Religiosity and Adolescent Narcissism: Implications for Values Counseling

MATTHEW C. AALSMA
DANIEL K. LAPSLEY

The authors show that the distinctive character of values counseling as a therapeutic intervention can be justified on empirical grounds. The fact that religiosity has been consistently associated with positive mental health outcomes is a warrant for counselors to explore the resources of one's religious tradition for therapeutic change. The authors also argue that pastoral counseling is particularly suited for addressing the ego development needs of adolescents and that the vicissitudes of adolescent narcissism can be effectively mobilized to support self-transcendence and relational autonomy, tasks that have both developmental and religious significance.

There is a general consensus, both popular and theoretical, that normal adolescence is marked by narcissistic vulnerabilities. Indeed, it is widely believed that certain narcissistic tendencies, such as heightened self-consciousness, exhibitionism, and touchy self-absorption, are endemic among teenagers. Moreover, a professional consensus is emerging that the management of narcissism may well differentiate normal from pathological adolescent development (Sarnoff, 1987). Consequently, an adolescent who seeks counseling may pose a significant challenge to a therapist who has a religious, values-based approach to counseling. There are two reasons for this. First, the evident narcissism of the adolescent might raise legitimate concerns regarding the psychosocial adjustment of the client. It might reflect, for example, just the sort of immaturity that needs to be surmounted during the course of treatment. Second, narcissism seems to be not merely a psychological immaturity, but a religious or spiritual one as well. For example, narcissistic attitudes seem to run counter to the traditional Christian insight that spiritual maturity requires self-transcendence (Flew, 1934). Hence the problem of adolescent narcissism presents itself as both a psychological and a religious challenge for the values-based counselor.

Matthew C. Aalsma is a doctoral candidate, and Daniel K. Lapsley is an assistant professor, both in the Department of Educational Psychology, Ball State University, Muncie, Indiana. Correspondence regarding this article should be sent to Daniel K. Lapsley, Department of Educational Psychology, Teachers College 524, Ball State University, Muncie, IN 47306 (e-mail: dklapsley@bsuvc.bsu.edu).

We argue, however, that although adolescent narcissism might well reflect both psychological and religious immaturity, it would be counterproductive to seek its suppression as a therapeutic goal. On the contrary, we would argue that narcissism can be effectively mobilized in the service of both psychological and spiritual development. In this article we attempt to show that narcissism has at least two faces, one that tends toward self-pathology, the other that tends toward mental health (Bleiberg, 1994). We then show that adolescent narcissism is largely of the second type and has its source in normative developmental tasks associated with separation-individuation. Furthermore, we argue that a values-based counseling perspective is a particularly useful context for sorting out the ego development needs of adolescents.

If religious commitment were shown not to matter with respect to personal functioning, then it would be difficult to justify a theistic approach to counseling. On the contrary, there is considerable support for a values approach to counseling, particularly one that openly explores the resources of one's religious tradition. From this perspective, we further argue that manifestations of adolescent narcissism are therapeutic moments in the spiritual development of the adolescent client. Indeed, we argue that values-based counseling is particularly suited for addressing the ego developmental issues of adolescents and that the proper counseling response is one that mobilizes adolescent narcissism in the service of self-transcendence, which is a distinctive goal of values-based counseling (Conn, 1994).

VALUES-BASED COUNSELING

There have been recurring attempts to clarify the parameters of values-based or religious-spiritual counseling. One view suggests that values-based counseling is uniquely suited for exploring the limit experiences of clients (Power, 1990) along with their felt yearning for relational self-transcendence (Conn, 1994). A second view is suggested by Bergin's (1980, 1985) early writing on religious values and psychotherapy. Bergin (1980) argued that religious and spiritual values should be at the center of therapeutic practice, rather than on its margin. He argued that the predominant value systems of counseling psychology are either indifferent or hostile to the religious convictions of most clients, but that a values-based approach nonetheless seems to have real therapeutic possibilities.

