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NARCISSISTIC DISORDERS IN CHILDREN: AN OBJECT RELATIONS STUDY

by

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I. INTRODUCTION AND LITERATURE REVIEW

Over the past thirty years, there has been a growing and active debate that centers on the etiology and treatment of narcissistic personality disorders. The divergent perspectives that have evolved from this controversy will be reviewed in the following sections. My understanding, which reflects a personal interest in child work, and the developmental thrust of much of the literature, is that disorders of narcissism are related to problems in the development of the self and involve an interference in the normal process of separation and individuation (Mahler, Pine & Bergman, 1975; Masterson, 1975). More specifically, that as a partial result of a parental difficulty in assisting particular children with the negotiating and relinquishing of normal omnipotence, these children have difficulties regulating self-esteem and establishing mutual, autonomous relationships. If accurate, children with a primary narcissistic disturbance, no matter what their clinical presentation, should all have common underlying self and object representations, which are laid down and consolidated during this period. These representations would reflect a reliance on an omnipotent sense of self, a refusal to acknowledge shortcomings and vulnerabilities, and a tendency to manipulate and use others for personal gain. Such findings would have implications for any therapeutic relationship and potential transference or countertransference dynamics. For example, treating these children (and adults),

because of their characteristic ways of relating to others, may require modifications to a clinician's usual technique or repertoire. Among other considerations, the phrasing of interpretations may require particularly careful attention, especially before a working relationship is established, in an effort to avoid a narcissistic injury that may lead to treatment being prematurely terminated. An understanding of narcissistic vulnerabilities would also help to modulate the inevitable and well-documented countertransference reactions (Beren, 1998). Identifying children with underlying narcissistic vulnerabilities and modes of relating through projective testing during the assessment process would aid clinicians in devising a treatment plan suited to their particular needs and limitations.

Narcissistic Personality Disorder (NPD) was introduced into our diagnostic system in DSM III (APA, 1980), due to widespread usage of the term by psychodynamically-informed clinicians. The DSM III definition arose from a summary of pre-1978 literature, which was largely theoretical and therapeutic, with little empirical examination (Gunderson et al., 1991). The vicissitudes of narcissism continue to be a major focus of the psychiatric literature, particularly among psychoanalytic clinicians. For the most part, current models of both normal and pathological narcissism are based upon developmental formulations supported by reconstructions from the analytic treatment of adults. The literature barely addresses narcissistic pathology in children. The absence of such a focus could be attributable to several factors. These include a paucity of developmental and clinical descriptions to facilitate conceptualizations, and a hesitation to diagnose characterological disorders in

children (Egan & Kernberg, 1984). In addition, a great number of these children are treated only for their overlaying Axis I disorders (with medication, short-term treatment, etc.), and therefore any underlying personality factors are left unaddressed (Rinsley, 1980). Although a few authors have examined narcissistic traits and disturbances as they emerge in children (Bleiberg, 1984,1988; Egan & Kernberg, 1984; Beren, 1992; Rinsley, 1980; Bene, 1979; Wilson, 1988), and their clinical descriptions can be remarkably consistent, there is not yet an agreed-upon definition of a narcissistic disorder in childhood.

Narcissistically-disturbed children may vary greatly in their interpersonal adjustment and observable behavior, and often present to the clinician with diagnosable Axis I disorders reflecting their problems in the management of anxiety, moods or behavior. For example, impulsive, aggressive behavior may lead to being characterized symptomatically as having Attention Deficit or Oppositional Defiant Disorder. As is true for adults, a disorder of narcissism as a primary clinical diagnosis is relatively unusual in both inpatient and outpatient settings (Gunderson et al, 1991). However, in the midst of this diagnostic diversity, common and specific features are apparent. For example, clinical descriptions converge in their emphasis on narcissistically-disturbed children's lack of empathy for others, over/under-valuing of themselves, and precocious or uneven areas of ego development. Parents and teachers refer narcissistic children to treatment for a variety of symptoms including "disturbances in interpersonal relationships; coldness, exploitativeness, excessive efforts to control and manipulate; impulsivity and poor tolerance for frustration; school problems (usually

underachieving); mood swings, irritability and lability in self-esteem; persistent lying, stealing and chronic violation of rules; exhibitionism, haughtiness, arrogance and a constant need for attention and admiration; self-doubts and intense envy" (Bleiberg, 1984, p. 504). Many of these children meet all or some of the DSM IV criteria for Narcissistic Personality Disorder in adults, which includes the following: grandiosity, preoccupation with fantasies of success, a sense of entitlement, shame/rage reactions to criticism, and a tendency to be interpersonally exploitative (American Psychiatric Association, 1994).

I became particularly interested in these children while studying at The Anna Freud Centre in London, where my first training patient was a narcissistic child. I worked with this nine year old boy (who will be presented in more detail later) for a year and a half on an intensive basis, and the treatment was fraught with difficulties. These were due to his rigid grandiosity and denial, exclusionary omnipotent fantasy play, and my strong countertransference reactions. After the termination of what seemed like a largely unsuccessful treatment, I became interested in learning more about children with similar disturbances, and the challenge they presented to clinicians. In the following sections, I will review the literature on the role of early object relations in the development of the self and then go on to consider how distortions in this process may lead to disorders of narcissism in children. Finally, I will address some of the psychological testing developed to elucidate narcissistic pathology and/or underlying self and object representations.

The Building up of the Self through Early Mother-Child Interactions

It seems essential to begin with reviewing some of the literature on the formation of the self - to think about the optimal development of narcissism - before considering the potential for pathology. Throughout this work the term "self" will be used to refer to a group of human experiences and representations: bodily sensations, feelings and perceptions, which, in the course of development, become increasingly organized into coherent self-representations. Following Hartmann (1964), Kohut (1971) and Kernberg (1975), narcissism is being understood as an emotionally significant investment of the self. Differences in these theorists' understanding of these concepts will be taken up in a later section. The literature on this subject is vast, and due to space constraints, I will only present those authors whose writing is most germane to my topic.

As Hartmann (1964) remarks, "narcissism is a many-faceted and frequently puzzling problem." In his work entitled "Narcissism: The Term and The Concept," Pulver observes that in the "voluminous literature on narcissism, there are probably only two facts upon which everyone agrees: first, that the concept of narcissism is one of the most important contributions of psychoanalysis; second, that it is one of the most confusing" (Pulver, 1970, p. 319). Freud first elaborated upon the concept of narcissism in 1911, in the third part of his discussion of the Schreber case. The concept of narcissism is thus a clinical hypothesis, and initially grew out of the observation of case material. In the Schreber case Freud believed he saw evidence of a megalomania or grandiosity that was not in itself a "new creation," but a heightened

state of a pre-existing condition, one belonging to a normative state of child development (Freud, 1911). Narcissism (or "self love") was the name Freud gave to the early stage in which the child's first "object choice" was his own body or bodily self (Freud, 1914). He made a distinction between a "primary" narcissism in which the libido is invested in the self in an undifferentiated way, "before sufficient ego structure exists for cathexis of a self-representation" (Bing, McLaughlin and Marburg, 1959), and a "secondary" narcissism. Freud's definition of "secondary" narcissism relates to the investment in self and others that comes when the boundary between self and others has been established. It has been suggested that this distinction be dropped in favor of the generic term "narcissism," since we are typically only dealing with what was known as secondary narcissism (Bing, McLaughlin and Marburg, 1959).

In trying to tackle the problem of narcissism, Freud discussed both the normative and the pathological. He drew inferences about the withdrawal of narcissistic libido from the object in schizophrenia and paranoia, about the increased narcissism of hypochondriasis, and turned his attention to the narcissistic object choice of the homosexual (Freud, 1914). He outlined various ways in which one can attempt to maintain a "narcissistic equilibrium" in one's relations with the object world. For example, holding on to a belief in the omnipotence of thoughts when this is no longer due to an insufficiently developed sense of reality, is a narcissistic defense against helplessness (in Van Der Waals, 1965). Though he presented the concept of narcissism in some detail, Freud spoke little of the interpersonal forum in which the

self develops or the disorders that may arise when self-investment goes awry, and instead challenged future clinicians to do so. I quote from Freud:

> "The disturbances to which a child's original narcissism is exposed, the reactions with which he seeks to protect himself from them and the paths to which he is forced into doing so - these are the themes which I propose to leave on one side, as an important field of work which still awaits exploration."
> *(Freud, 1914, p. 92)*

Freud's challenge has been taken up by a vast number of clinicians and theoreticians, psychoanalytic and otherwise, and thinking about narcissism and narcissistic disorders has preoccupied many writers since Freud's original paper was written over eighty years ago. The rise in popularity of narcissism as a topic of such intense speculation has been related to factors as varied as that of American culture increasingly fostering self-preoccupation (Lasch, 1978), to problems encountered in working with patients with narcissistic issues necessitating a revision of traditional psychoanalytic 'instinct' theory (Kohut, 1971). I quote from Westen:

> "Clinicians and writers speak of narcissism as a normal phenomenon, narcissism as a cultural phenomenon, narcissistic injuries, narcissistic defenses, narcissistic drives, narcissistic personality disorders, narcissistic perversions, regressions to narcissism, primary narcissism, phallic narcissism, and so on."
> *(Westen, 1990, pg. 184)*

In the following section some of the literature focusing on narcissism as a basic requisite for psychological health will be reviewed.

The Development of the Self

The definition of the self as reflecting an awareness of separateness from the "non-self" is acquired only gradually during the first months of life and the sense of self may be seen as arising as "islands of experience" that are only then, bit by bit, formed into more ordered clusters of images (Lichtenberg, 1975). Although self-experience plays a role from the earliest days of life, the danger of adultomorphism (i.e. using the exploration of the adult unconscious as a way of understanding the inner world of the child) is great when an attempt is made to describe how the infant senses his world (Lichtenberg, 1975). The self is at first not a cohesive unit - it is fused and confused with perceptions of object images and is composed of a constantly changing series of self-images which reflect the fluctuations of the primitive mental state (Jacobson, 1954). Stechler and Kaplan (1980) emphasize that there is no single indicator that specifies a precise moment when we can objectively say, "now there is a self." In contrast to progress in object relations, which we can observe, the building of a cohesive, separate and whole self-representation is elusive, and what the infant feels objectively eludes the observing eye. Emde stresses his view of the self as a process and not "as a psychic structure which is simply acquired at age 1 1/2" (Emde, 1983). Pine (1982) also addresses the experience of self, its contents and how they get to be experienced as part of "my self." All agree that eventually a confluence of bits and pieces of data permits us to make the assumption that a self is now operating. Stern places the beginning of this process in the first two months, citing research on gaze aversion as evidence that infants have already begun exerting major control over their lives (Stern, 1995). The presence of such a self becomes increasingly clear and

organized, and will manifest sufficient regularity, consistency and intentionality over time.

The infant starts with a number of physiological states that lack definiteness and are accompanied by varying degrees of fussiness, fretting and quiet alertness. The initial unity or "pre-self" that grows out of these physiological states is facilitated by good nurturance and reciprocal interactions (Stechler & Kaplan, 1980). The result of a successful, mutual adaptation is the baby's acquisition of a capacity for the regulation of its own states. It is not, however, until there is considerable maturation and development that clusters of early self and object images (still largely undifferentiated) become re-ordered and finally integrated into a cohesively experienced self. These archaic images derive their qualities and feeling tones from the child's experiences with others during these earliest developmental phases (Lichtenberg, 1975). With advancing ego development and an increasing capacity for perception, these images become unified, organized and integrated into more or less realistic concepts of the object world and of the self.

How the self develops is due to many factors including the simultaneous presence of constitutional givens, and a corresponding facilitating partner. During the early months of life children gradually put together in their minds the pieces of an image of the mother as well as pieces of their own self-image. The vague feeling of being one with the mother recedes - Stern suggests that this happens by 7-9 months (Stern, 1995) - as children develop an increasingly more accurate sense of what is inside and

what is outside, what belongs to them and what belongs to the mother. This question of the way in which the infant's sense of self and its mental representation become distinguished from his perception of the surrounding world has long preoccupied psychoanalytic clinicians, theorists and researchers (Tyson and Tyson, 1990). Early in life the infant's bodily experiences, self-other experiences and affective experiences are mostly in the context of the mother-infant relationship. Affectively meaningful mother-infant exchanges provide the context in which the infant begins to build some basic sense of himself and some sense of others as distinct, continuous and separate (Tyson and Tyson, 1990). From the basic core of mother-infant interaction, the infant builds what Stern (1985) refers to as a "core self/core other," what Emde (1983) calls the "affective core" and what Weil (1970) has called the "basic core." Infancy research has demonstrated an early capacity to represent these interactions that contribute to the emerging organization of self and object representations (Beebe and Lachmann, 1992). By about 15 to 18 months several developmental advances are evident to justify the conclusion that children can by now conceive of and refer to themselves as objective entities separate from their own immediate actions and the actions of others, and that a mentally represented sense of self and other has emerged. This is evident, for example, in the self-descriptive language and symbolic play that emerge during this period. In addition, children begin to label their own feeling states around this time, and this period is thought to mark the initial appearance of an observing ego (Zeanah et al., 1989).

D.W. Winnicott and the Role of the Mother

Winnicott (1956, 1960) speaks of the vital role of the mother in these early stages of development of the self, and emphasizes the reality of the external object and how facilitation by the environment is necessary for optimal development. This "good-enough" environmental provision in the earliest phase is essential to set the stage for the establishment of a sense of continuity of experience. The more the mother is there where the infant needs her to be, the more a "going-on-being," or core identity, is laid down (Grolnick, 1990). Winnicott speaks of this early process, when optimal, as laying the groundwork for future mental health. The more objective self and the beginning of a sense of separateness occur when the mother's adaptation to the infant's needs begins to show flaws. The sense of self develops because the mother inevitably fails to protect her infant from "impingements." According to Winnicott (1956) any impingement, or failure of adaptation, causes a temporary disruption of this sense of going-on-being. Tronick et al. (1978) have pointed out that, even in low risk infant-caregiver interactions, a large number of mismatches occur. Throughout the normal course of development, most infants develop mechanisms to cope with the mismatches in their environment and, if the mother provides a good-enough adaptation to need, the infant is disturbed very little by these environmental failures. However, for infants who are repeatedly subjected to non-reciprocal, inconsistent responses from their caregivers, the outcome may be more deleterious (Osofsky and Eberhart-Wright, 1988). Fraiberg (1982) has discussed the early emergence of pathological defenses in the midst of such early relationship disturbances. It is here that the importance of the mother in the early building up of the self is clear, because

it is a good-enough environmental provision in the earliest phase of life "that enables the infant to begin to exist, to have experiences, to build a personal ego, to ride instincts, and to meet with all the difficulties inherent in life" (Winnicott, 1956, p. 304). Good-enough adaptation and empathic responding by the parents include their tolerance for the child's inevitable frustrations - the confidence that the baby can be temporarily dissatisfied and remain unharmed - and provide the child with an experience of self across a range of states. This makes for a fuller, richer experience of the self (Stechler & Kaplan, 1980).

Winnicott describes the vital "mirroring" role played by the mother in these early stages of emotional development and states that the infant's experiencing of this reflection forms the basis of his well-being and safety (Winnicott, 1965). He believes that the infant discovers the world, and itself, in its mother's face. In psychoanalytic theory, references to mirroring go back to Freud (1920) who described a mirror game played by his eighteen month old grandson. Kohut (1966), Mahler (1975) and Pine (1985) have all discussed the importance of parental mirroring for the development of the self. Stern (1985) has introduced the term 'affect attunement', which he prefers to 'mirroring,' to describe reciprocal interactions between mother and infant. He believes that mirroring implies that the mother is helping to create something in the infant, rather than just participating in its subjective experience. Affective attunement refers to the mother's capacity to behave in a way that matches the infant's pace, intensity, and inner emotional state without imitating the exact expressions, and emphasizes the importance of emotions for understanding the developing

relationship. Our contemporary appreciation of the inter-relatedness of affect and object relations originated with Spitz's concept of mother-infant reciprocity (Basch, 1976). He first introduced this concept in a discussion of Harlow's work, which demonstrated the destructive influence of a lack of an affective, reciprocal dialogue between infant primates and their mothers (Spitz, 1950). The importance of affective aspects of early experience has also been emphasized by Spruiell (1975) and Emde (1983). According to Emde, emotions provide us with a core of continuity for our self-experience. After repeated experiences of affective exchanges within a relationship, a sense of consistency around an "affective core" becomes consolidated that in turn allows us to be empathic and sensitive to the feelings of others (Emde, 1983). In addition, Emde (1988) has emphasized the motivating influence of the early affective caregiving relationship in leading to the development of a meaningful sense of self in relation to others.

