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ATTACHMENT THEORY AND RESEARCH APPLIED TO THE CONCEPTUALIZATION AND TREATMENT OF PATHOLOGICAL NARCISSISM

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ABSTRACT: This article focuses on the relevance of attachment theory and research in the conceptualization and treatment of pathological narcissism. It is proposed that the relational context of individual development and the interpersonal interpretative capacities that emerge as part of the attachment system may be salient factors in the etiology and treatment of narcissism. Included is an overview of research on attachment models and their correlation to adult psychopathology and to narcissistic personality disorders. It is suggested that internalization and maintenance of a "secure base" and improvement in self-reflective functioning informs and enriches the clinical treatment of adults with narcissistic features.

KEY WORDS: narcissistic personality disorders; attachment theory; insecure dismissive attachment; "secure base".

INTRODUCTION

The discourse on the definition, etiology, and treatment of narcissism has sparked complicated debates within the psychoanalytic literature for years and is a focus of attention among personality and social psychologists as well as clinical social workers (Gabbard, 2000; Imbessi, 1999; Mitchell, 1999; Morf & Rhodewalt, 2001). Within the

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academic research community, investigators have found that the syndrome is difficult to define and measure. In the psychoanalytic community, the dissimilar explanations of narcissism as described by Kernberg (1975) and Kohut (1971) have created theoretical splits within analytic thought. However, viewing the development of narcissism through the lens of attachment theory suggests a beginning synthesis of the various strains of thought about this construct.

It has long been considered that traumatic parenting is central to the origins of pathological narcissism. Some of the parental qualities regarded as instrumental include inappropriate generational boundaries, a shaming humiliation of the child, an inability to gratify the child's dependency, and a failure to provide an optimal and gradual level of frustration in the child's early environment (Hertz, 1996; Imbessi, 1999). However, Imbessi (1999) argues that the disorder's etiology must be due to more than "faulty parenting or disturbed object relations" (p. 41), since these characteristics are common among many patients. In agreement with this premise, this paper suggests that attachment theory may enhance an understanding of the variables distinctive in the formation of this particular disorder. It is proposed that the relational context of an individual's development and the interpersonal interpretative capacities that emerge as part of the individual's attachment system may be salient factors in the etiology of narcissism. With that in mind, the discussion will focus on the relevance of attachment theory in the conceptualization of narcissism. Included is an overview of the research on attachment models and their correlation to adult psychopathology in general and to narcissistic personality disorders in particular. Concluding the discussion will be comments on the contributions of attachment theory to the treatment of adults with pathological narcissism.

THEORETICAL OVERVIEW OF ATTACHMENT

In recent years, there has been an increased awareness of the clinical usefulness of attachment theory as a framework for conceptualizing adult pathology and the therapeutic relationship (Bennett, 2004; Cortina, 2003; Eagle, 2003; Fish & Dudas, 1999; Fonagy, 2001; Holmes, 1996; Sable, 2000; Slade, 1999). The literature includes empirical attachment research that correlates psychopathology with attachment models, and scholars have begun to conceptualize the relationship between attachment patterns and personality disorders (Bateman & Fonagy, 2003; Blatt & Levy, 2003; Brennan & Shaver, 1998; Dozier, Stovall, & Albus, 1999; Holmes, 2003; Lyddon & Sherry, 2001). With

the increase of findings from longitudinal studies, research is evaluating the continuity of infant attachment models into adulthood and the connection between early attachment and adult psychopathology (Fonagy, 2003; Roisman, Padron, Sroufe, & Egeland, 2002). A review of this literature supports the hypothesis that the development of infant attachment is central to understanding attachment and narcissism in adults.

Development of Attachment in Childhood

The observations and ideas originally proposed by Bowlby (1969/1982, 1973, 1980) and empirically elaborated by Ainsworth (1967; Ainsworth, Blehar, Waters, & Wall, 1978) serve as the foundation for attachment theory. Bowlby (1969/1982) believed that the human infant has an inborn biological need for proximity to a caregiver in order to be protected, particularly in moments of danger and stress, and this need serves as the impetus for attachment. The dependent child forms a primary attachment to the caregiver who serves as a base to facilitate the regulation of feelings and behaviors that emerge when there are threats to the child's sense of safety. Though infants develop increasingly complex means of signaling their needs and controlling proximity during the first year of life (such as crying and smiling, reaching and crawling), they are not able to regulate themselves and must rely on a responsive caregiver for co-regulation of their feelings (Sroufe, 2000).

