

The Many Faces of Narcissism: Theory, Treatment and Nosology A Personal Journey

Arnold D Richards MD

Since the topic of this panel is Narcissism, I think it's appropriate to start with my own. But fear not ;I won't talk about my humility; I don't need to.-Instead, I will begin with the story of how I developed an interest in our subject, which begins when the Bergmanns invited us to a dinner party almost thirty years ago.

I was at my first CAPS meeting in Princeton, so Arlene had to go without me. She sat next to a member of the Washington Square Institute, Ernest Angel, who told her about a panel on the Self that he was planning. She told him about my interest in the subject, and he invited me to be one of the panelists. That presentation, *The Self in Psychoanalytic Theory and the Self Psychologies*, was, as far as I can remember, my first public presentation; it was published in the *Washington Square Journal* and then in *JAPA* in 1979 .

Here's where I was coming from at that time: After graduating from the New York Psychoanalytic Institute in 1969, I continued my education at the Madison delicatessen (now no more, alas) at 86th and Madison Avenue. A group of us had lunch there every Friday -- Bernie Brodsky, Sandy Abend, Charlie Brenner, Arlene, and some others that came irregularly. At one of our meetings, I think it was in 1972 or 1973, Charlie Brenner mentioned to me that a book had been published recently by his friend Heinz Kohut. He suggested that I read it and let our little group know what I thought. I thought he was implying that there would not be much there, so I was surprised to find the book interesting and challenging. I was struck particularly by the idea that narcissism does not have to have a pejorative connotation, and by how Kohut seemed to be offering a way of treating patients who were not accessible to classical psychoanalysis. What I did with this idea, you will hear shortly.

But first, a theoretico-historical digression. It's easy to forget that the use of the term narcissism to delineate a specific category of patients is relatively recent. Freud used the term narcissistic neurosis, in contradistinction to transference neurosis, in the context of broad generalizations regarding analyzability. Narcissistic personality disorder was not listed as a diagnostic category in either DSM I (American Psychiatric Association 1952), or DSM II (APA 1968). It first appeared in DSM III (1980), and was retained in the DSM III R (1987) and DSM IV (1994). The three DSM descriptions of narcissistic personality disorder draw heavily on the contributions of two psychoanalysts, Otto Kernberg and Heinz Kohut, both of whom began writing about this condition in the 1970s, one from an object relations point of view and the other from a self psychological one. The clinical descriptions in the diagnostic manuals attribute to narcissistic patients an unrealistically inflated sense of self importance, preoccupations with fantasies of unlimited success," and "an exhibitionistic need for constant attention and admiration. Narcissistic people, DSM suggests, tend to feel entitled to admiration even without appropriate achievement, but their exaggerated self-esteem is fragile, and grandiose feelings of superiority alternate with feelings of unworthiness and deprecation. So there is both grandiosity (what Bach calls *the over-inflated narcissistic type*) and insecurity and inadequacy (what Bach calls *the depleted narcissistic type*).

But while there is a fair amount of agreement with the diagnostic picture of narcissism, we find no such agreement about etiology, pathogenesis, or development -- or about treatment. That is, there seems to be consensus about the description, but not about the psychodynamics. Kohut and Kernberg, at least, although they dominate the manuals together in unlikely harmony are in sharp disagreement. For Kohut, the narcissistic disorders reflect a psychological deficit due to faulty development caused by parental empathic failure -- that is, an impaired self.

Kernberg, on the other hand, attributes them to rampant inappropriate feelings of rage and hatred brought on by the child's internalization of disturbed relationships with others -- that is, to pathological object relations. According to Kernberg, the narcissistic patient is the victim of exploitative and frustrating parents, toward whom the child responds with rage, which in turn provokes further aggression. This is followed by projection and paranoid constellations that are defended against by what Kernberg calls faulty grandiose behavior.

