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Psychotherapy with a Narcissistic Patient Using Kohut's Self Psychology Model

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Abstract

According to Kohut's self psychology model, narcissistic psychopathology is a result of parental lack of empathy during development. Consequently, the individual does not develop full capacity to regulate self esteem. The narcissistic adult, according to Kohut's concepts, vacillates between an irrational overestimation of the self and irrational feelings of inferiority, and relies on others to regulate his self esteem and give him a sense of value. In treatment, Kohut recommends helping the patient develop these missing functions. Kohut proposes that the therapist should empathically experience the world from the patient's point of view (temporary indwelling) so that the patient feels understood. Interpretations are used when they can help the patient understand his sometimes intense feelings about any empathic failure on the part of the therapist, and understand why he (the patient) needs to restore solidity and comfort after being injured by any failed empathic (self object) ties. As insight develops, the patient begins to understand why he might experience these apparently small empathic failures so deeply.

In this article, therapy with a narcissistic patient is approached from the point of view of Kohut's self psychology theory, and the successes and problems that were encountered with this approach are described and discussed.

Keywords: Kohut, self-psychology, narcissistic personality disorder, temporary indwelling, self object, empathy, psychoanalytic psychotherapy, mirroring transference, idealizing transference, transmuting internalization

Introduction

Narcissistic personality disorder (NPD) is one of the least diagnosed of the personality disorders. However, it is estimated that the disorder, or narcissistic traits, are present in a large number of patients presenting to a psychiatrist's office with complaints of depression or other mood symptoms. Approximately 18 percent of males and six percent of females have narcissistic traits.[1] The prevalence of the full-blown NPD in the clinical population ranges from 2 to 16 percent and exists in the general population at a rate of less than one percent.[2] This disorder tends to be more predominant in male subjects with 50 to 75 percent of NPD cases being male.[2]

The main characteristics of NPD are grandiosity, need for admiration, and lack of empathy (Table 1). These characteristic behavior patterns can affect a patient's interpersonal relationships and life in a profoundly negative manner. Often these patients will outwardly behave with a sense of entitlement and superiority, be dismissive of others, and often display disdainful or patronizing attitudes. However, behind these attitudes, and central to this personality disorder, are low self esteem and feelings of inadequacy. Although many patients accomplish high achievements, eventually the characteristics of this disorder interfere with both the patient's occupation and his or her personal relationships. This is because the patient often is unable to recover from criticism or rejection and also because he or she has behaved in an unempathic manner with overall disregard for others.

Table 1

DSM-IV (TR) diagnostic criteria for NPD

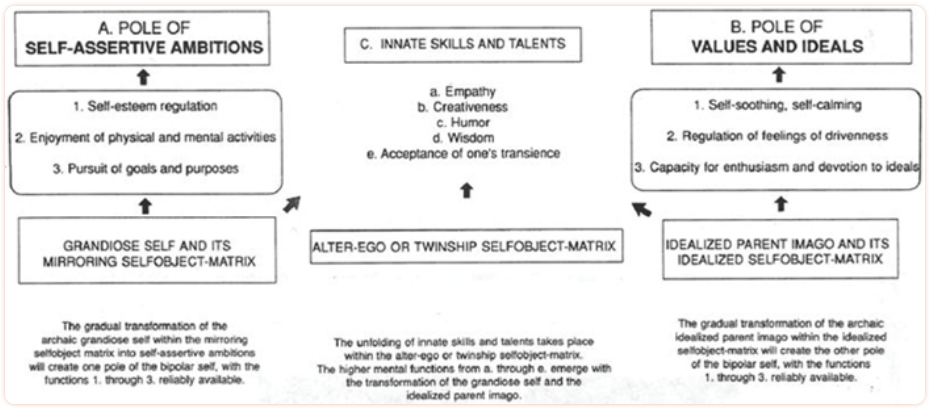
1. Grandiose sense of self-importance
2. Preoccupation with fantasies of success, power, brilliance, beauty
3. Belief that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people
4. Requires excessive admiration
5. Has a sense of entitlement
6. Is interpersonally exploitative
7. Lacks empathy
8. Is often envious of others and believes that others are envious of him or her
9. Displays arrogant and haughty behaviors