The Contribution of Infancy Research

Attachment and mother-infant research have increased our understanding of the importance of the earliest interactions of the dyad in the overall development of object relationships. The primacy of the human craving for connection with others is evident from birth and several empirical studies have established the importance of reciprocal mirroring behavior, illustrating that there is an ongoing interaction between the unfolding trends of the infant's constitution and the mother's attunement to these trends (Bleiberg, 1994). Mothers seem 'pre-tuned' to respond to their infant's expression of emotion and infants come 'tuned' to read their mother's emotions

(Basch, 1976). Each participant influences, and is influenced by, the other. Contrary to earlier formulations of a hypothesized non-related or 'autistic' phase (Mahler et al., 1975), infants are now seen as 'programmed' to relate, and endowed with a brain wired to generate, organize and pattern psychological experience based on interpersonal experience (Emde, 1988, p. 38). Both attachment and infancy research also strongly support the existence of a built-in predisposition towards self-regulation and mastery, and have demonstrated the infant's active regulation of incoming stimulation and states of internal arousal (Beebe and Lachmann, 1992). Emde (1988) and Sander (1980) have both illustrated how each infant arrives with a unique set of regulatory characteristics, and meets a caretaking environment with its own unique regulatory features. Sander describes infant and caretaker as an interactive system and has charted the move from an early coordination, concerned with biological issues, to the levels of adaptation concerned with fitting together between toddler and caregiver on the basis of correct inferences of intentions, goals, feelings, and language. Sander emphasizes how a context of mutual familiarity, built up via daily interactions around sleeping, waking, feeding, motility, etc., "provides the necessary condition to set the stage for precision in fitting together on the next, more subtle, levels of thought and inner perception that involve the 'reading' of intentionality, feeling states, and emotional expression" (Sander, 1980, p.198). Both the extensive psychoanalytic and infant research literature on normal gaze emphasize how mothers visual engagement imbues the pair with pleasure, and conveys an affectively alive, meaningful notion of himself to the infant (Beebe and Sloate, 1982). Infantile gaze aversion or distress as a regulatory response to maternal over- or under-stimulation is

also well-documented. Brazelton et al. (1974), in a film of an experiment conducted during an infant's first year of life, demonstrated the debilitating impact upon the infant of the caretaker's failure to meet expectations. Tronick (1982), in observations of infant behaviors when obstacles to mutual mother-infant interactions are introduced, also showed the negative influence on the infant of a lack of response by the parent. Stern (1974), in other mother-infant interaction studies, emphasized the importance of reciprocity in the development of early attachment and its significance for the building up of the self and early object relations. Mahler et al's (1977) observational study and later film analyses described five and eight month olds seeming to be almost electrified by approving and mirroring adults. Though acknowledging the role of a constitutional drive for attachment, they concluded that the "fueling of the environment" provided crucial narcissistic supplies (Mahler & Kaplan, 1977). Such studies have empirically demonstrated a cyclic quality of mother-infant interaction that is observable from the first weeks of life, but also the distortions that may be early precursors of the later difficulties that lead to psychopathology. For example, dysregulation of the mother-infant pair has been postulated as one of the later causes of narcissistic disorders and there has been some mention in the literature that the defensive gaze aversion and pervasive auditory tuning out pathognomonic for narcissistic disorders in children may be echoes of these early difficulties (P. Kernberg, 1989; Sloate, 1998).

Margaret Mahler and the Rapprochement Subphase

Margaret Mahler has described how children gradually put together an image of the mother in their minds, as well as the pieces of their own self-image, and locates this in the first 10-12 months of life. Fragmentary self-images resulting from "maturational forces, inner sensations, and experiences with caretakers coalesce into a core sense of self with more or less clear boundaries" (Bleiberg, 1988, p. 6). These experiences bring home to the child just how helpless and vulnerable they are. The emergence of self-awareness, which Mahler places early in the second year of life, is inevitably accompanied by a loss of fantasized omnipotence (Van Der Waals, 1965). In normal development, children typically respond to the discovery of their smallness by creating an omnipotent self-image that helps them deny their vulnerabilities. This corresponds to Mahler's practicing subphase, where narcissism is at its peak. This subphase is characterized by a significant gap between the toddler's actual power and an omnipotent sense of self associated with feelings of safety and satisfaction (Mahler et al., 1975). Omnipotent denial of smallness and vulnerability and a feeling of grandiosity erase the discrepancy and close the gap. According to Bach (1994), it is this "narcissistically enhancing sense of omnipotence of infancy and early childhood that is the foundation on which trust in oneself and the world is built" (p. 172). Recent developmental research demonstrates that children begin with relatively simple and poorly differentiated self and object representations and do "over-estimate both their power and importance in the grand scheme of things" (Westen, 1990, p. 228).

Without downplaying the continuing unfolding of constitutional potentialities, Mahler stresses the importance of parental admiration and approval during the practicing subphase. The toddler's sense of sharing in his mother's power - his 'delusion' of his own grandeur - depends on the emotional climate of the mother-child relationship (Lichtenberg, 1975). During the period before there is a clear and organized sense of self as separate from other, the mother must have empathically tuned into her infant's dependent needs in order for the feeling of shared omnipotence to have reached its fullest intensity (Mahler et al., 1975). The subsequent sustaining of this feeling, which gives the child a sense of independence and confidence, depends on the empathic support the mother can give to the toddler's emergence from her protective environment. For the child "to experience an age-appropriate omnipotent self-image in an atmosphere of security and safety, he must feel that his exhibitionistic display is mirrored by the gleam in his mother's eye" (Kohut, 1971, p. 116). Optimally, the parent's allowance of the child's grandiose fantasies helps him to learn his realistic limitations. When the child's inevitable disappointment in his parents and himself is within tolerable limits, "the child can more effectively build inner capacities for self-control, confidence and reliance" (Kohut, 1971, p. 107).

Sometime between thirty and forty-two months children are expected to respond to the developmental requirements that they relinquish omnipotence, accept separation and recognize that they lack absolute control over their environments. Even more importantly, the illusion of dual unity is lost when the child realizes that he and his mother are not of one mind, that their wishes do not coincide, and that their empathy

is no longer perfect (Stern, 1995). This is in part due to increasing environmental constraints and limitations that challenge the child's omnipotent fantasies (Settlage, 1977). Children "are inexorably driven from the gratifying but unrealistic vantage point of omnipotence to a far more complicated perspective that encompasses the pain and frustration of reality" (Bleiberg, 1988, p. 8). This is what Mahler (1972) has termed the "rapprochement crisis." But it is also due, it seems, to the child's growing autonomy and competence with dealing with the world and the decreasing distance between an ideal and a realistic self-image. Narcissistic vulnerability decreases and the child has less need to rely on omnipotence. A "good-enough" environment supports the child's growing competence and, at the same time, demands adherence to reality constraints (Bleiberg, 1984).

During the rapprochement subphase, the period when the child's omnipotence begins to become deflated, narcissism remains vulnerable and there may be a temporary collapse of narcissistic grandeur (Mahler et al., 1975). Crucial to the healthy resolution of the developmental issues of this period is the continued availability of the mother. "The child's sense of omnipotence, rather than being deflated precipitously and overwhelmingly, needs to be gradually replaced by belief in and enjoyment of his own rapidly developing ego capacities, by a developing sense of autonomy" (Settlage, 1977, p. 813). The mother must remain tolerant and available in the face of apparent regression from the independent behavior of the practicing subphase to the clinging behavior of the rapprochement subphase. At the same time, it is essential that the mother recognize and accept the child's developmental need to

become separate and independent. Problems negotiating this subphase (e.g. pathological or premature deflation of omnipotence) are apt to occur when the mother has difficulty with these tasks and the child experiences himself as "enmeshed in a bewildering seesawing relationship with his mother" (Lichtenberg, 1975). A too-sudden assault on the child's burgeoning sense of competence may evoke an ongoing grandiose view of the self and idealization of a parent who continues to be seen as all-powerful and omnipotent (i.e. the narcissistic defense described by Kohut). A reactive defensive omnipotence may arise, and magical beliefs may never yield to realistic evaluations. Instead of becoming modified, the child's illusions about his parents continue in a distorted way. In Mahler's view, the rapprochement subphase is concerned largely with internalization and beginning structure formation, and she points to the internalization of the mother's function of tension and anxiety regulation as essential for the successful outcome of the separation-individuation phase (Mahler et al., 1975). Failure to resolve the issues of this subphase can lead to faulty or incomplete structural development, predisposing a child to narcissistic or borderline disorders (Mahler, 1972, p. 494). Numerous other psychoanalytic investigations have found this phase to be significantly implicated in personality disturbances in which such structural defects are primary (see Tolpin, 1971).

Heinz Kohut and the Grandiose Self

The crucial contribution of the caretaker in internalization and structure formation has also been stressed by Kohut (1971), who speaks of the self as comprised of constituents, which are acquired in the interplay with those persons in our early

environment who are experienced as "self objects." The self object, for Kohut, is an object, which is used in the service of the self, or experienced as part of the self. Similarly to Winnicott, Kohut (1968) speaks of the child's early state of feeling one with primary caretakers and of a period in which the child's mirroring and idealizing needs must be sufficiently responded to. This takes place in spite of the inevitable failures of the mirroring and idealized self objects and, through a process of internalization, leads to the gradual replacement of the self objects and their functions by a self and its functions. Repeatedly experienced states of self in relation to other are internalized. Functions such as tension and self-esteem regulation become part of enduring internal psychic structure, and out of this process emerges a "nuclear self" (Kohut & Wolf, 1978). An adequate parental environment (e.g. Winnicott's good-enough mother) helps children internalize these functions by leading to the internalization of externally satisfied needs, but the ego's potential for developing such regulatory functions may not be fully realized unless the balance between gratification and frustration is within an optimal range (Lichtenberg, 1975, p. 463). In successful development early under- and over-estimations of the self are blended together into an integrated, cohesive self where modulated regulation of self-esteem has become an internalized function. The developing child would thus feel neither totally omnipotent nor totally helpless and the self-representation contain modified, more realistic evaluations of assets and liabilities. According to Kohut, who has conceptualized the acquisition of this function as part of a separate line of development, some children do not develop this internal regulatory capacity successfully due to traumatic disappointments in the early mother/child relationship

(Kohut, 1968). Where maternal care is markedly deficient or where gratification is excessive, the ego's potential for internalization will not be fully utilized, and the child will remain reliant on the external object (Lichtenberg, 1975).

In normal development the child's original narcissistic balance is disturbed by the inevitable shortcomings of maternal care and the child attempts to save the original experience of perfection by assigning it to a grandiose and exhibitionistic version of the self. Kohut (1968) has termed this the "grandiose self." Optimally, the grandiose self becomes integrated into the whole personality and is responsible for important aspects of our self-esteem and self-enjoyment. If the grandiosity of the early self, however, "has been insufficiently modified because traumatic onslaughts on the child's self-esteem have driven grandiose fantasies into repression, then the developing ego will tend to vacillate between an irrational over-estimation of the self and feelings of inferiority" (Kohut, 1966, p. 255). This may be the case, for example, if a child is deprived of the maternal acceptance necessary to transform undeveloped exhibitionism and grandiosity into a useful self-esteem and self-enjoyment (Kohut, 1968). Grandiose fantasies, because they are repressed, become inaccessible to the modifying influence of the external world. The development of a psychic structure for self-esteem regulation is interfered with, leading to mood swings and the excessive dependence on others to maintain narcissistic equilibrium. The maintenance of self-esteem continues to depend on the approving mirroring functions of an admiring self object, and others are important only in so far as they participate in the child's narcissistic pleasure and thus confirm it.

Kohut reconstructively focused on the development and function of the self, while Mahler investigated the same prospectively, through the observation of infants and toddlers. Like Kohut, Mahler is a developmentalist, who through direct observation, stressed the importance to her research of the real object and the actual external object relationship (Wolman, 1994). They shared a common interest in the investigation of self-esteem and the origins, development and functioning of the structures that regulate self-esteem throughout life (Levine, 1994). Other common ground between the two includes the importance of empathy, the impact of early environmental failure and the viewpoint that analysis embodies a developmental process. Where their views on narcissistic pathology diverge, is in Kohut's lack of emphasis on the role of the aggressive drive in the psychogenesis of these disorders and his view that a 'fixation model' fully explains their development. Mahler has stressed that it is a mistake to assume that all later pathology is a reflection of a real failure of the mother during the rapprochement period - these earlier 'affronts' have a significant effect on ongoing processes, but development does continue albeit in a distorted manner (Edwards, Ruskin and Turrini, 1994, p. 88).

Otto Kernberg and the Role of Aggression in Narcissistic Disorders

Otto Kernberg's theory of the narcissistic character has combined some elements of the ideas of both Mahler and Kohut, though he has less of a developmental emphasis. Kernberg's thinking is also built upon reconstruction derived from the analyses of adults but, though he accepts Kohut's description of a disorder of narcissism, his

understanding of its origin is different (Kernberg, 1970, 1974, 1975). For example, Kernberg also speaks of "chronically cold, narcissistic and at the same time overprotective mothers," but sees the main genetic determinant in the development of narcissistic pathology as the inborn intensity of the aggressive drive (Kernberg, 1975, p. 276). Based on his observation that narcissistic characters repeat in the transference early processes of devaluation of significant others and their internal representations as a defense against underlying conflicts around oral rage and envy, Kernberg (1971) takes issue with Kohut's formulation of this disorder as due to a fixation at an archaic level of normal development and related to the frustrations and failures of the significant childhood objects. He gives the following evidence for his assumption that the pathological narcissism seen in the treatment of narcissistic adults is a pathological process rather than a reflection of a normal developmental stage: grandiose fantasies of small children have a more realistic quality than those of narcissistic personalities; small children's over-reaction to criticism and need to be the center of attention coexists with feelings of love, gratitude and trust, while narcissistic adults are unable to depend upon other people beyond immediate need gratification; the demandingness of pathological narcissism is excessive; the coldness of narcissistic adults is very different from the warmth of the small child's self-centeredness; fantasies of power, wealth and beauty in children are mingled with a wish to be loved and accepted. According to Kernberg, narcissistic adults wish only to be admired (Kernberg, 1975, p. 272). Jacobson, Kernberg and many Kleinian analysts see the grandiose self of Kohut as an exclusively pathological phenomenon that emerges as a defense against a re-emergence of intense early oral envy and rage

and emphasize that one cannot divorce the study of narcissism from the vicissitudes of aggression (Jacobson, 1954; Kernberg, 1975). Kernberg has described the "aggressive onslaughts on the analyst" by narcissistic patients in great detail and understands narcissistic character defenses as protecting the patient against both the intensity of his rage and his fear of a world devoid of all good things (Kernberg, 1974). He sees the narcissist as needing to destroy sources of love and gratification in order to eliminate the source of envy and projected rage. Kohut seems to agree that the grandiosity of the narcissistic patient could be used defensively but sees it as mobilized, not merely against rage and envy, but primarily against the reality-based perception of the inadequate helplessness of the self (Kohut, 1966).

Kernberg believes that disorders of narcissism do not simply reflect an 'absence' of certain structures, but that a pathological self-structure develops and prohibits later normal development (Kernberg, 1975, p. 284). Like Kohut, he places the genetic origins of this pathology somewhere after the stage of self-object differentiation, and credits the timing of this disturbance with permitting a level of integration of the ego that provides for a better adaptation than, for example, the borderline patient. Unlike Kohut, however, he believes that ego and superego structures in the narcissistic personality suffer from pathological differentiation and integration as a result of the intensity of aggression and pathological early object relationships. These differences in theories of self-development have wide-ranging implications for the treatment and understanding of such disorders. Before thinking further about narcissistic disorders,

and how they manifest in children, the role of the parents, and their personalities, in such distortions of development will first be more carefully considered.

The Role of the Object in the Development of Pathological Narcissism

The self arises at the endpoint of a developmental process that begins with the specific hopes, dreams and expectations of the parents, especially the mother. These expectations exert a considerable influence on the developing infant. The self emerges as the result of the interplay between the newborn's innate equipment and the encouragement by parents to develop certain potentialities while others are ignored, or actively discouraged (Kohut & Wolf, 1978). Anna Freud (1966) speaks of how each and every environment has a selective influence upon the development of the constitutional endowment by nurturing some trends and discouraging others. If the parents, or self objects, are secure in their own worth - in touch with a bit of their original omnipotence - then they will be able to promote their child's realistic self-confidence and inner security, no matter how grave the blows to which the child's grandiosity is subjected (Kohut, 1971).

The significance of input from primary caretakers is enormous for the infant and young child. Although not infinitely malleable, each child is highly susceptible to external influence, especially during this early period. The parents' expectations and fantasies about their child (consciously or unconsciously communicated) have profound shaping effects, defining in a fundamental way the becoming self of the child (Pine, 1982). Both unconscious fantasies and conscious motivations determine parental attitudes. There are a multitude of reality factors that dominate the picture: constitutional givens, whether the child was planned or unwanted, the state of the parent's relationship, etc. These reality factors also, as a rule, seem to be connected to

specific unconscious fantasies concerning parenting and children (Coleman, Kris & Provence, 1953). Throughout pregnancy, an apparently new and unconscious network of fantasies tends to develop and older fantasies may be refocused or reactivated. Everything the infant (and fetus) does is frequently embedded in a maze of significance. The importance of this attribution of meaning has been recognized in several studies (see Brazelton & Cramer, 1990). The parents thoughts and feelings about their child's behavior and their consequent pleasure or anxiety will determine the infant's own set of values about their capacities. To a great extent "children's representations of themselves will be molded by parent's expectations, ideals, predilections and aversions" (Brazelton & Cramer, p. 134). In stressing the role of early interactions, it appears that children's development is almost as powerfully determined by parent's fantasies as it is by their own innate potentialities. These various forces are in constant interplay and mutually influence each other (Brazelton & Cramer, p. 137).

In themselves, projections from the parents are not pathological, and parental attitudes may dovetail with a child's actual capacities. In a study of parent's perceptions of their infants before and after birth, Zeanah et al. (1985) found that an absence of positive distortions is a grave prognostic sign. It is only when projections take on extreme characteristics that they may have a negative impact. In the most pathological projections, parents endow an infant with characteristics that are totally at odds with the infant's nature and children experience their "spontaneous gestures," in Winnicott's terms, as divergent from parental wishes and approval (Lichtenberg,

1975). The strength and nature of the parent's projections determine to what extent they are able to recognize the infant's own individuality or whether their unconscious takes over, casting the infant in the role of hero or villain. Clinically, these characteristics of projections are often revealed in the parent's descriptions of their children (e.g. as an aggressive monster, an infant genius, etc.). Stern, who refers to parent's perceptions as 'infant-centered schemas,' speaks of the 'morphogenesis' of the represented baby (Stern, 1995, p. 23). According to Stern, infants are represented in their mother's eyes as taking part in, and being woven into, themes that have been ongoing, conflictual and problematic for the mother - he refers to this as the 'dominant theme model' - and it is the pervasiveness and intrusiveness of these themes that may cause the child difficulty. Psychopathology results "when subjective reality has been distorted from some objective view of reality" (Stern, 1995, p. 36).