In fact, narcissism is a confusing business. In the 1950s, Heinz Hartmann asserted that narcissism is equally connected to id, ego, and superego, and that it extends across the entire developmental spectrum. Michael Robbins (1982) considers narcissistic personality disorder an unfortunate term precisely because it evokes multiple and confusing usages involving the concept of narcissism, which has itself been used to refer to a type of libido, the earliest undifferentiated developmental stage, a type of object choice, an aspect of internalization, a regressive configuration, as well as a personality type. Then there is the issue of the development of self-esteem regulation, which is closely related to the narcissism concept. Different theorists emphasize different stages. For Kernberg, it is the early oral; for Kohut it is presumably the anal phase around the time the nuclear self emerges. For Annie Reich it is the phallic period; for Erik Erikson adolescence. Probably all of them are correct, which argues for the non-specific nature of any attribution of narcissistic personality disturbance. In fact, the title of our panel is, appropriately, the many faces of narcissism.

Back to my story. Shortly after Brenner had given me my little assignment, I began treating a patient with severe hypochondriasis in analysis at that time, and I adopted that point of view toward him. (This was the treatment that I described in my paper *Self-Theory, Conflict*

Theory, and the Problem of Hypochondriasis, the case that will serve as the clinical text for my presentation this afternoon. But I'll get to that in a minute.)

Another of my reactions to Kohut's first book was that it sparked my attention to the place of self theory and theories of the self in other psychoanalysts' work -- John Gedo, George Klein, and others. At the time, I was mostly aware of curiosity. But as I look back on my work, it seems to me that my effort was basically to defend psychoanalytic orthodoxy -- As I look back on my work, it seems to me that my effort at that time was basically to defend psychoanalytic orthodoxy to defend the faith, if you will. This effort showed up very clearly in a series of book reviews that I wrote, beginning in 1981 with John Gedo and continuing with reviews of James Masterson, Leon Grinberg, Bela Grunberger, William Meissner, Merton Gill and Irwin Hoffman, Michael Stone, Arnold Goldberg, Robert Stolorow, Fred Pine, Lew Aron Stephen Mitchell, Mitchell and Black, and a paper that continued my critique of Mitchell, *Squeaky Chairs and Straw Persons*, which was published in the *Round Robin*. Some of these authors got better treatment from me than others. In my reviews of Loewenstein, Wallerstein and Rangell, and in my introduction to the *Festschrift* in honor of Charles Brenner, I did not live up to the reputation I had acquired as the Mack the Knife of psychoanalysis. OK; that's the end of this historical preamble, whose relevance I hope will become apparent later in my presentation. Now let me turn to the subject of the panel, the many faces of narcissism, and to the career of my paper on narcissism and hypochondriasis.

This patient, whom I treated in the 70s, had, as well as his hypochondriasis, irrational ideas about his body and his sexuality; some analysts would likely have seen these as delusional, and close to psychotic. But my operative assumption at the time was that his symptoms were psychological, and that he was not suffering from a disease that required anti-psychotic

medication. My patient wanted analysis, and I offered him that -- four times a week on the couch. And it turned out that the treatment was successful. He married, had children, advanced in his profession, and except for a brief exacerbation connected with the end of his analysis, he seemed to put his hypochondriacal and other bodily preoccupations aside.

As I wrote in my paper, which was published in the 1981 volume of *Psychoanalytic Study of the Child*, he had evidenced many of the traits of a narcissistic personality disorder: an inflated self regard alternating with a devalued self image; a preoccupation with himself and his body to the exclusion of others; and grandiose fantasies that alternated with paranoid concerns about devouring imagoes. Instead of prescribing Haldol, I embarked with my patient on his journey of self-exploration. The transference gave us the signposts that helped us understand the key pathogenic configurations of his childhood. We got to what seemed to me, and also to him, a useful understanding of how the ambivalence conflicts of his early years were central to the pathogenesis of his symptoms, his inhibitions, and his passivity.

