from reality, and suggests a regression to infantile ego states. This is often the case with those struggling with psychotic illness (Reich, 1960).

Although Reich accepted Freud's notion that psychotic illness is one form, pathological narcissism, she chose to focus her writing on others forms of this pathology. Instead, Reich was interested in studying narcissistic phenomena in higher functioning

individuals. According to Reich, narcissistic phenomena in this population suggest a "partial regression to earlier ego and libidinal states mixed with later, more highly developed structures."(Reich, 1960 as cited in Morrison, 1986). Her belief was that such partial ego regression manifests as abnormal modes of self-esteem regulation, and this became her particular area of focus. Reich identifies such patients whose functioning is compromised although not dominated by regression of ego states as *narcissistic neurotics*.

Reich referenced Edith Jacobson's (1954) definition of *self-esteem*. "Self-Esteem is the expression of discrepancy or harmony between self-representation and the wishful concept of the self."(Jacobson 1954 as cited in Reich, 1960 pp. 208) Reich expected that during normative child development the ability to evaluate one's own potential and develop realistic internal goals is achieved. The extent to which we are able to achieve our goals is a reflection of both our capability but also the nature of our expectations of ourselves. "Self-Esteem thus depends on the nature of the inner image against which we measure our own self, as well as on the ways and means at our disposal to live up to it" (Reich, 1960 p. 45). Therefore, Reich concluded that self-esteem regulation in non-pathological adults, is achieved through the process of living up sufficiently to super-ego demands.

According to Reich, patients dealing with narcissistic disturbances are often marked by extremely unrealistic yard-sticks by which they measure themselves (Reich, 1960). The nature of the narcissist's super-ego is intolerant, rigid, and unrelenting. For this population, no real life accomplishment can satisfy the inexhaustible demands of the super-ego. The super-ego continually demands perfection beyond the realm of

possibility, thus leaving narcissistic individuals preoccupied with a need for grandiose

accomplishments. And thus, self-esteem is severely compromised. Reich understood the

grandiosity often associated with narcissistic patients as a necessary compensatory

striving designed to regulate self-esteem (Reich, 1960). She also considered this striving

as a reaction to unbearable castration anxiety. In order to manage the overwhelming

feelings of inadequacy, one develops a grandiose, omnipotent character that couldn't

possibly experience the low self-image they battle. Similarly, intense fears of bodily

harm or castration anxiety are conquered by the projection of a flawless image onto

oneself. Reich noted that this flawless image is often the subject of the elaborate fantasy

life common to those dealing with narcissistic disturbances.

> The exclusive production of fantasies that aim at one's own aggrandizement reveals a serious disturbance of the narcissistic balance...they (fantasies) have become an intrinsic part of the personality. Indeed they have become life's main purpose, and the self is being measured against them.(Reich, 1960 as cited in Morrison, 1986, p. 49).

Reich adds that such fantasies make transparent the degree of identification with

idealized infantile objects.

Compensatory grandiosity is among the most conspicuous symptom of

narcissism. However, Reich noted that the flip side of this symptom reveals other equally

damaging conditions (Reich, 1960). For instance, narcissistically oriented patients often

struggle with relentless self-consciousness and hypochondriacal anxiety (Reich, 1960).

She attributed these symptoms to both a large deposit of "neutralized aggression" and a

super-ego disturbance which encourages dependence on outside approval (Reich, 1960 as

cited in Morrison, 1986, p. 47). Some patients experience persistent fantasies centered on

being the object of admiring attention. Reich understood this as a reflection of the wish

for merger with an idealized object. However, the effect of these fantasies is a preoccupation with attention from others which results in feelings of self-consciousness rather than the desired effect of omnipotence. Thus, clinicians dealing with this population are faced with extremely fragile individuals with incredibly compromised self-esteem who often present as not only confident, but arrogant. Often, presenting concerns include complaints about the incompetence of others in their lives, which Reich might understand as projections of harsh super-ego demands onto other objects. (Reich, 1960)

Reich, like Freud, had a particular interest in the ways in which the naturally occurring sexual and aggressive drives were over the course of development, repressed, thus resulting in a narcissistic character structure. However, unlike Freud, Reich's focus was on higher functioning individuals, of whom she thought could be effectively treated through psychoanalysis. Later theoretical developments criticize her focus on the primacy of drives and neglect for the relationship between mother children as it relates to the development of pathological narcissism.

Otto Kernberg

Otto Kernberg, a Chilean analyst particularly interested in "borderline conditions", would dispute the classical analytic notion that narcissism is a manifestation of quantities of libido directed inward. Ascribing to the American object relations tradition, Kernberg would assert that relationships and the associated affects (rather than drives) are primary (St. Clair, 2004). Kernberg defined *object relations* as the study of the ways in which interpersonal relationships are internalized and serve as the basis for

psychic structure (Kernberg, 1976). *Structure* is defined as "enduring psychological patterns" (St. Clair, 2004 p. 124). From Kernberg's perspective, the libidinal drive is merely the result of accumulated positive affective experiences. Similarly, the aggressive drive results from the accumulation of negative affective experiences (Summers, 1994). St. Clair noted that, "Kernberg's model thus ultimately makes the person innately responsive and relational rather than innately sexual or aggressive" (2004 p. 127).

Thus, the classical analytic assumption that drives are present at birth and the understanding of narcissism as a manifestation of a drive imbalance, exists in direct opposition to Kernberg's teachings. According to Kernberg,

> Severe narcissism does not reflect simply a fixation in early narcissistic stages of development and a simple lack of the normal course of development toward object love, but that it is characterized by the simultaneous development of pathological forms of self-love and pathological forms of object love.(Kernberg, 1970 as cited in Morrison, 1986 pp. 220)

This section of chapter III outlines Kernberg's notion that narcissistic character structure is a reflection of pathological object relations and therefore underdeveloped ego structure.

From an object relations perspective, the term *object* refers not only to mental representation of a person, but also to the feelings which color the perception of that person (Summers, 1994). Kernberg's work focuses on the manner in which our relationships with objects serve as the foundation for our entire psychic structure. Thus, the study of client's relationships to objects or *object relations* is central to Kernberg's style of psychological assessment. Kernberg asserted that any object relationship has three elements. These elements are: 1) An image of the object in the environment, 2) An image of the self in interaction with the object, 3) A pleasurable or frustrating affective experience (Summers, 1994)

Kernberg's Developmental Model of Narcissism

Kernberg posed a developmental model for the evolution of object relations; depending on which particular stage of psychological development a client is in, there may be overlap among these three criteria. For instance, during the first month of life images of self and object are completely undifferentiated according to Kernberg (St. Clair, 2004). The child does not yet experience herself as separate from the object; thus images of object and self are completely fused during the first month. Kernberg considered this fusion stage one of the development of object relations (St. Clair, 2004). Stage two begins at about the end of the first month and lasts until six or eight months. The key developmental task during this time centers on differentiation between self and object within positive affective experiences (Summers, 1994). During stage two an infant may have a sense of herself as a distinct being during pleasant interactions with a caregiver. However, during times of stress or frustration, the infant enacts a developmentally normative defense and regresses to a state of total undifferentiation. Both stages three and four are marked by the task of differentiating self from object. Differentiation begins on the most primitive level at around 8 months and continues through age 6 (St. Clair, 2004). During this time, the child gradually integrates good and bad images of objects, while simultaneously working on this same task in relation to her representation of herself. The development of the id, ego, and superego also begins during stage three but is not finalized for several years. Kernberg, unlike Freud, thought that infants are born only with the foundation for the ego which develops along with the superego through positive interactions with caregivers. However, the id does not come

into play until stage four when the defense, repression, is leveraged. "For Kernberg, then, the structure of the ego seems to precede the structure of the id, which radically, reverses the psychoanalytically sequence of the id existing prior to the ego." (St. Clair, 2004 p. 133). Despite Kernberg's acknowledgement of the presence of both aggressive and sexual drives, his conceptualization opposes Freud's with respect to when and how they develop.

Kernberg's Notion of Splitting

During early stages of development, frustrating experiences are kept separate from pleasurable experience through the defense mechanism termed *splitting* (Summers, 1994). Splitting preserves positive experiences by protecting them from being contaminated with anxiety. Over the course of development, healthy individuals increase their ability to integrate good and bad images of self and other, usually only using this defense during times of extreme stress or frustration. However, if the course of healthy development is contaminated by the process of excessively frustrating or frightening interactions with caregivers, splitting can become a primary defensive action for some individuals (St. Clair, 1994). For Kernberg, the overuse of splitting as a defense is diagnostically relevant. The psychic structure of an individual whose upbringing was marked by anxiety and aggression would have positive elements isolated from negative elements, and would therefore leave this person more prone to rely on splitting as a defense. Kernberg believed the development of this type of psychic structure has major implications for overall functioning, and would most likely result in borderline character pathology.

Kernberg on the Borderline Condition

Kernberg was particularly interested in the treatment of borderline personality

organization (of which he considered narcissistic character pathology a sub-type). The

term *borderline* refers to a diagnostic category existing mid-way between neurotic and

psychotic disorders (Berzoff, 2002). Kernberg understood the borderline condition as

fundamentally resulting from a failure to accomplish the key developmental task of stage

three, the integration of good and bad qualities in self and objects (St. Clair 2004). Thus,

for Kernberg, splitting is the hallmark of borderline personality organization. "The good

self and object representations are continually threatened by bad representations. The

integration of the ego, which leads to the tripartite division organized around repression

as the principal defense, does not develop, and the result is general ego weakness"

(Summers,1994, p. 200).

Kernberg on Narcissism

As a sub-type of borderline personality organization, Kernberg likewise

considered the narcissistic character structure to be the result of a failure in stage three of

the developmental process. Thus, patients struggling with narcissistic personalities also

rely heavily on splitting as a primary defensive process (Summers, 1994). However,

unlike other borderline patients, narcissists leverage an effective defense against splitting,

the *grandiose self.* The grandiose self reflects a fusion of the ideal self and the ideal

object (St. Clair, 2004). Patients utilizing this defense present as arrogant, self-absorbed,

and have a limited ability to empathize with others. The grandiose self also needs

constant fortification; therefore patients seek continual attention and admiration from the outside world. "The main characteristics of these narcissistic personalities are grandiosity, extreme self-centeredness, and a remarkable absence of interest in and empathy for others."(Kernberg, 1970 pp. 228)

While Kernberg considered the grandiose self to be inherently pathological, this defense also effectively helps clients to appear superficially higher functioning than other borderline counterparts. For instance, narcissistic individuals are more likely to have successful social relationships and careers than other borderline patients. The degree to which clients are able to achieve success and therefore reinforce the grandiose self, reflects the level of overall functioning. Therefore, an extremely talented individual whose development was fraught with frustration thus resulting in a weakened ego, fares better than someone with a similar upbringing with less striking talents. The positive feedback one receives given those exceptional abilities, would bolster the grandiose self and defend effectively against splitting. However, beneath the surface these individuals are still extremely fragile and prone to regression in the absence of support for the grandiose self. Additionally, relationships are often highly dysfunctional. "Their relationships with other people are clearly exploitative and sometimes parasitic. It is as if they feel they have the right to control and possess others…behind a surface which very often is charming and engaging, one senses coldness and ruthlessness."(Kernberg, 1970, p. 230). So in spite of the superficial air of success, clients often experience a sense of emptiness, an enduring feeling of needing to prove themselves and achieve for the sake of recognition from others. Thus, Kernberg considered the primary task of treatment as a

process of dismantling the grandiose self in order to yield meaningful results and permanent reduction of symptoms.

