

**FURTHER RESEARCH ON THE DEVELOPMENT
OF NARCISSISM IN CHILDREN: LAST DECADE**

A Summarized Report

by

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**THE VULNERABLE CHILD DISCUSSION GROUP
THE AMERICAN PSYCHOANALYTIC ASSOCIATION**

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Chairman:	Theodore B. Cohen, M.D.
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Discussants:	Joseph Lichtenberg, M.D. Leon Hoffman, M.D.
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In his introductory remarks, Dr. Cohen called for celebration of the 30th year of the Vulnerable Child Discussion Group, the oldest of any such group at the American Psychoanalytic Association as well as the Association for Child Psychoanalysis. Presentations to the previous meetings have been published in three Vulnerable Child volumes, edited by T. Cohen, M. H. Etezady and B. Pacella. A fourth volume is now in preparation which will include today's contributions.

Dr. Mary Davis gave an overview of the work of the Study Group on narcissism during the past four years of its eighteen year history. She described the group's effort to refine and define the concept of narcissism. In 1995, the discussion revolved around cultural issues and how narcissism may vary in different cultures and the implications of guilt, group loyalty and independence. The group tried to distinguish between normal and pathological narcissism and distinguish primary from secondary narcissism. How does narcissism develop in the normal infant and how does it affect other aspects of development?

Later, we looked at mind-body issues, including ADHD, developmental arrest and neurologically based deficit as seen in pervasive developmental disorders. The effects of medication used in these disorders. Tourette's syndrome was considered as a neurological disorder in which the child often develops mal-adaptive and pathological defenses with strong narcissistic components. The effects of chronic trauma and its relationship to developmental arrest was discussed. The work of Anna Freud's Center and the concept of the analyst as a developmental object was compared to the transference object and the real object. The role of the support system and a holding environment in situations of trauma was discussed. Intervention with children with organic delays was considered where the child knows he is defective. We discussed the developmental need to tolerate and regulate affect. Psychoanalytic technique contains affects and through the use of interpretation reduces the intensity. Children who have failed with behavior or pharmacological interventions have been shown to improve with analytic treatment. Children treated with medication with ADHD continue to experience themselves as defective. When this turns into tantrums and problems of anger management they are labeled as "bad kids" reinforcing their own sense of being bad. The group sees narcissism as connected to maintaining a positive feeling about oneself. This requires availability of some external supplies, varying according to the individual. There is an evolving consensus that narcissism as a state or a process is a function of the ego and a part of the regulation of the self. In 1997 and 1998, we discussed Dr. Fonagy's material on mentalization and the ability to see oneself and others as intentional beings with a mental life. Insecure attachment or trauma interfere with mentalization and development of empathy. In 1998-99, the structural aspects of narcissism were scrutinized. Some thought of narcissism as a cross modal entity that cannot be attributed to a particular part of the psychic structure. Although there is consensus that normal narcissism is regulated by a homeostatic process there is no agreement as to what drives it. The relationship between narcissism and the ego, libido, aggression and external supplies have been under discussion more recently. What leads to pathological narcissism? Deficit or other problems of

development? We have more questions than answers, and if we can answer any one of the questions we have raised, we will have made a significant contribution to psychoanalytic thinking.

In his discussion of Dr. Davis' presentation, Dr. Lichtenberg prefaced his comments by stating that narcissism is whatever any of us say it is. He referred to his own writings in 1969 and 1978, concluding that the experience of narcissism refers to: 1. An affect or mood state associated with a fantasy, 2. A type of object relationship, and 3. A type of perspective from which the experience originates. This was based on Freud's psychobiography of Leonardo. Here the affect is the boundless love. The fantasy is of reunion with the mother, the child singled out as special. A later variant of bliss is to fill the universe with stupification via eternal glory and renown, as one can in dreaming of flying. The self and the object are blurred in distinction. The perspective is the one-sided view of the little boy gazing in wonder on the world. In this approach, Freud probed all secrets of nature maintaining this subjective element regardless of the objective methods he employed. This psychobiography was almost an autobiography as Freud was in effect describing his own genius as a natural scientist in the guise of understanding Leonardo. It is important to note that this is an experienced description without use of any metapsychology. This is where Freud is at his best. The question is whether there can be any metapsychological frame that can accommodate the vast range of all the areas that are involved in this topic.

Dr. Etezady's presentation was titled "*Narcissism, Pathology, Aggression and Clinical Utility*". He gave an overview of past presentations on this topic, to this group when contributions of aggression to narcissism and considerations of pathology had not been addressed. He also proposed to illustrate the implications of these views in clinical practice.