Now keep in mind that my theoretical armamentarium at the time was based on what I had learned in my classical training at the New York Psychoanalytic Institute, where conflict, defenses against sexuality and aggression, and compromise formations were the key concepts. But while Freud may have considered that patients with narcissistic neurosis were not amenable to psychoanalytic treatment, I did not feel the same way. In fact, I wrote the PSC paper to "prove," or at least try to make the case, that hypochondriacal and narcissistic patients were not owned by the Kohutians. As I think back on it now, I saw myself as a soldier in a theoretical turf war, defending conflict theory from the onslaught of the self psychologists. I threw down a gauntlet. I provided what I thought was detached clinical material to demonstrate that tried and true classical conflict theory was up to the task, and that Kohut's new psychic structures and

transference configurations did not add much to our conventional wish/defense/conflict/compromise approach.

I was not surprised to discover that there were folks about who were happy to pick up my gauntlet and to show me where I had gone wrong both in my theory and my technique. Five years after I published my paper, in 1986, Frank Lachmann published a paper in *Psychoanalytic Psychology* in which he attempted to show what I had missed. My contention was that the patient had been "cured" through interpretation of the ambivalence conflicts of his childhood -- that he got better because of understanding. Lachmann's thesis was that although the patient had indeed gotten better, he improved for a reason different from the one I was pushing. He got better, Lachmann said, thanks to an adversarial transference which I had never noticed, but which Lachmann did.

In his paper, "Interpretation of Psychic Conflict and Adversarial Relationships: A Self-Psychological Perspective, Lachmann said that "The analytic approach to psychic conflict is to interpret what the patient defensively needs to ward off. The approach of self psychology is to interpret the self object functions that the patient needs for self consolidation and self maintenance. He argued for a both/and approach -- a conflict drive defense model *and* a self psychological developmental deficit model. Referring to infant observation research that he and Beebe had conducted, he presented the proposition that psychic structure can be achieved through the interpretation of developmental arrests as well as the interpretation of conflict and defense. He preferred to see psychic conflicts and the silent self object transference as alternating figure and ground. He also rejected my (and Leo Rangell's) thesis that conflict theory *includes* the propositions of self psychology -- and our answer to the "what new" question, i.e., that *What is new is not right, and what is right is not new*. He was responding correctly, I would say now, to

the tone of my paper, which some might call aggressive and others defensive, but which was certainly adversarial and polemical.

But this was the early eighties -- almost fifteen years after I graduated from the NYPI. I was hoping to become a training analyst, and I needed to establish my credentials as a soldier in the theoretical psychoanalytic wars. (Is being appointed a TA equivalent to becoming a "made man"? A stretch perhaps, since TAs don't usually break anyone's kneecaps. But they do acquire an appointment for life with many similar perks and privileges, including the undoubted financial benefit of access to a group of captive candidate patients). That was at least a part of where I was coming from.

I think that the challenge my paper presented to Lachmann had to do with whether self psychology was really needed to understand why my patient got better, or whether conflict theory would in fact suffice. Lachmann accepted my assertion that the patient improved greatly, and -- as best I could determine from public sources about his professional and personal success -- maintained that improvement for a long time after the end of the analysis. It wasn't a perfect follow-up, but Lachmann didn't contest it.

His discussion took off from my description of the patient's disappointment in his father, which Lachmann characterized more specifically as a disappointment "in his father as an idealizable self object, specifically with respect to his phallic qualities would have led to further self disintegration. The "self disintegration" that Lachmann saw as a response to his father's failure as a self object was the root of his hypochondriasis. Lachmann saw in my patient in addition to an unconscious image of his devouring mother "a transference organized around his thwarted early need for merger with a powerful idealizable paternal imago..

I remember that when I first read his paper, I said to myself, "Let stop right here. *How* could we know that my patient early on had had a frustrated need for merger with a powerful idealized paternal imago? And if we were sure that was the case, how could we or should we convey it to the patient? And what would the patient do with the information? In my orthodoxy I was at sea with a strange new metaphor, and I didn't realize it; I couldn't see its kinship in kind to the older metaphors with which I was familiar and comfortable -- of intrapsychic conflicts and interpersonal Oedipal struggles.