Kernberg's Treatment Strategy

Kernberg's perspective on treatment assumed that severe pathology requires a more direct, interpretive approach in order to undo primitive defenses (Summers, 1994). His belief is that the undoing of primitive defenses allows a higher level ego structure to develop, enhancing overall functioning. Therefore, Kernberg believed that undoing the grandiose self through interpretation was the primary task of treatment (Kernberg, 1970). Interpretation of the grandiose self , in Kernberg's view, will reveal oral rage and extreme anxiety. Patients become extremely angry and often fearful of the analyst, which Kernberg considered to be a normative element of the undoing of the grandiose self. Often patients describe the treatment as "boring" or "useless". Therapists treating narcissistic patients are likely to experience counter-transferential feelings of incompetence in response to patients leveraging projective identification as a defense. *Projective identification* is a primitive defense that refers to the subconscious act of inducing feelings into a therapist. Kernberg felt that attention to, and analysis of these feelings is an extremely important part of treatment (Summers, 1994). Furthermore, patients will project the grandiose self onto the analyst, experiencing the analyst as the ideal object. Often, this phenomenon is accompanied by the patient experiencing the analyst as punitive, harsh and critical. Therapists who use Kernberg's model interpret this projection, as another tactic aimed and breaking down the grandiose self (Kernberg, 1970).

Summary

Freud's initial understanding of narcissism as a libidinal investment in the ego provides an important foundation for later work on the topic. Theorists who ascribe to the Freudian tradition, like Annie Reich, have built on this idea adding valuable insight and flushing out some of the less developed areas of his theories. Other theories such as Kernberg's, take an entirely different approach by considering relationships, not drives, to be primary. The range of ideas inside and out of psychoanalytic thought, provide a rich understanding of the concept of narcissism, and speak to the complexity of understanding and treating this population.

CHAPTER IV

MODERN PSYCHOANALYSIS AND A CURABLE SCHIZOPHRENIA

"The human animal is a born killer; it is only maternal love that changes the killer into something else. When people are deprived of maternal love early in life, they grow up killers and induce in you the feelings that they had-that their mothers wanted to kill them and they wanted to kill their mothers." (Spotnitz as cited in Sheftel 1991, p. 31)

Hyman Spotnitz: Biographical Information

Hyman Spotnitz was born in 1908 in the North End of Boston, Massachusetts. Hyman was the first born child of Eiser and Annie Spotnitz, two Polish immigrants who owned and operated a candy store as a means for supporting their family (Marshall, 2000). From an early age, Spotnitz was required to work in his parents' store and developed some resentment at his parents (in particular his father) for this particular obligation. "And that was where I grew up, in the candy store. I had to work there all the time and whenever I had nothing to do, they put me to work. I was always rebelling against that" (Sheftel, 1991, p.10). This resentment and aggression towards his father surfaced as a theme throughout his life and served as an important motivator for the later development of Spotnitz' theory.

As an act of rebellion, Spotnitz became involved in crime at an early age by aligning himself with local neighborhood gangsters and performing petty crimes on their behalf. "I was a gangster. I used to be part of the mob there, and there wasn't any crime that they committed that I didn't commit along with them" (Sheftel, 1991, p. 10). Spotnitz' earliest rebellions manifested as both direct challenges of his parents authority

and as participation in a type of behavior of which his parents would disapprove. Ironically, Spotnitz considered his mob involvement as the less risky of his two forms of rebellion. According to Spotnitz, direct challenges to his father's authority yielded much more severe consequences than the legal system could offer (Sheftel,1991). For example, Hyman Spotnitz regularly challenged his father's authority by calling his mother by her first name, "Annie", rather than "Mother". This act enraged his father, provoking him into violent episodes. Spotnitz recalled, "He [my father] said to me, 'You've got to call her Mother,' and he beat the hell out of me. My sister saved my life; he was going to kill me, I'm sure. At least I felt that way" (Sheftel, year, p. 10).

Despite his father's severe even brutal response to his rebellions, Spotnitz' father was very supportive of his son's educational endeavors. And it was in this, the intellectual arena, where Spotnitz really thrived. Eventually, the energy he has previously devoted to rebellious activities was redirected into educational pursuits.

> When I started reading...I used to read a book a day-that was my goal! I read everybody, I read all the classics and all the popular novels...I was an omnivorous reader...I read Shakespeare when I was in the first year of high school and as I read, I used the thesaurus and studied the significance of every statement (Sheftel, 1991, p. 11).

This enthusiasm for the written word and learning continued on for the remainder of his high school education. A successful student, Spotnitz was eventually accepted to Harvard University where he developed an interest in conducting medical research. After graduating from Harvard, Spotnitz applied to medical school and was accepted to the University of Berlin which had just received a grant to build the Kaiser Wilhelm Institute for Brain Research. Thus, Spotnitz was introduced, early on, to methods of studying the brain, brain waves, and the psychophysiology of the senses (Sheftel, 1991).

After medical school, Spotnitz completed two consecutive residencies at the Neurological Institute of New York and the New York State Psychiatric Institute, respectively. It was at the Psychiatric Institute where Spotnitz first worked with schizophrenic patients. Spotnitz worked on a study that used intravenous insulin and ambulatory insulin on schizophrenics. The results of this study showed that schizophrenic symptoms were temporarily abated but then returned after the treatment stopped (Sheftel, 1991). It was during this time that Spotnitz' lifelong interest in "curing" schizophrenia first emerged. Spotnitz labored over the results of the study, wondering what kind of treatment would produce long-term results in schizophrenic patients. However, Spotnitz ultimately concluded that treating clients chemically only lasted as long as the patient's brain was being exposed to the chemicals. His primary interest was in developing a treatment that produced permanent alleviation of symptoms for schizophrenic patients.

Throughout his medical training, Spotnitz additionally nurtured an interest in psychoanalysis. His first wife, a social worker named Miriam Berkman, introduced her husband to psychoanalysis. During their time in Berlin, Miriam and Hyman met other medical students with a shared interest in psychoanalysis. The couple participated in a group where they analyzed each other and Spotnitz was pleased with the result. Spotnitz discovered that through the process of "saying everything and understanding what it meant" he could change himself. As a result, Spotnitz wondered how this process might also impact patients, and in particular, schizophrenics (Sheftel, 1991, p. 9). Thus the marriage of a neurological perspective on the brain and an interest in the effectiveness of psychoanalysis, encouraged Spotnitz to join the New York Psychoanalytic Institute with

the intention of using psychoanalytic treatment to cure schizophrenics. However, Spotnitz experienced much resistance from those analysts trained in the classical Freudian tradition. "They wanted to make an analyst out of me. I wanted to find out how to cure schizophrenia through psychoanalysis. We had different orientations. I didn't want to be an analyst. I wanted to cure schizophrenia" (Sheltel, 1991, p.7).

Spotnitz had a particularly adversarial relationship with his supervisors at the Institute and was actually kicked out of a supervision session. However, Spotnitz considered having been trained as a classical analyst an essential catalyst for the development of his own more inclusive treatment model, Modern Psychoanalysis. "I studied all the techniques that were available. I tried them all out...I would not say that Modern Analysis is very different from all the other psychotherapies; it's just my particular way of working with special patients"(Sheftel, 1991 p. 23).

The range of personal experience Hyman Spotnitz endured serves as a useful metaphor that elucidates the range of intervention used in modern analytical treatment. Modern Psychoanalysts are trained to mirror aggressive impulses presented by patients, formulate object oriented questions and administer the toxoid response. These interventions have the goal of establishing a narcissistic transference, ultimately aimed at overcoming resistance to treatment and alleviating symptoms. This treatment model incorporates an emphasis on raw aggression with a consideration for subtle nuances of any psychoanalytic intervention. Modern Psychoanalysis promotes a certain (sometimes radical) framework for treatment, and yet stresses the necessity of abandoning those criteria depending on the particular clinical endeavor. The Modern Psychoanalytic

framework flips the drive treatment perspective on it head, while still remaining loyal to many of the key principles of classical psychoanalysis.

Modern Psychonalysis and Development

Unlike many other psychodynamic models, Modern Psychoanalysis did not revise Freud's original developmental model. Spotnitz considered Freud's theory of development to be relevant and useful (Spotnitz, 2004). Freud's model held that sexual and aggressive drives are the basis of childhood and adult life. Drives are biologically rooted, internal stimuli which inform thoughts and behaviors (Freud, 1950). Early in development, drives are invested in bodily erotogenic zones relating to specific physiological needs for each phase. For instance, infants and children in their first year experience pleasure and aggression in their lips and tongue. This, *oral* phase, is characterized by a lack of differentiation between self and objects. Freud considered the meeting of basic needs to be central to the oral stage of development (Freud, 1950). The *anal* phase, begins in the 2nd second year, and continues on for about a year and a half; it centers on the retention and expulsion of feces. This stage is simultaneously characterized by potty training and the process of managing the tension between increased autonomy and responsibility for one's own safety. Toddlers have more autonomy than infants but, have not yet internalized or set up controls to keep them both physically and emotionally safe. Thus, the struggle for control of one's own environment is central to this developmental stage (Freud, 1950). The *oedipal or phallic* stage is both the most complex and controversial of Freud's stages. From the age 3 ½ for about two years the child becomes preoccupied with his or her genitals. The observation of

presence or absence of a penis is paramount during this stage. Children notice how their

genitals are either the same or different from their primary caregiver. During this time,

the child also has a more developed fantasy life that often centers on libidinal

relationships with parents and others. According to Freud, libido is directed towards the

opposite sex parent, and aggression towards the same sex parent. However, the child is

also more aware of societal pressure against incestuous relationships and therefore,

represses sexual feelings. The child may also repress the feelings of fear for the same sex

parent suggesting some castration anxiety. Freud named this process this oedipal

conflict, and considered it to be source of many neurotic symptoms (Freud, 1950).

