Psychoanalytic Diagnosis

Understanding Personality Structure in the Clinical Process

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for the therapist to demonstrate respect for his or her depth of conviction (see Lovinger, 1984); diagnosis-influenced interventions will be of value, but only secondarily. Similarly, it is sometimes more important, at least in the early phases of developing a therapeutic relationship, to consider the emotional implications of a person's age, race, ethnicity, class background, physical disability, political attitudes, or sexual orientation than it is to appreciate his or her appropriate diagnostic category.

Assessment of character structure is always provisional and never definitive; an ongoing willingness to reassess one's initial diagnosis in the light of new information is part of being optimally therapeutic. As treatment proceeds with any individual human being, the oversimplification inherent in our diagnostic concepts becomes startlingly clear. People are much more complex than our categories admit. Hence, even the most sophisticated personality assessment can become an obstacle to the therapist's perceiving critical nuances of the patient's unique material. Notwithstanding the advantages of the diagnostic process, it should not be applied beyond its usefulness.

SUGGESTIONS FOR FURTHER READING

My favorite book on interviewing, mostly because of its tone, is Harry Stack Sullivan's (1954) *The Psychiatric Interview*. Another classic work that is full of useful background and wise technical recommendations is *The Initial Interview in Psychiatric Practice* by Gill, Newman, and Redlich (1954). I have already mentioned my admiration for the work of MacKinnon and Michels (1971), whose basic premises are similar to the ones informing this text. Gabbard (1990), in *Psychodynamic Psychiatry in Clinical Practice*, has accomplished a masterful integration of dynamic and structural diagnosis and the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III-R; American Psychiatric Association, 1987). Kernberg's (1984) *Severe Personality Disorders* contains a short but comprehensive section on diagnosis and, in particular, on the structural interview. Most beginning therapists find Kernberg hard to read, but this section is lucidly written and seamlessly fills in the gap between the classic texts above and more contemporary psychoanalytic theorizing about personality structure.

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Psychoanalytic Character Diagnosis

Classical psychoanalytic conceptualization approached the study of character or personality in two very different ways, each deriving from an early theoretical model of individual development. In the era of Freud's original *drive theory*, an attempt was made to understand personality on the basis of fixation (at what early developmental phase is this person psychologically stuck?). Later, with the development of *ego psychology*, character was conceived as expressing the operation of particular styles of defense (what are this person's typical ways of avoiding anxiety?). This second way of understanding character was not in conflict with the first; it provided a different set of ideas and metaphors for comprehending what was meant by a type of personality, and it added to the concepts of drive theory certain assumptions about how we each develop our characteristic adaptive and defensive patterns.

An appreciation of these two approaches is at the center of my own visualization of character possibilities. I shall also try to show how the more recent developments in British object relations theory (and its American cousin, interpersonal psychoanalysis) and in the self psychology movement can illuminate aspects of character organization. In addition, my own understanding of personality and diagnosis has been enriched by less clinically influential psychodynamic formulations such as Henry Murray's "personology" (e.g., 1938), Silvan Tomkins's (1992) "script theory," and the ideas developed by Weiss and Sampson and the Mount Zion Psychotherapy Research Group (e.g., 1986), sometimes under the label of "control–mastery" theory.

The discerning reader may note that I am applying to the diagnostic enterprise several different models and theories within psychoanalysis that are held by some scholars to be mutually exclusive or essentially contradictory in nature. Because this book is intended for therapists, and because I am temperamentally more of a synthesizer than a critic or distinction maker, I have not addressed the question of which analytic model is most scientifically or heuristically or metapsychologically defensible. In this position I owe a substantial intellectual debt to Fred Pine (1985, 1990), whose efforts to integrate drive, ego, object, and self theories have been of incalculable clinical value. I am not minimizing the importance of critically evaluating competing theories. My decision not to do so derives from the specifically *clinical* purpose of this book and from my observation that most therapists seek to assimilate a diversity of models and metaphors, whether or not they are controversial or conceptually problematic in some way. Every new development in psychoanalytic theory offers practitioners a fresh way of trying to communicate to troubled people their wish to understand and help. Effective psychodynamic therapists—and I am assuming that effective therapists and brilliant theorists are overlapping but not identical samples—seem to me more often to draw freely from many psychoanalytic sources than to become ideologically wedded to one or two favored theories. They mistrust those whose professional identity centers on the defense of one way of thinking and working. Adherence to dogma is found in some analysts, but its existence has not enriched our clinical theory, nor has it contributed to the esteem in which our field is held by those who value humility about the extent of contemporary understanding and who appreciate ambiguity and complexity (cf. Goldberg, 1990b).