How effective attachment figures are in providing comfort and protection is based to a large extent on their ability to respond consistently and sensitively to their child's unique verbal and nonverbal cues. A child who is securely attached is one who has the good fortune of having his acute affective states reflected back to him in an accurate, but not overwhelming manner (Fonagy, 2001). In a "circle of security," this secure base of attachment supports the child's exploration of the world and then provides a safe haven of retreat when the child needs protection, comfort, and help in organizing feelings (Marvin, Cooper, Hoffman, & Powell, 2002). When misattunement does occur, the child is able to recover with the help of parents who can mend the rupture, thus maintaining an overall atmosphere of security. By implication this means that sensitively attuned attachment figures are able to read their child's cues and validate and reflect back to their child his or her uniqueness.

As a result of this relational and intersubjective experience, children begin to develop from a very early age what Bowlby (1969/1982) has called "internal working models" of self and other (Cortina, 2003). Lending empirical support to the reciprocal nature of this parent-child

bond, caregiver patterns perceived in the Adult Attachment Inventory (AAI) (George, Kaplan, & Main, 1996; Main, Kaplan, & Cassidy, 1985) have been correlated with the infant attachment patterns discerned through Ainsworth's (Ainsworth et al., 1978) Strange Situation observations. These studies suggest that a child with a history of a "secure" attachment pattern develops a model of self as being worthy of care and a model of significant others as being dependable and responsive. However, a child with a history of insecure "avoidant" attachment has parents who chronically ignore or dismiss legitimate attachment needs. This child begins to develop a model of self as unworthy of care and a model of significant others as rejecting, unresponsive, and uncomfortable with intimacy. A child with a history of insecure "ambivalent" or "anxious" attachment has experienced inconsistent and intrusive care. Hence, the model of self that is gradually constructed is one of being weak or needy, and others are seen as being unpredictable and intrusive. Finally, the "disorganized" child has been exposed to caregivers who are themselves abusive and/or unresolved about their own losses or abuse history, placing the child in an untenable approach–avoidance conflict that leaves them disoriented, afraid of their caregivers, and disorganized in their attempts to gain comfort (Soloman & George, 1999).

Developmental research has substantially documented the salience of the infant's model of attachment as a foundation and predictor for future emotional development. Longitudinal studies demonstrate that attachment security in infancy predicts empathy, social competence, and fewer behavior problems in childhood and adolescence, as well as an optimal developmental trajectory. In contrast, insecure attachments predict relationship and behavioral difficulties (Egeland, Weinfield, Bosquet, & Cheng, 2000) (see research from The Minnesota Longitudinal Study of Parents and Children, University of Minnesota). Further underscoring the importance of infant attachment, recent neurobiological research suggests that brain development is influenced by internal working models of attachment, and studies suggest that representations of affective experiences are stored in the right front lobe of the brain (Schore, 2000; Siegel, 1999). Determined by their attachment histories, children develop different patterns of physiological reactivity, affecting their self-regulation of emotion and their awareness of sensations (Schore, 2000). In other words, there are "behavioral, emotional, and physiological implications of attachment security" in infancy for future development (Egeland et al., 2000).