Although Spotnitz greatly valued Freud's contributions, his writings differ from

classical analysis in several fundamental ways. Unlike practitioners adhering to the

Freudian tradition, Spotnitz was most interested in pre-oedipal arrests in development

(Spotnitz, 1985). Spotnitz considered most severe pathology to be the result of pre-verbal

conflicts. Specifically, Spotnitz was interested in the oral phase of development.

Furthermore, Spotnitz had a particular focus on the aggressive drive. "Accordingly,

modern psychoanalysts place a greater emphasis on the role of aggression, an its

appropriate expression, which is seen as a major problem in many personalities"

(Kirman, 1977 pp. 2). Thus, libidinal conflicts, although relevant for some neurotic

patients, are not as diagnostically relevant as struggles with frustration for modern

analysts. The caregiver is viewed as having a responsibility to regulate the degree of

frustration the immature ego encounters. Spotnitz stressed the importance for all

individuals to experience the inevitable frustration implicit in the developmental process.

However, in his view, it is essential that the level of frustration the ego endures in early

stages of development is proportional to the level of structure present in the ego. Appropriate frustration helps build more structure. But too much frustration becomes highly problematic. From a modern analytic perspective, excessive frustration overwhelms the immature ego creating developmental arrests which significantly affect ego function over the lifespan (Spotnitz, 1985).

Spotnitz thought that excessive frustration was a result of the environment not meeting the child's individual needs. For instance, some children are genetically pre-disposed to becoming easily frustrated (Spotnitz, 1985). These children may require a particularly patient caregiver to help them navigate these feelings. In the absence of a caregiver with ample emotional resources or available time to support their child in this way, significant symptoms may develop. However, Spotnitz is careful not to blame individual parents or mothers for the later development of a child's symptoms. "More significant than whether the parent actually loved, hated, or was indifferent to her infant is the fact that the totality of his environment failed to meet his specific maturational need" (Spotnitz, 2004 p. 40). Instead, Spotnitz attributed these symptoms to the unfortunate pairing of an individual child with an inordinate inborn potential for aggressive impulsivity and frustration, to a parent without the emotional facilities or outside support to manage her child. "Even in cases where it was taught by the mother, her attitude may not have been pathological; there may simply have been disequilibrium between her emotional training and the infant's impulsivity" (Spotnitz, 2004 pp. 40).

Modern Analysis and Narcissism

From a Modern Analytic perspective, most pathological behavior is considered to be on some level, narcissistic. In the most extreme case, the psychotic break experienced by a schizophrenic client reflects a complete departure from reality and presents a "narcissistic wall" which the analyst must penetrate. Both narcissistic personality disorder and borderline personality disorder display the rigidity of maladaptive patterns of relating to others, where an inability to achieve healthy intimacy displays a different brand of narcissism. In depressed individuals we see a retreat away from relationship that can also be termed narcissistic. Yet, modern analysts would specifically link these and other symptoms with their root cause, the narcissistic defense. By definition, the *narcissistic defense* is the process of protecting the object from aggression by directing one's own frustration inward (Spotnitz, 1950). Continued leverage of the narcissistic defense overwhelms the ego and stunts its development. Spotnitz observed that the narcissistic defense is most often leveraged in relationships which were gratifying in some respects. "He (the infant) was sufficiently gratified to develop a strong craving for more gratification and, consequently, to place an unduly high value on the source of this bounty."(Spotnitz, 1961, p 284). Due to the high value placed on gratification, the infant consequently directs aggression inwards in hopes to protect the source of his gratification from his rage.

Unlike Freud's model which conceptualized narcissism as the result of undue amounts of libido directed inward, Spotnitz conceptualized narcissism as the result of excessive aggression directed inward. Rage directed inward results in interruption of maturational sequence and in some cases, fragmentation of the ego. This overload of

aggression overwhelms the ego, making it impossible for ego development to continue on a healthy course. Development is impeded, and although some individuals may outwardly appear to be progressing, lasting effects of undue amounts of aggression at an early age are felt. What the child does with the aggression implicates the kind of symptomatology that will later result. "The child who tends to discharge frustration-aggression into his body, is a likely candidate for psychosomatic illness. The highway to depression is paved with frustration paved into the superego, which then attacks the ego" (Spotnitz, 1976 p. 101). In cases where the child does not discharge the aggression, the ego becomes fragmented resulting in psychotic disorders such as schizophrenia.

Modern Analysis and Treatment

Modern Analysis has been the subject of scrutiny on the basis of an inadequate theory of development and a lack of explanation regarding the development of pathology (Schoewolf, 1990). However, similar criticism is rarely made regarding Modern Analytic treatment suggestions. "Modern analysis is primarily a clinical method and a theory of technique. Its primary contributions are to be found in its treatment procedures." (Margolis, 1987 pp. 227) Spotnitz considered the major task of treatment to be the reactivation of pathological ways of relating to the environment and objects in the treatment relationship (Spotnitz,1961). The narcissistic defense is thought to be the overarching maladaptive way of relating to environment resulting in schizophrenia and other narcissistic disorders. The resolution of this defense is the long term goal of treatment. This resolution is achieved through the development of various stages of transference and resistance that ultimately result in higher level functioning for the client

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and overall reduction of symptoms. "The modern analysts' strategy is to create a transference situation by having the patient communicate verbally from the couch. Cure is then affected through analysis and resolution of transference resistances: blocks to the expression of repressed feelings" (Spotnitz, Meadow 1976 pp. 1).

Modern Psychoanalysis and the Beginning Stage of Treatment

As explained earlier, Modern Analysis is primarily a theory of technique. Thus, included in Spotnitz' writing are specific recommendations for the course and method of treatment. This is especially true of the early stages of treatment. Clinicians working in the modern analytic tradition are offered a sturdy framework for managing initial meetings with clients. The treatment is conceptualized as starting as soon as the first telephone or written contact is made. Even in cases where the patient, herself may not have initiated contact, the treatment has begun. Modern Analysts are aware that several months may elapse between the initial contact and the first meeting. The expectation is that the motivating force behind a patient actually mobilizing and coming to the office is the alleviation of misery induced by symptoms (Spotnitz, 1987). During the initial interview, a brief family history is taken as well a description of the onset and duration of symptoms. However, Modern Analysts are very careful about not pressuring client's to produce information. "The candidate is placed under no pressure to give information that he has withheld; the diagnostic impression is based on his voluntary disclosures" (Spotnitz, 1987 pp. 140).

Beyond questions about family and symptoms, the modern analysts leaves this and most other interviews completely open-ended. If the client appears to be unclear

about what to do or say, the analysts suggests that the patient tell her life story or explain how she arrived at treatment. The analyst may also suggest that the client lay on the analytic couch as an aid to the telling of the story. Furthermore, the analyst is advised to avoid answering the patient's questions, however reasonable they may seem. "The patient's questions are usually countered with the analyst's questions. Even if solicited disclosures may be interpreted as a sign of weakness" (Spotnitz, 1987 pp.141). These are the only suggestions made of the client in the early stages of treatment. The expectation of the client is that she free associate in order to mobilize all feelings, including the aggressive impulses which are the source of her symptoms. "The minimum demands consistent with the treatment of his condition on an ambulatory basis are that the patient lie on the couch and talk. He is not instructed to free-associate" (pp. 141). All of these suggestions are developed on the basis that they help nurture the narcissistic transference.

Modern Analysis and the Narcissistic Transference

The initial stage of treatment involves the development and nurturance of the *narcissistic transference* in which the analyst encourages the activation of early undifferentiated object experiences. The term *transference* refers to the unconscious process of working through previous conflicts with other objects in the analytic relationship (Freud, 1912). Freud considered this subconscious re-working of previous conflicts in current relationships to be omnipresent. "Transference is merely uncovered and isolated by analysis. It is a universal phenomenon of the human mind" (Freud, 1912 p. 42). The term narcissistic transference refers specifically to a type of transference in which the client experiences the analyst as similar to or in extreme cases, the same as

herself. The development of this type of transference is central to the success of the modern analytic treatment relationship. Modern analysts believe that only through the process of revisiting early ego states can characterological change be achieved. Furthermore, the nature of the development of the narcissistic transference also serves as a useful diagnostic tool. For example, in the case of deeply disturbed individuals the client may state that the therapist does not exist. This is an example of a patient whose development was stalled so early that she has very little sense of objects existing outside herself. In a less severe case the transference object may be related to as similar to the self. "The transference object may also be related to as part of the self, as outside the self but a psychological twin image, or as part of the self but different from it" (Spotnitz, 1985 p. 142).

By functioning as an ego-syntonic object, the therapist nurtures the development on a narcissistic basis. An *ego-syntonic object* is an object which is not questioning, threatening, or dissimilar from the client (Spotnitz, 1985). This is an attempt at returning to the undifferentiated state of infancy. The assumption underlying the need for the narcissistic transference is that the patient requires corrective experiences with a therapeutic object in order to re-activate the stalled maturational sequence. "This kind of transference is necessary for progress when an individual's ego development did not proceed satisfactorily during the early years and he is initially unable to form object transference" (Kirman, 1977 p. 3). Through the development of the narcissistic transference, the analyst returns the client to a state of infancy and has the ability to provide a corrective experience which simulates an appropriate upbringing. Furthermore, the patient has the ability to expel harmful introjects onto the analyst (Spotnitz, 1985).

Early in development, narcissistic patients are not able to distinguish harmful feelings of their caretaker's from their own. The narcissistic patient experienced object feelings as being born inside her own ego. These introjects are toxic to the ego and must be externalized in order for ego development to progress. The development of the narcissistic transference enables the patient to project these harmful introjects onto the analyst, thereby externalizing them, and enabling the patient to begin to relate to the transference object as outside her (Spotnitz, 1985).

Techniques for the Development of the Narcissistic Transference

As consistent with most of his writings, Hyman Spotnitz outlined specific interventions for the development and nurturance of the narcissistic transference. Primarily, the therapist is advised to allow the client to do most of the talking and guide the client to direct the conversation during early stages of treatment. Spotnitz stressesd the importance of silence during these early stages of treatment. "The patient developing a narcissistic transference requires a virtually inanimate presence, preferably someone who does not even breathe...it communicates the message 'I do not want to disturb you in any way" (Spotnitz, 1989 pp.177). Intervention is suggested on the basis of presenting an inquisitive and yet not overly interested attitude. The decision to voluntarily communicate with the patient is very deliberate and limited in the early stages of treatment. The underlying assumption here is that narcissistic individuals will experience frequent interventions (especially interpretation) as an imposition which will ultimately interfere with the development of the narcissistic transference. Modern Analysts would

also consider the high potential for narcissistic injury when intervening with narcissistic individuals.