A third way to articulate the distinctiveness of values counseling is on the basis of empirical research, rather than on conceptual or theological grounds. Indeed, Bergin (1980) argued that a theistic approach to psychotherapy should be defended "on the basis of some evidence that supports it" (p. 103). Hence, one way to defend the singularity of religious or spiritual approaches to mental health is to show that religiosity has an empirically demonstrable influence on mental health and adjustment. Therefore, we build a case for using values-based counseling with adolescents by exploring recent empirical literature on the relationship be-

tween religiosity and mental health. We then examine the adolescent narcissism literature to reveal its spiritual and religious dimensions, and the implication this has for values-based counseling.

RELIGIOSITY AND MENTAL HEALTH

Our review of the recent religiosity and mental health literature is meant to be illustrative rather than exhaustive and focuses largely on studies that use adolescents or young adults as participants. Indeed, this literature is now growing at an encouraging rate. It tends to show, for example, that religious affiliation counterindicates deviant behavior and conduct problems among adolescents (Jessor & Jessor, 1977). Indeed, faith in a higher power and membership in a religious organization are often cited as protective factors for resilient adolescents who are exposed to high-risk environments (Baldwin, Baldwin, & Cole, 1990; Werner & Smith, 1992). Moreover, adolescents who draw existential meaning from their religious commitment and who attend church regularly are less prone to depression than are teens who evince little concern about religion or church attendance (Wright, Frost, & Wisecarver, 1994). Religiosity seems to counterindicate substance use and dependency (Kendler, Gardner, & Prescott, 1997) and to enhance the effect of a strong family (Oetting & Beauvais, 1987).

These findings support a general trend noted by Gartner, Larson, and Allen (1991) that the positive effects of religiosity on adjustment and mental health are most clearly demonstrated with respect to "hard variables." Hard variables are demonstrable life events (such as drug use) that can be reliably observed and quantified. In contrast, when adjustment is assessed with personological dispositions ("soft variables"), then the positive relationship between religiosity and mental health is less often observed. Consequently, a key issue in the study of mental health and religiosity is whether the mental health outcomes are assessed with hard or soft variables.

A distinction is also drawn between intrinsic and extrinsic religious orientations (Allport & Ross, 1967). An intrinsic orientation is one in which religious values are strongly internalized and serve as a guide for organizing one's life commitments. Individuals with intrinsic religiosity are committed to principled conduct and the search for truth. An extrinsic religiosity, in contrast, is largely utilitarian and serves as a means to acquire status, security, self-justification, and other personal goals. Research shows that an intrinsic orientation is associated with numerous psychosocial advantages. Hence, in contrast to extrinsic religiosity, individuals with intrinsic religious spiritual commitments report fewer depressive symptoms (Watson, Hood, Foster, & Morris, 1988) and good personality functioning (Bergin, Masters, & Richards, 1987). Among adolescents, intrinsic religiosity is negatively associated with substance use and premarital sexual activity (Ernsberger & Manaster, 1981; Spilka, Hood, & Gorsuch, 1985), whereas extrinsic religiosity is associated with negative outcomes (Donahue, 1985).

Indeed, as one commentator put it, "intrinsic faith is basically a salient moral referent for everyday behavior" (Spilka, 1991, p. 928).

The mechanism through which religiosity conveys its protective effect has been variously conceived. One possibility suggests that it is the relational aspect of religious life that conveys psychosocial benefits or else moderates the impact of risk exposure. It is well known that a supportive family environment, one characterized by cohesion, parental warmth, closeness, and the absence of chronic conflict, contributes to children's psychosocial resilience, as does the availability of relational supports outside the family (Rolf, Masten, Cicchetti, Neuchterlein, & Weintraub, 1990). It is now a truism in the developmental psychopathology literature to say that one good relationship, wherever it is found, offers strong protective possibilities. Clearly this mechanism is potentially active within communities of worship. Perhaps active participation in a cohesive religious community multiplies resources for problem solving and influences how one appraises negative life events and the propriety of certain modes of coping (Masten, Best, & Garmezy, 1990). Perhaps the relationships that are formed in such communities affirm important features of one's personality and give purpose to one's aspirations. Note that this explanation of the resilience-promoting properties of religious participation focuses more on the number and quality of relationship that church membership affords, rather than on the content of specific religious beliefs or practices per se. In other words, the emphasis here is on religious *participation*, rather than on *religious* participation.