Attachment and Adult Pathology

The continuity of infant attachment models into adulthood was predicted by Bowlby, and the longitudinal studies have begun to show an empirical correspondence between the attachment patterns in infancy and the classifications in adulthood (Fonagy, 2001). However, studies linking infant attachment patterns with adult personality characteristics are mixed in terms of their findings. There is evidence that secure attachment in infancy provides a protection against psychopathology, and that the disorganized infant category is generally the strongest predictor for later adult pathology; however, few studies actually link adult psychopathology with infant attachment patterns *per se* (Dozier et al., 1999; Fonagy, 2001). Nevertheless, Fonagy (2001, 2003) suggests that the salient empirical finding is not the predictive quality of attachment in terms of subsequent relationships or pathology, but rather evidence that infant attachment equips the individual with the capacity for mental processing, particularly mentalization (i.e., self-reflection) about relationships with one's self and others. He proposes that development is significantly affected by attachment because it provides the vital function of an "interpersonal interpretive mechanism" (2003, p. 226), or the ability to infer the emotional state of mind of another. Fonagy also suggests that the interaction between this interpretive capacity and the child's biological substrates (e.g., genes, constitutional traits, physiological processes) may lead to the development of a disturbance over time since interpretive capacity is central to discerning self, others, and the meaning of social experiences.

Blatt and Levy (2003) also have conceptualized the relationship of attachment patterns and personality development. They argue that many of the personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM-IV-TR*]; American Psychological Association, 2000) are interrelated and based on deficits in two primary areas of personality development—interpersonal relatedness and self-definition. They maintain that interpersonal relatedness (i.e., a desire to be connected) has often been contrasted with the need for self-definition (i.e., a need for self-sufficiency and autonomy), and this polarity has been a theme prevalent within psychoanalytic thought since the days of Freud. Blatt and Levy posit that the relatedness and self-definition polarities seem to parallel the polarities of seeking or avoiding interpersonal contact, which are characteristics of the two insecure models of attachment.

Indeed, numerous empirical studies suggest that the underlying insecure attachment classifications of anxious or avoidant attachment are linked to many of the Axis II personality disorders, and these

disorders emerge from an exaggerated emphasis on either the relatedness or self-definition dimensions of personality development, respectively (Blatt & Levy, 2003). For example, recent investigations have reported that dismissing avoidant attachment (the adult counterpart of childhood insecure avoidant attachment) was related to the disorders of narcissistic, antisocial, and paranoid personality (Blatt & Levy, 2003; Brennan & Shaver, 1998). These particular disorders appear to "express a preoccupation with establishing, preserving, and maintaining a sense of self, possibly in different ways and at different developmental levels" (Blatt & Levy, 2003, p. 139).

HISTORICAL OVERVIEW OF NARCISSISM

An expansive review of the literature on narcissism is beyond the scope of this discussion, but a definition of the construct and an overview of the main theories about narcissism are necessary to establish the relationship between narcissism and attachment. The *DSM-IV-TR* (American Psychological Association, 2000) defines narcissistic personality disorder as a pervasive pattern of grandiosity and need for admiration, and characteristics include an exaggeration of self-importance, a preoccupation with fantasies of success, power, and love, and a belief in how "special" one is. Indeed, a narcissist often thinks that only special people can *really* understand him, and that he should receive constant admiration. Of particular importance, a narcissist lacks real empathy and therefore exploits other people, generally displaying a sense of entitlement. Clinicians treating persons with this disorder are aware of how easily the therapist can shift from being an object of idealization to one of devaluation and how rapidly the patient can feel wounded and respond with anger or disdain. However, research has begun to suggest that narcissism is more of a fluid personality process than a static personality type.

In contrast to the trait definition of the *DSM-IV-TR*, the psychoanalytic literature has long defined narcissism along a continuum and within the context of developmental processes, though the processes vary according to the theorist. Numerous analysts have explored the development of narcissism, and Freud, Kernberg, and Kohut represent three of the primary lines of thought. Freud (1914) first introduced the concept by saying that initial self-love, or primary narcissism, is a "normal" and "healthy" stage of early development prior to object love (Brenner, 1957, p. 110). The degree of pathology within the individual becomes shaped by the amount of libido directed toward the self, and "healthy narcissism" becomes problematic when it serves as "a retreat

from attachments to others to a state of self-absorption" (Hertz, 1996, p. 331). Secondary narcissism was seen as a defense, an illusion of one's self-importance, and an overvaluation of self. Mitchell (1999) has said that "Freud regarded narcissistic illusions as the inevitable residue of the most primitive and infantile state of mind, and therefore, as both unavoidable and dangerous" (p. 157).