He reiterated the definition of narcissism elaborated in this previous presentation to the effect that narcissism as a homeostatic regulatory ego function serves to establish and maintain an affectively positive sense of the self. While primary narcissism belongs to the early preoedipal period, secondary narcissism is not operational until establishment of self and object constancy and resolution of rapprochement crisis. This is based on Freud's formulation stating that secondary narcissism begins when the libido is withdrawn from the object and is reinvested in the self. Primary and secondary modes of narcissism are distinct in character and quality and belong to two different developmental periods.

Dr. Etezady stressed the significance of Westen's view that narcissism deals with four separate but overlapping areas:

- 1). Ego-centrism: Ego-centrism is an attribute of primary narcissism in childhood which normally re-emerges in adolescence. In the fourth year of life, there is a cognitive transition that enables the child to hold in mind the world view of others and entertain alternative views of reality. This cognitive

transition depends on the ability of the primary object to play with the child's "pretend" thinking during a time when his actual thinking is inflexible and cannot accommodate the possibility of views or beliefs other than one's own. According to Fonagy, children deprived of such an opportunity in relationships with a libidinal object remain ego-centric and fail to achieve this cognitive capacity. This interferes with understanding of others, mentalization and empathic attunement.

2). Self organization and representation: Self organization is present at or before the moment of birth, on a hedonic level, pre-wired to seek attachment. Lichtenberg describes motivational systems that drive self-organization along several dimensions simultaneously and harmoniously. Stern identifies four periods of self-organization. First, is the emerging self, during the "normal autistic phase", when rudimentary elements coalesce to form emerging strategies for further organizing the experience. Second, is the core self, coinciding with the symbiotic phase, when the mother continues to lead the infant's own organizational resources to lay the foundation for confident expectation and trust. Third, is the subjective self of the differentiation phase and practicing sub-phase, when the infant begins to experience himself as a center of intentionality. Fourth, is the verbal self of the rapprochement sub-phase, when abstractions, sphincter control and the "semantic no" and a new level of ego maturity are present. Early introjects characteristic of primary narcissism begin to be relinquished. The healing of the split, fusion of good and bad and dissolution of infantile omnipotence follow. Disillusionment, loss and mourning lead to internalization, identification and structure formation.

3). Object relations: Object relations represent the interaction of the intrapsychic and interpersonal worlds. The ego, super ego and ego ideal structuralize around repeatedly recycled and re-metabolized introjects with their affective representations. The object world deepens as it also expands. Attachment to love objects maintains a mutually enriching connection to one's main sources of narcissistic supplies. Devotion to mankind and community is a higher order of sublimating this dependence.

4). Regulation of the state of the self and self-esteem regulations: There are contributions from the id and the ego on the child's side as well as on the mother's side. When the ego boundaries consolidate self-esteem becomes more definitively a province of the ego-ideal activated by signal affects, now emerging (anxiety, shame and guilt). When primary narcissism is retained and secondary narcissism has not proceeded in its development, self-esteem and regulation of the state of the self require primitive defenses against painful affects, i.e., idealization and omnipotent control of the bad object. The second and third year of life are crucial in the formation of identity and gender. During the phallic-narcissistic period, one's own gender, as reflected in the eye of the libidinal object, is the source of pride, self-esteem and self-acceptance. Exhibitionism is the hallmark of this period.

Dr. Etezady defined pathological narcissism as the persistent preponderance of primary narcissism beyond the third year of life when being on the way to self and object constancy should have begun. At this juncture, conflicts are triangular and resolutions are on the model of infantile neurosis, under the rubric of repression triggered by signal affects. While primary narcissism of the preoedipal period dominates in pathology, secondary narcissism couples with self and object constancy and a more mature phallic-oedipal mode of conflict resolution. Consolidation of the ego, super ego and ego ideal complete the cast of characters needed for conflict resolution and compromise formation. Unresolved conflicts or structural deficits in any of these components can lead to problems in development of secondary narcissism. Primary narcissism, like primary process thinking, is never completely relinquished and can be evoked in regression, creativity, dreams, etc.

Pathological narcissism can result from trauma, deficit, conflict or biological factors associated with regression, fixation or arrest. We encounter pathological narcissism in psychotic, borderline, organic or neurotic patients. In all clinical situations, we view narcissism as a potential ally, one that our technique seeks to protect and enhance. We encounter narcissism in all patients, not just in those we treat for narcissistic disorders.