According to Brazelton & Cramer (1990), a baby can also be seen as providing "the potential for realizing a longed-for ideal." The newborn may be idealized, adoration excessive, and parents may foster an infant's omnipotence by gratifying every whim. This may have the effect of instilling an insatiable hunger for absolute privilege and continued satisfaction in the child. Mild forms of these kinds of projection are universal but they are an important consideration when thinking about narcissistic disorders in children and, more significantly, the environmental failures that contribute to the pathogenesis of such disorders. During their early years, these children are often the center of attention of one or more adults who thought them brilliant and extraordinary, and who indulged their sense of omnipotence, along with

the feeling that they were special and deserving of preferential attention and treatment (Beren, 1992). This is more often than not the way they then relate to both peers and adults. Their natural development of self-feelings is imposed upon by their mothers' unconscious needs to see their children, not really for what they are, but for what they need them to be. The intrusion of such an image creates a false or unreal feeling of being special and affects the child's values and sense of himself (Brazelton & Cramer, 1990). This encroachment of parental needs is different for every child, and one could hypothesize that the differences in maternal need, or parental expectation, which are imposed upon these children explain the variation in the overt symptom picture. What these intrusions have in common, however, is that they greatly interfere with the gradual relinquishing of the child's natural omnipotence and therefore have an impact on the ongoing development of object relationships. These parents do not offer age-appropriate gratifications and frustrations. Instead they impose aspects of their own selves onto their children as well as hope to fulfill their own (often unconscious) narcissistic needs through their children.

A great deal has been written - primarily in the literature on narcissistic disorders in adults - about the type of parent that might characteristically endow a child with a pathological level of projection. Kohut talks about how parents with serious conflicts in self-esteem might experience their child as if he were an extension of their own psychic organization (Kohut, 1971). Such parents are typically over-involved in their growing child's life and demonstrate an excessive need for control. In order to maintain their own precarious narcissistic equilibrium, these parents may also project

onto the child unacceptable aspects of their own negative evaluations of themselves. The child is thus used as a narcissistic object, and great pressures are usually brought to bear on them to achieve, perform and succeed in order to stabilize parental self-esteem. These parents then view aspects of their children's' separation and individuation as a threat to their own self-esteem. Behaviors that herald separation and autonomy are felt as a narcissistic injury, separateness is not encouraged, and this has an enormous impact on these children's development of an internal regulatory capacity (Stechler & Kaplan, 1980).

The parents of narcissistic children usually have great difficulty responding to them in a comforting, supportive or appropriate manner based on their child's developmental needs. These parents have also been described, due to their own self-preoccupation, as either turning away from their children at important times or not emotionally present (Beren, 1992). This alteration between intense absorption and inattentiveness substantially disrupts the reciprocal rhythms of the early mutual regulation process. This has been observed by infancy researchers (Beebe and Sloate, 1982). It has been hypothesized that these parents themselves failed to develop adequate psychic structure for independent self-esteem regulation. According to Kohut (1968), they can be found to demonstrate the following classic hallmarks of narcissistic vulnerability: extreme vacillations in self-regard; an inordinate overdependence on, and an intense hunger for, the confirming approval of others; an extreme sensitivity to overt criticism or absence of praise. They rely to an excessive degree on the behavior of others (including their children) to determine their own subjective experience of

self-esteem. The narcissistic needs of these parents cause the child to remain enmeshed within the narcissistic web of their parent's personality.

Parental handling and needs have often allowed and encouraged these children to assert a kind of omnipotent control over their environments (Bleiberg, 1988). In this sense, to be a narcissistic object for a parent is a role that holds a powerful and seductive appeal. To feel so vital to one's parents' existence and to figure so prominently in their self-esteem provides fuel for the child's omnipotent grandiosity. The child's realization of his power to determine his parent's self-experience contributes to a heightened regressive pull to maintain this situation and his vital role in it. The child feels he must continue to be a narcissistic object for the parent, or risk the loss of the relationship and alienation from the family. Separation is therefore greatly complicated for these children, and their own self-esteem is impaired through identification with these parental projections. The child who must conform to expectations of the parents - validate the parent's projection - "confirms his early (normal) and unbounded expectation that his behavior determines the existence of the world" (Brodey, 1965, p. 183). At the same time these children have to endure an unusual degree of helplessness and intrusion by a narcissistic object.

For such children, this type of relationship alters the experience of existence itself. They are attended to only for what the parents believe or wish them to be and are responded to as "as if" children (Moore, 1975). In these cases the child has never really become the center of mother's interests for themselves, and the mother reflects

only her own mood or the rigidity of her own defenses. The child's reality and his mode of organizing reality are altered through such faulty mirroring or by other maternal impingements (Winnicott, 1965). An identity may be formed that is experienced as empty and false so that the child must constantly seek reassurance from others or defensively invest in a compensatory grandiosity in fantasy or action. It is during these times, when the caretakers mistiming and mistuning broadcasts too much of the 'other' and not enough of the child, that a pathological "false self" can occur (Grolnick, 1990). This self is disconnected from the infant's real needs and inner reality, and the child may attempt to conform to unempathic parental expectations. This contributes to a sense of futility, which may manifest itself as "a general irritability or feeling of emptiness" (Winnicott, 1965).

In the following section the children that present with such a background will be presented and the ways in which they typically come to the attention of clinicians will be described.

Narcissistic Disorders in Children

Narcissistic injuries are an inescapable part of both normal and pathological development, but for some children narcissistic difficulties are the central feature of their psychopathology. At this point a brief case illustration might be useful.

> Kevin, aged nine, was referred for assessment of multiple long-standing difficulties in the context of two parents with character difficulties of their own and a severely disturbed marriage. Kevin was described by his mother as a distractible child, who easily became tearful and angry if something went wrong. Unlike in his younger years, he did poorly in school and constantly complained of boredom; he had tantrums and would "make a scene" in front of anyone; was totally self-absorbed and would eat non-stop. He was clingy and demanding and would not let his mother out of his sight, expressed fears of the dark and of spiders and had long-standing sleep difficulties. He had no friends and was easily upset by other children. Kevin seemed particularly eager for adult attention and was universally unable to tolerate frustration or failure. In initial diagnostic interviews his enormous insecurities were apparent and the assessing clinician was struck by the peculiar quality of his communications and the relationship he made, attempting to identify himself with the adult or with their perceived expectation of him. He tried very much to maintain an adult style of interaction throughout his assessment and to appear a seasoned expert at clinics, tests, therapy, and whatever else might present itself. His treatment was characterized by Kevin's ineffective grandiose defenses and omnipotent, controlling fantasy play that excluded his therapist. Work with the parents, though largely unsuccessful, was aimed at understanding that their relationship with him was based largely on his fulfilling their own needs and identifications with him (e.g. as a misunderstood child prodigy).
>
> (*K. Weise, 1992, Unpublished case material*)

As previously noted, normal infantile fantasies of great power stem from the preoedipal period. When the child's fantasies and self-centered activity reflect age-

appropriate developmental needs, they serve to further psychic structure formation. In narcissistic children, however, grandiose fantasies and self-absorption serve to maintain a pathological equilibrium that interferes with differentiation and integration (Egan and Kernberg, 1984). These children are seriously compromised in accomplishing the developmental task of acquiring a relatively stable self-esteem (Bleiberg, 1984), and though they may appear haughty and self-assured, are prone to feeling like worthless failures. Children who experience such narcissistic dysregulation often exhibit extremely rigid coping mechanisms that involve reliance on an omnipotent sense of self, refusal to acknowledge personal failures, projection of disowned self-experiences onto others, and demands for affirmation of their power (Bleiberg, 1994, p. 38).

As explained previously, the diagnosis of a narcissistic personality, or character, in childhood is problematic. An important question is whether or not we can really consider children, still in the throes of developmental forces, as having a fixed set of personality characteristics, as is implied by the diagnosis of a personality disorder. The DSM IV, while having no category of personality disorders for children, does state the following:

> "Personality Disorder categories may be applied to children or adolescents in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent and unlikely to be limited to a particular developmental stage or an episode of an Axis I disorder. It should be recognized that the traits of a Personality Disorder that appear in childhood will often not persist unchanged into adult life. To diagnose a Personality

> Disorder in a person under 18, the features must have been present for at least one year."
> *(APA, 1994, p. 631)*

It is unclear whether personality disorders in childhood are identical to the adult disorders of the same name. For example, narcissistic children do not necessarily have a child-sized version of the better-known adult classification of NPD, and will not definitively go on to become adults with a diagnosable narcissistic disorder. Investigations into this type of assumption found that children with a borderline disturbance rarely grow up to become borderline adults (Kastenbaum, 1983; Lofgren et al., 1991). Since the origin of these disturbances is early childhood, it seems intuitively sound to suppose that we are in fact seeing a future adult disorder in status nascendi. However, it is important to keep in mind that this is not clear, and that the adult and child with narcissistic, borderline, or antisocial psychopathology may look different. One explanation for changes in overt symptomatology is that, though one's clinical presentation may change (due to intervening events and normal developmental forces), the underlying psychic "organization" may remain unchanged (Bernbach, 1998).

Other Diagnostic Issues: Narcissistic vs. Borderline Children

Due to the amount of clinical overlap, there has been some indication that seeing children with personality disorders as lying along a continuum is more useful than seeing each as having a distinct disorder. This seems especially true of narcissistic and borderline children. Bleiberg (1984) describes these two groups of children as

being connected by a great many symptoms, including being self-centered, attention-seeking, intense and unstable in personal relationships (e.g. alternating between idealization and devaluation of self and others), as well as responding with rage to rejection or indifference. From personal clinical encounters, I would add that both groups are prone to temper tantrums when frustrated, may be manipulative, and frequently exhibit an omnipotent denial of vulnerability.

It is not surprising that these different groups of children would be thought to have much in common, given the similarities in viewpoints on the psychogenesis of their disorders. Both share a related developmental basis as well as dynamics. That is, "...they share disordered internalized object relations, the pathogenesis of which is to be found in the vicissitudes of the early mother-infant relationship." (Rinsley, 1984, p. 2) As elaborated upon in the previous two sections, many authors have found it useful to understand narcissistic pathology as stemming from problems during the separation-individuation phase as outlined by Mahler (e.g. Kohut, Kernberg, Bleiberg, Rinsley). The same is true of borderline pathology. Some of the previously noted clinical theorists, including others such as Masterson (1975) and Chethik (1989), describe the cause of borderline disorder as a developmental arrest or distortion dating from the early part of the process of separation and individuation. This would have occurred either during what Mahler has termed the "hatching" or later "practicing" subphases (Mahler et al, 1975). Kohut (1966, 1971) suggests that the timing of the developmental arrest may be earlier for those individuals with borderline personality disorders. Kernberg (1970) does not attribute narcissistic

disorders to a primary developmental arrest but sees them as due to a regression from a higher level of development. He sees narcissistic disorders as a less primitively developed and organized manifestation of borderline personality disorder (a "sub-type"). Though there are similarities between narcissistic and borderline individuals, much of this speculation is based upon an agreement that narcissistic disorders seem somehow less severe. They are generally not characterized by severe ego deficits in thought processes and reality testing, or in the delineation of self from other (Settlage, 1977). Other clinicians have emphasized that the arguments concerning the fine points of a subphase-related chronology are largely irrelevant because any data is insufficient to allow precise formulations regarding timing (Rinsley, 1984). The most that can be said of both of these disorders is that, whether due to fixation or regression, they result from various degrees of a failure of separation-individuation.

Kohut has proposed that the distinction between borderline and narcissistic characteristics can sometimes be made accurately only on the basis of therapeutic experience. As noted above, many authors believe that these disorders constitute a developmental-based continuum wherein narcissistic patients have greater self-cohesiveness, stability in self-object relatedness, and a better capacity for aloneness than borderline patients (Adler, 1981). Masterson (1988) has stated that these two categories reflect two opposite types of "false selves": the deflated self of the borderline and the inflated self of the narcissist. Millon (1981), on the other hand, believes that descriptive similarities between the two disorders are minor, and that the borderline and narcissistic disorders are clearly delineated and easily separable. In

1991, Ronningstam and Gunderson attempted to demonstrate that it was empirically possible to differentiate between the two disorders. After a review of the literature, they hypothesized that the overlap in the two populations would include: both devalued and over-idealized relationships, a tendency to react angrily to criticism or defeat, and a sense of emptiness/boredom (Ronningstam and Gunderson, 1991, p. 231). Using a semi-structured diagnostic interview for narcissism (DIN) and definitions from DSM IIIR, they found that it was indeed possible to discriminate between the two groups, with the most useful difference being a tendency towards grandiosity in the narcissists. According to Ronningstam and Gunderson, the fact that it proved possible to differentiate NPD from BPD supports the conceptual distinctions found in much of the psychoanalytic literature as well as the categorical distinctions between them in the DSM. Their findings also support some of the theoretical distinctions. For example, Kohut and Masterson's emphasis on the grandiose self of narcissistic patients, and Kernberg's description of the two groups as sharing problems with rage and envy (Ronningstam and Gunderson, 1991, p. 231).

Mothers of both borderline and narcissistic children find their children's emerging individuality threatening and encourage their dependency. They may place their children in a "double-bind" situation (Rinsley, 1980). Some evidence suggests that parent(s) of those with a borderline personality preclude or inhibit both separation and individuation by communicating to their child that they must remain dependent in order to head off disaster (e.g. the loss or withdrawal of maternal attention). These mother-child interactions have been described in great detail (Rinsley, 1980, 1984;

Masterson, 1975). In narcissistic cases, the mother may reward the child's growth towards separation-individuation, but only in relation to herself, "thereby fixating the developing child's infantile grandiosity in relation to achievements which center upon the still partly fused self- and object-images." (Rinsley, 1980, p. 129) Kohut refers to these as stable archaic self objects, and contrasts them with the fragmented self objects of the borderline. This results in the narcissist's self-object boundary being firmer, albeit still vulnerable to narcissistic injury. Though there are similarities in the pathogenesis of these disorders, the narcissistically-disturbed individual appears more internally coherent and capable of sustained, genuine achievement (Rinsley, 1980).

Symptomatically, where these children might be said to differ is in the severe ego disturbances of the borderline child. The poor control over impulses, high levels of anxiety characterized by feelings of disintegration, and poor reality testing of the borderline child are not readily evident in narcissistic children, whose reality testing is typically not disturbed except in the area of fantasies of their own omnipotence. In narcissistic disturbances of childhood, as previously noted, withdrawal into fantasy is indeed a characteristic feature, and these children may be unwilling to relate to the outside world other than on the basis of their omnipotent fantasies. The following clinical excerpt, from a case treated at The Anna Freud Centre, illustrates the particular problems with reality testing exhibited by these children:

> "At home his parents described P. as a restless boy, immersed in his own thoughts, and excessively demanding in his relationship to them. For much of the time he watched television, preoccupied with monsters, space, etc. These preoccupations concerned a host of superheroes, about which he talked non-stop, emphasizing their enormous powers and strengths. His willingness to relate was clearly conditional on a reciprocal interest in these matters. His immersion in this fantasy world was inordinate, to the extent that his identification with the powerful superheroes appeared at times to blur the distinction between fantasy and reality."
>
> *(Wilson, 1988)*

The powerful, grandiose characters in P.'s fantasy world helped affirm his denial of vulnerability or weakness. Related fantasy themes of narcissistic children are the acquisition of unlimited wealth or power, beauty or recognition. Such fantasies persist even though there is usually an awareness that they are blatant misrepresentations of reality. In summary, when facing danger situations (e.g. a loss of control), narcissistic children experience fluctuations and secondary interferences in ego functioning, but are not typically vulnerable to the psychotic thinking and disorganization of borderline children.

Characteristic Object Relationships

The narcissistic child's sense of self and identity, though more cohesive than the borderline child, is characterized by a lack of authenticity (Bleiberg, 1994). Their experience of who they are is not based on an internal sense of themselves but instead on an idea of what others expect, or what will gain them admiration and special advantages. This is in part a result of their favored position in their families, which results in their feeling entitled to special treatment and advantage (Bleiberg, 1988).

Narcissistic children often have particular qualities that make them more likely to be selected for a special role in their families. Precocious language development and special skill in picking up interpersonal clues are common (Bleiberg, 1994, p. 44). These qualities increase their odds of being invested with their parent's narcissistic aspirations and chances that they will be called upon to play a unique role in maintaining their parent's self-esteem (Bleiberg, 1988). They may be treated as a source of pride and gratification, which fosters their omnipotence and sense of uniqueness. They are often treated as 'as if' children by their parents, and "may begin to experience those aspects of the self that elicit the parents delighted response, but cannot integrate the range of more troubled feelings, needs and self-images into the core sense of self" (Bleiberg, 1988, p. 9). All feelings of sadness and vulnerability are kept at bay and grandiosity emerges in their illusion of not needing anyone and of controlling every aspect of themselves and their environment. They defensively sever any emotional connection that might lead them to experience themselves as helpless or dependent, and are rarely conscious of what lies beneath this 'false self' (Winnicott, 1965). In this way their sense of self is less developed and more vulnerable and dependent on outside approval than normal children (Beren, 1992). The simultaneous over and under-valuation of their needs results in alternating feelings of grandiosity and worthlessness. Because of earlier expressions of vulnerability or sadness being ignored or rejected in favor of the fostering of a sense of uniqueness, the narcissistic child achieves an inner coherence only at the expense of a balanced, integrated personality (Edwards, Ruskin & Turrini, 1991).