If the frequency of interventions is important during early stages of treatment, even more important is the type of intervention used. Commands, Questions, and Joining are the three major types of interventions suggested during the early stages of treatment. *Commands* are used to both give the client information about the expectations for treatment, but also as an assessment tool. "Commands are not issued to secure obedience.The therapist's intent rather, is to find out whether the patient wants to obey or defy him" (Spotnitz, 1989 p.181). "Lay on the couch and talk" is an example of the type of command which may be administered in the beginning sessions. The response to a command is diagnostically relevant and paves the way for the expression and resolution of resistance later on in treatment (Spotnitz, 1989*). Questions* however are used for different reasons. Initially, object oriented questions are the only type of questions that are used in early in treatment. An object oriented question is any question whose focus is other than the client. For example, rather than asking "Why are you angry at your mother?" a Modern Analyst would say "What does your mother do that angers you" or "What is it about your mother's behavior makes you angry?" The basic function of this type of intervention is the resolution of resistance to communication (Spotnitz, 1989). It relieves the ego from the pressure of being the focus of the question by emphasizing the role of an object. "By verbally assuming some degree of responsibility for the distress, the therapist draws attention to what others might have done to cause it or might do to alleviate it."(Spotnitz, 1989 p. 184) *Joining* or *Mirroring* is the third equally valuable element to the beginning stages of analytic treatment. The purpose of this type of

intervention is to communicate a similarity between the therapist and client, therefore

bolstering the narcisistic transference. There are several ways this can be achieved. On

the most basic level, the ego-synchronic join is an intervention common to most

therapeutic practitioners. It merely involves expressing agreement with a client's feeling

state or opinion. Most often it is preferable to use some of the client's own language, and

to keep the intervention fairly brief. In some instances, it is not necessary to formulate an

entire sentence. In fact, just repeating the last word of a client's particularly salient

statement may communicate solidarity and support. For example, a client may say: "My

co-workers are just plain idiotic!" And in response, the modern analyst may just repeat

the last word, "idiotic", as a stand-alone intervention.

Modern Psychoanalysis and Later Stages of Treatment

Resistance

Psychoanalytic theory has long considered resistance analysis a crucial element of

treatment. Freud defined *resistance* as the expression of repressed, infantile sexual

fantasies. These fantasies are unconscious due to a fear of being punished for one's

libidinal impulses. Freud believed the key to overcoming resistance is transference

(Freud, 1950). Modern Analysis expands on Freud's initial understanding of the use of

resistance analysis. Rather than conceptualizing resistance as a force that interferes with

the recovery of memories specifically, modern analysts understand resistance more

broadly. All forces which present barriers to the patient communicating with the

therapist in an emotionally mature way are conceptualized as resistance (Spotnitz, 1989).

The resolution of this resistance takes the form of addressing a client's difficulty

communicating. This manifests as removing all obvious barriers to the client's ability to free-associate in session. "No attempt is made to be therapeutic, to help the patient solve an problems, indeed to help him do anything but verbalize freely whatever he is thinking or feeling at the time" (Spotnitz, 1985 pp.116).

Modern Analysts believe that the treatment relationship and development of transference activate different types of resistance. Through the process of developing an attachment to the therapist, the client encounters unconscious barriers to communication which paradoxically perform a communicative function for the therapist (Spotnitz, 1989). "These protective devices, activated in the analytic situation by transference, are recognized as characteristic expressions of the living personality" (Spotnitz, 1989 pp. 96). Resistance offers otherwise inaccessible information about the patient's life and history. Information which is not consciously accessible to clients and therefore not communicated directly is revealed through resistance analysis. These interruptions in communication manifest as external or internal resistance. *External resistance* refers to events or interferences outside the session which prohibit clients from actually coming to treatment, or from communicating when in session. "Such forces interfere with communication or threaten the continuance of the relationship. In either case the external obstacles are perceived as resistance in the technical sense of the term" (Spotnitz, 1989 pp. 96) External resistance may often seem to be the result of some force outside of the client's control, for instance the death of a family member or interruption in the service of the public transportation system. However, the significance of external resistance is the extent to which the client allows these events to interfere with the analytic relationship (Spotnitz, 1989). *Internal resistance* refers more generally to the defensive forces which

operate in the treatment relationship which prohibit free association.(Spotnitz, 1989)

Repression, intense feelings of guilt, exacerbation of symptoms after a prolonged period of progress, and insistence on physical contact with the analysts are all considered to be internal resistance. These occurrences perform a survival function for the client, and yet simultaneously the source of a client's difficulty. Thus, the ultimate resolution of resistance is the goal of treatment in modern analysis.

Techniques for Resolving Resistance

While the focus of beginning stages of treatment is the development of transference on a narcissistic basis and acceptance of the client's needs to leverage the narcissistic defense, the ultimate goal of treatment is the resolution of the narcissistic defense. This is achieved through the process of addressing individual resistances on a priority basis. For example, a *treatment destructive resistance* or TDR is the first priority. Counter to the modern analytic notion of creating a treatment system in which the analyst is largely inactive, the resolution of a treatment destructive resistance requires direct, immediate intervention. " The therapist's primary goal is to preserve the analytic relationship and to deal with any factor that threatens its therapeutic unfolding" (Spotnitz, 1985 pp.117). Therefore if a client is regularly missing appointments, engaging in risk-taking behavior, or exhibiting suicidal gestures a direct intervention is warranted. All of the aforementioned situations are viewed through the lens of potentially destroying the treatment relationship, and require immediate action on the part of the therapist.

The second priority of resistance involves any type of behavior which suggests a resistance to transference or the development of an attachment to the analyst. This type

of resistance is divided into 5 different categories which, for the purposes of this study will not be explored as that would detract from the central point being made here. However each category is dealt with using similar techniques. First, the analyst must study the resistance and consider the significance of this particular type of resistance in the client's life history. Second, the analyst gives a verbal description of the resistance to the client. Most often, this does not take the place of an interpretation, for fear of creating narcissistic injury, thereby strengthening the rigidity of defenses. Instead, the analyst would call attention to the resistance by using this time to mirror or join the affect of the client. This will feel significant to the client because of the largely inactive role of the analyst in session; however, the experience may be at first unconscious. This intervention is qualitatively different from the type of joining used to bolster the narcissistic transference in that it is administered in a way to solicit a small amount of frustration or aggression from the patient. Often called, an *over-join* or *toxoid response,* this is a paradoxical intervention that is designed to encourage the client to question a statement due to the subtle discomfort she feels at hearing it reinforced by another person. Such interventions begin the process loosening the fusion of object and self and pave the way for the development of the object transference. Once it becomes clear that the client has begun to expel the frustration impulse verbally in session rather than exclusively leveraging the narcissistic defense, the analyst may then begin to use interpretation. "Interpretative techniques are utilized o the extent to which they prove effective at that stage in facilitating progressive verbalization by the patient" (Spotnitz, 1985 pp. 126)

Object Transference

Initial stages of treatment are aimed at the development of the narcissistic transference in order to revisit the infantile state of undifferentiation. Essentially, the treatment is conceptualized as 1) meeting maturational needs which were unmet during childhood and 2) reversing the maladaption which developed in response to these unmet needs (Spotnitz, 1987). Once undifferentiation is affectively accomplished, different types of interventions are suggested. During the second stage of treatment, the analyst begins to use interpretation as a technique to both meet maturational needs and reverse maladaption. Unlike traditional psychoanalysis, the goal of interpretation is not to make the client aware of unconscious material (although this may be a desired after-effect) "Instead of trying to overcome resistance by explaining problems, the analyst uses interpretation to create the precise emotional experience that will resolve the problems...interpretation is consistently employed for maturational purposes"(Spotnitz, 1987, pp. 44). From this perspective, early interventions lay the foundation for clients to begin to differentiate from the analyst, and interpretation addresses differentiation directly. Modern Analysts consider that intervening affectively should provide the necessary level of frustration in order for the client to sometimes experience the analyst as separate from himself.

However, much care is given to the when and how an interpretation is employed. Spotnitz argued that an interpretation should not be employed unless the analyst can predict how the client will respond. In other words, this intervention is used very deliberately and sparingly with patients who have been sufficiently studied by their therapist's previously. Modern psychoanalysts are critical of what they consider to be

classical analysis's overuse of interpretation as the main tool of treatment. Instead,

modern psychoanalysts use this intervention only in rare instances, in order to further the

process of differentiation. Once differentiation has occurred the analyst may begin to

interact with a narcissistic individual in a manner more similar to traditional

psychoanalyst. Traditional psychoanalysis was designed to address Oedipal conflicts,

and the pre-Oedipal conflicts were addressed through the modern analytic process of

resistance analysis. Once differentiation has begun, modern psychoanalytic treatment

begins to more closely resemble this traditional model. Still using free-association as the

foundation for sessions, the analyst may during this stage share more of his own thoughts

and feelings rather than strictly mirroring the clients. This solidifies the process of

differentiation and models mature relating for the client.

Cure and Termination

The goal of treatment is the resolution of the narcissistic defense. Clients will be

better able to communicate frustration to others rather than direct it inward. The

implications of this resolution are huge for both the overall symptom picture and the

presentation in session. Ego fragmentation is the result of prolonged exposure to the

narcisisstic defense. Thus, ego integration should be achieved at the resolution of

treatment (Spotnitz, 1985). Successful treatment should result in 1) an increased ability to

tolerate frustration, 2) an increased attention to the existence and needs of others 3) a

pervasive ability to communicate and 4) a profound overall decrease in the existence of

psychosis in more acutely disturbed individuals. Therapists will notice more expression

of positive and negative feelings and better impulse control as well (Spotnitz, 1985).

At the first appearance of these progressive indications, the modern analysts begin

to approach the topic of termination with their patients. It is expected that some degree

of regression will occur during the months and weeks prior to termination. Thus,

discussing the termination at length is an attempt at limiting the regressive tendency.

CHAPTER V

SELF PSYCHOLOGY AND THE COHESIVE SELF

The nuclear psychopathology of these individuals concerns the self. Being threatened in the maintenance of a cohesive self because early in life they were lacking in adequate confirming responses from the environment, they turned to self-stimulation in order to retain the precarious cohesion of their experiencing and acting self. (Kohut, 1972 pp.626).