There are many theories about the causes of NPD. Often certain childhood developmental and parental factors have been implicated. An example of a developmental factor includes a postulated innate oversensitive temperament in the child; parental factors include excessive admiration by parents, lack of realistic feedback from parents during development, unreliable parental caregiving, and/or emotional abuse during childhood.[3]

Heinz Kohut proposes that in order to understand the narcissistic patient, the therapist must assume an empathic-introspective observational stance. By doing so, the therapist can understand the complex, inner world of the patient and the patient's inner subjective experience. The patient can then communicate freely, and the analyst becomes privy to what is being repressed or warded off by the patient. Self psychology, like object-relations theory, emerged out of an effort to treat patients who were not responding to ego psychology therapies constructed around the analysis of psychological defenses.[4]

Heinz Kohut asserts that adult narcissistic psychopathology is a result of parental lack of empathy during development. By failing to provide appropriate empathic feedback during critical times in a child's development, the child does not develop the ability to regulate self esteem, and so the adult vacillates between an irrational overestimation of the self and feelings of inferiority. Furthermore, the adult relies on others to regulate his self esteem and give him a sense of value, essentially looking for empathic feedback not received during development. Kohut believes that under normal circumstances, the developing infant has two important psychological constructs: the grandiose-exhibitionistic self

(normally evolving into self-assertive ambitions) and the idealized parental imago (normally evolving into internalized values and ideals). Pathology in the first area results in fixation on grandiosity, and pathology in the latter area results in deficits, where the psychopathology is rooted in fixations on archaic idealizations (Figures 1 and 2).[4]



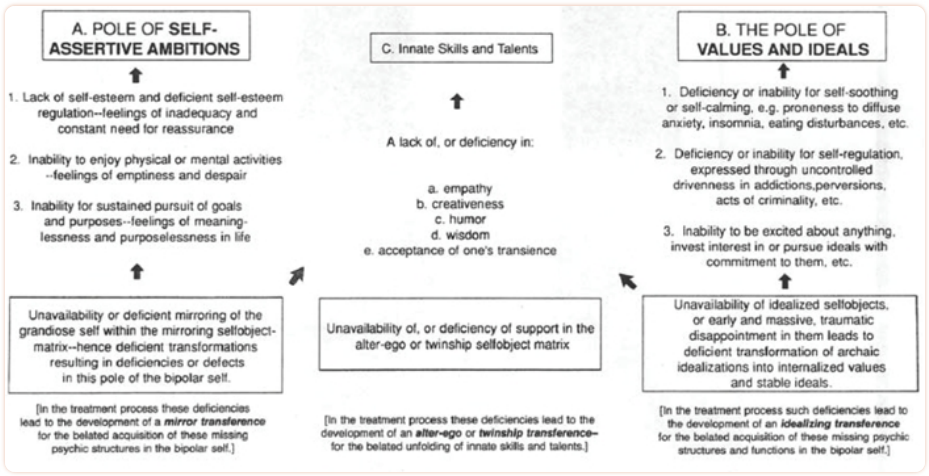


Figure 1 and 2

Structure and functions of the supraordinate bipolar self (deficient or derailed development, according to the self psychology model).

Used with permission from: Ornstein PH, Kay J. Development of psychoanalytic self psychology: A historical-conceptual overview. In: Tasman A, Goldfinger SM, and Kaufmann CA (eds). Review of Psychiatry, Washington, DC: American Psychiatric Press, Inc., 1990:303–22.