By virtue of their beauty, talent or precocity some narcissistic children are able to secure vitally needed admiration, but this may never be enough. They find themselves in an impossible dilemma - they require external approval to feel good, yet are threatened by such dependency because their grandiosity and fear of vulnerability requires an illusion of independence (Bleiberg, 1984). These children have enormous difficulty expressing and experiencing love, gratitude and an interest in others. Their grandiosity may be related to a need to devalue others, in order to keep seeing themselves as defenseless, and vulnerability at bay. These "mirror-hungry" personalities may feel compelled to display themselves and to elicit the attention of others (Kohut & Wolf, 1978). Reality testing is compromised in the service of maintaining a grandiose self-image; rules and regulations are discarded and others are manipulated and devalued with no constraints or guilt. The attention to rules and details that typically characterizes latency children is conspicuously absent. This grandiosity becomes a nucleus around which to establish a sense of self, and the world becomes a stage that reinforces this (Bleiberg, 1988).

In normal development, young children show genuine attachments and interest in others, and have the capacity to trust significant others. In disturbances of narcissistic regulation, concerns about being ignored, often coupled with doubts about being able to evoke responses from others, result in others being seen as a means to an end - as tools in the fight to stave off inadequacy and helplessness. This intense self-absorption and need to be the center of attention has an enormous impact on relationships with others, who may find narcissistic children provocative and

controlling. Others are not regarded for their attributes, but are needed in order to replace "the functions of the mental apparatus which had not been established in childhood" (Kohut, 1968). Attempts to recreate an early relationship with a parent who inflated the child's omnipotence and rewarded exhibitionistic displays of competence are largely unsuccessful, and this longing for a self object typically causes these children a great deal of difficulty. Therapeutic relationships with these children, for example, are frequently characterized by strong countertransference reactions of boredom and exploitation. It has been suggested that such feelings are the hallmarks of treatment of those with underlying narcissistic disorders, no matter what their original clinical presentation (Beren, 1992). The following are some excerpts from the treatment of a narcissistic child:

> "..she clearly wanted to have an audience and she wanted to use our sessions for me to be her audience and to admire her and give her my undivided attention. She had no interest in interacting with me. An example of this need for an admiring audience was her bringing her recorder to play in sessions. In reality she was not very accomplished because she spent very little time practicing. One had the clear sense that she believed she could be whoever she wanted just by wishing it... Her manner of playing was so difficult to follow and controlling that it made me feel confused and manipulated. It was as if there was no way to play with her other than to allow myself to be used as an extension."
>
> *(Beren, 1992, p. 268)*

The treatment of these children will be more fully discussed in the final section of this dissertation.

General Characteristics

By latency, these children have begun consolidating a character organization, which hinders subsequent development by limiting the flexibility and capacity to integrate new modes of functioning (Bleiberg, 1988). Narcissistic children most commonly come to the attention of clinicians once they are in school. These bright, verbal children typically fail to meet the promise they exhibit in their early years. Their language may be precocious and impressive, but their verbal cleverness often expresses a basically empty intellectualization and word play. Language "becomes a tool for exhibitionism and manipulation, a defense against shame, envy and vulnerability and a weapon to control, intimidate and keep people at a distance" (Bleiberg, 1994, p. 40). Cognitive functioning may be disrupted by their reliance on primitive defensive operations that interfere with logical thinking and awareness of internal and external reality (Bleiberg, 1984), and their capacity for sustained attention may be impaired. They may do poorly in school because they believe much of the work is beneath them or, more commonly, refuse to attempt tasks at which they fear they will not be a stunning success. One of my patients, described throughout this section, had fallen nearly two grade levels behind by the time of his referral at age ten. His mother insisted that this was due to boredom with non-challenging subject material. However, in treatment it became clear that he was unwilling to "put himself on the line" by risking failure. Grandiosity could not be relinquished in order to compete with peers, and it was impossible to take winning and losing in stride. Not being the best at something was equivalent to feeling annihilated.

Socially, narcissistic children may have even more difficulty. At home, the mother may provide an ideal self object for their grandiose self-imagery but, at school, students and teachers may not. Such a child is in danger of becoming an "arrogant isolate, a teased scapegoat, a learning problem, or a school refuser" (Noshpitz, 1984, p. 21). His every contact with the social world may be a constant struggle. Narcissistic children may choose friends whom they can boss or manipulate - people who may help them maintain their feelings of esteem. They may experience a wide range of comments and acts by others as hurtful or humiliating. For many of them, the ordinary teasing and conflict of childhood become almost unbearable. They are enormously sensitive to criticism, and go to great lengths to hide their vulnerable nature, including lying excessively. In settings where they are less likely to be criticized they may become tyrannical and excessively demanding, because these children must experience themselves in a grandiose way in order to feel good at all. They are only at peace when they are the center of attention, giving orders to those around them (e.g. calling their mothers - or therapists - "slaves"). According to Noshpitz (1984), narcissistic children:

> "...from a remarkably early age...are giving orders to adults and setting the tone of the household. They are said to have a "will of iron" and the parents are helpless to manage them. They insist on having their own way, they will not permit their mother to talk on the telephone, they are endlessly demanding, and they struggle mightily to be the continuing center of household attention. When denied the rewards of narcissistic gratification, they fly into a towering rage and would destroy, or obliterate, the authors of their pain."
>
> *(Noshpitz, p. 32)*

As described above, when denied narcissistic gratification, narcissistic children commonly fly into a rage. Kohut (1972) has written extensively of the rages that may occur when narcissistically vulnerable individuals feel they have suffered an injury at the hands of others. All such rages, according to Kohut, share a specific psychological flavor that may be characterized by the need for revenge, or the often anticipatory inflicting on others of those narcissistic injuries of which they are most afraid of suffering themselves (Kohut, 1972). Kernberg (1970) has also described the aggressive qualities of these patients in some detail. Narcissistically-disturbed children typically express such rages in the form of explosive temper tantrums, which occur when their omnipotent grandiosity or narcissistically-perceived vision of the world is threatened by external reality. At other times they exhibit anxiety bordering on panic, or may be driven into extreme despair by the tiniest disappointment or slightest experience of failure (Reich, 1960).

> "Kevin (now aged 11 yrs.) arrived with his escort, complaining of feeling unwell. He insisted that we both speak in whispers throughout the session and spent a good part of our meeting lying on the couch. I said that I could see that he had been hoping to come here for some peace and quiet today. He agreed and allowed that his parents had been fighting a lot at home. When I later tried to connect his wish to have me be quiet with his longing to be able to make his parents stop shouting, he became enraged and, throwing a toy at me, accused me of implying that he was "an orphan." When I wondered about this as a worry he began sobbing and ran down to the waiting room, throwing himself on the floor. He refused to return to the room for the remainder of the session, screaming that he hated me."
>
> *(K. Weise, Unpublished Case Material)*

Summary

The above-described characteristics of narcissistic children can all be captured by the following related criteria as outlined in the DSM IV:

- Lack of empathy and awareness of self and for others as may be indicated by interpersonal exploitativeness (e.g. controlling and manipulative behavior)
- Problems in self-esteem regulation as evidenced by grandiose or omnipotent thoughts or fantasies, a need for attention/admiration of others, hypersensitivity to criticism (e.g. rage reactions)
- Omnipotent denial of unhappy or painful feelings, or vulnerability

In this dissertation support will be provided for the impression of experienced analytically-oriented clinicians that there is indeed a discrete clinical entity of narcissistic disorders in children, and that certain object relationships are the hallmark of these disorders. In the following section measures developed to assess narcissism and narcissistic modes of relating will be reviewed.

The Assessment of Narcissism and Narcissistic Modes of Relating

Several authors have called for research concerning the differential diagnosis and treatment of individuals suffering from character pathology (Blatt and Lerner, 1983; Kernberg, 1975; Westen, 1991). All have stressed the importance of careful diagnostic assessment of these individuals, especially using psychological testing, for treatment planning and the management of issues related to transference and countertransference (Hilsenroth et al., 1996). Though Narcissistic Personality Disorder was first included as a diagnostic category in the third version of the DSM (APA, 1980), empirical research on narcissism has lagged behind theoretical interest, and the literature on narcissistic disorders is comprised for the most part of case material. In the absence of research, the value of the category has rested solely upon the attributions of clinical utility from a widely recognized, psychodynamically-informed clinical literature. However, recent efforts have begun to systematize and describe the characteristic features of NPD and aid in differentiating NPD from related personality disorders (e.g. borderline, histrionic and antisocial) (Gunderson et al, 1991). I will limit my review of this literature to those instruments that deal particularly with the identification and measurement of narcissistic features.

The Measurement of Narcissistic Characteristics

The few existing studies have investigated narcissism by means of both objective and projective techniques, mostly focusing on adult populations. Several of these have used personality inventories (i.e. self-report measures) developed to assess narcissism. The majority of these studies have employed the Narcissistic Personality Inventory

(NPI) (Shulman and Ferguson, 1988). This is a 54 item self-report questionnaire developed by Raskin and Hall (1979) and selected to conform with DSM III criteria for Narcissistic Personality Disorder. Data indicates consistent validity for the NPI (see Emmons, 1984 & 1987). The Millon Clinical Mulitaxial Inventory (MCMI), a true-false inventory of psychopathology, has been used to assess Axis II disorders (Millon, 1983). Examination of the diagnostic efficiency statistics across all of the MCMI personality disorder scales suggests that the MCMI may only have limited utility in identifying specific personality disorders. Authors of one study have found that the MCMI tends to overdiagnose Narcissistic Personality Disorder and is generally poor in identifying patients who meet the DSM IIIR criteria for NPD (Chick et al, 1993). The Personality Disorder Questionnaire (PDQ), developed by Hyler, Rieder, Spitzer and Williams (1982) is another true-false inventory, but was developed specifically to assess the diagnostic criteria for DSM III personality disorders. The PDQ has proven useful in measuring overall personality disturbance, although its ability to distinguish between specific disorders may be less effective (Hilsenroth, et al., 1996). Other studies (Ashby, 1979; Solomon, 1982) have reported on the use of an MMPI Narcissistic Personality Disorder Scale, which consists of 19 items from the MMPI, and has been shown to distinguish between those with healthy and pathological self-esteem, and narcissistic patients from those found to be suffering from non-narcissistic psychopathology (Hilsenroth et al., 1996).

Structured interviews have also been used in the psychological assessment of pathological narcissism. The Structured Interview for the DSM Personality Disorders

(SIDP) was developed by Pfohl, Stangl and Zimmerman (1983) and was designed to diagnose DSM III personality disorders. Early work on the SIDP has demonstrated reliability and validity with DSM III Axis II disorders and in determining the presence or absence of a personality disorder. Results of preliminary studies indicate that the SIDP can accurately identify patients diagnosed within the Cluster B personality disorders (antisocial, borderline, histrionic, narcissistic) (Stangl et al., 1985). The Personality Disorder Examination (PDE) is another structured interview developed for the assessment of Axis II disorders (Loranger, 1988). On a small sample, Loranger has demonstrated that there is high agreement (97%) between the presence or absence of NPD on the PDE and the DSM III criteria for NPD. The Structured Clinical Interview for DSM IIIR Axis II personality disorders (SCID-II) developed by Spitzer, Williams and Gibbon (1987) assesses each personality disorder in succession with one or two questions that directly measure each personality disorder/symptom. Use of the SCID-II to diagnose NPD resulted in the lowest overall diagnostic power, compared with its use for the other ten personality disorders. The Diagnostic Interview for Narcissism (DIN) is the first instrument to be specifically developed from and applied to clinically diagnosed narcissistic patients (Hilsenroth et al., 1996). The DIN was developed from a review of relevant clinical literature, clinical experience and a systematic examination of NPD patients (Gunderson & Ronningstam, 1987). This semi-structured interview has been shown to separate NPD from non-NPD patients with a high degree of accuracy. In addition, these authors have paid careful attention to the differential diagnosis between NPD and BPD patients, and have found the items investigating 'grandiosity' and those

concerning 'fantasies of unlimited success' to be most robust in differentiating the two groups. Less robust in discriminating between NPD and other Cluster B personality disorders were items measuring 'rage', 'envy' and 'a lack of empathy' (Gunderson et al., 1991).

Projective testing has been less frequently utilized in the investigation of narcissistic symptomatology, but several studies seem worth mentioning. In 1958, Grayden used the Blacky Picture Test to assess narcissism and several other variables. This measure is comprised of a series of drawings that are thought to correspond to Freudian psychosexual stages. In a study that later used the Blacky Picture Test and three TAT cards, Young (1959) confirmed the hypothesized relationships between level of narcissism and psychopathology. Exner (1969), in an attempt to classify narcissism, gave a sentence completion test to a group of subjects to determine whether or not they were egocentric, and then studied their Rorschach responses. He found that there were significant differences between responses of different groups on the dimension of reflection (i.e. the frequency of seeing mirror responses in the stimuli). A few recent studies have used the Rorschach in differential diagnostic research for NPD (Hilsenroth, et al., 1996). In general, it seems that the Rorschach may be helpful in identifying NPD patients from various other clinical groups. For example, in relation to BPDs, narcissistic patients develop higher levels of object representations, employ less primitive and severe defenses, and project less aggressive imagery (Hilsenroth et al., 1996). Farris (1988) found that compared to BPD patients, NPD patients showed significantly higher cognitive-perceptual

functioning, body narcissism and phallic-oedipal issues. Berg (1990) also investigated the difference between NPD and BPD on the Rorschach and found that the BPD group exhibited less grandiosity compared with an NPD group. Gacono et al. (1992) noted that both antisocial and narcissistic patients produced a similar number of reflection responses compared with BPDs and Exner's non-patient men. They also found that the narcissistic group produced a large number of idealization responses, a finding similar to Hilsenroth et al. (1993). Hilsenroth et al. (1993) further investigated differences between BPD and NPD by comparing these subjects to a clinical control group of Cluster C personality disorders. In examining Rorschachs, they found that NPDs evinced significantly higher levels of egocentricity and idealization than both borderlines and the clinical control group.

Though several psychiatric conditions have been studied using the TAT, few studies have used the TAT to examine character pathology. The first study to assess the ability of the TAT in the assessment of a narcissistic character style was the work of Leary (1957) who used TAT stories to determine an 'interpersonal style.' Though this work pre-dated current diagnostic classification systems, Leary characterized certain stories as 'narcissistic' or 'exploitive.' Harder (1979) used early memories, the TAT and Rorschach in the assessment of an 'ambitious narcissistic character style.' He scored these in conformity with theories of narcissistic character (Reich, 1933). These studies demonstrate that it is possible to obtain adequate reliability and validity when narcissism is assessed by means of a projective (Shulman, McCarthy and Ferguson, 1988). The Narcissism-Projective (N-P) developed by Shulman and

Ferguson (1988) is a measure with four parts, in which subjects are asked to write descriptions of two TAT cards and share two early memories. They are then interviewed and identified as either high or low narcissists. Each of the protocols and interviews are next scored according to criteria adapted from the DSM III definition of Narcissistic Personality Disorder. Clinical validity of the N-P was indicated by 85% agreement for N-P and interview ratings of narcissism.

Narcissistic Object Relations

Narcissistic modes of relating - as opposed to narcissistic characteristics - have been assessed via measures developed to look at object representations. Greenberg and Mitchell (1983) have defined object relations as an "individual's interactions with external and internal (real and imagined) other people, and to the relationship between their internal and external object worlds" (p. 13). More generally, "object relations concern the cognitive, affective and emotional processes that mediate interpersonal functioning in close relations" (Stricker and Healey, p. 219). The unconscious representations of object relations can be inferred from projective sources that elicit information on human relationships. A variety of psychological tests and scoring systems have been developed with this in mind, including those using the Rorschach, the Thematic Apperception Test (TAT), and Early Memories. For a more detailed review of the literature on the projective assessment of object relations, see Stricker and Healey (1990).

There are several methods of assessing modes of relating using the Rorschach, the two most extensively researched being the Developmental Concept of the Object Scale (in Blatt and Lerner, 1983) and the Mutuality of Autonomy Scale (Urist, 1977). The former scale, drawn from developmental psychology, assesses several content-based dimensions and has been used both to show developmental changes in object representations and to differentiate between various diagnostic categories. Most relevant to this dissertation is that differences were found in the level of object representations in narcissists vs. borderlines (Farris, 1988). Urist's Mutuality of Autonomy Scale (MOAS) incorporates self psychology, ego psychology and object relations theory and focuses on the developmental movement toward separation-individuation (Stricker and Healey, 1990). There has been some disagreement about whether the MOAS is most useful in measuring developmental changes in object relations or if it is more a measure of pathology (Stricker and Healey, 1990). One particularly interesting difference between these two scales is that, because the MOAS also scores animal and inanimate movement responses, children can be assessed with this scale more readily. A significant amount of the research with the MOAS has used children as subjects (Tuber, 1992). Though not as yet used in specifically highlighting the attribution of narcissistic characteristics to object representations, some of the scale points appear to reflect this (e.g. the 'reflection/mirroring' category). Also using the Rorschach, Berg et al. (1993) found that borderlines and narcissistic patients produced a significantly greater number of object relational scores representing figures in need of some external source of support than a schizophrenic group. Rorschach protocols of the narcissistic group

reflected a difficulty in relating to others on a mutually autonomous basis, thereby relying solely on need satisfying relationships. These findings appear to highlight prior theoretical work concerning patients with disorders of the self, such as the work of Kohut (1971).