But Lachmann offered a viewpoint that to some degree could accommodate us both. His formulation was that "unresolved issues with the autonomy-robbing mother and the search for an idealizable father produced subtle self object transference implications. With regard to the latter, Lachmann said, I gave the patient the experience of a benign antagonist -- what he called an adversarial relationship -- which served him both as a contrast to his own enfeebled self, and as a source of strength. I could understand what Lachmann had in mind under the rubric of the concept of identification that the patient could identify with a strong father figure and so feel stronger himself. But Lachmann contended that since I did not recognize the patient crucial developmental need for an idealizable powerful father, I also missed seeing his accompanying need to see the analyst as the embodiment of phallic power which he longed for. If I had, Lachmann asserts, it would have made a difference in the termination phase.

And that was something of a facer, because Lachmann had zeroed in correctly on the fact that as termination approached the patient hypochondriacal concerns returned. What I described as a resistance to termination and independence, Lachmann saw as similar to the initial resistance encountered in the treatment, "a product of the analyst theoretical convictions

clashing with the patient understandable exhibitionistic needs. I did not understand that "archaic self object needs were still operative -- that is, his needs for an idealizable powerful father

So, Lachmann implied, the patient got better not through interpretation, but through the use of an idealized self object. And according to Lachmann, I had not created the proper therapeutic and curative milieu of attuned engagement/attuned disengagement, of rupture and repair, that he saw as necessary for the "accretion of psychic structure. So, and this is the clincher, "the self object function had not undergone development transformations to become internalized, an aspect of the patient self regulatory structure.

Lachmann went on to parse another vignette from my paper -- the patient's memory of deliberately losing at ping-pong when he played with his father because he did not want to embarrass him. I had understood that to have to do with defenses against competitive wishes. Lachmann stressed the patient's need to maintain an idealized father image, and that recognition and acknowledgment of a patient needs is necessary for the patient internalization of the analyst self object functions. Lachmann concludes that my firm stand on several issues -- the psychological rather than physical basis of my patient problems, my mental health ethic, my privileging autonomy over infantilizing -- looked to the patient like an embodiment of the firm, powerful, even adversarial, idealizable father image the patient needed. But my theoretical commitments and my blind spots about the self object transference meant that there might be a limitation to the eventual outcome of the treatment. I had interpreted conflicts and defenses, and worked through resistances, but I had thwarted the patient needs for acknowledgment and for mirroring affirmation which could eventuate in both continued structural vulnerabilities and the renounced disavowal of aspects of self experience.

Mea culpa? Lachmann said, if my patient were left with less than an optimal capacity for empathy or for accepting the self object functions needed of him from others -- that is, if he ended up behaving like a narcissistic SOB.

So there we were, caught in two simultaneous narcissisms of small differences -- the theoretical struggle over my patient's psychopathology, and the interpersonal struggle between Frank and me, as we tried to understand and appreciate each other despite our different vocabularies, viewpoints, and anxieties. Twenty year later, as we shall see, our field is still playing out these narcissisms and these struggles.

Because the saga of this paper does not end here. Shortly after Lachmann's critique was published, a student in Doris Silverman's course on Ego Psychology and Object Relations, Mary Jennes Riane, wrote a discussion of it, which she called "The Conflicted Baby Goes Out with the Bath Water. In that paper Riane rightly faulted me for coming across as hostile to self psychology, for my either/or treatment of unconscious conflict and developmental deficits as polar opposites, and for my assertion that self psychologists downgrade the observational and intellectual skills of the analyst, placing, "an overriding importance on empathy. She thought that given my beliefs and my training, integration of a new point of view would not be possible. She nailed me, you might say, as the ideological captive of a training that had made me deaf to new points of view. And she was partly right; certainly I was having trouble hearing at that time. In my own defense I would say that I didn't yet understand the power of thought collectives and thought styles. I was part of the thought collective of classical psychoanalysis, and an as-yet unconscious partaker of a thought style that emphasized the roles of wish and fear, and of defense and conflict and compromise, at the expense of other possibilities. (It may also be true that I followed a little too closely Fleck dictum that everyone who belongs to a thought