Heinz Kohut: Biographical Information

Heinz Kohut was born into an affluent family in Vienna in 1913. His father, Felix, and mother, Else, were trained as a concert pianist and vocalist, respectively. Felix was a talented musician who enjoyed much critical acclaim. Along with his beautiful wife Else, Felix Kohut was considered to be part of the "assimilated world of Viennese Jewry" (Strozier, 2003 pp.11). Kohut's mother, Else, was described as a beautiful and dramatic woman, prone to passionate and intense relationships. Such was true of her relationship with her son, Heinz, during the first year of his life, "She had an intense relationship with her little boy. As long as he remained a baby, the interweaving of her with him, seemed to bring out her healthiest attitudes. He was the apple of her eye" (Strozier, 2003 pp. 12). During this time, the family enjoyed Felix's successful career and stable relationship with one another.

During the summer of 1914, the tides of Heinz Kohut's blissful first year began to change. War engulfed central Europe, and Austria was allied with Germany in a fight against France, Britain, Italy and Russia. Felix Kohut was summoned to defend his country against Russia and later Italy. He was a successful military man, absent for several years, including the time from 1915-1918 when Felix was held captive in Italy. During this time Else and Heinz went to live with Else' parents in the countryside.

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Although limited information about this time is known, Heinz, himself, reported that he shared a bed with his mother and that intensity of their relationship was magnified by the stress of Felix's absence.

Upon Felix's return in 1918, the family returned to Vienna; however, relationships were strained. Heinz slept on a couch in his parents' bedroom and reported being fearful of his parent's sexual encounters, including an inability to differentiate them from their arguments. The family was clearly overwrought by the terror of war and relationships were changed. Kohut said about his father's return from the war, "I was deprived of a young, vigorous father. He was replaced by an old man, a grandfather, and that was not the same" (Kohut, 1980 as cited in Strozier, 2001). Felix was severely traumatized by the war, and apart from now being unable to touch a piano (the former joy of his life), he became extremely withdrawn and unavailable. During this time, Felix also became increasingly critical of Heinz, berating him for being dissimilar from the other children his age. Witnesses cite this situation as particularly painful due to both to Kohut's physical likeness to his father, and also the extent to which Heinz idealized his father (Strozier, 2001). Furthermore, the relationship between Else and Felix deteriorated. While, they initially feigned interest in each other when Felix first returned from the war, the couple became estranged and eventually each took on mistresses and lovers. Heinz was aware of his mother vacillating from extreme closeness to distance and indifference. His father remained distant until Kohut's teens when they began to build a relationship that Kohut understood as being facilitated by the absence of his mother, an overbearing presence for both of them.

Else was intensely involved in many aspects of Kohut's life from the time that he was a young child. It was reported that during his toilet training, Else took special interest in inspecting his feces. When Heinz was a teenager Else made a ritual of inspecting his skin every Saturday, squeezing blemishes with her fingernails. Heinz reported anxiety at the thought of his skin being perfectly clear, due to the undue amount of pleasure Else seemed to derive at removing his blemishes (Strozier, 2001). Activities like this, suggest the extraordinary level of fascination with her son's body and mind.

Heinz Kohut entered the University of Vienna in 1932 at the age of 19. He chose the medical, track, and over the course of the next 6 years studied to become a doctor. During much of this time, Kohut continued to live at home, and was continually entangled in a difficult relationship with an overbearing mother. He is described as an "isolated and lonely young man in the early years at the university" (Strozier, 2001 p. 42). Furthermore, in 1937 Kohut endured a devastating blow. His father, Felix, died from an acute form of leukemia, leaving his son riddled with grief. This profound loss prompted Kohut to seek out his first psychotherapeutic treatment with psychologist, Walter Marseilles (Strozier, 2001). Finding this experience to be unsatisfactory, Kohut terminated treatment after three months. Years later, after Kohut's writing had become widespread and his name well-known in the medical community, Marseilles approached Kohut at a lecture asking about his experience in treatment. Kohut replied, "You didn't damage me much, you just took things too fast" (Strozier, 2001 pp.49).

After being disappointed by Marseilles, Kohut yearned for a more positive treatment experience. He then sought treatment with August Aichorn, a skilled and experienced analyst. Aichorn was extremely helpful and Kohut became profoundly

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attached to this analyst. Kohut deeply appreciated the "integrity" which seemed to govern

Aichorn's practice. Aichorn seemed genuinely interested in Kohut's story, a striking

experience for Kohut (Strozier, 2001). Somewhat un-orthodox in his approach, Aichorn

kept his dachshund, Schnidi, in session with him. Schnidi regularly jumped up on Kohut

during his sessions. Kohut was saddened by the death of this dog, remarking "Poor

Schnidi, he was very close to me-he must have often had to fulfill the role of brother to

your patients and felt some ambivalent feelings directed on to him, but I, an only child,

had more of a feeling of identification with him" (Strozier, 2001 p. 52).

During Kohut's college years and first treatment experience, Austria was under

extreme political and military stress from neighboring Germany. In 1938, Hitler

demanded an, anschluss, or union between the two countries. Shortly thereafter, Hitler

ordered that Kohut's hometown, Vienna, be "Jew-free" in the next four years. Despite,

Nazi regulations limiting times when Jewish students could take exams, Heinz Kohut

graduated from the University of Vienna on November 3, 1938 with his medical degree.

Over the next year Heinz learned English and secured the paperwork necessary for

emigration. He and his mother moved to Chicago via London in March of 1939. Once in

Chicago, Kohut completed a year long internship and was then hired as a neurology

resident at the University of Chicago, where he eventually became chair of the neurology

and psychiatry department. Overtime, Kohut became dissatisfied with neurology, "The

work was too much about the laboratory and not sufficiently in touch with real human

feelings and suffering. Neurology failed to excite Kohut's creativity" (Strozier, 2001 p.

76). Shortly thereafter, Kohut enrolled in the Chicago Institute for Psychoanalysis where

he began his formal analytic training. This experience served as the foundation for his

classical psychoanalytic practice, and eventual departure into the development of self-psychology.

Self Psychology and Development

Kohut devised a different line of development than classical analysis. Freud understood the development and navigation of psycho-sexual stages as the process by which one becomes emotionally mature. This perspective asserts that sexual and aggressive drives are present from birth; development involves negotiating conflicts which result from the interaction between drives and the socialization process. Kohut agreed that drive conflicts exist, but he also considered that the ability to manage these conflicts is dependent on some other factor (Baker and Baker, 1987). Unlike Freud and the classical analysts, Kohut believed that drives are secondary to other structures in the mind (St.Clair, 2004). These structures, the archaic essence of which are present at birth, develop into a cohesive self under the right conditions. Drives arise only during times of stress when mind structure is fragmented (St. Clair, 2004). Thus, Self Psychology departs from the traditional analytic view in its acceptance of drive induced conflict being a suitable explanation for pathology. Instead, self-psychologists employ different basic assumptions about the structure of the human mind and in turn, the development of psychopathology. In Self-Psychology *development* refers to the process of fundamental needs being met and the subsequent growth of internal structure as a result.

The development of these internal mental structures results in the formation of the cohesive self. Kohut defines *self* as "the center of the individual's psychological universe" (1977 p. 311). The self is the fundamental essence of any human being,

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including all self-representations, and experiences. The self houses sensations, feelings, thoughts, and attitudes (Banai, Mikulincer & Shaver, 2005). It encompasses aspects of the id and superego, performing many function formerly thought to be ascribed the ego (St. Clair. 2004). At birth, the self is a rudimentary center that includes innate potential, and inclination. The self is the driving force which motivates a child to cry when hungry or scared, or coo at attachment figures. However, during this stage of development called the *narcissistic* phase, the infant experiences the mother as part of the self. Needs are absolute and the archaic structure of the self allows for no understanding of the mother's own separate needs and experiences (St. Clair, 2004). Kohut considered this narcissistic state to be normative and the necessary foundation for later development of a more complex structure. Over the course of healthy development, the self progresses from being unaware of others to believing they exist for the purpose of meeting self-needs. Throughout childhood, caretakers perform essential emotional functions which are performed by the self. The healthy adult will eventually be able to achieve a state in which objects are understood as completely separate. However, Kohut maintained that even healthy individuals require objects to sometimes perform internal functions such as assisting in self-esteem regulation.

Self-Objects Needs and Empathic Attunement in Self-Psychology

Kohut believed that certain essential needs must be met in order for the self to develop properly (Kohut, 1977). These requirements are called "self-object" needs. *Self-*

objects are objects that perform essential internal function, which the self cannot yet perform alone. At birth, the rudimentary self is entirely dependent on self-objects to perform all functioning. Over the course of healthy development, the self will increase its internal capacity and become less reliant on self-objects (although never entirely escaping its need for them). This process is referred to as *transmuting internalization*, and refers to the process by which the interaction between the self and self-object stimulates the development of self structure.

> Self-object relationships form the essence of psychological life from birth to death, and that a move from dependence to independent in the psychological sphere is no more possible, let alone desirable, than a corresponding move from a life dependent on oxygen to a life independent of it in the psychological sphere. (Kohut, 1984 p. 47).

The extent to which the self is able to assume functions formerly ascribed to self-objects is dependent on the empathic attunement of parental figures. *Empathy* is defined as an "understanding so intimate that the feelings thoughts and motives of one are readily comprehended by another" (Baker & Baker, 1985 pp.2). Without empathy, no development of self-structure would be possible. The term, *empathic failure,* refers to events in which caretakers are not willing or able to appropriately understand the subjective experience of a child. The timing and extensiveness of these failures directly relates to the severity and type of pathology. However, some empathic failures are inevitable, and actually necessary for the course of healthy development. Early, non-traumatic failures allow the infant to begin to understand herself as separate from her caretaker and result in the development of the three major elements of the self and in turn, their corresponding self-object needs. This is the first step of many in which the

interaction between self and object facilitates the development of more sophisticated self structure.