Different clients have a way of making different theories or models relevant: One person stimulates in the therapist thoughts of concepts promulgated by Kernberg; another sounds like a type of person described by Horney; still another has an unconscious fantasy life so classically Freudian that the therapist starts to wonder if the patient boned up on early drive theory before entering treatment. Stolorow and Atwood (1979) have shed considerable light on the emotional processes that contribute to the development of a theory of personality, and they have made a persuasive case that the central character themes in the theorist's life become the issues emphasized in that person's theories of general psychology, personality formation, psychopathology, and psychotherapy. Considered in this light, it is not surprising that we have so many alternative conceptions. And even if some of them are *logically* at odds with one another, I would argue that they are not *phenomenologically* so, and that they apply differentially to different kinds of people.

Having stated my own biases and predilections, I now offer a brief and necessarily oversimplified summary of diagnostically significant models within the psychoanalytic tradition. They are covered in order to give the student with minimal exposure to psychoanalytic theory some basis for comprehending the categories that are second nature for analytically trained therapists. I will also specify some underlying assumptions inherent in these models before applying them more or less uncritically to various personality constellations.

CLASSICAL FREUDIAN DRIVE THEORY

Freud's original theory of personality development was a biologically derived model that stressed the centrality of instinctual processes and construed human beings as passing through an orderly progression of bodily preoccupations from oral to anal to phallic and genital concerns. It was theorized that in infancy and early childhood, the person's natural dispositions concern basic survival issues, which were experienced at first in a deeply sensual way via nursing and the mother's other activities with the infant's body and later in the child's fantasy life about birth and death and the sexual tie between its parents.

Babies, and therefore the infantile aspects of self that live on in adults, were seen as uninhibited seekers of instinctual gratification, with some individual differences in the strength of the drives. Appropriate caregiving was construed as oscillating sensitively between, on the one hand, sufficient gratification to create emotional security and pleasure and, on the other, developmentally appropriate frustration such that the child would learn in titrated doses how to replace the *pleasure principle* ("I want all my gratifications, including mutually contradictory ones, right now!") with the *reality principle* ("Some gratifications are problematic, and the best are worth waiting for"). Freud talked little about the specific contributions of his patients' parents to their psychopathology. But when he did, he saw parental failures as involving either excessive gratification of drives, such that nothing had impelled the child to move on developmentally, or excessive deprivation of them, such that the child's capacity to absorb frustrating realities was overwhelmed. Parenting was thus a balancing act between indulgence and inhibition—an intuitively resonant model for most mothers and fathers, to be sure.

Drive theory postulated that if a child was either overfrustrated or overgratified at an early psychosexual stage (as per the interaction of the child's constitutional endowment and the parents' responsiveness),

he or she would become "fixated" on the issues of that stage. Character was seen as expressing the long-term effects of this fixation: If an adult man had a depressive personality, it was theorized that he had been either neglected or overindulged in his first year and a half or so (the oral phase of development); if he was obsessional, it was inferred that there had been problems between roughly 1½ and 3 (the anal phase); if he was hysterical, he had met either rejection or overstimulating seductiveness, or both, between about 3 and 6, when the child's interest has turned to the genitals and sexuality (the "phallic" phase, in Freud's male-oriented language, the later part of which came to be known as the "oedipal" phase because the sexual competition issues and associated fantasies characteristic of that stage parallel the themes in the ancient Greek story of Oedipus). It was not uncommon in the early days of the psychoanalytic movement to hear someone referred to as having an oral, anal, or phallic character, depending on which issues seemed central to him or her. Later, as the theory became more sophisticated, analysts would specify whether it was oral dependent or oral aggressive (sucking versus biting aspects of orality being seen as preponderant, respectively), anal retentive or anal expulsive, early or late oral, anal, or phallic, and so forth.