Two other, less used scales could be relevant to this dissertation. Mayman thematically assessed object relations with the Rorschach, early memories and dreams (Mayman and Farris, 1960; Mayman, 1967). His scale, called the Object Representation Scale for Dreams (ORSD), assesses the subjects' internal world as desolate, at one extreme, and filled with fully human, complex beings, at the other. Coonerty (1986) developed the Separation-Individuation Theme Scale (SITS), which is based on Mahler's theory of borderline development (Mahler et al., 1975). This scale scores for separation-individuation vs. pre-separation-individuation material and contains subscales for measuring differentiation, narcissism and rapprochement.

Though there have been a few scales developed to measure TAT responses, only Drew Westen's Social Cognition and Object Relations Scale (Westen et al, 1985) has been specifically designed to study object relations. This scoring system will be explained fully in the following Method section. Other scales for the TAT that may be considered to have relevance to this dissertation, though not primarily designed to measure object relations, are Phebe Cramer's Defense Mechanism Inventory (1988) and Anne Thompson's Affect Maturity Scale (1986). The former scale assumes a developmental hierarchy of defense mechanisms and three subscales of denial,

projection and identification are scored based on their presence in TAT responses. The dimension that examines the mechanism of denial seems most relevant to a study of narcissism. Thompson assumes a developmental hierarchy of affect and measures a subject's experience of affect. At one extreme feelings are seen as a singular, physical state and, at the other, individuals are seen as having their own complex and well-delineated feelings. Though not specifically designed to elucidate object relations, this scale is relevant to such a study because it looks at attributions of affect to others and so examines internal perceptions of self and other.

Though all of the studies cited in this section seem relevant to a study of Narcissistic Disorders in Children, I have determined that the Coonerty, Urist and Westen scales all seem good matches, both theoretically and in terms of construct validity. Unfortunately, the data currently at my disposal does not include enough Rorschach protocols to allow for a viable study using the Rorschach. I will therefore be using the SCORS (Westen et al., 1985) to analyze the TATs of narcissistically-disturbed children. As the SCORS shares my interest in the object relations of these children and a developmental orientation, I believe it will prove most helpful in an investigation of the underlying self and object representations of these children, and thus will be useful in thinking about their treatment. My hypotheses, a more detailed description of this instrument, and the relation between the two, will be more fully elaborated upon in the following Method section.

II. METHOD

Though the children being studied here may present for evaluation and treatment with a variety of symptoms, there is an accepted, discrete diagnostic category of narcissistic disorders in children that meet the following behavioral criteria (as outlined by the DSM IV definition of Narcissistic Personality Disorder in adults):

- **Lack of empathy and awareness of self and for others as may be indicated by interpersonal exploitativeness (e.g. controlling and manipulative behavior)**
- **Problems in self-esteem regulation as evidenced by grandiose or omnipotent thoughts or fantasies, a need for attention/admiration of others, hypersensitivity to criticism (e.g. rage reactions)**
- **Omnipotent denial of unhappy or painful feelings, or vulnerability**

My hypotheses, which are drawn from the literature, are outlined below.

Statement of Hypotheses

These children, as a consequence of particular difficulties in the separation-individuation process as outlined in the Literature Review section, have certain types of self and object representations in common in addition to the above symptoms, and these are measurable by projective testing. More specifically, on the TAT they have a significantly high number of responses reflecting the following combinations of characteristics:

- **A profound self-preoccupation and lack of concern for the feelings of others (e.g. their stories are often characterized by need-gratifying relationships)**
- **Difficulty in the management of aggressive impulses, (e.g. narcissistic 'rage')**

- **Unrealistically negative or positive self-feelings**
- **An unstable or undeveloped sense of self**

The above findings all have implications for the treatment of such children, in that traditional psychodynamic psychotherapy, in which there is a great deal of focus on the interpretation of conflict and defense, may prove ineffective or futile. Instead, any treatment plan may have to be based on the understanding that these children's primary difficulties lie in the development of a realistic sense of self and other and, consequently, focus on providing these children with a forum for the development of stable, reciprocal object relationships.

Methodology

Description of Sample/Population

The sample consists of thirty-two subjects drawn from a population of elementary school-aged boys and girls of low to middle socio-economic status. All thirty-two were referred for psychological assessment at two different outpatient psychological centers over the course of the last forty years. These children were referred for a variety of different symptoms and were assigned diagnoses such as Attention-Deficit Disorder, Obsessive-Compulsive Disorder, Oppositional Defiant Disorder, etc. Of these thirty-two children, sixteen are considered to be 'narcissistic.' By this I mean that they have been found to meet all of the previously outlined four criteria for a narcissistic disorder by the clinicians involved in their assessment or treatment (all a minimum of Master's level child therapists trained in assessment and treatment of this

age group). These children's symptoms were stable and long-standing (duration of at least one year) as outlined in the DSM. To test the reliability of the identification of eligible subjects, two independent clinicians were asked to blindly assess eighteen cases potentially able to be included in the sample. After reviewing the cases to determine whether or not the subjects met the criteria for a narcissistic diagnosis as defined for this study, the independent raters confirmed that sixteen were eligible for inclusion. The sixteen members of the control group were referred for treatment of various DSM IV Axis I diagnoses, including those characterized by depression, behavioral acting out, learning difficulties and hyperactivity, but do not meet the criteria outlined here for a disturbance in narcissism. Exclusionary criteria included evidence of psychosis or IQ below 70. Material used in the assessment process included diagnostic interviews, school reports and psychological testing.

Data used in this study were archival and included behavioral summaries, social histories and IQ tests (mostly WISC-Rs, with some Stanford-Binets). These thirty-two records are complemented by TAT protocols that were administered by several different examiners with formal coursework in psychological assessment affiliated with two different psychological centers - one hospital outpatient department (NY) and one child guidance center (London). TAT administration was consistent with the procedure recommended by Bellak (1986), with probes generally limited to characters' thoughts and feelings and story antecedents and outcomes (Ornduff and Kelsey, 1996). All legal guardians of subjects gave informed consent to each

institution at the time of the assessment, and participant's identities were kept strictly confidential. Permission to use material was granted by each agency.

Summary of Pilot Study

For the pilot study I ran four subjects - two control and two narcissistic subjects. Because of the unavailability of trained coders I attempted to score all four using an updated version of the SCORS coding manual (in the process of being revised) myself, and analyze the data to see if the results confirmed or disproved my hypotheses, which are that narcissistically-disturbed children will show particular distortions in their self and object relationships. More specifically, that these children would have generally lower mean scores than the clinical comparison group on all three dimensions that were examined: Complexity of Representations of People, Affect-tone of Relationship Paradigms and Capacity for Emotional Investment. Responses to TAT Cards 1, 2 and 4 were rated using the SCORS. These cards were selected based on their representation in all of the subjects' records and because they have all been used in other investigations using the SCORS (Barends et al., 1990; Freedenfield et al, 1995; Ornduff et al., 1994; Westen et al., 1991).

Significant results were only obtained on the dimension reflecting **Capacity for Emotional Investment in Relationships and Moral Standards**, indicating that the mean response for the "narcissistic group" was significantly lower than that of the clinical comparison group. Results on the Dimension of **Affect-tone of Relationship Paradigms** were nearly significant, and those for **Complexity of Representations of**

People were not significant. For further details on current versions of each of these sub-scales, please see below.

Description of Materials and Instruments

The TAT (Murray, 1943) is widely used in both clinical practice and research (Alvarado, 1994). The subjective validity of this measure among clinicians appears to be that it provides meaningful information about the emotional responses of subjects to pictures depicting "certain classical human situations" (Murray, 1943, p. 2). The value of the TAT for clinicians is that it is thought to reveal thoughts and feelings not readily available to consciousness because, for the most part, of the operation of defenses. Several authors have provided extensive discussions of the typical story themes generated by the various TAT Cards (Bellak, 1986). For example, it has been noted that some cards pull for typical family relationships or certain types of affect (Cramer, 1996). The TAT represents a particularly useful way of assessing object relations because it pulls for descriptions of a variety of self, other and interpersonal relationships (Westen, 1991; Ornduff and Kelsey, 1996). As Westen points out, "the TAT is an excellent test for assessing object relations because subjects are asked to apply their experiences of relationships in creating stories about ambiguous social scenes, including what happened, the outcome and what the characters are thinking and feeling" (Westen, 1991, p. 57). In a study investigating the hypothesis that there are shared attributions to the TAT pictures, Alvarado (1994) found a certain amount of support for Westen's (1991) suggestion that when meaning was attributed to TAT cards, it often involved object relations being incorporated into the story-telling. Her

findings suggest that there is a "normative meaning for each picture based on factors important to object relations" (Alvarado, 1994, p. 74). More specifically, though she states that level of verbal functioning and card content have remained confounds in Westen's studies, his dimensions examining the affect-tone and object relationships depicted in TAT stories (as outlined below) bear further investigation.

The measure to be used was developed by Drew Westen et al. (1985) and is the only TAT-based instrument to assess object relations in any depth (Stricker and Healey, 1990) though other instruments, such as Thompson's (1986) Affect Maturity scale for the TAT, have a significant object relations component. The SCORS was developed to enable clinicians to look beyond the overt presentation of the patient and evaluate more dynamic facets of personality functioning (Ackerman et al., 1998). Derived from both object relations theory and social cognitive research, "this scoring system provides a framework for understanding and assessing an individual's object relational processes and structures, which give rise to interpersonal functioning" (Ornduff et al., 1994, p. 225). Known as the Social Cognition and Object Relations Scale (SCORS), this measure focuses on dimensions of object relations and social cognition as measured from Thematic Apperception Tests responses (Murray, 1943). The SCORS has been revised several times since its original inception in 1985. The latest revision, the "Social Cognition and Object Relations Scale: Q-sort for Projective Stories (SCORS-Q)" (Westen, 1995), is in the process of being validated. In the Q-sort, two separate measures for relationships and dominant interpersonal themes are investigated from both TAT stories and interview data. I am only

interested in the relationship measures (which are largely developmental), and am using a modified Likert scale developed by Mark Hilsenroth and colleagues at the University of Arkansas (1998). The eight dimensions of the modified scale (derived from the Q-sort) are as follows: *Complexity of Representation of People, Affective Quality of Representations, Emotional Investment in Relationships, Emotional Investment in Values and Moral Standards, Understanding of Social Causality, Experience and Management of Aggressive Impulses, Self-esteem,* and *Identity and Coherence of Self.* The theoretical underpinnings of this scale are rooted in object relations theory. The concept of object relations in psychoanalysis refers, most broadly, to interpersonal behavior and the cognitive and affective processes mediating the capacity for relatedness to others (Westen et al., 1991, p. 400). Object relations theorists propose that many individual differences in this area reflect developmental differences, and attribute severe interpersonal disturbances to early developmental failures. Patients with severe personality disorders, for example, would evidence lower levels of development in their object relations. As explained in prior sections, I am understanding that narcissistic children would have just such gross disturbances in their self and object representations, and that this is due to early problems in the parent-child relationship. The SCORS thus shares my developmental perspective, and aims to measure the level of distortion caused by such early failures.

This scale is fundamentally a developmental one, and it's underlying logic is that there is a movement from poor to complex differentiation between oneself and others; need-gratifying relationships to an investment in others; an absence of causal

understanding to a complex understanding of the mediating role of mental events (Westen et al., 1990b). For the most part the SCORS addresses these developmental lines from a psychoanalytic perspective, however, the subscale measuring *Understanding of Social Causality* - which is not being used here - has it roots in developmental social cognition. Two dimensions, *Affective Quality of Representations* and *Self-esteem* are not based on a conception of "normal" development, the assumption being that at no stage of development is it appropriate to see object relationships as fundamentally destructive, or view oneself as loathsome (Westen et al., 1991).

The eight dimensions (or subscales) of this measure were developed to assess different levels of object relations and social cognition. The first dimension, *Complexity of Representation of People*, assesses the extent to which the subject clearly differentiates the perspectives of self and others and recognizes the complexity of personality and subjective experience of self and others (Westen, 1991). The logic of the scale is that there is a movement from poor to increased differentiation between people. I will not be measuring this particular attribution. The second attempts to measure the *Affective Quality of Representations* and was designed to assess the extent to which a person expects relationships to be destructive vs. enriching (Westen, 1991). At the lowest levels subjects demonstrate malevolent expectations of relationships, whereas higher scores indicate that interpersonal interactions are expected to be predominantly positive (Westen et al, 1991). The third and fourth dimensions seem particularly relevant to a study of narcissism - *Emotional Investment*

in Relationships and *Emotional Investment in Values and Moral Standards.* (Note: In the original scale these two dimensions were combined). The first subscale was designed to assess the extent to which the person transcends a need-gratifying orientation toward relationships and is capable of forming mutual bonds with others in which there is a real involvement and investment in others (Westen, 1991, p. 62). The latter dimension measures how much an investment in behaving in a thoughtful, compassionate way towards others is evident in the story told. Another dimension is *Understanding Social Causality.* I will not be using this particular subscale in my study as it seems perhaps least relevant. This dimension attempts to assess the logic, complexity and accuracy of attributions. The underlying logic of this subscale is a move from an absence of causal understanding to a more complex understanding of the mediating role of mental events (Westen et al, 1991). In addition, I will be using the subscale on *Experience and Management of Aggressive Impulses*, which assesses how much anger is depicted and how this is dealt with by the characters in the story. The final two dimensions, which will be included, measure the *Self-esteem* (from negative to positive) and the *Identity and Coherence of Self* (from unstable to stable) attributed to characters.

The reliability and validity of the Social Cognition and Object Relations Scale to rate TAT stories has been demonstrated in a number of previous studies investigating the object relations of a wide range of psychological conditions (in Ackerman et al., 1998). These studies have validated the original measures with both normal and clinical populations and both adult and adolescent samples (Ackerman, Clemence et

al., 1998; Ackerman, Hilsenroth et al., 1998; Barends et al., 1998; Cogan and Porcerelli, 1996; Hibbard et al., 1995; Westen et al., 1990a, Westen et al., 1990b; Westen et al., 1990c; Westen et al., 1990d, Westen et al., 1991). More specifically, the measures have been able to distinguish borderline patients from psychiatric and normal comparison subjects in both adult and adolescent samples (Westen, Lohr et al., 1990; Westen, Ludolph et al., 1990). In a normal sample, the original four TAT scales have largely been shown to correlate with four similar scales developed for interview data such as early memories, psychiatric interviews or psychotherapy transcripts (in Westen, 1991). This research also found predicted correlations between the TAT scales and relevant validated instruments such as Loevinger's (1976) Sentence Completion Test for Ego Development, which correlates with both "affect-tone" and "capacity for emotional investment", and Blatt, Wein, Chevron and Quinlan's (1979) measures of complexity and affective qualities of parental representations applied to descriptions of significant others (Westen, 1991, p. 57). Other studies have found developmental changes in all scales except for affect-tone (as predicted) between second and fifth graders and between ninth and twelfth graders (Westen et al., 1991). Another found a systematic relationship between object relations assessed in adolescence and several developmental history variables such as disrupted attachments in childhood (Westen et al., 1990b). More recently, studies using this measure have undertaken to point out important differences in the object representations of both sexually and physically abused children/adolescents, and subjects with both Borderline Personality Disorder and Major Depression (Ornduff et al., 1994; Ornduff and Kelsey, 1996; Hibbard et al, 1995).

Over the last decade, there has been some investigation of TAT narratives from the protocols of narcissistically disturbed adults, but most of these have been case studies (Abrams, 1993). Ackerman, Clemence, Weatherill and Hilsenroth (1998) are the first to use the TAT in the assessment of three DSM IV Personality Disorders (Antisocial, Borderline & Narcissistic Personality Disorder). This is the first study to examine the reliability and validity of the eight SCORS variables in the assessment of DSM IV Cluster B Personality Disorders, and to use the SCORS to differentiate between them. The validity of the SCORS-Q is in the process of being established. This dissertation is the first attempt to apply the 'Hilsenroth' Likert scale to children with character disturbances.

Description of Procedures

TATs were administered in two different outpatient clinical settings over a period of many years. Each TAT was given by an experienced professional who gave identical or near-identical instructions, and a series of cards were administered in a standard sequence (i.e. numerical order). Subjects were asked to tell a story with a beginning, middle and end - to describe what was happening in the picture, what happened before, and what came after. In addition, subjects were asked to describe what the characters were thinking and feeling. Prompting was minimized. All examiners were unaware of each child's diagnosis/presentation symptoms at the time of the administration. All stories were transcribed verbatim.

TAT responses were coded by two raters blind to the age, sex and diagnostic category of the participants. Personal information on each subject was kept on a master code sheet, which was kept separate until the analysis of coded data began. Coders were given typed stories organized in a random order, and four TAT cards were coded on five dimensions: *Experience and Management of Aggressive Impulses, Self-esteem, Emotional Investment in Values and Moral Standards, Identity & Coherence of Self* and *Emotional Investment in Relationships.* I was particularly interested in the results of those subscales that are most relevant to my hypotheses: *Self-esteem, Emotional Investment in Values and Moral Standards,* and *Emotional Investment in Relationships.* These four cards (1, 2, 3BM and 4) were chosen on the basis of their representation in each of the protocols to be evaluated, and their appearance in several previous well-validated SCORS studies. Each scale has seven levels with Level 1 representing the most primitive response and Level 7 the highest level response. Scoring requires extensive training using a comprehensive manual (Westen et al., 1995) that includes standards for establishing scorer reliability (Westen, 1991). A brief synopsis of the revised 'Hilsenroth' Likert Scale is included in Appendix A.