In Kohut's self psychology model, the dyad occurring between a child and his parents is a continually evolving process (via the formation of *self objects*). In Kohut's theory, a self object consists of the developing child plus each of those people who give the child the abilities to maintain self structure and firmness and a sense of cohesion and steadiness.[5] They are self objects because, according to Kohut, the infant is unaware that they are not part of his- or herself and that they are providing functions the infant will later learn to do on his or her own as these functions are incorporated into his or her psychic structure. In Kohut's model, when certain self object needs are not met empathically, a developmental arrest occurs and pathologic narcissism can occur. Kohut describes three reasons for this relative lack of parental empathy to occur: 1) A poor fit between the child and parents in regards to the disposition of both; 2) the parent(s) is unable to react to and nurture the child, which can often be secondary to physical or mental limitations; and/or 3) the child has unusually great self object needs.[6] Whatever the reason, the earlier and more pervasive the failures occur, the more severe the developmental arrest and the degree of narcissistic pathology in the adult.

Case Presentation (Composite Case)

Michael was a 38-year-old man who presented with complaints that he lacked the ability to develop and maintain friendships. He spent most of his adult life employed as a police officer but had made few friendships with his coworkers. He attributed this to their jealously of his intelligence and overall better skill, but also felt that it was also due to his inability to make small talk with people. He desired therapy because in one month he would be switching careers from law enforcement to fire fighting. He said that he wanted a quick fix in order to have an easier time making friends with his new coworkers. Furthermore, he said he was depressed, with low energy, poor focus and concentration, early morning awakening, decreased interest and motivation, and feelings of guilt and shame. Most of the stressors in his life were due to the fact that he did not have many friends or family in his life. In fact, he hoped that by learning to make friends he would also be able to form relationships with his children, with whom he had not had much contact in at least a year.

Michael was born an only child. His parents divorced while his mother was pregnant with him, and after his birth, his mother was left to raise him without the help or support of his father (His father left town never to be heard from again except on a few occasions in Michael's life). Consequently, Michael's mother worked two jobs in order to financially support herself and her son. This left Michael to be raised by various relatives in many different homes, as his mother would ask relatives if they could temporarily adopt Michael for short periods of time. Consequently, he lived in 11 different homes, many in different states, and attended nine different schools from kindergarten through high school. During his last years of high school, he lived with his mother and her boyfriend and was verbally abused by both. After high school graduation, he left his mother's home and married soon after. He and his wife had two children. They divorced after six years of marriage because “I just didn't love her anymore. She wasn't doing anything for me.” He remarried approximately three years later and had two more children. This marriage lasted nine years. Michael reports that his second wife “became too demanding and needy,” which he had difficulty tolerating.

Michael's children were all living in his current town, yet he did not have a close relationship with any of them. Michael named this as one of his sources of sadness and stated that more recently, as he was aging, he was starting to feel that they should want a closer relationship with him. He was able to admit that he was not a good father to them and was “emotionally not there.” Despite wanting a closer relationship with them, he felt that he had gone out of his way to communicate with them by e-mailing each of them and stating that he was not to blame for being a poor father since he was only parenting the best way he knew how. To do more, he stated, would “be letting them walk all over me.” He felt there was nothing more he could do and that they should voluntarily come to him.

Self Psychology

By describing the quest for a narcissistic individual to fulfill unmet self object needs, Kohut describes a certain aspect of narcissism inherent in all of us. Kohut describes the self as “the center of the psychological universe” and believes we spend our entire lives trying to build and maintain our self esteem through the use of self objects.[7] However, in contrast to other theorists, Kohut does not believe this type of narcissism to be pathologic and argues for continuity between normal infantile narcissism and pathologic narcissism. Kohut argues that pathologic narcissism occurs only with early self object failures. When these failures occur, these patients search for gratification of missing childhood self object needs in their adult lives. They also are fearful of encountering, or repeating, earlier past failures. Therefore, they may present with an attitude of superiority or haughtiness, reflecting anxiety they feel over encountering further self object failures.[7] This fear may also manifest itself in relationships. Patients with NPD may have a history of many failed relationships secondary to disappointment that the relationship is not giving them the longed-for childhood grat-

ification and their missing self object needs.[7] In the case presented in this article, Michael's perceptions of his current interpersonal relationships reflect this need for gratification, fearfulness, disguised as haughtiness, of encountering earlier past failures, and disappointment in current relationships causing him to abandon them.