Regarding the role of aggression in narcissism, Dr. Etezady explained that an affectively positive sense of the self is produced when the fusion of libido and aggression results in an equilibrium that favors the libidinal charge. Initially, aggression is split off in order to protect the pleasure ego and selfobject representations from annihilation. Through holding and containing function, the good enough mother libidinizes the child's experience in facing obstacles so that the aggression mobilized by pain and frustration can be mitigated and neutralized. This is the highest achievement of the rapprochement period which sets the foundation for realistic yet subjective assessment of reality, internal, interpersonal or external. This ushers in the complexity of higher order of affects which are the currency of relatedness to others and to one's own subjective universe. In secondary narcissism, neutralized aggression is the reservoir of energy for the ego and its defenses. "Spoiled" children have mothers who sidestep rather than contain the child's transgressions, which perpetuates the symbiotic illusion of omnipotence and entitlement. When the libido-aggression balance favors aggression, the masochistic self controls the sadistic object by clinging and enduring pain. In narcissism, however, the object is abandoned in favor of the idealized selfobject. When aggression is not neutralized it may be externalized by attacking the object or one's own self as in self-mutilation, suicide or self-beratement.

Dr. Etezady then gave two examples. One concerned the analytic treatment of a failing professional with depression, addiction, somatization, polymorphous perversion and constant groping for symbiotic merger states. He was the first born of a depressed mother who hated him as he reminded her of his abusive alcoholic father. When he was thirteen months old a sister was born who was the apple of the eye of the

mother. Feeling lost and rejected, he created a universe of fantasies in which he was a lofty prince, hand-picked by a “queen-godmother” who needed him for giving her endless pleasure by sucking her genitals. This defended against his rage, hunger and sense of worthlessness. Using Mahler’s framework as a beacon of orientation, the analysis succeeded in neutralization of his aggression by containing his rageful hunger. This led to the healing of the split and ego growth. Oedipal conflicts were then amenable to resolution within the transference. Finally, he was able to live humbly, happily and gratefully, in the real world as a devoted father, caring husband and a competent professional.

In his second example, Dr. Etezady described treatment of many children with antisocial and coercive behavior who were reliving their “terrible two’s” and their unresolved rapprochement crisis. Once it was possible to teach the parents how to establish and maintain a predominantly positive emotional atmosphere in their interactions with the child, welcome results were prompt and gratifying.

Dr. Etezady proposed that Mahler’s separation-individuation theory provides the most helpful of all psychoanalytic models of the mind in addressing developmental, etiological and clinical aspects of narcissism. It is the only theory that both views object relations from an ego psychological point of view and sees the intrapsychic from an interpersonal perspective. It describes the subjective universe of one-person psychology in the intersubjective language of a two-person psychology and explores the intersubjective in terms of a one-person psychology.

In his discussion of Dr. Etezady’s paper, Dr. Lichtenberg commented that ego-centrism, object relations and self regulations are areas that Freud described and dealt with. However, every attempt that has been made to deal with these areas ends up as a theory of development rather than the narrow focus of narcissism. Regarding problems of metapsychology, it is obvious that the hydraulic model cannot apply here because in the mother-child relationship, it is not a matter of one gaining and the other losing, it is rather a matter of mutual enrichment. What matters is the mother’s ability to recognize what is going on in her baby. This determines the nature of a response that can make sense at any given time. She can only do that if she can process her own inner world, through a reflective awareness of the impact of what affects her, through her own inner monologue, which she often says out loud to her child. This is taking responsibility for dealing with conflict and building something that involves words. This is a matter of how things are worked out in a dyad, it is not about quantities of drives of any sort. This is the same with the father who is involved in his own dyadic relationship along the same lines. The matrocentric notion of our theory is another concept that doesn’t apply because that is not how a family group works.

Another problem is the use of two separate lines of development, object libido and narcissistic libido which even Kohut started with. In my way of thinking, it is a matter of whatever is the dominant need or theme that the mother or the therapist is responding to. This may be physiological regulation at one time. Other

times the dominant need may be attachment. Self-assertion may be the need in another situation. When humor and play are included along with other motivational systems then the real life of the child is being addressed. Aversion is another idea with self-protective antagonism and withdrawal. Sensual-sexual system of motivation would be another focus. Addressing these motivational systems and responding accordingly is a better way of dealing with a clinical situation than trying to sort out whether something is primary or secondary narcissism.