Yet another possibility suggests that it is one's felt relationship with God that conveys mental health advantages. According to Kirkpatrick and Shaver (1990, 1992), one's relationship with God can be usefully described by the same theoretical categories that describe the attachment bond that develops between infants and caretakers (e. g., Bowlby, 1969). Hence, God, as the divine attachment figure, is a loving, accessible, and reliable protector; a secure base and haven of safety; and a comforter who is responsive to our signals for proximity and our distress cues. But just as human attachments can be secure or insecure, so too can our felt relationship with God. And just as secure maternal attachment conveys numerous psychosocial advantages for a child, so too does felt attachment to God convey similar advantages for a believer.

Indeed, Kirkpatrick and Shaver (1992) found that adult respondents who reported secure attachments with God also reported greater life satisfaction and less anxiety, depression, and loneliness than did respondents who reported insecurity in their attachment relationship with God. It is interesting that security of attachment to God also predicted greater security in adult attachment relationships, but only among participants who reported insecure maternal attachment. This suggests that religious beliefs might serve a compensatory function; namely, one's felt attachment to God may serve to compensate for poor attachment experiences with one's primary caretaker.

It seems, then, that religiosity is broadly compatible with mental health coping and adjustment (Pargament, 1997), critics notwithstanding (Ellis, 1980).

Indeed, on the basis of this research there are increasing calls for counselors to actively explore the religious commitment of clients to better capitalize on its resources for sustaining positive adjustment (Georgia, 1994). Arguably, the implications of the religiosity literature is particularly relevant to those who are engaged in values-based counseling, insofar as clients who seek this sort of treatment are receptive to an intervention that capitalizes on their religious or spiritual sensitivities. At the very least the psychological literature would support efforts by counselors to actively explore the resources of one's faith community to effect positive change, growth, and adaptation. We now attempt to show that such an approach is particularly fruitful with adolescent clients who present with narcissistic vulnerabilities. Nevertheless, it is important for counselors to bear in mind the twin manifestations of narcissism, which we address from both a theoretical and empirical perspective.

THE TWO FACES OF NARCISSISM

Theory

Narcissism is a difficult construct with multiple theoretical sources (Morrison, 1986). Although most theorists agree that narcissism is not pathological per se, much of its interest as a psychological construct is derived from its role in self-pathology and as a personality disorder. Hence, the diagnostic markers of narcissistic personality typically point toward such things as grandiosity; exhibitionism; fantasies of success, power, or brilliance; a sense of entitlement; and interpersonal exploitativeness.

According to Mitchell (1988), two traditions have emerged with respect to how narcissism has been conceptualized within clinical psychotherapy. One tradition (Kernberg, 1975; Sullivan, 1953) suggests that various features of narcissism are mobilized as defensive, compensatory illusions, perhaps to assist the adolescent to cope with the travail of separation-individuation (Blos, 1962; Rothstein, 1984). Hence, according to this first tradition, narcissistic displays are used defensively to ward off feelings of dependency on others who have been experienced as disappointing and frustrating. Instead, by way of compensation, the grandiose self is experienced as complete and self-sustaining. There is an illusion of self-sufficiency and perfection. Self-admiration is accompanied by deprecation of others, contempt for dependency, and disdain for relationships. And these "narcissistic illusions operate as defensive retreats not only from disappointments in reality in general, but also from anxiety and dread connected with separation" (Rothstein, 1984, p. 185). In clinical practice this defensive grandiosity undercuts treatment and is a source of resistance that must be challenged (Kernberg, 1975; Sherwood, 1990).

A second tradition (Kohut, 1977; Winnicott, 1992) views narcissism more positively as the cutting edge of the growing, creative self (Mitchell, 1988).

For Kohut (1977) grandiosity and exhibitionism are one pole around which a healthy, cohesive self coalesces, and it is derived from a child's relationship with the mirroring self-object (typically mother). Winnicott (1956/1992) pointed out that in the facilitating environment, moments of illusion are created for the child by the good-enough mother who completes the child's gestures and actualizes the child's desires. The child then experiences a sense of subjective omnipotence that is not entirely corroded by the child's inevitable accommodation to objective reality. Hence, for Winnicott (1956/1992), mental health is characterized by a capacity to play (rather than Freud's, 1914/1957, dictum: to love and to work). That is, mental health is envisioned as the "freedom to move back and forth between the harsh light of objective reality and the soothing ambiguities of lofty self-absorption and grandeur in subjective omnipotence" (Mitchell, 1988, p. 188). Indeed, periodic recourse to narcissistic illusions may provide the creativity that supports the exploration of identity options. These illusions have a growth-enhancing function in the encouragement of healthy self-assertion and ambition, and their ability to make visible a world of possibilities for the self. Although not directly related to adolescent narcissism, there is growing empirical literature that now documents the positive benefits of certain kinds of self-regarding illusions (Taylor & Brown, 1988).