Case Presentation, Continued

Michael's concerns over his children were soon placed on a backburner when his new career began. Instead of mentioning his children, every session focused on peer relationships with his coworkers and how he was feeling left out. He complained that he was never included in card games played during down times at the firehouse and that no one seemed to like him. He could not understand why this was happening to him again as it did with the police force. He said that he was "…someone they should all like. I mean, I'm cooler than most of them." He also struggled with learning that he was not the most skilled among his peers. During his training, all of his evaluations from his supervisors indicated that his physical fitness and knowledge of firefighting were average. They also indicated that he needed to listen better to suggestions provided by his more experienced peers. One supervisor said that it would serve Michael well to learn to better accept criticism.

Self Psychology, Continued

Kohut emphasizes that we all desire to be perfect, that all of us think of ourselves in a grandiose manner, and that these desires and thoughts are not initially subject to reality testing in the infant. However, with adequate parenting, these ideas are gradually lessened over time (although never entirely destroyed) through inevitable minor self object failures or optimal frustrations. These minor frustrations are necessary for shaping a child's sense of self but are not psychologically traumatic.[7] Kohut points out that it would be erroneous to believe parents can (or should) at all times meet the self object needs of a child as parents themselves are human and are not with the child at all times. Kohut believes these failures are necessary to alter the innate grandiose delusional ideas with which we are born because they require the child to learn internal mechanisms to self sooth and maintain his or her self esteem, despite not being perfect. Once these mechanisms are in place, the child relies less on self objects for appreciation and praise to regulate self esteem because the child can regulate it himself. In the narcissistic patient, self object needs were not met during childhood, and so these mechanisms never develop and he or she will continually look to others (self objects) for buttressing self esteem. Therefore, the narcissistic individual is very sensitive to any criticism or apparent rejection.

Case Presentation, Continued

Michael understood that he had a difficult time interpreting social cues and felt that this was the reason for his inability to make small talk or feel comfortable with making conversation. He would openly ask at almost every session what the therapist thought of his social skills. Later, he began directly asking how the therapist perceived him and how his coworkers might perceive him. He would often ask for the therapist's opinion on his appearance and the rightness and wrongness of his actions, and seek the therapist's advice on major and minor decisions. However, he only seemed to tolerate positive feedback and would become enraged if he received anything that he interpreted as criticism. Whenever offended, he would respond with such statements as, "Well how would it make you feel? You haven't had much experience as a therapist, have you?"

Practice Points

Parents normally meet self object needs of a child largely through two processes: The parent reflects back to the child the feelings and thoughts that the child is experiencing to give the child a sense of being validated and understood (mirroring transference), and the parent accepts that the child wants to view the parent as his or her protector and feel a sense of strength and comfort from doing so (idealizing transference).In the course of therapy with a narcissistic patient, these self object needs can emerge and are referred to as self object transferences. The two transferences that most often surface in therapy are the mirroring and idealizing transferences.[6]

Mirroring transference. The mirroring transference occurs when the analyst is experienced in fulfilling a structure-building function, a function the patient cannot yet perform for himself.[4] A simple example of mirroring might occur when a parent shows a sense of delight with the child and conveys a sense of value and respect. A narcissistic patient may need the therapist to provide the mirroring he never received in order to build a missing structural part of the self. In this simple case, any feedback deemed non-praising may leave the patient feeling worthless and not valuable. At times, unempathic interventions of the therapist may inadvertently repeat earlier similar trauma, easily injure the self, and result in anxiety with temporary fragmentation of the cohesion of the transference. Narcissistic rage may occur at times, which Kohut believes is caused by a deflation of one's archaic grandiosity or to a traumatic disappointment in an idealized figure (see 'Idealizing transference" next), and this rage can evoke intense and violent destructive responses. As such, it is a reactive aggression and is present as long as the self remains seriously vulnerable and prone to fragmentation.