Dr. Myersberg observed that some of our older theories do not take into consideration recent expansion in scientific discoveries, as we hold on to what we know not to be true any longer. We tend to view the infant as an isolated entity when it has been shown that the child does not survive outside of a dyadic system or thrive when the dyadic relationship is disturbed.

Dr. Etezady responded that even though he agrees with the preceding comments and conclusions, he strongly disagrees with the idea that we should discard older and earlier models. Since all theories have their own short comings and no models would suit all situations all the time, we would be in a better position to use the existing models of the mind to the extent that can serve our clinical needs. The fact that new knowledge has provided us with new theoretical concepts does not mean that we should discard our classic concepts such as the drive theory.

Dr. Share commented that our interest in narcissism started with the recognition that normal narcissism was very important in development and it was being missed. This also interfered with the proper understanding of pathology, since much of the latter was due to deficit in development of normal narcissism.

Dr. Lichtenberg commented that he didn't imply that our old theories should be discarded. Also, that Dr. Etezady's use of Mahler's theories in understanding his patient worked well for him. But the unanswered question is how it is that many others use many other theories and still achieve good results using different approaches and divergent views.

Dr. Freeman's presentation was titled, "*Narcissistic Well Being and Integration: Semantic and Developmental Perspectives on Narcissism*". Addressing problems with the term "Narcissism", Dr. Freeman elaborated on the variety of ways we have used the term remote from its original meaning. Some time, narcissism connotes a healthy state of secure positive feeling about one's self and one's relationships with others. Other times it refers to pathological grandiosity and lack of meaningful relationships. While narcissism originally denoted pathology, it was later used to describe secure confidence concerning one's own worthiness and positive value in the eyes of others. Pathological narcissism is a pressured state of unsated neediness, a grandiose self image in absence of stable self-esteem. Feelings of inadequacy are negated by creating an illusory omnipotent image. Normal and pathological narcissism are at two opposite

poles. Pathological narcissism is a defensive striving for unattained narcissism. It is a solipsistic self-indulgence that fails to build true safety or esteem worthiness: what troubled Narcissus was a lack of healthy narcissism, not an excess or altered version of normal narcissism.

The term “narcissistic object choice” is another example of this paradoxical usage. The term narcissistic object choice refers to the choice of a friend or a mate not because they are like one self, but because one feels less than complete and wishes to acquire the admired qualities of that person. We need to distinguish epigenetic stages in developmental line of narcissism from pathological phenomena.

When we use the term normal narcissism we refer to a positive affective state of well-being achieved as a result of ego and auxiliary ego activities, reliably fulfilling libidinal needs. It is a derivative of the state of pleasure and satiety of early childhood when the needs for affectionate intimacy and ego needs for mastery have been gratified. Before the differentiation of object and self, the infant’s affectionate feelings are global and one cannot speak of “self-esteem” before there is a sense of self and a capacity to conceptualize being esteemed and valued.

In healthy narcissism, the individual is secure in his experience of being valued by himself and others. In pathological narcissism, the individual tries to reverse inadequate self regard by grandiose fantasy and seeking confirmation from others without really relating to them.

In infancy urges for interactive pleasure energize and activate a search for a responsive mirroring being. When the mother reacts with a twinkle in her eyes, the baby reciprocates, setting up a resonant smiling and babbling social interaction. Libido is invested in the global “self-mother” experience of sensuous intimacy. The purified pleasurable self-object memories of this universe are divided in three groups; pleasurable images of self, mother and their interactions. Pleasurable experiences derived from the infant’s inner and surface sensations contribute to the core of narcissism. Purified pleasurable memories that come from the child’s outer-oriented perceptual modalities become organized as a good “transformational object” image that become the focus of affectionate feelings that later develop into love. Purified, pleasurable memories of mirroring, attunement and projective identification contribute to the formation of empathic awareness of the feelings of others.

Accumulated memories of effectiveness also contribute to healthy narcissism. The infant’s cry initially functions as a reflex signal. Later, vocalization is used as a tool of appeal. If the mother-child relationship is stable, the child develops confident expectation concerning the future and his own ability to seek and achieve satiety. The infant experiences affectionate feelings towards the omnipotent mother as an active agent of transformation.

The baby is driven by a libidinal hunger to take in pleasure through affectionate interaction with the mother. External supplies are actively sought and appealed for. However, as the individual matures, healthy narcissism depends less on external supplies and more on the person's own ego function, mastery self-evaluation and sense of inherent worth. Healthy narcissism may be better described as confidence in one's ego ability to adapt, autonomously and/or with the help of others, as well as a contented feeling of esteem and lovability in one's own eyes and the eyes of others. It is based on the ego mediated maintenance of narcissistic integration rather than a refueling, although it does include the flexible ability to fall back upon, and be strengthened by relationships with others.