The clinical response to narcissism in this second tradition is quite different from that of the first tradition. Here the counseling situation becomes an analog of the holding or facilitating environment provided by the good-enough caretaker, who manages to present the intrusions of reality in a way that does not crush the playful grandiosity and exhibitionism of the child. According to Mitchell (1988), the ideal parental response to narcissistic illusions "consists of participation coupled with the capacity to disengage, a capacity to enjoy and play with the child's illusions, to add illusions of his or her own, and to let the illusions go, experiencing the child and herself in more realistic terms" (p. 196). Healthy narcissism, then, reflects a delicate balance between illusion and reality. The ideal parental, and, by implication, therapeutic, response is a flexible movement between the two extremes, neither giving in completely to full immersion in illusion on the one hand, nor crushing hope with "cynical rationalism" on the other (Mitchell, 1988).

This account of healthy narcissism as the cutting edge of the developing, creative self seems particularly relevant for the values-based treatment of adolescents, largely because the normative developmental task of adolescence invariably invites recourse to narcissistic defensive postures on the part of teenagers. These postures seem most typical of the presenting problems brought to the attention of counselors. There is consensus that the normative developmental task of adolescence is separation-individuation. According to a standard account, the adolescent must reconstruct his or her self-representation so that it is established on grounds independent of parental conceptions (Blos, 1962). During the years of childhood one's self-

image is typically derived from parental conceptions of the child. Yet, during adolescence, there is an attempt to establish a self-conception in a way that seems newly created, on independent grounds, and an attempt to regulate self-esteem from internal sources (Josselson, 1980). The opening move is to psychologically divest oneself of parental introjections, a move that nonetheless leaves the teenager vulnerable to mourning reactions (because the adolescent has, in fact, lost the durable self-image of latency), and its accompanying feelings of depletion, ambivalence, and inner emptiness. This feeling of impoverishment is a form of separation anxiety, which is compensated by narcissistic self-inflation (Rothstein, 1986).

Hence the upsurge of adolescent narcissism is a transitory phase whereby the ego is supplied with the aliments that are necessary to maintain self-esteem during separation-individuation. The narcissistic defense characteristic of adolescent ego development supports the adolescent in his or her principal task, which is to maintain a hold on object relations in the face of separation anxiety, and to reestablish firm ego boundaries.

Yet this "defensive" use of narcissism should not obscure its essentially creative function, which is to support the adolescent's search for an individuated selfhood in the context of on-going relationships. The goal of adolescent ego development is to flexibly balance the ongoing dialectic between agency and communion, and between assertion and connectedness—what Bakan (1966) has termed the fundamental duality of human existence—and the transitory phase of narcissism is an important aspect of this developmental project. Adolescent narcissism is not mere self-aggrandizement, but is rather object relational in its aim. It is a defensive stance, to be sure, but one that is in the service of creating the kind of self that is capable of sustaining authentic relationships.

It is of interest to note that the goal of adolescent ego development, described here as the creation of an individuated self in the context of ongoing relationships, is precisely identical to the notion of relational autonomy that Conn (1994) built into his conception of self-transcendence, which he saw as the goal of values counseling. According to Conn, values counseling uniquely discloses the fullness of self-transcendence, which in his view is a "radically, interpersonal, relational reality" (p. 178). As such, self-transcendence includes "the two great yearnings of the human person: the desire for separation, differentiation and autonomy on the one hand; the desire for attachment, integration and relationship on the other" (Conn, 1994, p. 178).