Idealizing transference. A developing child needs to rely on the parent for safety, comfort, and calmness. In a normal child's development, the need for comfort from the external self object (parent) decreases as the child's internal means of self soothing increase.

The narcissistic patient may need to use the therapist for self soothing as this capacity was never fully developed. In doing so, the patient might assign his or her therapist imagined characteristics, such as strength, high intelligence, or beauty, in order to feel a greater sense of safety and calmness.[6]

Case Presentation, Continued

Michael seemed to have much difficulty with being the patient in the doctor-patient relationship. He also did not seem to tolerate the one-sided nature of psychotherapy and eventually said, "I think I'll go and see a different therapist, one who doesn't pretend to be perfect. I've been to better shrinks than you and they didn't just listen, they also shared about themselves. You act like you're a princess and like you don't have any problems. In fact, they say that shrinks are the most mentally ill people out there. You act like I'm the mentally ill one. I'm not mentally ill."

Michael also had difficulty in a social skills group, which was affiliated with a local hospital program and something he learned about through an advertisement on the radio. Even though joining the group was Michael's idea, he was reluctant to go because he was not convinced that he truly needed help with his social skills. Once in the group, he became more distressed and complained that he did not belong there. He became blameful and complained, "I can't believe you thought that the group would be a good idea for me. I can't believe you think I'm like them. They all have big problems...they're really messed up and I'm not at all. This makes me think that you don't know what you're doing." He attended several more sessions with the therapist's encouragement, but reported that the other group members didn't like him. Eventually, the other group members told Michael that he acted as though he was "better than all of us." Michael told them that he essentially felt that this was true and that he was leaving the group. The other group members did not seem upset by this news or ask him to stay. Following his exit from the group, he continually sought an apology from the therapist for thinking "that I was all screwed up like them."

Teaching Point

In addition to self object transferences, defenses may also develop during the course of psychotherapy. These defenses are used as protection against the possibility of re-experiencing self object failures in the therapy that were experienced in the patient's past. There are three major defenses, all fairly primitive and available early in life, used by patients with NPD. These are projection, denial, and distortion.8

Projection is defined as reacting to unacceptable inner feelings as if they were happening outside of one's body. Often these unacceptable inner feelings are attributed to or projected onto another person.[8] A patient with NPD will often feel uncomfortable with being the patient and feeling that he or she might have a mental illness. Projection was evident when Michael spoke of "shrinks" being mentally ill. In reality, it was too painful for Michael to face his fear that he might be mentally ill.

Denial is defined as completely ignoring awareness of painful stimuli or facts.[8] Denial differs from repression in that it does not just defend against effects, it ignores external reality. In NPD, denial is used as a means of maintaining self esteem in addition to avoiding painful aspects of life that might shed a negative light on the patient's behavior. Michael had a difficult time reviewing his parenting skills and thus denied the fact that he was almost entirely responsible for the lack of relationship with his children. Instead, it seemed easier for him to focus on how they were mean and cold children for not wanting him in their lives.

Distortion is defined as largely changing and transforming external realities to fit the person's internal needs.[8] Patients with NPD will use this defense so that reality meets his or her sense of entitlement. Michael distorted the reasons why his co-workers did not include him in their friendships, transforming those reasons into jealous ones. Believing that jealously was the reason they did not like him was a better fit for Michael's overall psyche.