Dr. Stanley Cath commented that what has been said applies throughout the life cycle. In old age, however, self-renewal and self-reliance is less independent of others. Emotional refueling in relationships with others, be it one's offspring or therapist, gains even more importance.

Dr. Lichtenberg said he views the difference in the old age not in terms of needs which are present throughout life, but in terms of the dominant motivational systems, wishes and desires. Dr. Lichtenberg elaborated on the cultural interpretations of the myth narcissus in the Greek origin as opposed to its Judeo-Christian version - psychoanalysis needs a better theory of how cultural values are established, what values in one's self are allowable or disallowed. The most pathological sources of self-regard are: a). trauma, b). abuse, c). contempt. Contempt by parents is the most profound cause of paralysis of a sense of self-worth. Contempt and shame are central in this regard, yet contempt is never talked about in psychoanalysis. In my motivational systems, there are values that are always present from day one. They are present intersubjectively and not only in representational, but in procedural memory. Our affective procedural life is solidly based on values and what elicit those values.

Dr. Ruttenberg's presentation was titled "*Thoughts on Narcissism: A Distillation*". He defined narcissism as a superordinate and integrating force necessary for normal psycho-emotional and structural development that combines libido and narcissistic supplies of the economic theory together with ego function and self-image of the structural view. Its changes over the life span, can be described in terms of object and social relations, mastery, enhanced self-esteem and replenishment of narcissistic supplies. Margaret Temeles described such a developmental line based on affectionate interplay and response to achievements that enhance narcissistic supplies and elicit self-esteem. Collarusso has followed this through the late mature and retiring years.

Congenital and prenatal factors conspire to enhance or often impede the initial endowment of the life force that is the precursor of narcissism. Spitz has described this impediment post-natally in analytic depression and marasmus. The term primary narcissism can be loosely applied to this initial endowment. We can view the development of normal narcissism as a continuum associated with gradual development of object

relations and sense of self. One form of pathological narcissism is retention of or reversion to a predominance of primary process type narcissism beyond its phase specific stage. Here the person feels unrealistically entitled and is seen by others as self-centered or “narcissistic”. Retaining a degree of primary narcissism acts to give coloring, flair and eccentricity to one’s personality. This initial endowment drives the infant’s behavior toward engaging the world eliciting affecto-motor responses that re-enforce the infant’s solicitation. In this way, mastery over helplessness augments healthy narcissism. Partaking of intentionality with direction and goal, (like a drive) is linked with assertiveness, ambition and aggression. Body control and parents’ positive mirroring reactions create a sensory motor body image from which derives a more mentalized sense of self. At that point, self-esteem becomes a part of an ever expanding internalized mental representation, through mastery first of the body and then of objects in its surroundings. Self-esteem then is a precipitate of a sense of accomplishment affirmed by objects of attachment and monitored by the ego capacity for reality testing. Because normal narcissism affects all aspects of development, its precise definition is difficult to formulate. By studying pathology, where the development of narcissism has failed, we can learn more about the normality of narcissism.

For example, children with healthy narcissism usually do not become self destructive or hatefully aggressive which would represent a lack of bonding with the nurturing environment and no regard for human life, neither for others or one’s own.

Self-mutilation and head banging in stimulus-deprived children on their way to marasmus suggests that what we see is a last ditch effort to avoid a total collapse of a sense of self, thus a part of life instinct not a death instinct. This supports a unitary theory of instincts and is an example of how a study of pathology of narcissism can lead to a broader understanding of the complexity of the forces driving behavior and how it can guide our clinical approaches.

In his presentation, Dr. Share noted the many confusing and at times conflicting references to the concept and stressed the difference between normal and pathological forms of narcissism. Normally, the individual possesses a sense of himself as a totality with adequate feelings of self-esteem. He is gratified by his accomplishments, takes deficiencies in stride and relates to others in relative comfort. Narcissistic pathology represents a failure of the processes that are needed for these functions. These formative processes are connected with intrapsychic conflict triggered by anxiety or other dysphoric affects. Thus this pathology concerns absence or deficit. Grandiosity, omnipotence and hypersensitivity fit such a schema as do many depressive diatheses and personality problems. This is comprehensive in scope, affectively and cognitively based and inseparable from biological and psychological development. While normal narcissism appears to operate like a drive, its cognitive and affective roles are much more important. These are conceived in terms of ego and superego functions, self-reflection, self-esteem, self-regulation and love or approval from others, i.e., narcissistic supplies. Mastery generates gratifying affects from

within as well as the environment. These affects are connected closely with built-in physiological modalities which perceive and monitor motor and organ functions. Self-reflection and self-gauging are present from early and gradually mature in proximity and affective relationship with the nurturing object. They are influenced by genetic endowment and neurophysiological status. Temeles has described the role of parents' love and approval in enhancement of narcissistic supplies, essential in formation of positive self-image and normal narcissism.