Therefore, the goal of values counseling (self-transcendence, understood as relational autonomy) and the goal of adolescent ego development (individuation, in the context of ongoing relationships) point toward the same end. Indeed, adolescent separation-individuation is just the developmental aspect of self-transcendence. It is a phase in the spiritual development of the person in the sense that separation-individuation moves the adolescent toward a clearer apprehension of the possibilities and conditions of personhood. It exposes the self to the fundamental ambivalence of inde-

pendence and inclusion and to the vagaries of self-affirmation when older established certainties must be given up for the risks of developmental growth. Kegan (1980) has argued that herein lies the inherent religious dimension of developmental frameworks. The motion of development toward integrity and wholeness, the recurring partial resolutions of differentiation and integration and of disequilibrium, and the experience of losing the sense of self and of regaining it, all point toward a religious impulse. "For in those periods where we are forced to experience the disjunction between how we are presently composed and who we are, we make contact with the ultimate ground of which we are a part. As our emergence from the old balance gets further underway, we experience a sense of our own inadequacy, a sense which William James refers to as the essence of religious conviction" (Kegan, 1980, p. 421).

Values-based counseling, then, is singularly indicated for the care of adolescents, their evident narcissism notwithstanding, just because their narcissism is the instantiation of hope—hope in self-transcendence, hope in the establishment of a new way of relating, and hope in the new creation of selfhood and self-affirmation. Indeed, Kegan (1980) argued that the dialectical tension between differentiation and integration (between agency and communion, independence and inclusion) is "the very exercise of hope itself" (p. 414), insofar as this developmental tension points toward the fundamental and competing longings of the developing person. Clearly, religious traditions are not silent on questions concerning the fundamental longings of the human person. Indeed, the Christian religious tradition is largely an answer to the fundamental question posed by Jesus (Luke 9:20, *New International Version*) "Who do you say that I am?" – a question of identity and of identification not unlike that posed by the existential longings of the adolescent.

How, then, does one respond to the narcissistic adolescent? Much like the good-enough mother, the counselor must provide a holding and facilitating environment, one that permits the adolescent to experience the illusions of subjective omnipotence. The empathic counselor must be responsive to the adolescent's need for admiration. One must "mirror" their narcissistic strivings, which, in Winnicott's (1956/1992) eloquent expression, is a way of "going to meet and match the moment of hope" (p. 309). In other words, one participates in the adolescent's illusions, while "never losing sight of the fact that this is a form of play" (Mitchell, 1988, p. 196). One must strike a balance between "joyful play" and the "affirming embrace of reality" (Mitchell, 1988, p. 196). In Kohutian terms one must effect the transmutation of narcissism by withdrawing, in phase-appropriate ways, the mirroring support, thereby channeling the adolescent's narcissistic needs in realistic directions (Lapsley & Rice, 1988).

Research

Research with the Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979), which is arguably the most commonly used assessment of narcissism, has

documented the usefulness of the distinction between adaptive and maladaptive narcissism. The development of this questionnaire was initially based on the *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised (American Psychiatric Association, 1987) criteria for the narcissistic personality disorder, although it was assumed to measure normal manifestations of narcissism in the general population. There is both a 54-item and a 40-item version of the scale reported in the literature, with both forms demonstrating a considerable degree of construct validity (Emmons, 1987; Raskin & Terry, 1988). Moreover, factor analytic studies have shown that the scale can be usefully decomposed into (four or seven) factors that differentially predict adjustment among collegiate adults. For example, research using a four-factor solution shows that narcissistic entitlement and exploitativeness are consistently linked with maladaptive outcomes, whereas narcissistic leadership-authority and superiority are linked with positive adjustment (Emmons, 1984, 1987; Watson, Little, Sawrie, & Biderman, 1992). Similarly, research using a seven-factor solution shows that maladjustment is predicted by the narcissism dimensions entitlement, exploitativeness, and exhibitionism, whereas adjustment is predicted by narcissistic self-sufficiency, superiority, vanity, and authority (Raskin & Novacek, 1989). These results were recently replicated in one of the first empirical studies of narcissism in samples of younger adolescents (Aalsma, Varshney, Arens, & Lapsley, 1997).

The empirical literature suggests, then, that the two faces of adolescent narcissism have important counseling implications. But the two faces of narcissism also have religious or spiritual significance. For example, Watson and his colleagues have shown, in numerous studies, that intrinsic religiosity counterindicates the negative dimensions of narcissism (e.g., Watson et al., 1988; Watson, Morris, Hood, & Biderman, 1990) while predicting its positive dimensions (Watson, Morris, & Hood, 1989). Hence, the healthy dimensions of adolescent narcissism not only convey real adaptational advantages and are hence of clinical significance, but they are also compatible with the sort of religiosity that has pastoral significance.