Data Analysis

Reliability was established via intra-class correlation coefficients (Shrout and Fleiss, 1979), as outlined in the SCORS Manual (1985). The ICC (3,k) is typically used when materials are all rated by the same judges and these judges are the only ones of interest. Reliabilities for the four studies in the above-quoted papers by D. Westen et al (1990a,b,c,d) ranged from .91 to .97 on all four scales during different

administrations. The two coders employed for the present study had extensive prior experience in the development of the modified SCORS, and interrater reliabilites for their ratings ranged from .72 to .99, demonstrating that each of the variables utilized in this analysis are highly reliable (see Table A). Dimensions in boldface are of special relevance to this project.

TABLE A

Intraclass Correlation Coefficients for SCORS Variables

Variables	ICC (3,k)
Complexity of Representations of People	.81
Affective Quality of Representations	.92
Emotional Investment in Relationships	**.99**
Emotional Investment in Values and Moral Standards	**.84**
Understanding of Social Causality	.72
Experience and Management of Aggressive Impulses	**.81**
Self-esteem	**.95**
Identity and Coherence of Self	**.89**

For this Between-groups design, means and standard deviations were calculated for both the narcissistic and the clinical comparison group. Significance was determined via one-tailed t-tests for independent means on each of the five relevant dimensions, or variables. Further explorations of the data included a multivariate analysis of variance (which also looked at Gender and Gender by Group as dependent variables) and multiple regression procedures.

Hypotheses

My hypotheses, which are derived from my review of the literature and survey of previous studies, are that narcissistic children, when compared with a clinical comparison group of a similar age will:

1. Have fewer relationships, of poorer quality
2. Exhibit a lower investment in values and moral standards
3. Demonstrate difficulty with the experience and management of aggressive impulses
4. Manifest unstable self-esteem
5. Show less self-cohesion, and exhibit problems with identity

As further elaborated upon in the following results section, all five of my hypotheses correspond to dimensions, or variables, of the modified SCORS (Hilsenroth et al., 1998).

III. RESULTS

Subjects & Data

Breakdown of Subjects and Data Coded

There were thirty-two subjects included in the study and they were broken down as described in Table 1.

Table 1: Subjects

Dataset	16 Control
	16 Data
Gender	16 Male (8 Controls, 8 Data)
	16 Female (8 Controls, 8 Data)
Coder	23 protocols coded by R.W.
	9 protocols coded by S.A.
Age	12.1 (Control Group Mean)
	10.9 (Data Group Mean)

All subjects gave responses to cards 1, 2, 3BM and 4 on the TAT (Murray, 1943) and those four cards were coded using the SCORS on the following five variables, or dimensions: Emotional Investment in Relationships (EIR); Emotional Investment in Values and Moral Standards (EIV); Aggression (AGG); Self-Esteem (S-E); Identity and Coherence of Self (ICS).

The five hypotheses to be tested correspond to SCORS variables, and the narcissistic group was compared to the clinical control group on all of these dimensions. Means (M) and standard deviations (SD) were computed for each group. Scores range from 1

through 7, with a low score generally being more pathological than a higher one. (See Appendix A for further elaboration). T-tests for independent samples (see Table 5A-E), were employed and significance of findings was determined. The following two tables first break down the scores (or values) by card, and by variable across all cards and groups:

Table 2: Mean Response for each Variable by Card
(n = 32)

	Mean	Std Dev	Minimum Score[1]	Maximum Score[1]
Card 1				
EIR	2.88	1.21	1	5
EIV	3.69	.97	2	6
Aggression	3.91	.64	2	5
Self-esteem	4.13	.79	3	6
Identity	4.50	.62	3	6
Card 2				
EIR	3.13	1.10	1	5
EIV	3.72	.92	2	6
Aggression	3.91	.64	2	5
Self-esteem	4.09	.69	3	5
Identity	4.22	.49	3	5
Card 3BM				
EIR	2.66	1.31	1	5
EIV	3.34	1.10	1	5
Aggression	3.34	1.10	1	5
Self-esteem	3.63	.98	2	5
Identity	4.16	.85	2	6
Card 4				
EIR	3.13	1.13	1	5
EIV	3.66	.97	1	5
Aggression	3.62	.87	1	5
Self-esteem	3.84	.85	1	5
Identity	4.16	.95	1	5

[1]Scores range from 1 –7 (see Appendix)

Table 3: Descriptive Statistics by Variable[1]

	MEAN	STD DEV	KURT	SKEW	MIN	MAX
EIR	11.781	2.511	.809	.414	6.00	16.00
EIV	14.406	2.367	.809	.414	9.00	19.00
AGG	14.781	1.996	.809	.414	10.00	18.00
S-E	15.688	2.177	.809	.414	12.00	20.00
ICS	17.031	1.959	.809	.414	13.00	21.00

[1]Mean has been computed from sum of responses across cards for each subject

Scores tended to be lowest, but most varied, on the EIR variable for both groups.

Highest, but least varied, were ICS scores.

Exploring the Integrity of the Scale

Intercorrelations of TAT Scores

Pearson correlation coefficients (r) were used in order to check the intercorrelation of the Independent Variables (e.g. the potential overlap between variables) and how well the model fits the data.

Table 4: Intercorrelations of TAT Scores (n=32)

		EIR	EIV	AGG	S-E	ICS
EIR	r					
	Sig.					
EIV	r	.015				
	Sig.	.933				
AGG	r	.145	**.620****			
	Sig.	.430	.000			
S-E	r	.123	**.564****	.310		
	Sig.	.503	.001	.084		
ICS	r	.342	**.505****	**.571****	**.418***	
	Sig.	.055	.003	.001	.017	

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Correlations among scales revealed moderate degrees of inter-relationship, as expected. Five correlations emerged, with the key finding being that the EIV variable was significantly correlated with three of the other variables. The most significant relationship (.620 at $p \leq .001$) was between the "Aggression" and "Emotional Investment in Values and Moral Standards" variables. This indicates that there is a strong potential of overlap between scale dimensions measuring the management of aggressive impulses and how likely one is to behave selfishly and/or without remorse (i.e. is poorly invested in values and moral standards). It makes intuitive sense that these variables might be looking at similar phenomena, however, this significant correlation does not discount any findings. It rather suggests that results obtained may be less powerful. The ICS variable was also shown to be correlated with three of the other variables (EIV, AGG and S-E), and two of these relationships reached significance ($p \leq .001$).

Chi-Square Tests were carried out to insure that there were no significant differences between groups being studied. The results were as follows:

- **Gender** of subjects was split evenly between the control and data groups, so there were no significant differences between males and females
- Protocols scored by each **coder** were evenly divided between control and data groups so that there was no significant difference between coders on which group material was taken from
- There was a difference noted between **gender of subjects coded** by R.W. (54.5% Female/ 45.5% Male) and S.A. (20.0% Female/ 80.0% Male) but this was not significant on Fisher's Exact Test (Fisher's Exact Probability = .124).

Examining the Hypotheses

The hypothesis that narcissistic children have fewer relationships of poorer quality than their non-narcissistic peers was investigated via the SCORS variable Emotional Investment in Relationships (EIR), in which a lower mean score indicates that a subject is more focused on their own needs, or has "shallower" relationships.

Table 5A

SCORS Variable	Narcissistic Group (N=16) Mean (SD)	Control Group (N=16) Mean (SD)	t (30)	p
EIR	12.75 (1.73)	10.81 (2.83)	2.33	.028

According to these findings, the narcissistic group showed a significantly higher investment in relationships, than the control group. This finding is contrary to predictions, though mean scores for both groups are substantially lower than for other scale variables.

The hypothesis that narcissistic children exhibit a lower investment in values and moral standards than their control-group peers was investigated via the SCORS variable Emotional Investment in Values and Moral Standards (EIV). A lower score on this dimension may indicate that a subject behaves in a selfish manner with little evidence of remorse or guilt - the higher the score the more likely that the subject will think abstractly about moral questions or is compassionate towards others.

Table 5B

SCORS Variable	Narcissistic Group (N=16) Mean (SD)	Control Group (N=16) Mean (SD)	t (30)	p
EIV	13.00 (2.10)	15.81 (1.72)	-4.15	<.001

The narcissistic group had a significantly lower mean score on this variable, as predicted, indicating a lower investment in values and moral standards.

The hypothesis that narcissistic children have difficulty with the management of aggressive impulses was investigated by using the SCORS dimension Experience and Management of Aggressive Impulses (AGG). The lower the score on this variable, the more likely a subject is to be impulsive, or in poor control of aggression - a higher score indicates that one can defend against anger, or express anger appropriately.

Table 5C

SCORS Variable	Narcissistic Group (N=16) Mean (SD)	Control Group (N=16) Mean (SD)	t (30)	p
AGG	13.75 (2.02)	15.81 (1.38)	-3.38	.002

As predicted, narcissistic subjects scored significantly lower on this scale, indicating that they are in poorer control of their aggressive impulses than the control group.

The hypothesis that narcissistic children manifest unstable self-esteem was examined by using the SCORS variable, Self-Esteem (S-E). A low score on this item indicates that the subject views himself or herself as inferior, or is unrealistically grandiose. Higher scores are seen in subjects who tend to have a more realistic range of positive and negative feelings about themselves.

Table 5D

SCORS Variable	Narcissistic Group (N=16) Mean (SD)	Control Group (N=16) Mean (SD)	t (30)	p
S-E	14.69 (2.27)	16.69 (1.58)	-2.89	.007

Here again the narcissistic group had a significantly lower mean score, indicating more of a problem with the regulation of self-esteem than the control group, again as predicted.

The final hypothesis, that narcissistic children show less self-cohesion and have problems with identity, was tested by examining ratings on the SCORS variable Identity and Coherence of Self (ICS). A low score on this item indicates that a subject may have a fragmented or fluctuating sense of self.

Table 5E

SCORS Variable	Narcissistic Group (N=16) Mean (SD)	Control Group (N=16) Mean (SD)	t (30)	p
ICS	16.44 (1.90)	17.63 (1.89)	-1.77	.09

There was a trend towards significance on this item, with the narcissistic group showing more of a tendency towards identity instability than the control group.

Further Exploring the Hypotheses

Another way to test the hypotheses of differences on these variables is via a Multivariate Analysis of Variance (MANOVA) with the five scales as independent variables and Group and Gender as dependent variables. Using a MANOVA to analyze data allows a controlling for Type I error and enables an exploration of the interaction between dependent measures (e.g. Group & Gender). If there is an intercorrelation between dependent variables, a richer analysis of the data is made possible.

Assumptions of MANOVA are that the dependent variables must be distributed normally, that the subjects' scores on the dependent variables are not influenced by the other subjects in his/her group (i.e. observations are independent) and that the covariance (the variance shared by two variables) for all unique pairs of dependent measures be equal for all groups. The first two assumptions were met by the design of the study, and the third was tested via Box's M, which was significant at .031. Descriptive statistics, summarized for the purposes of the Multivariate Analysis of Variance, are available in Appendix B.

Multivariate Tests

Multivariate tests were employed to look for significant differences between Group, Gender and Group x Gender across all five of the independent variables (i.e. SCORS dimensions). A significant difference between groups was found but no Gender main effect, nor an interaction effect between Gender and Group. All effect sizes were large, the largest being that for Group. The effect size (percent of variance explained) addresses the magnitude of the finding. Sixty-five percent (.65) of variance can be explained by a subject's membership in either the data or control group, while a subject's gender (.15) or gender combined with group membership (.21) accounted for much less. Effect sizes (eta^2) of .01 are considered small, .06 are medium, .14 and above are large (Stevens, 1996).

Table 6: Differences and Effect Sizes between Groups

	Pillai's Trace	F	df	p	eta^2	power
GROUP	.650	8.905	5.0	**.000**	.650	.999
GENDER	.149	.837	5.0	.536	.149	.248
GROUP x GENDER	.211	1.281	5.0	.305	.211	.373

Multivariate tests were followed by univariate tests to examine between-subjects effects for each scale variable separately. As seen in the earlier t-tests, significant differences were found between data and control groups for all variables except for 'Identity', where there was a trend towards significance and a medium effect size. There were no significant differences by Gender on any of the five variables. There were, however,

some significant differences between scale variables when looking at Group by Gender interaction. On 'Self-Esteem,' for example, there was a significant interaction, with non-'narcissistic' females having more stable self-esteem than their data group counterparts (see Appendix B for a breakdown of Group by Gender scores). This finding was also true of male members of the clinical control group, but the results did not reach significance. On the variable measuring 'Emotional Investment in Relationships' there was a trend towards a significant interaction. Though investment in relationships is remarkably consistent for female subjects, male 'narcissists' scored significantly higher than male members of the clinical control group. Both findings had medium effect sizes.

Table 7: Between Subjects Effects by Variable

		F	df	P	eta^2	power
GROUP	EIR	4.914	1	**.035**	.149	.572
	EIV	16.632	1	**.000**	.373	.976
	AGG	12.139	1	**.002**	.302	.920
	S-E	10.572	1	**.003**	.274	.881
	ICS	3.076	1	*.090*	.099	.395
GENDER	EIR	2.116	1	.157	.070	.290
	EIV	.056	1	.814	.002	.056
	AGG	2.877	1	.101	.093	.374
	S-E	.248	1	.622	.009	.077
	ICS	.427	1	.519	.015	.097
GROUP/GENDER	EIR	3.444	1	*.074*	.110	.433
	EIV	.358	1	.554	.013	.089
	AGG	.291	1	.594	.010	.082
	S-E	4.362	1	**.046**	.135	.523
	ICS	.096	1	.759	.003	.060

Significant findings are in bold type

Trends are in italics

Supplemental Analyses

Multiple Linear Regression Analyses

Since four of the SCORS variables were significant in group comparisons, a dimensional investigation of the variables' ability to predict group membership was undertaken. The first analysis used a **forced entry** multiple regression procedure. Here all predictor variables of interest in the analysis are entered in the equation, regardless of whether they explain a significant amount of variance (see Table 8). Sixty-five percent (.652) of the variability in Group status is explained by the five independent variables taken together. An Analysis of Variance was then computed to test the null hypothesis that there is no linear relationship between the DV and the IVs (i.e. that $R^2 = 0$).

Table 8: Forced Entry Multiple Regression Results

	SS	Df	Mean Sqd.	F	Sig.
Regression	5.219	5	1.044	9.76	**.000**
Residual	2.781	26	.107		
Total	8.000	31			

$R = .808$; $R^2 = .652$; $p<.001$

Since the observed significance was $p<.001$, the null hypothesis was rejected. Additionally, in order to compare the relative importance of the variables, standardized regression coefficients (SRCs) were utilized to specify which SCORS variables in the regression were most useful in predicting group membership. The results indicated that scores on the 'Emotional Investment in Relationships' (EIR) (beta = .50, $p<.001$) and the 'Experience and Management of Aggressive Impulses' (AGG) (beta = -.348, $p<.05$)

scales were associated with a significant portion of the variability. High EIR scores, reflecting how invested one is in developing mutual, sharing relationships, predicted membership in the data group, as did low aggression scores.

The strength of the linear relationship among the IVs is measured by a statistic called tolerance. For each IV, the tolerance is the proportion of the variability not explained by the other IVs. If two or more IVs are highly correlated it is difficult to determine their separate effects on the DV (group membership). Tolerance values range from 0 to 1, with a value close to 0 indicating that a variable is almost a linear combination of the other IVs. Such data is considered to have a multicollinearity problem, and thus less power. This could possibly be the case for the EIV variable, which, according to the earlier Pearson Correlation Coefficients computed, is highly correlated with the AGG variable. Again, this does not disqualify any results obtained but rather, lessens the power of findings.

Table 9: Multicollinearity Diagnostics for Forced Entry Regression Analysis

	Correlations			Collinearity Statistics	
	Zero-Order	Partial	Part	Tolerance	VIF
EIR	.392	.614	.459	.844	1.185
EIV	-.604	-.230	-.139	.440	2.272
AGG	.392	-.389	-.249	.514	1.945
S-E	-.467	-.353	-.222	.640	1.562
ICS	-.308	-.073	-.043	.537	1.861

An alternate method of analysis is to use a **stepwise variable selection.** This resembles the previous analysis, except only variables that explain a significant amount of the criterion variable (DV) are entered. This means that variables are removed whose importance has diminished as additional predictors are added. The decision to enter or remove a variable is based on how much it changes multiple R^2 - the percentage of variation in the criterion (group membership) that can be predicted by the predictor variables in the regression model.

Table 10: Multicollinearity Diagnostics for Stepwise Regression Analysis

		Correlations			Collinearity Statistics	
		Zero-Order	Partial	Part	Tolerance	VIF
1.	EIV	-.604	-.604	-.604	1.000	1.000
2.	EIV	-.604	-.663	-.610	1.000	1.000
	EIR	.392	.503	.401	1.000	1.000
3.	EIV	-.604	-.439	-.310	.610	1.640
	EIR	.392	.570	.441	.970	1.031
	AGG	-.525	-.385	-.265	.597	1.675
4.	EIV	-.604	-.242	-.148	.451	2.217
	EIR	.392	.623	.471	.948	1.055
	AGG	-.525	-.434	-.284	.593	1.688
	S-E	-.467	-.369	-.234	.664	1.506
5.	**EIR**	**.392**	**.635**	**.501**	**.972**	**1.028**
	AGG	**-.525**	**-.597**	**-.454**	**.892**	**1.121**
	S-E	**-.467**	**-.509**	**-.360**	**.897**	**1.114**

At the final model, the variable EIV had been removed (see Table 10) because it had become less relevant and $R^2 = .629$. The null hypothesis was rejected as significance at the final model was $F(3,28) = 15.81$; $p<.001$. SRC were utilized to specify which SCORS variables in the regression were most useful in predicting group membership. As in the previous regression analysis, scores on EIR (beta = .50, $p<.001$) and AGG (beta = -.481, $p<.001$) scales were significantly associated. In addition, scores on the scale measuring "Self-Esteem" (S-E) were significant at beta = -.380, $p<.01$, indicating that a lower self-esteem score was a good predictor of whether or not a subject could be considered a "narcissist." Thus, 'Self-Esteem' as a predictor only reached the level of significance when using the stepwise regression analysis.