collective believes that all who do *not* belong to it are incompetent.) And Lachmann belonged to a different thought collective, self-psychology, which had a thought style of its own that emphasized the centrality of self object transferences and empathic immersion. But what interested me at the time -- and what even from my post-Fleckian and more tolerant perspective I think is an interesting addition to this history today -- was that Raine found in Lachmann's paper a lack of conceptual clarity and terminological precision, and she proceeded to offer a list of points where she felt that Lachmann's rebuttals to my points were weak.

To summarize, she had a problem with Lachmann's argument that analysis of conflict doesn't do for the accretion of psychic structure the same thing that the delineation of self object transferences that are called adversarial will do. "The transference may have been organized around an early need for merger with a father," she says. "But where is the evidence for that?"

She was more persuaded by my depiction of the patient's repetition in the transference of his experience of a devouring mother -- where the analyst was a leech and a bloodsucker, robbing him of his money and his autonomy. She felt that Lachmann downplayed the wish-defense conflict constellation related to competitive and aggressive strivings. Hence her title about the baby and the bathwater. She concluded that the self psychological baby may be a frightened, dependent, and lonely baby, a thwarted baby, a needed baby, a vulnerable, infirm, or weak baby, but never an aggressive, rageful or conflicted baby. Raine missed Melanie Klein's infant in Lachmann's theoretical world. Yet yet another analyst putting her own narcissism on the line in an effort to clarify the elusive question of narcissism means in psychopathology.

Now let's fast forward to 2006, when Kenneth Newman delivered an unpublished paper at the 2006 self psychology meetings in Chicago. His title was "Therapeutic Action in Self

Psychology with a Special Focus on Two Dimensions of Self Object Failure. Ken was a member of Kohut's first group, the one that included Arnold Goldberg, Paul and Anna Ornstein, the Tolpins, David Terman, and others whom you all know. Newman discussed in his paper some of the directions that self psychologists have taken over the more than thirty years since Kohut launched a breakaway approach to psychoanalysis organized around the dichotomy of Guilty Man and Tragic Man. He took on the issue of the adversarial transference too, but his view was different yet again from Lachmann's -- and, of course, from mine.

Where Lachmann had taken my lemons and made lemonade, finding therapeutic value in my adversarial position to the patient resistances, Newman presents a different position. He wrote:

"Emphasizing that we as analysts are being deployed in the transference to fill in uncompleted psychological structure and to validate the significance of emotional requirements, relieves us from taking a role that patients experience as adversarial. We become focused on illuminating and accessing the patient's needs rather than discovering and interpreting hidden and illegitimate infantile wishes." Defense analysis creates an adversarial atmosphere, he says, and he cites Shafer's view that it is the pejorative view of resistance in the classical tradition that encourages adversarial positions. Lachmann, as I've said, thought that an adversarial atmosphere -- something easier to come by in the classical than in the self psychological tradition -- was useful here; part of my point in telling all these old stories on myself is to point out how long it is taking to resolve some of our questions about narcissism. Newman emphasized the environmental narcissistic trauma that produce developmental arrest, characterizing as "narcissistic" the self object transference? that "as they became elaborated appeared as

admixtures in rigidified form of the original needs as well as the adapted/maladapted defensive solutions. And he focuses on narcissistic *needs*, not the sexual or aggressive *wishes* central to conflict theorists. Where I aimed at interpreting the wish, for Newman the goal is to acknowledge the need. Where conflict theorists *interpret* the wishes connected with ambivalence conflicts of childhood, for Newman the goal is to *reactivate* arrested structures; the empathic relationship with the analyst -- not an adversarial one -- allows the development to resume.