In his original formulation Kohut identified three elements inherent in the development of a cohesive self: the grandiose self, an idealized parental imago, and a tension arc strung between each (Goldstein, 2001). Kohut referred to this developmental model as the *bi-polar self*. The *grandiose self* or "pole" develops as a result of early inevitable non-traumatic empathic failures, occurring between the ages of 2 and 4 (Goldlstein, 2001). In response to these failures, the child attempts to return to a former state of undifferentiated bliss and invests libido in the self, resulting in the grandiosity pole (Summers, 1994). This pole and its corresponding need for reinforcement or *mirroring* requires objects to bolster confidence by responding enthusiastically to fantasies and praising developmental achievements. The grandiosity pole encompasses a continual need for reinforcement of ones talent, goodness, and worth, along with no suppression of unrealistic fantasies or ambitions (Goldstein, 2001). The child's need for grandiosity results in her relating to attachment figures as a means for bolstering of the self not as a separate object. "The delighted gleam in the mother's eye is essential to the child's development. This response mirrors back to the child creating internal self respect" (Baker, and Baker 1987 pp. 3). After the grandiosity pole has emerged, around ages 4-6, the child begins to develop a second self-object need or need for merger with an idealized object. This need is referred to as the *idealized parental-imago*. The idealized self is somewhat antithetical to the grandiose self (Summers, 1994). The implication is not that the child herself is perfect, but that someone else is perfect. This pole encompasses a yearning for security based in the power of the perfection of the idealized

object. The development of the idealized parental imago does not replace the grandiosity

pole, but represents the development of a more complex self-structure. During the early

development of this aspect of self, the child oscillates from recognition of the parent as

other and a safer regression to a more primitive state of merger (Summers, 1994).

Eventually, both poles become relatively stable resulting in tension between a need for

reinforcement of one's own grandiosity and a somewhat contradictory need to believe an

outside object is perfect. This development of this tension arc represents a developmental

achievement, and is the hallmark of more cohesive self-structure (Summer, 1994).

While Kohut's original model only included two poles, he later revised his theory

to include a third pole with its own set of corresponding self-object needs. This later

model, the *tri-polar self,* highlighted a third essential component to the self - the twin-

ship or alter-ego pole. This twinship pole encompasses a child's need to perceive an

object as being similar to her in interest or ability, or as sharing some kind of bond as in

kinship or group membership (Goldstein, 2001). Often, extended family members or

even peers meet this self-object need.

The healthy individual with a cohesive self has experienced both parental

responsiveness and also occasional non-traumatic empathic failures as well. According

to Kohut, both of these elements are essential for the formulation of a cohesive self and in

turn satisfying life experiences. A strong cohesive self offers a person a sense of self-

esteem, creativity, and an inner-calm or peacefulness.

Self-Psychology and Narcissism

In the case of some individuals, a repeated lack of empathic attunement has left them with infantile self-object needs and severely impaired emotional development. If self-objects are excessively frustrating or too stimulating, the self leverages defenses to protect itself. Kohut referred to the fear of loss or damage to the self as "disintegration anxiety" and he believed this anxiety to be the most powerful motivational force (Kohut, 1971). The strong defenses erected in reaction to this anxiety protect the vulnerable childhood self and also block further development (Summer, 1994). Kohut thought that three types of pathology develop out of a lack of empathic failures. These three types of pathology are psychosis, pathological narcissism, and structural neurosis (Summer, 1994). *Psychotics* are individuals who operate at the level of consciousness before an awareness of the separateness of self-objects exists. For this reason, Kohut saw psychotic individuals as *self-less*, unable to be treated analytically. Patients struggling with *structural neurosis* represent the highest functioning level of pathology. These neurotic patients have a strong self, but often present with inability to achieve goals. Kohut did contribute some material on the treatment of these individuals. However Kohut's most profound contribution is in the area of narcissistic individuals. Kohut believed that narcissistic individuals struggle with underdeveloped self-structure that is easily compromised. Some narcissistic patients may have achieved a level of cohesion of self-structure but, under stress, this structure is prone to temporary fragmentation and severe regression (Summers, 1994).

While Kohut argued that we all have ongoing narcissistic needs which persist throughout the lifespan. His developmental model specifically serves to explain the

subjective experience of those individuals with extremely archaic self-object needs. According to Kohut, the narcissistic individual exists in a reality where everyone and everything is both an extension of the self and serves to accommodate the self (St. Clair, 2001). These individuals likely experienced a chronic lack of appropriate mirroring and opportunity to merge with an idealized object. Thus, self-structures are stunted and unable to deal with anxiety; minor disturbances are experienced as significant destabilizing traumas. Narcissistic individuals struggle with maintaining a precarious balance in which one's sense of self is both threatened by a lack of one's own achievement and the accomplishment of others. For these patients, the idealized parental imago and grandiosity pole are not well integrated into the structure of the ego. They are separate structures each with intense overwhelming needs. For this reason, many narcissistic individuals have difficulty developing relationships in which self-object needs are sufficiently met.

Other Self-States

Self-Psychology and Treatment

In self-psychology, the ultimate goal of treatment is the reactivation of original developmental arrests indicated by an underdeveloped self-structure. This reactivation is achieved through the nurturance of different types of narcissistic transferences (Goldstein, 2001). Kohut suggested that trying to understand a patient's subjective truth through the process of near empathy activates self-object transference. Each transference relates specifically to one of the three poles: grandiose, idealized or twinship (St. Clair, 2004). The mirror transference, for example, manifests as clients seeking acceptance, confirmation, and validation of their goodness and relates to the grandiosity pole. Clients

who experience this transference position often display accomplishments, or recount achievements in order to bolster their positive sense of themselves. The idealizing transference refers to clients who have deep admiration for the strength, intelligence, and inherent good in their therapist. The twinship transference becomes visible when client's express a sense of similarity between themselves and the therapist. In some severe manifestations of the mirror transference, clients may even begin to dress of talk like the therapist. While it is possible for all of the elements to exist in a treatment relationships, Kohut suggest it is likely that one will predominate during and given time-frame. Yet, over the course of treatment the development of a more cohesive self may partially manifest as a shift in predominant transference theme (St. Clair, 2004).

Special attention is given to the manner in which the patient perceives the therapist which in turn, reflects the type of transference being developed. The type of transference often reflects where in the two poles the most significant self-object failures occurred. "The therapist establishes a situation that encourages the reactivation of original developmental tendencies. For the narcissistic personality these unfinished developmental tasks are manifested in the narcissistic transferences" (Kohut, 1977 p.130). Leverage of empathic sensitivity is especially important in understanding and responding to transferences. However, because the development of self-object transferences represents a return to earlier states of vulnerability, defenses are sometimes erected to protect the fragile ego from the development of transference. This may manifest as a resistance to the treatment relationship. Unlike the traditional analytic view, Kohut considers this defense to be strength of the patient. In the face resistance to transference, Kohut considers the main goal of treatment to be assisting the client to

overcome a fear of being retraumatized, through empathic understanding. "The therapist serves as an auxiliary ego for the patient, relieving the underdeveloped structure from some pressure and responsibility" (Kohut, 1977 p. 130). This process helps the client to endure anxiety, loosening the hold of the immature defenses developed as a result of previous repeated empathic failures.

Some controversy exists within self-psychology regarding how to respond to client's direct requests to be gratified by the therapist. Some self-psychologists interpret Kohut's suggestion to respond empathically to narcissistic needs to include accommodations for client's reasonable requests which relate to specific self-object needs. In fact, these practioners argue that during early stages of treatment the patient, may not be at all conscious of a need to be mirrored or respond to an idealized object, yet are unable to function if these needs are not met (St. Clair, 2001). Other self-psychologists argue that empathic attunement does not necessarily include gratifying specific self-object related requests. Instead, they argue that the healing occurs as a result of the analyst's ability to understand empathically the client's unique need for the particular requests, an offering an interpretation. In the self-psychological context, interpretation serves not to make the unconscious conscious as in traditional analysis. Rather, it offers the optimal frustration necessary from the development of more self structure (Summers, 1994). Both schools advocate careful consideration of any request before responding, while also considering the varying needs of clients based on their own unique life experiences.

Narcissistic Rage

Inevitably, in the treatment of narcissistic individuals therapists will empathically

fail their clients. Even the most conscientious, committed worker will intervene in such a

way which provokes a regressive return to less integrated ego states. Often, a therapist

will come to understand they have empathically failed their clients when confronted with

narcissistic rage. Classical analysts understand narcissitc rage as the break-down of the

superego's regulation of the aggressive drive. However, Self-Psychologists understand

narcissistic rage differently. "Narcissistic rage arises when self or object fails to live up

to the expectations directed at their function" (Kohut, 1972 p. 644). Thus, the experience

of empathic failure from a self-psychological perspective, returns the narcissistic

individual to an unintegrated state of consciousness. (Mollon, 2001). Synonymous with

this state is *disintegration anxiety*, which self psychologists believe to be the most

extreme form of anxiety. "When experiencing disintegration ...the terror arises not from

a presence of an impulse or feeling but from an absence-a crack, a fissure in the mind"

(Mollon, 2001 p. 2) Because self-psychology understands the development of self as the

primary motivator in life, disintegration of the self is consequently the thing most feared.

Narcissistic rage thus represents a defensive attempt to ward off a regression to a

narcissistic stage when disintegration anxiety was prevalent. (St. Clair,2004). The

powerful emotion expressed correlates to the intensity of the ongoing need for self-object

attunement. Less extreme examples of narcissistic failure may not result in narcissistic

rage. In these instances, regression may manifest differently. Patients may report other

indications of a collapse of the self including lethargy, worthlessness, and powerlessness

(Summers, 1994).

Transmuting Internalization

Although, instances of empathic misattunement are uncomfortable for both therapist and client, ultimately recovery from these experiences can assist in clients achievement of treatment goals. In response to regressive periods or narcissistic rage, self psychologists examine their own behaviors hoping to uncover the source of a client's renewed symptoms. By accepting a level of accountability for missteps in the treatment, and interpreting the impact of these mistakes on the client, the therapist is able to restore treatment equilibrium. However, after such mishaps the treatment never returns to the exact place it was previously. "Each disappointment in the analyst leads to a microscopic bit of internalization of the functions provided by the idealized figure" (Summer, 1994 p. 275) Gradually, as a result of empathic attunement and consequent internalization, the client's ability to function independently of the therapist increases. This process is referred to as *transmuting internalization*. It is this incremental progression of idealization, disappointment, and restoration which ultimately facilities the development of self structure (Summers, 1994).

Self Psychology and Cure and Termination

As the client begins to develop a more cohesive self, the therapist will notice several changes in both the treatment relationship and the client herself. Clients will be better able to identify and secure more effective self-objects outside of the treatment relationship. In some cases, clients will pursue these self-objects, themselves. However, other individuals will require encouragement from their therapist in order to take risks in relationships, work, school, and other areas of life (Goldstein, 2004). Therapists will

notice the client's ability and willingness to ask for guidance in these areas, which exhibits a marked difference from archaic self-object transference position. Furthermore, clients are likely to express an increased interest in hobbies, a more developed sense of creativity, and enhanced yearning for closeness with others. Kohut would understand these changes as the manifestations of vitality driven by the development of a cohesive self. "[Cohesion] allows us to evoke…such diverse yet defining attributes of the self as those given by our abiding sense of being a center of initiative" (Kohut, 1984 p.99). Individuals who experience a successful treatment experience feel a sense of wholeness, balance, an continuity in time (Mollon, 239).