Additional Correlations

The final piece of data available for this sample was the age of each of the subjects and so, though this variable was not central to this study, preliminary analyses were run to explore whether there was any significant correlation between age of subject and score on each of the five SCORS variables. Ages of subjects ranged from 7.0 to 15.3, with the mean age being 11.4 (SD = 2.14). Table 11 shows this data broken down by group. Appendix C has a more complete breakdown by subject.

Table 11: Breakdown of Subjects by Age

GROUP	Mean	N	Std. Dev.
Control	12.10	16	2.013
Data	10.88	16	2.146
Total	11.49	32	2.138

Correlations between age of subjects and the five IVs were generally not significant, although there was a trend towards significance on 'Identity and Coherence of Self ' (ICS) (see Table 12). This was a positive correlation, indicating that the higher the score on this scale variable, the higher the age of the subject (and visa versa). This means that the subjects (in both control and data groups) showed a tendency to display a firmer identity and more cohesive sense of self (as measured by the SCORS) the older they were.

Table 12: Correlations based on Age & Variable

Variable	r	sig
EIR	-.292	.104
EIV	.208	.252
AGG	.050	.785
S-E	.156	.394
ICS	.317	.077

IV. DISCUSSION

Summary of Results

The primary focus of this study was to investigate whether there is evidence of a discrete diagnostic category of narcissistic disorders in children. Using a clinical sample, children who met some of the behavioral criteria for an adult narcissistic personality disorder (i.e. problems in self-esteem regulation, a lack of empathy, omnipotent denial of vulnerability) were compared to a second group of referred children for whom narcissistic issues were not determined to be primary. Based on information outlined in the literature review, it appears that these children have developed a primary narcissistic disturbance as a result of early relationships with parents who treated them as an extension of themselves – who perhaps looked to their child for their own narcissistic gratification and maintenance of self-esteem. Given that disorders of narcissism are thought to develop in the context of early relationships, the assumption was that observed narcissistic characteristics are manifestations of underlying self and object representations laid down and consolidated during this period, and that these representations could be investigated via the Thematic Apperception Test (TAT) (Murray, 1943).

A modified Likert scale derived from the Social Cognition and Object Relations Scale Q-Sort (SCORS-Q) (Westen, 1995) was used to look at representative TAT stories of both groups of children. Five different scale dimensions thought to capture narcissistic

characteristics were used to measure levels of self and object representations. The prediction was that, no matter the overt diagnostic presentation, children who met the study criteria of "narcissistic" would score lower than the clinical control group on each SCORS dimension. Three of the hypotheses were borne out, indicating that the narcissistic children in this sample do indeed appear to have more trouble with maintaining empathy for others (EIV variable), managing their aggressive impulses (AGG), and regulating self-esteem (S-E). These findings provide empirical support for the clinical literature, which has described these children as exhibiting a profound self-preoccupation and lack of concern for the feelings of others. The following example of a TAT story told by a narcissistic child received a low rating on the EIV variable, and may help to illustrate the first significant finding - that these children represent relationships characterized by a lack of remorse or compassion:

> Card 4: Someone did something bad in this one too. The man is trying to get away from her. He thinks, "I'm too good for her; I've got to get out of here." And she thinks, "please don't go – I'll forgive you. I'll do anything you want." And he says, "forget it. You're stupid." (?) He had another girlfriend. Next he'll leave, and have a great time without her. (?) She'll be sad and then she'll know she's better off without him and find a better man. So, it's a happy ending. *(DW, female, age 10)*

An unevenness of self-feelings, which vary from omnipotent to helpless, is also evident in the relationships of narcissistic children. Low scores on the S-E variable indicate that the subject views himself or herself as inferior, or is unrealistically grandiose. Findings for this hypothesis were highly significant ($p = .007$). The following is an example of a

response rated low on the S-E variable due to the unrealistically low self-esteem exhibited by the main character, but also because of the denial of vulnerable feelings.

> Card 3BM: A person was crying on the chair because he had gotten beaten up at school. His mother told him that if you got beaten up at school, you are getting into trouble. They are going to keep picking on you. (?) They are going to keep on beating him up. (?) No one has any idea how it started. (?) Nothing, he doesn't care. He doesn't care about any of them. *(DG, male, age 11.1)*

In addition, a difficulty in the management of aggressive impulses (e.g. narcissistic rage) is a well-documented characteristic of both children and adults with narcissistic vulnerabilities. These children, even before school-age years, replace developmentally appropriate efforts to regulate self-esteem with a defensively derived fantasy. They develop their sense of self around an illusion of perfection and invulnerability, and rigidly persist in disowning any experience in which the self fails to measure up to the ideal. Experiences of helplessness, envy or pain are completely denied when feasible. When this is not possible, they may fly into rages or strike out at others in a desperate attempt at self-protection. An example of a TAT story given by one of the narcissistic children described in previous sections follows. This response received a low score on the AGG variable and provides not only an example of the impulsivity and unmodulated aggression depicted by some members of the data group, but again, of their typical denial and minimization of strong negative feelings or vulnerabilities.

> Card 3BM: This girl had an argument with her mum, who's by the tree. And the mum hates her so much that she's going to

> shoot her with a machine gun. She'll do the same to all of her children until she's very old. When her husband finds out, then he'll shoot her. (?) Then everyone will be happy. And they'll live happily ever after. *(KR, male, age 9.8)*

There was a trend towards significance for the hypothesis measuring stability of self-concept in the data group, signifying that the narcissistic children in this study showed more of a tendency towards identity instability than the control group. The hypothesis that a predominance of narcissistic concerns would interfere with the establishment of a secure sense of self was not fully borne out. It is possible that this finding did not achieve significance because, while narcissistically disturbed individuals may fluctuate greatly in the quality of their self-feelings, it is possible that their self-concept is more firmly established. In some narcissistic subjects, their sense of identity was characterized by a well-integrated, yet somewhat grandiose, presentation. The following is an example of such a story given by a member of the data group:

> Card 1: This boy is mad at his mother. He doesn't want to play the stupid violin. He wants to play with his computer. He was working on inventing a new computer game when his mother interrupted and told him to practice. (?) He's thinking – "this sucks." (?) He'll sneak out and go back to his computer. *(EP, female, age 9)*

Another reason for the lack of statistical significance on this variable assessing Identity and Coherence of Self (ICS) may have to do with the developmental nature of the scale dimension. As discussed in the methodology section, the SCORS is primarily a

developmental scale and its underlying logic is that there is a movement from poor to complex differentiation between oneself and others; need-gratifying relationships to an investment in others; a fragmented to an integrated person with long-term ambitions and goals (Westen et al., 1990b). The ICS variable, as demonstrated by supplemental analyses run to determine correlations between age of subject and score on each of the five SCORS variables, was the only variable positively correlated with age that approached significance. This may have had some impact on the lack of significant results obtained when comparing the narcissistic group to their control group peers on the ICS variable. This means that higher ICS scores tended to be achieved by older subjects. As the mean age of control group subjects was higher, and a higher ICS score tended to be positively correlated with age (though at a significance of p=. 08), it seems possible that the finding that the non-narcissistic group had a more stable self-representation did not achieve significance because it could not be clearly attributed to group membership. The trend observed could in fact be due to the higher mean age of the control group, and not due to the absence or presence of narcissistic pathology.

One hypothesis, that narcissistic children would represent fewer relationships, and of poorer quality, than their non-narcissistic peers, was not substantiated. In fact, the data group showed a significantly higher investment in relationships than the control group. The significant finding that the narcissistic group showed a higher Emotional Investment in Relationships (EIR), which was contrary to the hypothesis, may be related to some ambiguity in what this variable is measuring. Based on information elaborated upon in the literature review, it seemed reasonable to predict that the quality of relationships

depicted by the data group would be poor (e.g. focused primarily on their own needs). The following is an example of a TAT story illustrating this idea:

> Card 4: Hey, these are scenes from old movies, right? This wife loves her husband and he sort of loves her. And now she's gonna have a baby because she's pregnant. She's trying to tell him, but he doesn't believe her. (?) In the future, he's gonna be mad at her for getting herself pregnant. (?) He's feeling happy and she's feeling sad. (?) He's thinking that she's a pain and she's thinking that she's beautiful. *(EG2, female, age 7.0)*

Upon closer examination, however, the EIR scale variable is also concurrently measuring the quantity of relationships depicted in the stories. For example, the more relationships are mentioned, or the more a character seems to be striving to form relationships (of any sort), the higher the score. While it is true that narcissistic disturbances typically include strong defenses against significant object relationships (e.g. omnipotent denial of need), narcissistic individuals are also known to exhibit a kind of "object hunger" (Modell, 1975). So, though the narcissistic children in this study may be prone to problematic, precarious relationships – characterized by little capacity for give and take – they are also thirsty for self objects whose confirming and admiring responses will nourish them. This need for narcissistic supplies, as elaborated upon in the literature review, may be understood as a wish to replace an unloving, critical part of themselves with a more satisfying one. In their TAT stories, the data group was therefore more focused on relationships and wanting their needs fulfilled through their relationships, than the clinical control group. The following is an example of a story by a narcissistic child that received a high rating on the EIR variable, which illustrates this point:

> Card 2: The harvest was over that year. Many people were hungry. One day this lady came and said, "if you use your time well and you are good people, then I will give you rain, sunshine, light and growth." So that was what they did, but one day one of the peasants stole the gold tin and his fields were dead. There wasn't any rain so they couldn't grow any crops. They prayed for the lady to come back but she didn't, so they starved.
> *(MS, male, age 8.5)*

Supplemental analyses were conducted to investigate whether a subject's gender had a significant impact on their score across all five of the independent variables (IVs). Only a significant difference between Groups was found, but when univariate tests were used to examine between-subjects' effects for each variable separately, a different picture emerged. Though there were no significant differences between scale variables when looking at Gender itself, there were some significant results for Group by Gender interactions. For example, there was a significant finding on the Self-Esteem (S-E) variable, with narcissistic females showing much greater variability in the stability of their self-esteem than female members of the clinical control group. Vicissitudes in self-esteem are an inevitable aspect of latency because the child's capacity for restraint is thought to be relatively weak in relation to strong external and internal pressures and prohibitions (Tyson & Tyson, 1990). However, by the age of nine or ten children are thought to have a clearly formulated sense of self-worth and competence in many areas, and these feelings tend to be increasingly stable (Harter, 1983). We would therefore, even at this age, expect to be able to obtain some measurement of self-feelings. The literature on narcissistic disturbances in children has nothing definitive to say about any gender differences and thus the additional finding that narcissistic males may show less

unevenness on the S-E dimension than females, when compared to their non-narcissistic male peers, was not predicted. These gender differences in self-esteem may also be related to the broader issue of differences in rate of referral and diagnosis. As subjects included in this study were referred to outpatient mental health centers for assessment, and it is known that school-aged boys are referred more frequently than girls, the female subjects may have been more seriously impaired than their male cohorts. It is also possible that this significant finding for the S-E variable is related to the second noteworthy Group by Gender result, described below, in which there was a trend towards significant interaction.

Though Emotional Investment in Relationships (EIR) was consistently high for female subjects (no matter which group they belonged to), male members of the narcissistic group scored significantly higher on this SCORS variable than the male members of the clinical control group. Females thus demonstrated a significantly higher investment in relationships than males in the control group, but in the data group, males actually received slightly higher scores. Why might there be such a significant difference between how invested in relationships males and females are based on group membership? Though it would be a mistake to over-emphasize this finding, which only approached significance, it seems possible that narcissistic boys may value relationships more than their same-aged peers or are more poorly defended against dependency needs than other latency-aged males. This would be because of their overwhelming hunger for a self-object relationship, as previously described. Leslie Brody and Judith Hall (1993) have summarized the research on differences in emotion and emotional expression between the

sexes, and vividly describe boys as "being schooled to minimize feelings having to do with vulnerability, guilt, fear and hurt" (p. 454). Often parents, perhaps particularly in our culture, teach their male and female children very different lessons about the handling and communication of emotions. Given that dependency needs may be discouraged in boys, and seen as a more feminine trait, what might it be like for these narcissistic boys to be more emotionally invested in relationships? One would imagine that it could be highly humiliating, and that this might even contribute to the characteristic rage responses displayed by these children when confronted with their vulnerability, and so vividly described by the therapists that treat them.

The question then remains why females in this study, irrespective of group membership, exhibited such high means scores on the EIR variable. There have been some well-documented studies which have demonstrated that school-aged girls not only place a higher value on relationships than their male peers, but also derive a good deal of their positive self-feelings from these interactions (Gilligan, 1982). Gilligan, in her book In a Different Voice, reported on a study of pre-adolescent girls and boys and the different ways they locate themselves in relation to the world. One important difference, she writes, is "a (male) self defined through separation vs. a (female) self delineated through connection" (p. 35). Citing several studies that span the life cycle, she emphasizes that a sense of belonging or being connected to others, is critical to women's self-concept. The structuring of women's sense of self and preservation of a positive self-image, according to Gilligan, "is organized around being able to make and then maintain affiliations and relationships" (p. 48). Boys take pride in a lone, tough-minded independence and

autonomy, while girls see themselves as part of a web of connectedness. Thus, boys are threatened by anything that might challenge their independence, and girls are more threatened by a rupture in their relationships. This contributes to an understanding of the significant Group x Gender differences on the Self-Esteem (S-E) variable. By this I mean that there is clearly a connection between a need for relationships and the maintenance of self-esteem, and that this may especially be the case for latency-aged females. What is certain, however, is that all of these unpredicted findings based on gender need further exploration. They seem to indicate that there are gender differences between narcissistic boys and girls, but it is unclear why this might be true.

Results in the Context of Previous Studies

This study is the first to use the SCORS in an analysis of narcissistic character development in children, so there is no previous data available for comparison. There have, however, been several studies using this measure that looked at either a similar age group or a population with related diagnostic issues. Convergent and inconsistent findings from some of these studies will be briefly discussed below.

In 1991 Westen, Klepser et al. compared "working representations" of object relationships in childhood and adolescence. This study aimed to emphasize the developmental nature of several of the SCORS dimensions and found that there were significant differences in mean scores both between second and fifth graders, and between ninth and twelfth graders. Hypotheses that the older a child or adolescent was, the higher their mean scores on three SCORS variables would be (i.e. COM, EIR, SC)

were all borne out, as was the hypothesis that there would be no difference on the AFF variable. It should be stressed that this was not a clinical sample, and that only one of these variables, Emotional Investment in Relationships, was used in the present study. Of potential relevance is that a small gender difference was noted. Female subjects in this study tended to show higher mean scores on the EIR variable, no matter which age group they belonged to. This gender difference was also noted in the present study, where female members of the control group showed significantly higher EIR scores. Interestingly, this finding was not true of the data group, where the narcissistic males had slightly higher EIR scores than female members of the data group. However, this was not found to be significant.

The SCORS has yet to be used in the investigation of narcissistic character pathology, with one recent exception. Ackerman et al (1998) attempted to use the SCORS to differentiate between different Cluster B Personality Disorders (i.e. Antisocial, Borderline and Narcissistic) and to distinguish these from a group of Cluster C Personality Disorders (i.e. Avoidant, Dependent and Obsessive-Compulsive). The only hypothesis specifically focusing on the NPD group was the prediction that they would have significantly higher ratings on the self-esteem (S-E) variable than all other personality-disordered subjects. This hypothesis was supported. The other significant finding was that, in comparison to other Cluster B Personality Disorders, NPD patients in this sample had the least disturbed levels of functioning and most potential to engage in relationships with others (i.e. highest mean EIR scores). These results are somewhat consistent with those obtained in the present study.

The present study extends these earlier findings by using the SCORS to look at object relations in children with narcissistic character pathology, and to tease out differences between this group and a clinical sample of similarly-aged cohorts. Through examining the TAT stories of children identified as having predominantly narcissistic issues, and measuring their object relations, it has been empirically demonstrated that these children have certain underlying self and object representations in common. These narcissistic children, it has been shown, form a cohesive group for which issues around self-esteem, empathy, and the management of aggression predominate. Additionally, a tendency to have a vulnerable sense of identity, and to be preoccupied with seeking out and developing relationships with others, differentiates these children from peers with similar behavioral and diagnostic profiles.

Implications of Findings

In addition to providing an empirical foundation for clinical findings long reported in the literature, results of this study have implications for the assessment and treatment of these disorders. Recent research has found psychoanalytically-informed assessment to be an accurate predictor of ultimate diagnostic understanding and treatment outcome (Sugarman and Kanner, 2000). One of the most valuable contributions is in the measurement and description of internal representations of self and other (Blatt et al., 1990). Variables measured by a psychoanalytic approach to testing can then be applied to the treatment setting. For example, the therapeutic process that a particular patient will create in psychotherapy is determined by the same personality variables as those

measured by such tests as the SCORS (e.g. the EIR variable). Although there has been some disagreement about the use of projective testing to "estimate personality characteristics" (particularly in children), this seems to be more a warning against using such material as the exclusive tool in the assessment of psychological disorders (Klein, 1986).