Counseling Recommendations

We have suggested that narcissism can take maladaptive and normative forms and that it has, therefore, "two faces" that can be presented to counselors. We also noted, with respect to its normal developmental form, that counselors must present a facilitating environment that permits flexible exploration of narcissistic illusions. Indeed, providing mirroring-support, reflecting back to the teen his or her own sense of narcissism, encouraging the teen to hope for the possibilities of relational autonomy, may be critical to the successful counseling of teens. Yet it remains a question as to how a counselor can differentiate the two faces of narcissism in an adolescent client. How does one know, for example, whether the form of narcissism presented by a teenager is of the type that is adaptive and playful, and which is deserv-

ing of mirroring-support, or is of the type that is dysfunctional and maladaptive, and which needs to be confronted with harsher realities? Here the empirical literature offers some guidance.

We noted earlier that adolescent narcissism that is manifested in such things as leadership, authority, superiority, and even vanity has adaptive possibilities. In contrast, adjustment is counterindicated by narcissism that is manifested as entitlement, exploitativeness, and exhibitionism. To differentiate these forms, we suggest that a counselor use items from the NPI that tap these dimensions to structure the intake interview with adolescents in order to get some sense of the direction their narcissistic strivings are taking. For example, if, during the course of one's interrogatory, the adolescent does not reject exploitative ("I can make anybody believe anything I want them to believe") or exhibitionistic ("I get upset when people don't notice how I look when I go out in public") concerns, then a maladaptive form of narcissism is probably indicated. On the other hand, if narcissism revolves around assuming leadership and authority ("I would prefer to be a leader"), superior achievement ("I wish someone would someday write my biography"), and recognition ("I like to be complimented"), then a more adaptive form is indicated. Of course, it is also possible for an adolescent to present with a melange of adaptive and maladaptive narcissistic forms. Under this condition, the task of the counselor is more challenging, of course, although our recommendation is a straightforward one. The task is to carefully differentiate the two forms and to organize treatment accordingly.

In our view, the therapeutic response to the two faces of adolescent narcissism must also be twofold. For example, a "Kohutian" response, one that emphasizes mirroring support and transmuting internalization, is probably indicated in order to mobilize adaptive forms of narcissism. In contrast, a "Kernbergian" response, one that attempts to undercut and challenge defensive grandiosity, is probably indicated to counteract maladaptive forms of narcissism. This twofold response is derived, of course, from the fault lines of clinical theory discussed earlier. Consequently, counselors with strong theoretical allegiances to one or the other clinical tradition will not find the adaptive flexibility implied by our recommendation attractive. The counseling modality appropriate for the care of adolescents will undoubtedly command further reflection and study.

CONCLUSION

We have attempted to contribute to the ongoing articulation of values-based counseling as a mode of therapeutic intervention. To this end, we addressed two questions. First, what is the empirical warrant for using theistic or religiously grounded psychotherapy? If one cannot show that religiosity makes a positive contribution to mental health functioning, then one cannot be confident that values focused counseling should ever be indicated over a more secular based form of counseling. Our approach to this question was

decidedly empirical. Our review of the literature clearly shows that varying aspects of religiosity predict adjustment and coping and encourage resilience in the face of risk exposure. Hence, a religious or spiritual exploration of the resources of one's religious tradition might have tangible therapeutic benefits.

Our second question addressed whether values-based counseling might be uniquely indicated for certain kinds of presenting problems. We argued that the normative crisis of adolescent separation-individuation presents counselors with both a psychological and a theological problem, largely because of the narcissism that is evident in the adolescent's demeanor and outlook. Yet we argued that the developmental task of adolescence is perhaps uniquely suited for religious counseling just because it aims for self-transcendence in relational autonomy. To engage in separation-individuation is to wrestle with the limits of one's developmental experience. As others have argued, the search for self-transcendence (Conn, 1994) and confrontation with limit experiences (Power, 1990) are the very stuff of counseling with adolescents. Finally, we suggested that rather than being a therapeutic problem, the evident narcissism of the adolescent is, in fact, a resource that can be usefully mobilized to effect ego development. Through the provision of mirroring support, the counselor goes "to meet and match the moment of hope" (Winnicott, 1992, p. 309), an encounter that has decided religious significance.