For Newman, narcissistic needs, the needs of an impaired self, are central. Now, it is possible to make a case that conflicted sexual and aggressive wishes also impair the self. But if one did want to make that case, one probably wouldn't put it like that. Because the concept of self is central to what Ludwik Fleck, the Polish sociologist of science, would call the self psychology *denk Kollektiv* -- the thought collective of self psychology, and its characteristic thought style. In fact, the concept of self is so central to self psychology that it effectively differentiates it from all other psychoanalytic thought collectives. To check out this hypothesis I just went through Newman's paper and counted the number of times the word *self* appeared in his presentation. By itself 50 times. *Self objects* or *self object transferences* 55 times, plus 4 instances of *self-self object transferences*. *Self psychology* itself was referenced 23 times.

Vocabulary can define a theoretical group (cf. Wittgenstein's Language Games), and Newman's paper is a dramatic example of this principle. First you talk the talk and then you walk the walk. (Or is it the other way around? Fleck would say that first you think the think and only then can you talk the talk.) This may be why groups tend to separate, and why psychoanalysis is so prone to splitting. Self psychologists now hold their own meetings and have their own institutes. Same thing with the Relational School; they had a meeting in New York last December, and they've got their own journal. I am sure we could find the words that define *them*

-- relational instead of self; intersubjective and co-constructed transferences instead of self object or self-self object transferences. Classical analysis can be defined by its vocabulary, too; all psychoanalytic schools, I would argue, share the defining characteristics of a distinctive vocabulary. We probably share other things, too, like Fleck's sardonic dictum that the members of any thought collective tend to see outsiders as incompetent; this applies to all of us, and it explains in part the animosity between our different schools that has been so hard to mitigate. It certainly sheds some light on my own at times polemical and strident contributions, and on the responses of some of my would-be adversaries to them. At least that's how I understand it now. But now that this tendency has been pointed out to me, of course, I am trying hard not to see "outsiders" as incompetent; I leave it to others to judge whether I have tried hard enough.

In his discussion of my paper, Lachmann faulted me for taking an exclusive either/or position as compared with his inclusive both/and one. Raine did too, and they were both partially correct. But on rereading my paper in preparation for this presentation, I was somewhat surprised to be reminded that I had in fact discussed and delineated psychic conflict and developmental deficit not as polar opposites, but as interactive variables -- a view not so different from Lachmann's favored metaphor of the figure and the ground. Childhood ambivalence conflicts affect development, and developmental difficulties impact upon psychic conflict. In fact, I faulted Kohut (as I later on faulted the relationalists) for theorizing in the form of forced dichotomies: two kinds of libido -- narcissistic and object; two kinds of patients -- narcissistic and neurotic (my patient was both narcissistic and neurotic); two different conceptions of the mechanisms of therapeutic action -- transmuting internalization and change through insight; two kinds of dreams -- self state dreams and wish-fulfilling dreams. And above all, two broad classifications of the human situation -- guilty man versus tragic man, guilty man

suffering from conflicts and tragic man suffering from developmental defects caused by parental empathic failure. For Kohut, conflict theory is applicable only to guilty man and self theory to tragic man.

I wrote in the original paper: since Kohut sees people today as essentially tragic rather than guilty, he considers the conflict drive model as less relevant and less applicable to psychopathology and the clinical situation than the self model. Nor should it come as a surprise that in his later writings, particularly *The Restoration of the Self*, Kohut moves toward discarding the classical drive-conflict model and toward adopting a unitary position in which the psychology of the self is transcendent. Now, in my post-Fleck incarnation, I would see this as another figure/ground alternation, where the transcendent theory reflects current circumstances, but does not preclude other theories that in other circumstances might take on greater salience.