Thinking, motor performance and response to stress depend on issues of self-esteem as an important part of normal narcissism. Adaptation to danger is aided by normal narcissism as are overall mental and perhaps physical functioning. Neuroscientists have shown that affective evaluation of danger occurs via thalamo-amygdala circuits bypassing the cerebral cortex which contributes to a more accurate representation somewhat later, after affective aspects of danger are already in place. Emotionally tinged memory of danger is retained. The animal can anticipate the danger and react accordingly. There are two key implications, that affect is encapsulated in memory and that there is little or no memory without affect. From early on, affective influences link synergistically with genetic and biochemical processes essential for normal narcissism. Adaptive functioning is often regarded as characteristic of healthy secondary narcissism. The quality of secondary narcissism is a function of the quality of internalized object relations. Libidinal drives are considered the prime movers of the process even though they have been modified to become ego functions. These adaptive functions are indispensable for optimal development and conflict resolution. In this formulation, assertiveness and mastery are seen as closely tied to normal narcissism and, therefore, not related to Freud's dual instinct theory. This view of normal narcissism supports a conceptual split between assertiveness and mastery on the one hand and destructive aggression on the other, e.g., that in the presence of healthy narcissism destructive aggression does not tend to appear. Mastery and assertiveness in this view are outgrowths of ego maturation rather than sublimation of aggression. One may still regard aggression and libido in degrees of fusion as the constant force behind these psychological processes and are based on individual, genetic and biological connections.

In his discussion of this material, Dr. Lichtenberg offered total agreement in separating assertiveness from antagonism and aversiveness. Regarding destructive behavior, attachment research shows that securely attached children show empathy for others and engage in altruistic behavior easily. Anxious, ambivalent children feel an attraction, become afraid and then withdraw. The dismissive children don't look to the mother for a sense of safety or to register a protest. They contain a mass of antagonism internally and become the bullies in the school yard. Children who are anxious-resistant look for something good in others but easily turn away. They are the victim children. The ability to idealize, feel safe and valued in the presence of the other is an important aspect of healthy narcissism. The capacity to provide this sense of safety is absolutely essential if one is to be an effective therapist. The other group of children are the disorganized children who can't even establish a strategy to get what they need from others. They are the

borderline and dissociative who go from one extreme of appealing to another of antagonizing. They typify pathological narcissism. Attachment is based on three essential components. One is safety and protection. Second is affection and desire for one's presence. Third is being able to obtain information that enables one to form their own world and network of information and inner monologue that provides contact with the inner experience. This is what we tap into through free association. The person who puts their inner monologue closer to their discourse is one who we say has healthy narcissism. The person who is afraid of how this may be received and whether it might be safe is the person we would say has pathological narcissism. Between the ages of three and six, play, pretend and reality have to be distinguished along with the recognition that experience varies according to perspective. That the same person can be nice or mean and that you can have an influence on how this plays out. That thoughts can be private and people really cannot read your mind. Reflective awareness has to begin. Complex distinctions are established between the inner monologue and spoken discourse. By the age of six, an autobiographic narrative begins. All this between ages of three and six have to come about in order to allow for healthy narcissism.

Rather than talking about healthy narcissism, one just as soon might talk about how to function best in mental health. My superordinate approach is to talk about a cohesive sense of self, at work with the exigencies of the intersubjective world of the individual.

Dr. Freeman spoke of not needing to resort to a single perspective dismissing all other theories but how to put together all the parts of the elephant in a single whole using simple everyday words. This is especially important if we are sharing our views with people from other disciplines or other cultures who are not familiar with our jargon.

In his paper titled "*What are the Origins of Ego and Narcissism?*", Dr. Rashkis likened the events of early infancy to the "Big Bang" theory and the subsequent tranquillity of viewing from a distance that can give us an idea of what may have occurred "in the beginning". He offered material from the treatment of a middle-aged man to consider the early beginnings of ego and narcissism.