Kernberg on Narcissism

Kernberg (1975) also saw narcissism as a defense, but he combined his ideas with Klein's theories about infant envy. He proposed that narcissism is a defense against primitive, pathological oral aggression. A person establishes a "grandiose pathological self" to defend against unacceptable aggressive impulses projected onto the envied other or to identify with the idealized other to deny dependency. The arrogant dismissiveness of the narcissistic person defends against feelings of worthlessness and unmet needs to be loved. Kernberg's technique for the treatment of narcissism is to quickly and aggressively interpret the defensive purposes and unreality of any of the patient's transferences related to illusions about the self or analyst and to challenge the patient to accept his dependency, envy, and rage. It has been suggested that Kernberg's description of this pathological splitting in narcissism is much more typical of borderline patients, and disparities between the theories of Kernberg and Kohut may stem from the dissimilar client populations that shaped their ideas (Gabbard, 2000; Hertz, 1996; Mitchell, 1999).

Kohut on Narcissism

Kohut presented a very different perspective on narcissism than the classical, conflict models of Freud and Kernberg. Like Winnicott before him, Kohut (1971) viewed narcissism as a developmental process and saw narcissistic illusions in later life as indications of both deficits in parental functions and deficits in the intrapsychic self-structure of the individual. Patients who appear to have narcissistic illusions in psychotherapy in the form of idealization and grandiosity demonstrate their desire to fill needs that were not met through their childhood relationships. Such patients are actually developmentally arrested and need mirroring or idealizing self-object responses from others to prevent the self's fragmentation (Gabbard, 2000).

Eventually rejecting the classical structural theory of Freud, Kohut proposed a significantly new understanding of self-development and took a dramatically different approach to the treatment of narcissism

(Mitchell, 1999). In contrast to Freud and Kernberg, Kohut argued for the cultivation and nurturance of childhood narcissistic illusions, viewing narcissistic disturbance or pathological narcissism as longings and signs of a true sense of self. He believed that the empathic attunement of the analyst, in an accepting and supportive environment, eventually would enable growth for the patient. Ongoing repair of the inevitable empathic ruptures that emerge in psychotherapy would lead in time to an intrapsychic transformation for the patient. Kohut proposed that this process of "transmuting internalization" would stimulate the reemergence of the patient's core healthy narcissism.

Mitchell's Relational Views

Kernberg and Kohut represent two polarities in the explanation and treatment of narcissism, with Kernberg viewing narcissism as a defense *against* frustration and despair and Kohut viewing it as a *sign* of the true self's growth. Mitchell (1999) proposed that these divergent views of narcissism represent the contrasting drive and relational paradigms within psychoanalytic literature, yet he argued that the Kernberg and Kohut paradigms of narcissism are actually similar in that they "overlook the extent to which grandiosity and idealization function as relational modes, arising as learned patterns of integrating relationships, and maintained as the vehicle for intimate connections with others" (p. 169). Although Freud, Kernberg, and Kohut are considered to be significantly different in their understandings of the etiology and treatment of narcissism, the major similarity among them is their view that narcissism is an *internal* and unconscious psychic process. In contrast, Mitchell (1999) viewed narcissistic processes "most fundamentally as a participation with others" (p. 170).

ATTACHMENT THEORY AND NARCISSISM

The salient link between attachment and narcissism is that the attachment process is intimately connected with the parent's validation of the child; hence narcissism is embedded in attachment relationships from infancy. Later in development, the regulation of self-esteem moves into different domains such as peer relations, romantic relations, and recognition or validation within groups. In other words, from early development the need to be protected and the need to be validated are inextricably related. Consequently, self-esteem progression usually follows the vicissitudes of the secure or insecure developmental pathways set by the attachment relationship during infancy unless

there is a change in the quality of the relationships through significant life events, such as the arrival of new attachment figures or intensive psychotherapy (Cortina, 2003). More complex models of self-esteem development involving defensive processes grow out of disorganized attachment relationships, shaped by the trauma and unresolved loss of the parents. These parent–child relationships, which negatively and reciprocally influence the internal working model of the child, serve as foundations for the development of more severe personality disorders.