Treatment

Using Heinz Kohut's self psychology model, the goal of therapy is to allow the patient to incorporate the missing self object functions that he needs into his internal psychic structure. Kohut calls this process *transmuting internalization*. In this sense, these patients' psyches are "under construction" and therapy is a building time. In order to achieve this goal, a therapist does not just try to imagine what feelings a certain situation might evoke, but rather can feel what the patient felt in that situation. This has been referred to as "temporary indwelling."[4,9] This empathy has been credited with being one of the vehicles for making lasting changes in therapy. Without it, the patient, whose self is too weak to tolerate more aggressive interpretation, would not benefit from therapy and in fact may suffer more damage. In accordance with providing continued empathic acceptance to what is transpiring in therapy, self psychology asserts it is not wise to agree, disagree, or gratify wishes of the patient or provide advice. To do so would change the therapeutic environment from one of empathy to one of judgment.[4,6]

Self psychology does not endorse using interpretations early in the therapy. Instead, self psychology asserts that allowing the transferences to unfold completely is the vehicle to helping the patient gain insight. When interpretations are called for, it is best to provide interpretations that focus on the patient's need to restore solidity and comfort after being injured by broken or failed self object ties (Table 2).[4]

Table 2

Main principles of self psychology

I. Separate developmental line of narcissism/new model of personality development and of the mind
II. Reconceptualization of empathy
III. Reexamination of transference (mirroring, idealizing and twinship)
IV. Deficit vs. conflict psychopathology
V. Reformulation of drive theory
VI. Therapist's contribution to psychotherapy
VII. Nature of cure: transmuting internalization
VIII. Reconceptualization of idealization

Presentation, Continued

Toward the end of therapy, Michael began to notice how “prickly” he could be with people and would comment on this. He began to notice that his frustration with people over their common mistakes or not living up to his expectations was excessive. Michael was also able to see that these expectations were too high, and consequently, his tolerance rose. In fact, Michael became noticeably more tolerant in therapy and less defensive. At one point, he stated, “You know, I'm constantly thinking about the reasons I'm angry when I get upset with people. You've made me stop and think if I'm out of line.” Likewise, Michael reported that he was feeling more comfortable at the firehouse. He even had a “buddy” who seemed to include Michael in the social aspects of the firehouse group.

Discussion

Self psychology has both critics and supporters. Critics have likened self psychology to nothing more than supportive psychotherapy and have doubted its ability to make lasting changes in patients. Some have stated that is too supporting of these pathologic patients, which allows them to bypass any responsibility for their conflicts.[10] Other critics have stated that although the theory of self psychology has broadened our views of narcissism and its development, it is incomplete and does not address some of the unconscious introjects of a patient's psyche. In other words, self psychology can adequately account for some of the pathogenesis of narcissism, but self psychology cannot be a “one size fits all” label applied to all narcissism. Instead, some think it better to think of narcissism as a behavioral syndrome with a number of different pathways of pathogenesis.

Supporters state that self psychology is a form of psychoanalytic psychotherapy. They argue that empathy, one of the crucial elements of self psychology, is comparable to interpretations in making lasting changes. In fact, supporters of self psychology feel that narcissistic patients have such fragmented selves that they are unable to tolerate interpretations at an early point in therapy. Empathy, one of the primary tools in self psychology, allows first for a therapeutic alliance to form. Then, the patient is able to fill in developmental voids by processing the positive experiences happening between him and the therapist through transmuting internalization. As therapy progresses, empathy allows the patient, who now trusts the therapist as a positive self object, to look beyond what the therapist can offer in the way of mirror-

ing or an idealizable self object. Instead, the patient is now able to examine his own perceptions of situations. Once this happens, the patient discovers further repressed conflicts and developmental needs and is now able to tolerate interpretations that focus on these repressed needs.