The patient is a well-respected, married professional who women find attractive and invite him into sexual relationships which he is unable to rebuff. He fears if he rejects their advances he would face **DOOM**, i.e., an extreme of isolation and rejection. Yet if he complies, he is exposed to another more realistic doom. The conflict as to which doom to choose drives him "crazy". He was referred for treatment a long time ago by a woman who was trying to convince him to divorce his wife and marry her as the only rational course to follow.

Dr. Rashkis described his own involvement in writing definitions of 25 psychoanalytic terms for the American College Dictionary and later as consultant to Webster's Third, Unabridged, the meaning of

narcissism was cited as “heavy investment of libido in one’s own ego”. This makes no sense to him now and he hopes in future editions this will be changed. Dr. Rashkis shared in the impression of some of the colleagues who view narcissism as a vital force, even before birth, serving the survival of the organism. Differing from others, he sees narcissism as an operating system that persists throughout life. The ego, dealing with the harshness of reality becomes another operating system. He sees the two operating systems intertwined , each requiring input from the other, to produce a balanced individual with, among other terms, color and shading added by narcissism, which provides magic, romance and nostalgia. On the other hand, narcissism’s call may be regressive. But how are these influences developed in the child?

It becomes the job of the ego to modulate the more primitive regressive impulses while the energy for both systems is derived from libido. Narcissism comes largely from the mother. Most of the post-conception year is spent in the mother’s womb. Mitochondrial DNA comes only from the ovum. The patient mentioned here had a seductive and domineering mother. The father was overwhelmed by life circumstances and by his wife. Much of the ego ordinarily comes from the father, although some mothers may be a better source.

Babies receive narcissistic supplies for merely being there. If they don’t, they won’t thrive. But not much is initially done for ego development. When children receive supplies for being there, this goes to narcissism. When they are applauded for accomplishment and intentional acts serving mastery it goes to the ego. Eventually, we learn how to deal with flattery. Caregivers decide when to complement a child on the basis of projection of what they would have intended if they had done what the child seemed to be doing. The most well-intentioned parents may unwittingly overfeed their child with narcissistic supplies or starve it. “The preceding formulation may not be familiar” Dr. Rashkis noted, “but as a perennial consultant I expect to do more than repeat the conventional wisdom”.

In his discussion of these presentations, Dr. Hoffman commented on the inability of narcissistic patients to learn from experience and their reaction to routine frustrations of life as if they were catastrophic. He presented a vignette, from the treatment of such a patient, age seven, who reacted to his comment with rage and paranoia and refused to return to the office which resulted in the interruption of her treatment.

Dr. Hoffman described a countertransference error which he had not recognized at the time. He had commented to the patient, “I don’t understand why it is so difficult for you to lose a point, even though you win every game”.

This kind of failure often occurs with patients who do not possess a narcissism which serves to establish and maintain an affectively positive sense of self, as Dr. Etezady discussed. This patient exemplifies problems described as four distinct and overlapping domains of narcissism: ego-centrism, self-

differentiation and representation, object-relatedness and regulation of self and self-esteem. Dr. Etezady states, “neutralization of aggression which is the highest achievement of the anal-rapprochement period sets the foundation for realistic yet subjective assessment of reality, internal, interpersonal or external”. Dr. Etezady points out how mothers, like my patient’s mother, who have difficulty taming their own aggression cannot help their infants do the same. Some may say my annoyance at the moment was a result of projective identification in which the child provoked my aggression. The analyst needs to be aware of his or her own aggression stirred up by these vulnerable patients who are ego-centric with poor self-differentiation, problems in their object relations and in their self-esteem regulation. I think narcissism, aggression and mentalization are closely connected. Fonagy and others have stressed the importance of mentalization in the taming of anti-social impulsivity, beginning within the mother-child dyad. Mayes and Cohen have studied this process and theory of mind which develops by age 3-4 and refers to the capacity to understand that another person has a mind independent from the child’s own mind. In a chaotic early childhood, the infant fails to achieve the ability to feel safe in a relationship and to develop reciprocity. They are unable to anticipate or predict interpersonal events and cannot tolerate normal frustration. Impoverished relationships with others leads to impoverishment in cognition and relatedness which results in pathological narcissism. Dr. Fonagy prefers the term mentalization or reflective function which denotes the understanding of one’s own as well as others’ behavior in mental terms. Freud notes that civilization has to use its utmost efforts in order to limit man’s aggressive instincts and their manifestations by reaction formation. Hence, the use of identification and aim-inhibited relations of love and the commandment to love one’s neighbor as oneself. Nothing runs so strongly counter to the original nature of man. I suggest that this group consider the integration of cognitive theories in distinguishing normal from pathological narcissism.