If attachment theory is used as a lens for viewing the development of the various forms of narcissism, it becomes apparent that attachment and narcissism are part of a matrix that is *both* relational and intrapsychic. Attachment models, be they secure, insecure, or disorganized, penetrate all parts of the child's development, including affect regulation, arousal, and sense of self-worth. The child who develops an internal working model of a secure attachment will, most likely, also develop a healthy sense of self-worth because this child has internalized a mental representation of someone both available and responsive to the child's need for protection and validation. The child's internal working model then serves as the foundation for the development of a healthy or normal narcissism, a process compatible with Kohut's theories.

If, on the other hand, the child develops an insecure avoidant model of attachment based on the internalization of a parent's dismissive pattern of relating, the child is at risk of narcissistic pathology due to deficits in the interpersonal interpretive capacities that emerge from this attachment model. Fonagy (2003) has proposed that deficits in the capacities of mentalization and self-reflection interact with genetic makeup and ongoing socialization to create the eventual development of adult pathology. Differences influenced by variables such as inborn temperament and capacities for physiological regulation may contribute to variations in the behavioral presentation of individuals with pathological narcissism. For example, Gabbard (2000) notes that some narcissistic persons whom he calls "hypervigilant" are actually "inhibited, shy, or even self-effacing," while others, described as "oblivious," are "arrogant and aggressive" (p. 502). Conceivably, these variations along the narcissistic continuum may be influenced by inborn temperament, but deficits in mentalization or self-reflection, emerging from the attachment process, are at the root of the personality disorder itself.

The child who has internalized an ambivalent model of attachment due to parental anxiety or preoccupation, or a disorganized attachment due to an attachment figure who is abusive, or unresolved regarding loss, may have a higher risk for borderline personality disorder (Bateman & Fonagy, 2003; Blatt & Levy, 2003; Fonagy, Target, &

Gergely, 2003). It has been suggested that Kernberg's theory of destructive or entrenched narcissism is actually based on an understanding of a defensive organization similar to borderline personality disorder (Gabbard, 2000; Hertz, 1996; Mitchell, 1999), and it follows that this form of narcissism likely develops in persons with an internal working model of disorganized attachment.

INCORPORATING ATTACHMENT PRINCIPLES INTO TREATMENT

In addition to enhancing the understanding of the definition and etiology of narcissism, attachment theory and research may deepen the discussion about clinical treatment. It is not proposed that attachment theory offers an explanation for all of human behavior or provides a fully-developed paradigm of clinical practice. In fact, there has been more emphasis on empirical developmental research than on the application of attachment theory to treatment technique. Nevertheless, Slade (1999) argues that attachment theory offers "the potential to change the way clinicians think about and respond to their patients, and the way they understand the dynamics of the therapeutic relationship" (p. 577). She adds that "an understanding of the nature and dynamics of attachment *informs* rather than *defines* intervention and clinical thinking" (p. 577). With Slade's comments in mind, two contributions from attachment theory will be discussed for their usefulness in informing the treatment of pathological narcissism.

"The Secure Base"

Bowlby's (1988) concept of the "secure base" is particularly beneficial for understanding the therapeutic relationship with narcissistic patients (Eagle, 2003; Holmes, 1996; Marvin et al., 2003; Mitchell, 2000; Sable, 2000; Slade, 1999). Analogous to the parent–child relationship, the therapeutic relationship can be seen as the provision of a secure base for the patient's exploration of "the various unhappy and painful aspects of his life, past and present," many of which the patient finds "difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and on occasion, guidance" (Bowlby, 1988, p. 138). Ideally, the therapist follows the lead of the patient, akin to an autonomous parent attuned to the needs of her securely attached child. When the *patient* feels secure enough to explore the internal or external world, the therapist facilitates this process; when the patient sends cues of

stress and a need for comfort, the therapist provides help in organizing and regulating the feelings, cognitions, and affects of the patient. This ongoing, reciprocal, and circular process is founded on recognition that the attachment and exploratory systems are intricately linked—successful exploration occurs when the patient experiences a sense of security, and the patient returns to the safe haven of the relationship when anxiety or fear triggers a need for proximity.