REFERENCES

Aalsma, M. C., Varshney, N. M., Arens, D., & Lapsley, D. K. (1997, October). *The two faces of narcissism and adolescent mental health.* Paper presented at the annual meeting of the Midwestern Educational Research Association, Chicago.

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology, 51,* 432–443.

American Psychiatric Association. (1987) *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

Bakan, D. (1966). *The duality of human existence.* Boston: Beacon.

Baldwin, A. L., Baldwin, C., & Cole, B. J. (1990). Stress-resistant families and stress-resistant children. In J. Rolf, A. S. Masten, D. Cicchetti, K. H. Neuchterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 257–280). New York: Cambridge University Press.

Bergin, A. E. (1980). Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology, 48,* 95–105.

Bergin, A. E. (1985). Proposed values for guiding and evaluating counseling and psychotherapy. *Counseling and Values, 29,* 99–116.

Bergin, A. E., Masters, K. S., & Richards, P. S. (1987). Religiousness and mental health reconsidered: A study of an intrinsically religious sample. *Journal of Counseling Psychology, 34,* 197–204.

Bleiberg, E. (1994). Normal and pathological narcissism in adolescence. *American Journal of Psychotherapy, 48,* 30–51.

Blos, P. (1962). *On adolescence.* New York: Basic.

Bowlby, J. (1969). *Attachment and loss. Volume 1: Attachment.* New York: Basic.

Conn, W. E. (1994). Self-transcendence: Integrating ends and means in value counseling. *Counseling and Values, 38,* 176–186.

Donahue, M. J. (1985). Intrinsic and extrinsic religiousness: Review and meta-analysis. *Journal of Personality and Social Psychology, 48*, 400–419.

Ellis, A. (1980). Psychotherapy and atheistic values: A response to A. E. Bergin's "Psychotherapy and religious values." *Journal of Consulting and Clinical Psychology, 48*, 635–639.

Emmons, R. A. (1984). Factor analysis and construct validity of the narcissistic personality inventory. *Journal of Personality Assessment, 48*, 291–300.

Emmons, R. A. (1987). Narcissism: Theory and measurement. *Journal of Personality and Social Psychology, 5*, 11–17.

Ernsberger, D. J., & Manaster, G. J. (1981). Moral development, intrinsic/extrinsic religious orientation and denominational teachings. *Genetic Psychology Monographs, 104*, 23–41.

Flew, R. N. (1934). *The idea of perfection in Christian theology*. New York: Humanities.

Freud, S. (1957). On narcissism: An introduction. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud*. (Vol. 14, pp. 237—258). London: Hogarth. (Original work published in 1914)

Gartner, J., Larson, P. B., & Allen, G. U. (1991). Religious commitment and mental health: A review of the empirical literature. *Journal of Psychology and Theology, 19*, 6–25.

Georgia, R. T. (1994). Preparing to counsel clients of different religious backgrounds: A phenomenological approach. *Counseling and Values, 38*, 143–151.

Jessor, R., & Jessor, S. L. (1977). *Problem behavior and psychosocial development: A longitudinal study of youth*. New York: Academic.

Josselson, R. (1980). Ego development in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology* (pp. 188–210). New York: Wiley.

Kegan, R. (1980). There the dance is: Religious dimensions of a developmental framework. In C. Brusselmans (Ed.), *Towards moral and religious maturity* (pp. 403–440). Morristown, NJ: Silver Burdett.

Kendler, K. S., Gardner, C. O., & Prescott, C. A. (1997). Religion, psychopathology, and substance use and abuse: A multi-measure, genetic-epidemiologic study. *American Journal of Psychiatry, 154*, 322–329.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. Northvale, NJ: Aronson.

Kirkpatrick, L. A., & Shaver, P. R. (1990). Attachment theory and religion: Childhood attachments, religious beliefs and conversion. *Journal for the Scientific Study of Religion, 29*, 315–334.