And the new PDM too installs Kohut and Kernberg as the defining polar contributors to the nosology of Narcissistic Personality Disorder. Kohut, as I have indicated, focuses technically on empathic attunement and exploration of the empathic failures of the therapist. On the other hand, and I stress that it IS on the other hand -- an opposite point of view -- Kernberg focuses technically on the systematic exposure of defenses against shame, envy, and normal dependency and their narcissism is blended with sadistic relations. The Kohutian baby is the unaffirmed baby; the Kernbergian baby is rageful, spiteful, and envious. Two babies, one diagnosis, two treatments.

Once upon a time, I would have concluded that a single diagnosis could not be based on diametrically opposite points of view; and that any diagnosis whose authority descended from incompatible arguments should be thrown out with the bathwater. In fact I made that argument

article in a 1994 paper, *Some Thoughts on the Diagnosis and Treatment of Narcissistic Personality Disorder* (*Issues in Psychoanalytic Psychology* Vol. 16, No. 1.).

Similarly, in my hypochondriasis paper, I asked: was my patient suffering from a symptom neurosis or from a narcissistic personality disorder? I concluded that he was struggling with both neurotic and character issues, and while clearly techniques may be honed to address different problems, I questioned any approaches that yoked theory and technique to clear-cut diagnostic categories -- such as the prescription of conflict theory for neurotic problems, self psychology for narcissistic disturbances, and object relations for borderline patients.

But now I am not so sure. Now I would consider that Kernberg and Kohut belong to two different thought collectives based on two different thought styles—Self Psychology and Object Relations Theory -- and that pending some determinative evidence, we will have to possess our souls in patience and tolerate two different understandings of a phenomenon with which we're all familiar. Physicists must wait for an adjudicating experiment before they can lay the steady state vs big bang dispute aside, and we are going to have to wait, too. And we may have to wait for a long time, since human development doesn't lend itself practically or ethically to controlled experiments.

It's easy to see how the personal and historical determinants of these thought collectives influence the theories they favor. Kohut and Kernberg had a lot in common. They were both raised in Vienna; they both trained as physicians and as psychoanalysts; they both ended up here. But Kohut was influenced by August Aichhorn and his non-confrontational approach to the treatment of delinquent youth. Kernberg was greatly influenced by Melanie Klein and her theoretical allies, both in Chile and in London. The two men may have seen very different

patients -- the ones Kernberg saw at the Menninger Hospital were likely far more disturbed than the ones Kohut saw in his private office on Michigan Avenue in Chicago.

Both developed techniques in keeping with their theories -- Kohut a non confrontational, feelings-sparing approach, and Kernberg a much more challenging and less supportive one.

There was a more active debate between the Kernbergians and the Kohutians in the 70s and 80s than there is now, when the two groups have for the most part gone their separate ways. In some ways the differences have gone underground -- the seamless entwining of their points of view in our diagnostic manuals testifies to this.

Yet fundamental theoretical differences remain unresolved. Not only the difference between the etiologies proposed by Kernberg and Kohut, but the more fundamental one between the self as individual and the self as experience. It's not like people haven't been trying, either. In 1952, Heinz Hartmann said:

In using the term narcissism, two different sets of opposites often seem to be fused into one. The one refers to the self (one person) in contradistinction to the object, the second to the ego (as a psychic system) in contradistinction to other substructures of personality (p. 12).

Hartmann was allowing for two separate frames of reference, and giving them both credence. He wanted to add the concept of the self to Freud's metapsychology, and the crux of his view was that the concepts of ego and self belong to two different domains. He was proposing a terminology clarification that would separate the subjective-personal realm from the objective-organism one, distinguishing between an organismic ego and the subjective self.

Hartmann proposed the term self representation as the correct opposite of object representation.

Ben Rubenstein put it this way: The self is the person a person is to himself, or Arlow

similarly, The self has been described as residing within the body or more likely within the head. The ego, however, resides within text books and monographs or psychoanalytic theory.

However, it took the self psychology thought collective to bring the concept of the self into psychoanalytic parity with the concept of the ego.