The end of self-psychological treatment, as in many other models, is often marked by some degree of regression. Kohut would explain regression as a manifestation of a state of mourning of the final relinquishment of childhood objects (Kohut, 1973). During the termination phase of treatment, the patient truly detaches from archaic self-object relationships in exchange for more sophisticated self object relationships. The result of the development of these new relationships is a "gradual transformation of the archaic grandiose self and of the archaic omnipotent imagoes of childhood into which the self was merged" (Kohut, 1977 as cited in Strozier pp. 289). The abandonment of omnipotent imagoes liberates creative energy, allowing for a sense of vitally never before experienced. This fullness of life is the ultimate manifestation of a cohesive self and the ultimate realization of Self Psychological treatment goals.

CHAPTER VI

MODERN ANALYSIS AND SELF PSYCHOLOGY: COMPARISONS AND
CONCLUSIONS

The research question guiding this study is: How do Modern Psychoanalysis and

Self Psychology define pathology, treatment, and cure as they relate to the concept of

pathological narcissism? The purpose of this study is to identify the strengths and

weaknesses of each theory while also considering areas of overlap in hopes to provide a

more comprehensive understanding of pathological narcissism. Ultimately, the goal is to

assist in the development of a higher standard of care for narcissistic patients.

Chapter III offered a brief overview of varying theoretical standpoints on

pathological narcissism. The chapter began with an introduction to DSM IV perspective

on the disorder. DSM is currently the primary tool used by social workers and other

clinicians for aid in diagnosis. Often, DSM criteria determine treatment plans, even for

psychodynamically oriented clinicians. It is for this reason the chapter begins with a

broad DSM understanding of narcissism, and then develops the chronology of analytic

thought on the disorder. Beginning with Freud's conceptualization of narcissism as

sexual drives turned inward, continuing with Reich's revisions of the drive perspective,

and ending with Kernberg's object relations conceptualization, the chapter offers insight

into the impetus for development of the two main theories examined in this study,

Modern Analysis and Self Psychology.

Neither Freud, nor his successors held a particularly humanizing view of the

narcissistic individuals. Freud deemed narcissists an untreatable nuisance, while Reich

developed a model specifically for high functioning narcissistic/neurotic patients. Kernberg engaged in treatment with narcissistic individuals; however, he leveraged abrasive interpretation techniques aimed at breaking down the narcissistic exterior. Thus, a need for more inclusive, humane treatments for narcissistic individuals was apparent during the time both Self-Psychology and Modern Analysis were developed. Chapters IV and V begin with biographical elements contributing to the development of the two theories, and then overview key components of Modern Analysis and Self-Psychology respectively including: development, definition of narcissism, treatment, and cure/termination.

Modern Analysis and Self Psychology differ dramatically in their conceptualization and treatment of pathological narcissism. Each theory understands development, definition of the condition, and treatment differently. Broadly speaking, the two models assume virtually opposite positions on the disorder. However, upon closer consideration some areas of overlap do exist. The following section of this chapter will review key concepts of each theory, highlighting areas of dissimilarity and overlap. Furthermore, it will explore ways in which complementary concepts from each theory can be used to enhance the other treatment model. Lastly, social work implications of the finding will be addressed, with consideration of the limitations of theoretical research.

Modern Analysis and Development

Modern Psychoanalysis subscribes to the traditional analytic developmental model. Like Freud and his followers, modern analysts assume the presence of distinct psychosexual stages in which specific developmental tasks are achieved. These stages correlate to biological based sexual or aggressive drives. Traditional analysis focuses on libidinal conflict which takes place in or around the oedipal stages, and correlates to the sexual drives. Modern Analysis is more concerned with early, pre-verbal stages of development which correlate to the aggressive drive. From a Modern Analytic perspective, symptoms are conceptualized as resulting from aggression turned inward, which results in ego fragmentation. From this developmental model, drives and drive conflict are considered primary motivators and sources of symptoms.

Self Psychology and Development

Self Psychology assumes its own developmental model. Kohut argued that through the process of effective empathic attunement, children develop a cohesive self. This self is comprised of three poles, grandiosity, idealized, and twinship. Each pole represents a significant developmental need, and relates to similar goals and abilities later in life. The degree of cohesion of the self directly correlates to the extent to which needs in each pole were met. Unlike Modern Analysis, Self Psychology does not consider drives to be major sources of motivation or drive conflict to be the primary source of symptoms. Rather, drive conflict only becomes problematic for those whose sense of self is underdeveloped, and thus unable to navigate conflict.

Development: Areas of Overlap and Dissimilarity

Modern Analysis and Self-Psychology leverage entirely different developmental models. The key area of dissimilarity is the disagreement regarding the relevance of drive conflict. Modern Analysis considers drives to be the primary source of motivation and conflict. Self Psychology relegates drives to secondary status, choosing instead to focus on self-structure. The two theories agree that some interruption in the developmental sequence results in ego fragmentation and ultimately symptomatic behavior.

Modern Analysis and Narcissism

Modern Psychoanalysis conceptualizes all symptoms to be the result of aggression turned inward as a method for protecting important objects. This internalization of aggressive energy is called the narcissistic defense. From this theoretical perspective, all symptoms are conceptualized as "narcissistic" as they are resulting from re-direction of aggressive drives internally. As a consequence of the narcissistic defense, the ego becomes fragmented by aggression. In the most extreme cases, severe ego fragmentation can result in psychosis. However, chareterological and neurotic symptoms also result from the use of the narcissistic defense.

Self Psychology and Narcissism

In Self-Psychology, the hallmark of narcissism is a lack of a cohesive self. This is reflected by a lack of integration of the poles, resulting in the erection of immature defenses. These defenses block the normative developmental trajectory, further impeding

self cohesion. Thus narcissistic individuals are left with extremely archaic self-object

needs. Self Psychology argues that narcissistic individuals understand everyone as

extension of themselves, or as a means to accommodation of their needs. Their

dependence on others often results in extreme "disintegration anxiety". Thus minor

disturbances are extremely destabilizing for narcissistic individuals, often prompting

regressive episodes.

Narcissism: Areas of Overlap and Dissimilarity

Modern Psychoanalysis and Self Psychology both assume that symptoms result

from a lack of effective parenting that somehow results in ego fragmentation. However,

the theories differ in their understanding of what interrupts development. Modern

Analysis suggests that internalized aggression results in symptoms, while Self

Psychology perceives a lack of empathic attunement to be the cause. Furthermore,

Modern Psychoanalysis defines narcissism more broadly than Self Psychology. From the

modern psychoanalytic perspective, neurotic, characterological and psychotic disorders

all have narcissistic elements. Self Psychologists would disagree, deeming narcissism a

characterological disorder.

Modern Analysis and Treatment

The goal of treatment in Modern Psychoanalysis is the resolution of the

narcissistic defense. The resolution of this defense is achieved through the process of

developing stages of transference and resistance in the treatment relationship. From this

theoretical perspective, resistance to treatment is indicative of pathology. The more

healthy and individual, the more willing she is to participate in the development of therapeutic treatment alliance. Furthermore, the therapist is said to have an objective understanding of dynamics in the treatment relationship. Unusual countertransferential responses are conceptualized as "induced feelings" from the patient. Ultimately, cure is achieved through the process of free association, by which aggressive feelings are discharged. Object oriented questions, mirroring, and the toxoid response are all techniques which assist with the discharge of aggression.

Self Psychology and Treatment

The goal of treatment in Self-Psychology is the client's development of a cohesive self. This is achieved through the therapist's empathic attunement to the client's unique subjective experience. Through this process, the client develops one of the three major self-object transferences, mirror, idealized, or twinship. The therapist understands that any resistance to the development of transferences as reflecting ego strength and is careful to respect limits patients set around this issue. Self-Psychologists use an intersjubjective approach to their understanding of the treatment relationship. The treatment reality is considered to be co-constructed, reflecting both the subjective experience of the therapist and client. The analyst uses mirroring, introspection, and interpretation to assist in the development of a cohesive self. Through the process of transmuting internalization, the patient begins to internalize aspects of the therapist and experience a reduction in symptoms.

Treatment: Areas of Overlap and Dissimilarity

Modern Psychoanalysis and Self-Psychology differ in their understanding of treatment goals. Modern Analysis identifies the resolution of the narcissistic defense as the primary goal while Self Psychology serves to facilitate the development of a cohesive self. Each theory understands the experience of the treatment relationship very differently. Modern Analysts focus on the therapist's objective understanding and directly contradicts the self-psychological intersubjective approach. Finally, each theory identifies its own techniques for achievement of treatment goals. The only overlap here is that both theories leverage *mirroring*. However, this concept is defined differently each theory, despite the common name. For Modern Analysts *mirroring* refers to the process by which the analyst mimics behavior, opinions, language of the client so as to express similarity. In Self-Psychology the concept refers to reinforcing the goodness, intelligence and achievement of the patient. However, the concept of modern analytic *mirroring* seems to directly relate to the nurturance of the *twinship transference* in Self-Psychology. Both theories highlight the importance of client feeling that she is in someway similar to the therapist.

Modern Analysis and Cure and Termination

For the Modern Psychoanalyst the hallmark of successful treatment is the ability to communicate frustration rather than direct it inward. This is evidenced by the client's increased ability to tolerate frustration along with an ability to express both positive and negative feelings. Additionally, successful modern analytic treatment produces clients who are more engaged with the experiences of others, with increased capacity for success

in romantic and other relationships. The termination process is said to begin once the analyst begins to notice increased verbal expression of frustration. The hope is that by introducing the concept relatively early in treatment, some of the regressive tendency can be avoided. Although, Modern Analysts expect that some resurgence of symptoms will occur around discussions of treatment.

Self Psychology and Cure and Termination

The ultimate goal of Self-Psychological treatment is the development of a cohesive self. This manifests as a patient's ability to seek out and secure effective self-object experiences. Also, the intensity of self-object needs diminishes, along with the likelihood of regression in the face of self-object failure. Clients report a sense of vitality, increased creativity, and appreciation for their own unique person. Often, the termination phase may include a period of mourning of the loss of childhood objects. This may account for some degree of regression in treatment, and resurgence of symptoms.