Kirkpatrick, L. A., & Shaver, P. R. (1992). An attachment-theoretical approach to romantic love and religious belief. *Personality and Social Psychology Bulletin, 18*, 266–275.

Kohut, H. (1977). *The restoration of self*. New York: International Universities.

Lapsley, D. K., & Rice, K. (1988). The "new look" at the imaginary audience and personal fable: Toward a general model of adolescent ego development. In D. K. Lapsley & F. C. Power (Eds.), *Self, ego, identity: Integrative approaches* (pp. 109–129). New York: Springer.

Masten, A., Best, K., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology, 2*, 425–444.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.

Morrison, A. (Ed.). (1986). *Essential papers on narcissism*. New York: New York University Press.

Oetting, E. R., & Beauvais, F. (1987). Peer cluster theory, socialization characteristics, and adolescent drug use: A path analysis. *Journal of Counseling Psychology, 34*, 205–213.

Pargament, K. I. (1997). *The psychology of religion and coping*. New York: Guilford.

Power, F. C. (1990). The distinctiveness of pastoral counseling. *Counseling and Values, 34,* 75–88.

Raskin, R., & Hall, C. S. (1979). A narcissistic personality inventory. *Psychological Reports, 46,* 55–60.

Raskin, R., & Novacek, J. (1989). An MMPI description of the narcissistic personality. *Journal of Personality Assessment, 53,* 66–80.

Raskin, R., & Terry, H. (1988). A principal-components analysis of the Narcissistic Personality Inventory and further evidence of its construct validity. *Journal of Personality and Social Psychology, 54,* 890–902.

Rolf, J., Masten, A. S., Cicchetti, D., Neuchterlein, K. H., & Weintraub, S. (Eds.). (1990). *Risk and protective factors in the development of psychopathology* (pp. 257–280). New York: Cambridge University Press.

Rothstein, A. (1984). *The narcissistic pursuit of perfection.* New York: International Universities.

Rothstein, A. (1986). The theory of narcissism: An object-relations perspective. In A. P. Morrison (Ed.), *Essential papers on narcissism* (pp. 308–320). New York: New York University Press.

Sarnoff, C. A. (1987). *Psychotherapeutic strategies in late latency through early adolescence.* Northvale, NJ: Aronson.

Sherwood, V. R. (1990). The first stage of treatment with the conduct disordered adolescent: Overcoming narcissistic resistance. *Psychotherapy, 27,* 380–387.

Spilka, B. (1991). Religion and adolescence. In R. M. Lerner, A. C. Petersen, & J. Brooks-Gunn (Eds.), *Encyclopedia of adolescence* (Vol. 2, pp. 926–929). New York: Garland.

Spilka, B., Hood, R. W., & Gorsuch, R. L. (1985). *The psychology of religion: An empirical approach.* Englewood Cliffs, NJ: Prentice-Hall.

Sullivan, H. S. (1953). *The interpersonal theory of personality.* New York: Norton.

Taylor, S., & Brown, J. D. (1988). Illusion and well-being: A social-psychological perspective on mental health. *Psychological Bulletin, 103,* 193–210.

Watson, P. J., Hood, R. W., Foster, S. G., & Morris, R. J. (1988). Sin, depression and narcissism. *Review of Religious Research, 29,* 295–305.

Watson, P. J., Little, T., Sawrie, S. M., & Biderman, M. D. (1992). Measures of the narcissistic personality: Complexity of relationships with self-esteem and empathy. *Journal of Personality Disorders, 6,* 434–449.

Watson, P. J., Morris, R. J., & Hood, R. W. (1989). Intrinsicness, religious self-love and narcissism. *Journal of Religion and Christianity, 8,* 31–37.

Watson, P. J., Morris, R. J., Hood, R. W., & Biderman, M. D. (1990). Religious orientation types and narcissism. *Journal of Psychology and Christianity, 9,* 40–46.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood.* Ithaca, NY: Cornell University Press.

Winnicott, D. W. (1992). The antisocial tendency. In *Through paediatrics to psychoanalysis: Collected papers* (pp. 306–315). New York: Brunner/Mazel.

Wright, L. S., Frost, C. J., & Wisecarver, S. J. (1994). Church attendance, meaningfulness of religion and depressive symptomatology among adolescents. *Journal of Youth and Adolescence, 22,* 559–568.