Lest this oversimplified account sound entirely fanciful, I should stress that the theory did not spring full-blown from Sigmund Freud's fevered imagination; there was an accretion of data that influenced and supported it, collected not only by Freud but by his colleagues as well. In Wilhelm Reich's (1933) *Character Analysis*, the drive theory approach to personality diagnosis reached its zenith. Although the language of that book sounds archaic to most contemporary students, it is full of fascinating insights about character types, and its observations still frequently strike a chord in the sympathetic reader. Ultimately, the effort to understand character entirely on the basis of instinctual fixation proved disappointing. Freud's colleague Karl Abraham devoted his formidable intellect to the task of correlating psychological phenomena with particular stages and substages, yet he failed eventually to achieve a satisfactory set of conclusions about such relationships. Although the drive-based fixation model has never been rejected by most psychoanalysts as completely misconceived, it has been supplemented with other ways of understanding character that have more explanatory power.

One way in which the original drive theory model is retained or echoed to some degree is in the tendency of psychodynamic practitioners to continue to think in terms of maturational stages and to understand psychopathology in terms of developmental arrest or conflict at a particular phase. Although few analysts now reduce all

phenomena to classical drive categories, most assume a basic stage theory of development. Efforts like those of Daniel Stern (1985) to rethink the whole concept of predictable developmental phases have met with respectful interest, but these new ways of thinking do not seem to have deterred many clinicians from construing their patients' problems in terms of some unfinished developmental task, the normal source of which is seen as a certain phase of early childhood.

In the 1950s and 1960s, Erik Erikson's reformulation of the psychosexual stages according to both the interpersonal and intrapsychic tasks of each phase received a great deal of attention. Although Erikson's work (e.g., 1950) is usually seen as prototypical of the ego psychology tradition, his stage theory echoes many assumptions in Freud's drive model of development. One of Erikson's most appealing additions to Freudian theory (Erikson saw his conceptualization as supplementing rather than replacing Freud's) was the renaming of the early stages in the interest of modifying Freud's biologism.

The oral phase became understood by its condition of total dependency, in which the establishment of *basic trust* (or the lack thereof) was the specific outcome of the gratification or deprivation of the oral drive. The anal phase was conceptualized as involving the attainment of *autonomy* (or, if poorly navigated, of shame and doubt). The prototypical struggle of this phase might be the mastery of toilet functions, as Freud had stressed, but it also involved a vast range of issues relevant to the child's learning self-control and coming to terms with the expectations of the family and the larger society. The oedipal phase was seen as a critical time for developing a sense of basic *efficacy* ("initiative versus guilt") and a sense of pleasure in *identification* with one's love objects. Erikson extended the idea of developmental phases and tasks throughout the life span. He also broke down the earliest phases into subdivisions (oral-incorporative, oral-expulsive; anal-incorporative, anal-expulsive).* In the 1950s, Harry Stack Sullivan (e.g., 1953) offered another stage theory, one that stressed communicative achievements like speech and play rather than drive satisfaction.

*For some reason, probably including its muting of Freud's emphasis on our animal nature, Erikson's theory got into academic curricula, unlike much subsequent analytic work of comparable quality. The isolation of analysts in freestanding training institutes has been convenient for them in some ways, but, overall, the estrangement between psychoanalysis and academic psychology has been a great misfortune. Most university-based psychologists, even those who routinely teach Freud, Jung, Adler, and Erikson, are unfamiliar with the last 40 years of psychoanalytic theory. And analysts have been deprived of the stimulation and discipline of working in the company of diverse and skeptical colleagues, many of whom are interested in questions of some relevance to analytic theory.

Like Erikson, he believed that personality continues to develop and change well beyond the first 6 or so years that Freud had stressed as the bedrock of adult character.

Margaret Mahler's work (e.g., Mahler, 1968, 1972a, 1972b; Mahler, Pine, & Bergman, 1975) on the phases and subphases of the separation–individuation process, a task that reaches its initial resolution by about the age of 3, was a further step in conceptualizing processes that are relevant to eventual personality structure. Her theory is generally placed within the object relations area, but its implicit assumptions of fixation owe a debt to Freud's developmental model. As Erikson subdivided the oral phase, Mahler broke down what were to Freud the first two stages, oral and anal, and looked at the infant's movement from a state of relative unawareness of others (the autistic phase, lasting about 6 weeks) to one of symbiotic relatedness (lasting over the next 2 or so years—this period itself subdivided into "hatching," "practicing," "rapprochement," and "on the way to object constancy" subphases) to a condition of relative psychological separation and individuation.