While this process may seem simplistic in its explanation, complexity emerges in the recognition that young children miscue their caregivers in an effort to maintain proximity and relationship with the caregiver. The child with a dismissive parent learns to avoid contact with his caregiver, yet these behaviors belie the basic attachment needs. Likewise, a narcissistic patient with a dismissive adult attachment inevitably miscues attachment needs, exacerbated by limited capacities for self-reflection. These patients have developed a psychological structure that minimizes and deactivates attachment due to their rigidly contained and overregulated expression of memories, affects, and cognitions (Slade, 1999). They often appear distant, disdainful, and derogating—characteristics of adults with dismissing attachment classifications—but when these forms of interaction appear in the clinical exchange, the therapist is encouraged to recognize their connection to attachment. It is suggested that the therapist facilitate exploration about the triggers precipitating these interactions, giving attention to the intersubjective nature of the relationship.

Some questions to consider regarding the treatment process include the following: Is the patient dismissing the therapist due to the patient's misinterpretation of current real relational dynamics, or is his dismissing attachment model activated unconsciously through the transference? Is the therapist misattuned regarding the patient's current readiness to explore versus his need for comfort, or is the therapist's own countertransference activated by the grandiose and arrogant personality traits of the narcissistic patient? It is understandable, for example, that a therapist may interpret a patient's defenses or encourage too forcefully the examination of negative behaviors in an unconscious effort to distance him. At those moments, the patient may be miscuing the therapist and become wounded when his needs for connection are misunderstood. The therapist inadvertently assumes the role of the patient's dismissing parent, thereby enacting the patient's relationship history. In other words, attention to attachment needs in the treatment of a narcissistic patient incorporates aspects of both interpersonal and intrapsychic treatments in both a real and transferential manner. Attention to cues and miscues becomes a central focus

of treatment, and repair of misattunement is vital to maintenance of a "secure base" of treatment.

Coherence and Mentalization

A second area of attachment literature that contributes to the treatment of narcissism is the groundbreaking work of Main and her colleagues on the AAI (George et al., 1996; Main et al., 1985), as well as the previously mentioned work of Fonagy (2001, 2003). Their ideas are related, and it has been said that the work of Main and Fonagy dramatically adds to the relevance of attachment theory for adult psychotherapy (Slade, 1999). The AAI is a semi-structured interview that asks adults to describe memories about their childhood attachment relationships, including memories about separation, rejection, abuse, and loss. The AAI has demonstrated that the primary characteristic of a secure and autonomous adult attachment is the individual's capacity to describe his or her attachment experiences in a consistent, collaborative, and coherent manner (Hesse, 1999). The discourse of the individual is truthful and based on supporting evidence from life experiences. The speaker is able to talk in a succinct yet complete fashion with comments that are relevant, clear, and orderly.

In contrast, adults considered to be dismissing of attachments are generally restricted in their expressions and often portray their attachment experiences in a glowing, idealizing manner not supported by their experiences. They also may be derogating and devaluing of attachment experiences. According to Hesse (1999), "Dismissing speakers attend chiefly to providing a positive impression of childhood experiences while avoiding discussing particular events" (p. 398). Notably, these characteristics tend to parallel narcissistic personality traits (although, as mentioned earlier, all persons with dismissing attachment classifications might not be diagnosed with narcissistic personality disorders). The clinical exchange with narcissistic patients is deepened when a therapist recognizes that attachment patterns (and the meaning of the exchange) may be discerned through understanding the coherence or incoherence of the actual discourse. Slade (1999) has said, "Attending to what can and cannot be told, and to how it is told, helps the therapist to imagine patients' early experience in powerful and direct ways" (p. 582).

In addition to coherence, the AAI focuses on the importance of metacognitive monitoring, which is the ability of the individual to monitor personal thought processes, recognize contradictions and biases, and in particular to acknowledge that reality may not be what it appears to be (Hesse, 1999). A hallmark of secure attachment, metacognitive monitoring is similar to Fonagy's concept of mentalization or reflective

functioning, the capacity "to reflect upon and contemplate the complexity and diversity of one's internal, mental states" (Slade, 1999, p. 582). In the treatment of narcissism, increasing self-reflective functioning is crucial to recovery. Recognizing that reality may be perceived differently by others and acknowledging one's own biases and interpersonal distortions becomes key to the diminishment of grandiose illusions.