Empirical studies directly comparing self psychology techniques to other forms of psychotherapy are rare. One randomized, controlled study found self psychology to be more effective than cognitive orientation treatment in treating eating disorders.[13] The patients treated with self psychology had significant improvements while those treated with cognitive orientation did not. The process of uncovering the patients' underlying conflicts, which were not necessarily directly related to food intake, was proposed by the authors as the explanation for the success of the self psychology approach in contrast to cognitive therapy.[13]

On the other hand, Adler[10] mentions several limitations of self psychology. According to Adler, one of these limitations is that self psychology overlooks guilt as important in the psychopathology of narcissism. He contends that Kohut dismisses guilt because it is more likely an “intrapsychic phenomenon” rather than something that occurs as a result of interpersonal conflict, situations happening between two individuals, or empathic failures. This, as Adler points out, also lends credit to the critics that say Kohut's self psychology does not address unconscious or intrapsychic phenomena. Furthermore, Adler believes that a patient's guilt can be the cause for certain negative reactions in therapy, rather than always being reactions to empathic failures on the part of the therapist. Kernberg has some similar criticisms.[11]

As self psychology evolves, it continues to be in a state of flux.[14] Some may always argue that self psychology is nothing more than warmth and empathy and that most patients, to some degree, will have mirroring and idealizing transferences in the course of therapy as this is something we all desire.

Despite this, there does seem some lasting contributions of self psychology to the psychoanalytic field. It is unclear whether self psychology will remain a singular form of therapy or rather be broken apart into contributing pieces.[14] These contributions include the fact that self psychology provides a new developmental pathway of narcissism. Narcissism is less a “dirty” word since the advent of self psychology. Second, self psychology emphasizes the importance of empathy and how this tool may advance treatment. Third, self psychology very clearly elucidates the self object transferences. And fourth, self psychology brings to the forefront the therapist's contribution to therapy and the idea of intersubjectivity.[15] This intersubjectivity can be described as an interplay between the subjective experiences of both the therapist and patient and their “reactions to one another.”[15] The patient's psychology is understood only through the analyst's subjective lenses, so to speak.[15] In fact, a new relational perspective of therapy is beginning to gain ground.[15] In this perspective, facets of self psychology and intersubjectivity are combined along with facets from many other psychoanalytic theories.[15] This relational perspective focuses more on the two-person nature of therapy than that of classical analysis.[15]

Conclusion

Patients with NPD suffer a great deal. Kohut describes the depression and anxiety that a narcissistic patient may feel as “the deepest anxiety a man can experience.”[6] NPD has also been described to be as overwhelming as the fear of death.[6] The torment narcissistic patients suffer should never be discounted. Furthermore, these patients can and do present a risk. They feel less than human when they encounter even minor failures and, in order to regain a sense of unity within themselves, they act in ways that seem narcissistic to others, including suicide.

In formulating Michael's treatment program, the developmental model of self psychology was used to explain the pathogenesis of Michael's narcissism. His self object needs clearly were not met empathically by his over extended mother. As therapy progressed, however, it became clear that there might be other factors to consider in the development of Michael's narcissism, especially that of his basic biological and psychological temperament.

As treatment unfolded, the neutral and empathic stance, which according to self psychology the therapist should always maintain, became a difficult task. Michael's rage and sarcastic defenses were, at times, triggers for negative countertransference. In self psychology, it is the job of the psychiatrist to help these patients build for themselves the lattice of self object experiences in order to thrive beyond the therapy. However, narcissistic patients, such as Michael, can bring about quite a bit of countertransference in the psychiatrist, and at times, this may be overwhelming. In order to appropriately treat these patients, the psychiatrist must understand and be fully aware of these countertransferential feelings so that they do not interfere in therapy. Empathy has been referred to as crucial to the curative process in self psychology.[9] Countertransference can interfere with empathy, and without empathy, the tone of therapy will not allow for the patient's full elaboration of his self object needs. This was difficult to achieve during Michael's therapy.

Although providing therapy to a patient such as Michael who has NPD can prove challenging, it is also rewarding. Through growth in therapy, Michael ultimately found some relief, fleeting at first, from his depression and anxiety and learned ways to change some of his behaviors in a lasting way. As therapy progressed, Michael began to find some sense of unity, giving him a more durable peace within himself that was usually able to sustain him.

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