Twenty or thirty years after the narcissism wars, in his chapter on a psychoanalytic-based nosology in the PDM, Wallerstein distinguishes broadly between borderline states and narcissistic disorders, connecting Kernberg primarily with the first diagnosis and Kohut with the second, even though Kernberg wrote about both. He gives Kernberg credit for his contribution to our understanding of the psychogenesis, psychopathology, and psychoanalytic theory of the borderline states. But, he writes:

"The caveat here is that of a beguiling pseudo precision in the elaboration of nosological distinctions and the boundaries from the neurosis on the one side and from the psychosis on the other side, a pseudo-precision that can be—but should not be—drawn from Kernberg's formulations."

He offers a similar caveat about the contributions of self psychology to the genesis, pathology, and analytic treatment of narcissistic states: that is, that we must be wary of "an equally beguiling pseudo-ubiquity in being able to see narcissistic pathology everywhere, with a concomitant minimizing or ignoring object-catheted pathology." Certainly my patient's concern with a devouring maternal imago suggests the latter situation.

And it's unlikely that either Kohut or Kernbert, or Freud or Hartmann or anyone else, for that matter, has said the final word on narcissism. We are all aware of unanswered questions that come up in our practice, to which our theory provides no "good enough" answer. For example, self-esteem regulation may be affected by specific traumatic situations: childhood illnesses and

surgery; primal scene observations; sexual overstimulation; denigration of the child by parents and others. Self-esteem problems at any stage will affect the consolidation of self-esteem later. The problem we get into with the diagnostic category of narcissistic personality disorder used by Kernberg, Kohut, and others is that they are neither broad enough to encompass the variations we routinely encounter with individual patients nor specific enough to cover unambiguously the range of patients which show the characteristic clinical picture.

Reflections like these remind me of my own training -- not at the NYPI, but my earlier my residency at the Menninger Foundation. Karl Menninger anti-nosological approach was presented in a book, *The Vital Balance*, which my fellow residents and I had the privilege of reading chapter by chapter as Karl and Paul Pruser wrote it. The essence of the book is captured by Thiel who described what he considered the psychoanalyst point of view:

"When he is sitting behind the couch he is not thinking of a disease in the nosological sense, but of a personality with its uniqueness, with its strictly individual life history; he is feeling his way empathically into the complexities of his patient behavior and tries to understand and elucidate the dynamics and the genetic aspects of this behavior. He does not think of brain function, heredity, or constitution in general. He does not isolate symptoms into different disease entities, but sees them as possible and interchangeable ways of adaptation and Session of homeostatic equilibrium in this individual patient."

Wallerstein concludes with an acknowledgment: that there are "a plethora of new and still not fully resolved issues within the realm of psychoanalytic nosological formulations." Still, the worldview of the DSM is by now firmly established -- with insurers, third-party payers, mental health researchers -- and with us.. When we look at the patients in front of us, we bring more than our diagnostic handbooks to the task. We also bring to the consulting room our

personal histories and the theoretical allegiances that determine the diagnostic choices we make and the understandings on which we base them. Our understandings reflect the thought collectives we belong to, and may be different from the understandings of the therapist in the next room.

This may offend our narcissism and our need to be sure that there is a single exclusive truth that can be known. But to recognize this state of affairs will give us a better handle on the inevitable political and theoretical wars that haunt us now, and that -- unless we permit ourselves a more dispassionate understanding of the way scientific theories develop, and accord them the patience to develop as they must -- are likely to haunt us for a long time yet.

Development, after all, is a long process, both for theories and for people. While we wait for our theories to catch up with our observations, I would offer one caveat on the treatment of narcissism that applies equally to both of the thought collectives that I've talked about today. We should be wary of encouraging our patients to see themselves as victims, whether of a derailed developmental process (Kohut) or of an unmanageable instinctual endowment (Kernberg). We are better advised to encourage them to understand themselves as active participants, both in the developmental experiences that have coalesced in their pathology and in the therapeutic process of promoting change.

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