It seems likely that strengthening self-reflection and metacognitive functioning for a narcissistic patient can *only* take place in the context of a treatment relationship that serves as a "secure base" for the patient. These patients are acutely hypersensitive to slights (though they may appear otherwise) and cover their vulnerability with illusions about their importance, and at times with condescension and rage. The intersubjective nature of the relationship often triggers countertransference for the therapist who may feel competitive or even sadistic in response to such grandiosity (and at times pomposity). Yet the patient will not be able to explore his interpersonal distortions or the relational dynamics in the transference unless he feels understood by a therapist who sees beneath the distancing persona. If in an effort to increase the patient's self-reflection, the therapist makes an interpretation that is accurate, but ill-timed or too intellectual, it dismisses the patient further, enacting the patient's attachment history. On the other hand, a more effective interpretation is one that is attuned to the patient's affective state (i.e., hidden vulnerability), which increases the likelihood of the patient feeling understood. As Eagle (2003) says, "the patient looks to the therapist as an attachment figure, not only to serve as a secure base for self-exploration, but also as someone who will respond in a manner that is critically different from his or her parental attachment figures" (p. 50). This new relationship enables the patient to "alter early maladaptive cognitive-affective schemas," which "are not always susceptible to change via interpretation and insight, but require noninterpretive, interactional, and strong emotional experiences in order for them to change" (p. 50).

CONCLUSION

Implications that have emerged from attachment theory and research are both similar and divergent from traditional understandings of narcissism. Fonagy (2001) suggests that Kohut's views about narcissism are "closely linked to attachment constructs," (p. 109) particularly his observations regarding the impact of the internalization of caregiver responsiveness; Kernberg's theories about severe pathology have similarities to an understanding of disorganized attachment, but

his "notions of drives and psychic agencies...have no place in an attachment theory framework" (p. 115). In terms of treatment, attachment theory seems most compatible with self and relational theories. Although Kohut focused on intrapsychic processes, the provision of a secure base within psychotherapy resonates with self-psychology's emphasis on attunement and optimal responsiveness. Finally, attachment theory's recognition of the importance of real relationships throughout development seems clearly in keeping with the views of Mitchell (2000) and the contemporary relational school.

However, attachment theory is not affiliated with any one school of clinical practice, clearly does not address all aspects of psychopathology, and does not provide a well-developed model of treatment technique. Instead, it offers contributions through an expansive body of research about the link between attachment, child development, and adult relationships. It deepens assessment and formulation of severe personality disorders, such as narcissism, by recognizing the influence of the patient's attachment model on emotional regulation and physiology, on the coherence of discourse, and on current behaviors, cognitions, and relationships. It enriches understanding of the therapist's role by acknowledging the parallels with infant–caregiver relationships. It sharpens the therapist's ear by directing attention to patient narratives in a more meaningful way. It expands clinical direction through the recent emphasis on interpretative capacity and self-reflective functioning. Perhaps most importantly, attachment research gives validation and documentation change that takes place through the influence of new relationships. Even patients with pathological narcissism can change their relational patterns through the relationship with a secure and sensitive therapist.

Recognizing the relational and fluid nature of narcissism can be both hopeful and challenging. It shifts the paradigm from one that views narcissistic pathology as something "out there," located solely, intrapsychically in the patient, and something that must either be fixed or viewed as entrenched and therefore doomed to failure. This is not to say that working with persons with severe degrees of narcissism can be an easy and always successful endeavor. Indeed, such persons can be among the most challenging patients to one's professional sense of self-esteem. The inevitable ruptures that develop within these complicated therapeutic relationships could be viewed as "projective identifications" (as Kernberg might) or as "empathic failures" (as Kohut would say). Or the therapist could recognize that narcissistic presentation evolves out of a relational context and may be the patient's pattern of attachment, even if the patient's grandiosity and dismissive stance seem to push others away.

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