Any findings about the characteristic object relationships of these children would have implications for a therapeutic relationship and potential transference and countertransference dynamics. An understanding that children with primary narcissistic disturbances bring such issues to treatment as problems with self-esteem regulation, a lack of empathy for others, and difficulty with the containment of aggressive impulses would be valuable information in thinking about how to approach the treatment of a child with narcissistic vulnerabilities. There is common agreement in the literature that narcissistically-disturbed individuals present special problems in treatment. For example, because of a failure in the development of autonomy of self-esteem, they depend upon others for regulatory functions that would normally be a part of internal psychic structure (Kohut, 1968). Work with the parents of these children is also particularly challenging because they frequently employ rigid narcissistic defenses and have a great need to uphold the status quo (i.e. maintain their child's role in their own self-esteem regulation). Clinicians may find themselves needing to deviate from their usual method of working because of the high level of guardedness and denial of problems exhibited by these children (Beren, 1992). This poses a particular difficulty for the therapist, and it may be hard to feel that a working alliance has been established. For the therapy to move

forward, the therapist has to find a means of preserving the child's narcissism while at the same time presenting herself as a separate object that the child can gradually tolerate (Beren, 1992, p. xxii).

All children seen in treatment have narcissistic problems to a certain extent, mainly expressed in problems of self-esteem. However, the predominant way of relating described above is typical of children whose disturbance is primarily in the development of the self. Any treatment plan would have to be based on the understanding that these children's primary difficulties lie in the development of a realistic sense of self and other, and focus on providing these children with a forum for developing stable, reciprocal object relationships. A brief excerpt from a case illustration of the treatment of a child with a profound narcissistic disturbance may help to illustrate some of these points.

> The distance he set up between us appeared to be related to early fears of being overwhelmed and overwhelming. Rather than recognize me as a separate person with the potential to expose him to experiences of inadequacy and frustration, he defensively withdrew into grandiose fantasy. Here he fortified himself with the inner experience of omnipotent control and power. Additionally, he sought to include me as part of this grandiose world, seeking gratification of his wishes to be cared for and admired, yet denying the reality of my separateness and so avoiding the frustrations and dangers this implied.
>
> *(Wilson, 1988)*

The way one thinks about the cause of a disturbance influences the way clinical material is approached. In dealing with disorders of narcissism, the emphasis put on the role of inborn envy or rage vs. some sort of environmental failure in the child's early

development would affect both our understanding of the patient, and our choice of intervention (Bene, 1979). For example, if grandiosity or omnipotence were seen, besides its defensive significance, as an outcome of fixation or failure in a holding environment, the emphasis in treatment would be on creating an atmosphere in which these early unfilled needs may be expressed and accepted. There is a history of disagreement upon the most effective way to treat narcissistic adults in the literature, with the two main viewpoints defined by Kohut (1968) and Kernberg (1970). Those cases in which favorable changes seem due to the establishment of a corrective relationship offer support for Kohut's emphasis on the role of an empathic relationship and the mirroring of one's grandiosity in the treatment of narcissistic disorders. Kernberg's strategies, such as reality testing and confrontation techniques for treating pathological grandiosity, have shown that disillusionment can also have beneficial results. As previously mentioned, there is little written about the treatment of narcissistic disorders in children but experiences in the clinical literature support the provision of a particular kind of growth-promoting relationship as an adjunctive therapeutic factor, and important for building some semblance of a working alliance. Interpretation would also seem to have its place, and would be directed at the rejection of unacceptable aspects of the self, and the omnipotent defenses mobilized against shame, humiliation and rage (Levine, 1994). Any further comparison between the techniques employed by adult and child therapists in working with narcissistic individuals is beyond the scope of this dissertation, but would be an interesting area for further study.

A particular treatment approach seems indicated for children with narcissistic disturbances, who display some of the characteristic difficulties outlined in this study. Among other considerations, the phrasing of interpretations may require particularly careful attention, especially before a working relationship is established, in an effort to avoid a narcissistic injury that may lead to treatment being prematurely terminated. Otherwise the most benign intervention or interpretation may be violently rejected, with the child acting as if his very life were at stake. In patients such as these, even the referral for treatment may have been perceived as a narcissistic slight. There is typically a lack of tension and anxiety when the therapist complies with the child's wishes/demands for admiration, and a sense of outrage when the therapist attempts to interpret the defensive nature of the grandiosity. Much needs to be accomplished with tactful exploration at an ego-strengthening level before the child will have sufficient trust and motivation to allow their defenses to be challenged in any way. One may need to permit, tolerate and be a part of the child's grandiose and omnipotent fantasies without interpreting for some time (Bene, 1979). In time, gently interpreting insistent denials of weakness as a defense against underlying vulnerability helps to strengthen the therapeutic alliance. In the absence of such comments, a child may be left after a typical defiant, or rage-filled, interaction with a more ingrained feeling of being hopeless or unlovable. If forewarned about a patient's narcissistic sensitivities, a therapist would only begin to broach the child's defensive compensations after a great deal of preparatory, desensitizing dialogue, while simultaneously providing empathic support to help contain the child's anxiety. It has also been suggested that these children are more easily able to tolerate interpretations couched in a humorous way (Beren, 1992).

Work with narcissistic children may move very slowly, and the play is typically so repetitive and controlling that both therapist and patient may feel bored and restless. Play and behavior have a provocative quality characterized by a rigid insistence on demanding that others do their bidding. In addition, these children typically deprive the therapist of a recognition of her own separate existence. The therapist is often treated as an extension of the child's self, with no autonomy or individuality permitted. There is no sense of being important in their own right, and narcissistic children often express no curiosity about their therapists' private life, interests or activities. Therapists are required to be unconditionally available to accept and reflect their omnipotence, and to participate in the maintenance of this defensive fantasy. This is understood as these children attempting to recreate a situation that has long been familiar to them – being treated as if they did not exist as individuals with their own feelings and wishes. These fantasies can reach grandiose proportions, and compensate for a profound sense of helplessness. All of the above may evoke feelings in the therapist of being ineffectual, and doubtful about the usefulness of treatment (Beren, 1992). An understanding of narcissistic vulnerabilities would help to modulate the inevitable and well-documented countertransference reactions that arise in response to being treated in such a way (Beren, 1998). Identifying children with underlying narcissistic vulnerabilities and modes of relating through projective testing during the assessment process would aid clinicians in devising a treatment plan suited to their particular needs and limitations, but also prepare potential treatment providers for the inevitable reactions evoked by such children.

Limitations and Future Research

There were a number of limitations in the design and execution of this study, which are important to outline here. Firstly, generalizability of results obtained may be limited by the relatively small sample size. And, although the subjects in the study were not diagnosed as 'narcissistic', per se, it is possible that these children's TAT stories may have contributed to diagnostic formulations made during the assessment and treatment process. The projective data used to confirm that these children were primarily narcissistically-disturbed, and to differentiate them from other referred children, would therefore have been the same material that led clinicians to recommend their patients for this study. Because this potential confounding variable could not be ruled out, subjects' case material (not including projective testing) was 'blindly' assigned to either control or data groups by independent raters at the onset of the study.

Data collected and analyzed were from three different archival samples, and several different examiners in more than one assessment location administered tests. This may have influenced the quantity and quality of material produced. For example, although all testing administrations were documented as "standard" (i.e. queries were limited to asking about characters thoughts and feelings, and story antecedents and outcomes), there was no way to account for differences in styles of examiners, or for requirements of clinical settings. It is possible that more systematic probing may have allowed for closer evaluation of the range of subjects' functioning at both ends of the object relations'

continuum. Similarly, the inclusion of more TAT cards may have provided a better sampling of the representational world of subjects.

A related issue concerns the use of the SCORS with young children, a population that the scale has not been extensively validated for (Freedenfeld et al, 1995; Ornduff and Kelsey, 1996). The stories children produce to projective stimuli are often shorter, and less detailed (esp. affectively) than those given by adults. On the SCORS, "default" codes are assigned if a subject does not give enough information to score a particular dimension, and these default scores could have had an impact on the results (Westen et al., 1985). For example, on the EIR dimension, if no relationships are depicted, a score of '2' is coded (on a scale from 1 through 7). This relatively low score would be seen as indicating a poor investment in relationships. On the AGG variable, if no angry feelings are mentioned, a score of '4' is coded, suggesting that the subject manages their aggressive impulses in neither a noticeably positive or negative manner. While this method of scoring seems intuitively correct, the likelihood that the SCORS is giving an accurate portrayal of children's object relations could be called into question if their were a preponderance of 'defaults.' This did not seem to be the case in the present study, where 'default' ratings were assigned on only thirty-five cards, or .05% of all responses given. And, as the current study compares two similarly aged groups, results obtained informing us about their relationship to each other should not be greatly impacted. In addition to age, IQ has been shown to affect the length and level of detail in projective responses (Klein, 1986). This potential problem was addressed in part by excluding subjects with IQs below 70. In fact, IQ data was available for several of the subjects, and

these scores tended to be in the Average to High Average range. As data was collected from outpatient mental health facilities where children were primarily referred for psychological evaluation and screening for psychotherapy, it is likely that most IQs would have been in this range.

The implications and limitations of this work suggest many potential areas for future research. To provide an even fuller picture of narcissistic children at the referral and assessment stage, data from other projective measures (e.g. the Rorschach) and object relations scales could be combined to obtain more information on these children's functioning, and to aid in treatment planning. There has been some work exploring the Rorschach responses of narcissistic children, for example. This data was not readily available at the time of the present study. Given that implications for treatment and recommendations for intervention were suggested, data from outcome studies of work with narcissistic children would also be of value, and might validate and expand upon suggestions offered by this study. The literature on the treatment of these children is so far only anecdotal, and available on a case by case basis.

In addition to further investigation into the gender differences outlined in the findings of the current study, further exploration of differences between groups of children with similar types of disturbance might be useful. As described in the Method section, the SCORS has been found to be helpful in differentiating between narcissistic, antisocial and borderline disorders in adults (Ackerman et al., 1998). It is commonly accepted that these types of character disorders lay along a spectrum, and are connected by a great

many symptoms (Bleiberg, 1984). It would be interesting to see whether similarities and differences noted between children with borderline and narcissistic disorders, for example, are reflected in their object relations as measured by the SCORS.

Lastly, some attempt to connect what has been shown about the object relations of these children to vulnerabilities demonstrated by their parents would be an important direction for future research. Given that the parents of narcissistic children are thought to play a crucial role in the development of their disturbance, empirical investigation focusing on possible connections between parental pathology and childhood disturbances of this type might lead to a more developed understanding of the psychogenesis of these disorders. In addition, to be able to corroborate findings of studies being done on early object relations with actual developmental information for individuals with impairment in this area would greatly enrich our theoretical and clinical knowledge.

SOCIAL COGNITION AND OBJECT RELATIONS SCALE – GLOBAL RATINGS
(Westen, 1995)

a. ***Complexity of representation of people:*** 1 = is egocentric, or sometimes confuses thoughts, feelings, or attributes of the self and others; 3 = tends to describe people's personalities and internal states in minimally elaborated, relatively simplistic ways, or splits representations into good and bad; 5 = representations of the self and others are stereotypical or conventional, is able to integrate both good and bad characteristics of self and others, has awareness of impact on others; 7 = is psychologically minded, insight into self and others, differentiated and shows considerable complexity

1 2 3 4 5 6 7

b. ***Affective quality of representations:*** (i.e., what the person expects from relationships, and how s/he tends to experience significant others and describe significant relationships): 1 = malevolent, abusive, caustic; 3 = largely negative or unpleasant, but not abusive; 5 = mixed, neither primarily positive nor primarily negative; (needs to have some positive to be scored 5); 7 = generally positive expectations of relationships but not pollyannaish), a favorable and affirmative view of relationships. Note: where affective quality is bland, absent, or limited, code 4

1 2 3 4 5 6 7

c. ***Emotional investment in relationships:*** 1 = tends to focus primarily on his (her own needs in relationships, has tumultuous relationships, or has few if any relationships; 3 = somewhat shallow relationships, or only alludes to others; 5 = demonstrates conventional sentiments of friendship, caring, love, and empathy; 7= tends to have deep, committed relationships with mutual sharing, emotional intimacy, interdependence, and respect, positive connectedness and appreciation of others. Note: where only one character is described and no relationship is depicted, code 2

1 2 3 4 5 6 7

d. ***Emotional investment in values and moral standards:*** 1 = behaves in selfish, inconsiderate, self-indulgent or aggressive ways without any sense of remorse or guilt; 3 = shows signs of some internalization of standards (e.g., avoids doing 'bad" things because knows will be punished for them, thinks in relatively childlike ways about right and wrong, etc.), or is morally harsh and rigid toward self or others; 5 = is invested in moral values and tries to live up to them; 7 = thinks about moral questions in a way that combines abstract thought, a willingness to challenge or question convention, and genuine compassion and thoughtfullness in actions (i.e., not just intellectualized) Note: where no moral concerns are raised in a particular story, code 4

1 2 3 4 5 6 7

e. ***Understanding of social causality:*** 1 = narrative accounts of interpersonal experiences are confused, distorted, extremely sparse, or difficult to follow, limited awareness and coherence; 3 = understands people in relatively simple, but sensible ways, or describes interpersonal events in ways that largely make sense but may have a few gaps or incongruities; 5 = tends to provide straightforward narrative accounts of interpersonal events in which people's actions result from the way they experience or interpret situations; 7 = tends to provide particularly coherent narrative accounts of interpersonal events, and to understand people very well, understands the impact of their behavior on others and others behavior on them. Note: where subject describes interpersonal events as if they just happen, with little sense of why people behave the way they do (i.e., alogical rather than illogical stories that seem to lack any causal understanding), code 2

1 2 3 4 5 6 7

f. ***Experience and management of aggressive impulses:*** 1 = physically assaultive, destructive, sadistic, or in poor control of aggression, impulsive; 3 = angry, passive-aggressive, denigrating, or physically abusive to self (or fails to protect self from abuse); 5 = avoids dealing with anger by denying it, defending against it, or avoiding confrontations; 7 = can express anger and aggression and assert self appropriately. Note: if no anger content in the story, code 4

1 2 3 4 5 6 7

g. ***Self-esteem:*** 1 = views self as loathsome, evil; rotten, contaminating, or globally bad; 3 = has low self-esteem (e.g., feels inadequate, inferior, self-critical, etc.) or is unrealistically grandiose; 5 = displays a range of positive and negative feelings toward the self; 7 = tends to have realistically positive feelings about him (herself). Note: needs to have some positive to be scored a 5 or above

1 2 3 4 5 6 7

h. ***Identity and coherence ofself:*** 1 = fragmented sense of self, has multiple personalities; 3 = views of, or feelings about, the self fluctuate widely and unpredictably; unstable sense of self; 5 = identity and self-definition are not a major concern or preoccupation; 7 = feels like an integrated person with long-term ambitions and goals. Note: ambiguity about a goal is still considered a goal and may be scored in the higher range

1 2 3 4 5 6 7

Westen, Drew (1995); ***"Social Cognition and Object Relations Scale: Q-sort for Projective Stories (SCOR-Q).*** Unpublished manuscript: Department of Psychiatry, The Cambridge Hospital and Harvard Medical School.

Mean Scores on Each Variable by Group and Gender

Variable	Group	Gender	Mean	Std Dev	N
EIR	Control	Female	12.2857	2.2887	8
		Male	9.6667	2.7839	8
		Total	10.8125	2.8336	16
	Data	Female	12.5714	1.1339	8
		Male	12.8889	2.1473	8
		Total	12.7500	1.7321	16
	Total	Female	12.4286	1.7415	16
		Male	11.2778	2.9267	16
		Total	11.7813	2.5111	32
EIV	Control	Female	16.1429	1.0690	8
		Male	15.5556	2.1279	8
		Total	15.8125	1.7212	16
	Data	Female	12.8571	1.0690	8
		Male	13.1111	2.7131	8
		Total	13.0000	2.0976	16
	Total	Female	14.5000	1.9904	16
		Male	14.3333	2.6789	16
		Total	14.4062	2.3672	32
AGG	Control	Female	16.5714	.7868	8
		Male	15.2222	1.4814	8
		Total	15.8125	1.3769	16
	Data	Female	14.1429	1.9518	8
		Male	13.4444	2.1279	8
		Total	13.7500	2.0166	16
	Total	Female	15.3571	1.9057	16
		Male	14.3333	2.0000	16
		Total	14.7813	1.9957	32
S-E	Control	Female	17.2857	.9512	8
		Male	16.2222	1.8559	8
		Total	16.6875	1.5798	16
	Data	Female	13.7143	1.4960	8
		Male	15.4444	2.5550	8
		Total	14.6875	2.2721	16
	Total	Female	15.5000	2.2101	16
		Male	15.8333	2.2029	16
		Total	15.6875	2.1767	32
ICS	Control	Female	18.0000	1.7321	8
		Male	17.3333	2.0616	8
		Total	17.6250	1.8930	16
	Data	Female	16.5714	1.8127	8
		Male	16.3333	2.0616	8
		Total	16.4375	1.8963	16
	Total	Female	17.2857	1.8576	16
		Male	16.8333	2.0651	16
		Total	17.0312	1.9590	32

Data Broken Down by Age and Gender of Subjects

Data Group

Assigned ID		Age		Gender
EG2		7		F
MS		8.5		M
EP		9		F
AL		9.3		M
KR		9.8		M
DW		10		F
QS		10		F
JL		10.2		M
RW		11		F
YM		11		F
DG		11.1		M
KL		12		F
AK		12.9		M
DH		13		M
JM		14		M
NB		15.3		M

Control Group

Assigned ID		Age		Gender
AMC		9		F
BL		9		F
SL		10		F
GC		10.6		M
AB		11		F
MD		11		M
SA		11		M
JN		12		F
SF		12		F
TH		13		F
MB		13		M
KU		13		M
RH		14		M
ZE		15		M
LM		15		M
AM		15		M

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