Cure and Termination: Areas of Overlap and Dissimilarity

Modern Analysts consider a cure to be evidenced by an ability to tolerate and discharge aggression verbally, while self psychologists highlight the effective acquiring of appropriate self-objects to be evidence of successful treatment. Both theories highlight attention to the needs of others as a clinically significant milestone, and also agree that a period of decompensation often occurs. Self-Psychology adds increased vitality and creativity as an the essential manifestation of cure

Theoretical Conclusions

At the heart of the disagreement between Modern Analytic and Self Psychology, is their varying definitions of what clinical phenomena actually constitute a narcisstic diagnosis. Although Self-Psychology in later years has been applied to a broader population, it was, in its inception developed in response to a lack of effective tools for the treatment of narcissistic character individual(Goldstein, 2001. Modern Analysis, although eventually applied to a larger population was developed for the treatment of schizophrenia.(Spotnitz It is this impetus for development, that I believe lies at the heart of the theoretical differences. At their cores, the theories speak to the treatment of differing clinical populations. Furthermore, the appropriateness of using each theory with different demographic groups varies. It is for this reason, that I do not propose a synthesis of the two theories as a solution for the treatment problem. Perhaps a more in depth analysis of the similarities between the two theories could enhance individual treatment approaches. For example, the exploration of the Modern Analysis' narcissistic transference through a self-psychological lens could offer some useful insight. Furthermore, exploration of the ways in which self-objects in Self Psychology help promote the development of narcissistic transference may also be warranted..

Social Work Implications

The merger of psychoanalytic theory and social work practice has long been the subject of scrutiny among some social work professionals (Donner, 1988 Horowitz, 1998, Goldstein 2001). Social work's person in environment focus can quickly feel lost in conversations about instinctual drives, innate aggression, and psycho-sexual stages. And

yet, some social workers find that in spite of the limits of psychoanalytic thought, analytic thinking can offer useful insight into the lives of our clients. "When used discriminatingly psychoanalytic thought has enriched the social profession, and allowed social workers to help individuals groups and families at a level of sophistication not otherwise possible" (Donner, 1988 p. 17). This portion of the analysis will leverage Horowitz's 1998 assertion that social work theory should be both *two person* and *post-modern*. By two person, Horowitz refers to a therapeutic setting in which the patient's reality and perception are equally valuable as the therapist's. Similarly, the post-modernist view discredits the existence of objective truth, preferring a co-constructed understanding of reality (Horowtiz, 1998). Horowitz argues that for psychoanalytic theory to be compatible with fundamental social work values, it must consider the impact the analytic situation has on the client. "The analyst's mind is also seen as shaped by his theory, his subjectivity, and the conscious and unconscious conversation with his patient. Working toward truth is done in dialogue with the patient comparing (Horowitz, 1998 p. 370). The following section of the paper will include a sub-analysis of the appropriateness of the use of Modern Analysis and Self Psychology for social workers working with narcissistic clients.

Modern Analysis: Two person and Postmodern?

Horowitz (1998) defines *modernism* as reflecting a belief in an objective truth. Freud, for example, thought it was possible for an analyst to study and ascertain the objective reality about his patient's symptoms. Horowitz argues that all of classical analysis and drive theory are slanted in the direction leveraging a modernist lens

(Horowtiz, 1998). Hyman Spotnitz defines his model as both "modern" and a drive

based theory. The existence of an aggression served as a foundation for Spotnitz'

conceptualization of narcissism and structuring of the treatment formulation. Spotnitz

believed strongly that repression of an innate aggressive drive was the source of the

symptoms. For this reason, the theory does not meet Horowtiz' requirement that theory

be post-modern in order for it to be appropriately applied to social work settings. Post-

Modern theories allow for flexibility and overlap in understanding of symptoms, while

Modern Analysis employs a rigid concrete framework for symptom analysis.

Furthermore, in Modern Analysis client feedback on treatment is often

conceptualized as resistance to transference. Clients who question the therapists methods,

ask for accommodations, cancel or miss scheduled sessions are considered to be resistant.

However, a strictly resistance based understanding of the clinical relationship diminishes

the impact of reality-based factors such as inaccessibility to reliable transportation,

culturally informed stigmas regarding therapy, lack of child care, and other such class

and racially influenced considerations. Acknowledgment of these factors is an essential

component of a two person theory. Yet, Modern Analysis does not make allowances for

the particular context in which behaviors and symptoms arise. Thus, those who do face

external barriers to treatment are considered to have more resistance and therefore more

pathological.

Furthermore, Modern Analysis requires that clinicians not broach any topic

clients do not directly address, making it impossible to initiate conversations about the

power differential in the therapeutic relationship which might prohibit clients from

addressing uncomfortable power dynamics in the first place. The rigidity of the model

does not allow for accommodation of socio-economic factors and their impact on the treatment relationship. Given Horowtiz' requirements that theories be two person and post-modernist, it would be difficult to argue for the application of this theory in the context of social work practice.

Self Psychology: Two person and Postmodern

Self-Psychology, like Modern Analysis assumes the objective presence of mind structure. The theory presupposes the tri-polar self as the fundamental essence of any being. However, this concept is relatively vague and fairly flexible. For example, Kohut suggests that every individual needs effective mirroring in order to bolster the grandiosity pole and achieve the appropriate balance in the self. However, Kohut considers that each child has different mirroring needs. These needs can be structured by different values of varying demographic groups. A clinician working in the self-psychological model could appreciate that given the value placed on motherhood and child-bearing, criticism of teen pregnancy could represent significant self-object failure for some individuals and cultures. In Self Psychology, the assumed structure of the mind accommodates differing socio-cultural based needs. It could be argued, that this accomodation represents a degree of post-modernism as the theory does not explicitly define each type of self-object need. The theory assumes a level of subjectivity common to post-modern theories.

Furthermore, the theory's emphasis on empathic attunement to the client's unique experience challenges the one person modernist perspective on treatment. Kohut's criticism of traditional analytic methods was in part informed by the rage often evoked by interpretive methods. Such interpretations reflected the analyst's truth, but did not

account for the experience of the patient. In fact, some interpretations may have been formulated for the sake of disproving the client's perspective. Kohut's emphasis on near empathy requires clinicians to stretch their perspective, to incorporate the unique experiences of clients. Rather than intervening with the therapist's observations, on symptoms, and patterns of behavior, self psychology encourages clinicians to manufacture interpretations which communicate understanding a connectedness. This emphasis is indicative of a two-person theory.

The breadth of concepts and treatment methods within psychoanalytic thought allows for varying compatibility with social work values. The criteria assigned by Horowitz in her 1998 article, requires that a theory be both two person and post-modern in order for it to be appropriately applied in a social work setting. The concepts leveraged in modern analysis do not meet criteria for being the best theoretical choice in social work settings, while self-psychology appears to be more compatible with social work values.

Theoretical Strengths and Limitations

Theoretical studies allow for the examination of concepts which are not quantifiable. This analysis provides a deeper understanding of development, narcissism, treatment formulation, and cure. Theoretical studies do not measure clinical phenomena, but rather elucidate nuances of complex theoretical comparison. Rather than measuring the effectiveness of a certain model, theoretical analysis promotes in depth understanding of each theory considered, providing social workers with the needed analysis in order to make an informed decision regarding the appropriateness of varying theories. The choice of a theoretical model is a highly personal decision, incorporating both the ability to

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address treatment questions relevant to a particular population, and also the innate qualities and strengths of a particular clinician. As social workers, we have opportunity to choose from varying theoretical frames, the effectiveness of many, are empirically based.. And yet our investment in any given frame, our belief in its truth and goodness, also weighs heavily in our ability to use theory in order to assist clients. For this reason, a theoretical analysis of Self-Psychology and Modern Analysis, two extremely different theoretical frames, offers clinicians more information that may help them to make informed decisions regarding which theoretical frame genuinely represents their own beliefs about development, pathology and cure.

However, theoretical theses are most effective paired with other data supporting the treatment questions. Stand alone, theoretical data merely allows clinicians a deeper understanding of theoretical concepts. Paired with analysis of the effectiveness of these concepts for particular treatment populations, clinicians would be best equipped to make decisions regarding theoretical choice, for treatment of pathological narcissism.

References

Banai, E., Mikulincer, M., Shaver, P.R. (2005). "Selfobject" needs in Kohut's self psychology. *Psychoanalytic Psychology*, 22 (2), 224-260

Berzoff, J., Melano Flanagan, L., Hertz, P. (2002). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts.* Rowman & Littlefield Publishers Inc

Baker, H.S. , Baker, M.N. (1987) Heinz Kohut's self psychology: An overview. *American Journal of Psychiatry,* 144, 1-9

Diagnostic and statistical manual of mental disorders (DSM-IV). (2000). Washington, D.C. American Psychiatric Association

Elson, M. (1986). *Self- Psychology in clinical social work:* NY, New York Norton Paperback

Freud, S. (1914) On narcissism: An Introduction. *Standard Edition,* 14:67-102. London: Hogarth Press, 1957

Freud, S.(1912).The dynamics of transference. *The standard edition of the complete psychological works of Sigmund Freud,*12, 98-121

Goldstein, E.G. (2001). *Object relations theory and self psychology in social work practice:* Free Press

Horowitz, J. (1998). Contemporary Psychoanlysis and social work theory. *Clinical Social Work Journal*, 26, 369-383.

Kernberg, O. (1976) *Object relations theory and clinical psychoanalysis.* New York: Aronson.

Margolis, B. (1987). Treatment and transition: Observations on modern psychoanalysis. *Modern Psychoanalysis,* Vol. 12, No. 2

Marshall, R. J. (200). Hyman Spotnitz and Sandor Ferenczi: Psychoanalysts of passions. *Modern Psychoanalysis*, 25, 1, 53-74

Meyer, W.S. (2004). The Psychoanalytic Social Worker/The Social Work
    Psychoanalyst: What Shall Be Our Message? *Clinical Social Work Journal* (28)
    4 355-367

McWilliams, N. (1994*) Psychoanalytic diagnosis: Understanding personality
    structure in the clinical process.* New York: Guilford Press.

Mitchell, S.A., Black M.J. (1995). *Freud and beyond: A history of modern
    psychoanalytic thought.* New York: Basic Books.

Reich, Annie, (1986). Pathological forms of self-esteem regulation. In Morrison, A. P.,
    (Ed.), Essential papers on narcissism. pp. 44-60. Reprint from (1960)
    Psychoanalytic Study of the Child. Vol. 15, pp. 205-32.

St. Clair, M. (2004).*Object relations and self-psychology: An introduction.*
    Belmont, CA: Thompson Learning.

Strozier, C. (2001). *Heinz Kohut: The making of a psychoanalyst.* New York: Other
    Press, LLC.

Sheftel, S. (1991). The Supervisory Process: Experiences of Some Institute Trained
    Analysts. Modern Psychoanalysis, 20:233-249.

Spotnitz, H. (2004). *Modern psychoanalysis of the schizophrenic patient.* New York:
    YBK Publishers