Dr. Freeman makes a profound and provocative suggestion that pathological narcissism is not a distortion of normal narcissism, but an absence of true narcissism. Does a child who will later develop pathological narcissism have a defect in his or her capacity of a reflective function? Blos spoke of defective symbol formation as a factor in acting out which excludes mastery and serves avoidance. Perhaps, we can further our understanding of these children via the concept of mentalization. Perhaps, with our new imaging techniques we can understand connections between emotional trauma and brain development. We can also observe the actual impact of psychotherapy on the brain, as in a recent Finnish study. Dr. Ruttenberg comments that from the very beginning parents’ positive reinforcement and reflective cheering one on provides a milieu that regenerates libidinous energy. Parents who can provide this positive cheering allow their babies to develop their own reflective function. Dr. Share proposes a clinical split between assertiveness and mastery in contrast to destructive aggression. In those with adequate reflective function, the aggression, regardless of intensity would not preclude a total lack of understanding of the other person’s point of view. Finally, Dr. Rashkis’ idea that the ego modulates narcissism’s regressive impulses, while the energy for both is derived from libido may be conceptualized from the perspective of cognitive

development. Without adequate cognition, regressive impulses, particularly aggression cannot be mastered.

In helping these patients, a long-term predictable and neutral relationship is essential. For these patients, the transference is real, not “as if.”

Fonagy stresses patience and interpretations of the moment to moment changes in the patient’s emotional stance as well as focusing the patient on the therapist’s experience. With my patient, my frustration interfered with my patience to wait for the opportunities to understand her inner experience in order to help her reflective function.

In his concluding remarks, Dr. Etezady took issue with the tendency to question whether narcissism does or does not consist of or include the ego or the drives, whether it is libido or what kind of libido. If we consider Brenner’s idea that every psychic entity is a product of compromise formation between all components of the mind, then this question can be dispensed with. He, also, saw no justification for dismissing Freud’s dual instinct theory on the basis of Dr. Rutterberg’s observation of self-injurious behavior in autistic children. Similarly, he questioned the validity of Dr. Share’s observation that assertion is not related to aggression since it is not destructive. He felt there is no need for dismantling currently existing psychoanalytic theories in order to understand narcissism. Destructive aggression does present itself in normal narcissism, but it is contained by ego mastery and it is in the service of the ego. Regarding normality versus pathology, he said we find primary or secondary narcissism can each appear in either normal or pathological forms. Pathological narcissism can already have begun during the first year of life.

He described his presentation as an attempt to present a unitary theory in standard and familiar terms that draws upon all the existing models without a need for dismantling, dismissing or antagonizing any school of thought. All models have their own virtues as well as their limits. It is a matter of what we find most helpful in our clinical work. He said in his own work he finds Mahler’s theories most advantageous because they view the intrapsychic world of the infant in interpersonal terms and bridge ego psychology with the intersubjective experience of the infant as well as the mother. It is compatible with, and complementary to, both attachment theory and self-psychology. It sheds much needed light on modes of prevention, treatment, research and parenting.

Dr. Freeman agreed with Dr. Etezady’s critique of Dr. Rutterberg’s ideas of a life force driving self-injurious behavior in autism. There are no means of confidently identifying the energetic sources of the behavior which we observe in infants. He, also, emphasized the value of integrating all of our knowledge and observations to enrich our understanding, as each individual frame of reference is a valuable tool to work with.

Dr. Share agreed with a comment by Dr. Lichtenberg to the effect that affects override cognition and the important bearing of this notion on the clinical work. He, also, commented on the work of the neuroscientists which is related but different from our psychology, even though we need to include their findings in our formulations when a correspondence is present.

Dr. Rashkis commented that our science is based on our clinical experience. We need to reduce our theories to clear concepts before we can look for biological or chemical correlates.

Dr. Lichtenberg stated that all vertebrates need to process information. All primates need to process and communicate. Humans, in addition, need to communicate symbolically. Language is an absolutely essential characteristic of humans. Infants do better if they are viewed by their mother, before they are born, as lovable and appealing. Regarding Dr. Hoffman's case, Dr. Lichtenberg observed that the problem was paralysis of empathy and failure to consider the child's perspective.