These contributions were greeted eagerly by therapists. With the post-Freudian advances in stage theories, they had fresh ways of understanding how their patients had gotten "stuck." They could now also offer interpretations and hypotheses to their self-critical clients that went beyond speculations about their having been weaned too early or too late, or toilet trained too harshly or with too much laxity, or seduced or rejected during the oedipal phase. Rather, patients could be told that their predicaments reflected family processes that had made it difficult for them to feel security or autonomy or pleasure in their identifications (Erikson), or that fate had handed them a childhood devoid of the crucially important preadolescent "chum" (Sullivan), or that their mother's hospitalization when they were 2 had overwhelmed the rapprochement process normal for that age and necessary for optimal separation (Mahler). For therapists, such alternative models were not just interesting intellectually, they provided ways of helping people to understand and find compassion for themselves—in contradistinction to the usual internal explanations that human beings generate about their more incomprehensible qualities (viz., "I'm bad," "I'm ugly," "I'm lazy and undisciplined," "I'm just inherently rejectable," "I'm dangerous," etc.).

Many contemporary commentators have said at one time or another that our propensity to construe problems in developmental terms smacks of reductionism and is only questionably supported by clinical and empirical evidence (e.g., Kernberg, 1984). Others have pointed to different patterns and stages of psychological development

in non-Western cultures (e.g., Roland, 1988). Still, the tendency of therapists to see psychological phenomena as residues of problems at a particular maturational phase persists. Perhaps this persistence reflects the fact that the general developmental model has about it both a kind of elegant simplicity and an overall humanity that appeals to the mental health community. There is a generosity of spirit, a kind of "There but for fortune go I" quality, to believing there is one archetypal, progressive, universal pattern of development, and that under unfortunate circumstances, any of us could have gotten stymied at any of its phases. It may not be a *sufficient* explanation for personality types or psychopathology, but it feels to most practitioners like a necessary *part* of the picture. As readers may note in the Chapters 3 and 4, one of the axes on which I have aligned diagnostic data contains this developmental bias, in the form of symbiotic (psychotic), separation–individuation (borderline), and oedipal (neurotic) levels of personality organization and psychopathology.

EGO PSYCHOLOGY

With the publication of *The Ego and the Id* (1923), Freud introduced his structural model, and a new theoretical era began. Analytic investigators shifted their interest from the *contents* of the unconscious to the *processes* by which those contents were kept out of consciousness. Arlow and Brenner (1964) have argued cogently for the greater explanatory power of the structural theory, with its emphasis on understanding ego processes, but there were also practical clinical reasons for therapists to welcome the changes of focus from id to ego operations and from deeply unconscious material to those wishes, fears, and fantasies that were closer to consciousness and accessible if one worked with the defensive functions of a patient's ego. A crash course in the structural model and its associated assumptions follows, with apologies to sophisticated readers for the brevity with which complicated concepts are covered.

The *id* was the term Freud used for the part of the mind that contains primitive drives, impulses, prerational strivings, wish–fear combinations, and fantasies. It seeks only immediate gratification and is totally "selfish" in the lay sense, operating according to the pleasure principle. Cognitively, it is preverbal, expressing itself in images and symbols. It is also prelogical, having no concept of time, mortality, limitation, or the impossibility that opposites can coexist. Freud called this primitive kind of cognition, which survives in the language of dreams, jokes, and hallucinations, *primary process thought*.

The id is entirely unconscious. Its existence and power can, however, be inferred from *derivatives*, such as thoughts, acts, and emotions. In Freud's time, it was a common cultural conceit that modern, "civilized" human beings were rationally motivated creatures who had moved beyond the sensibilities of the "lesser" animals and of non-Western "savages." (Freud's emphasis on our animality, including the dominance of sex as a motivator, was one reason for the degree of outrage that his ideas provoked in the Victorian and post-Victorian eras.)

The *ego* was Freud's name for a set of functions that adapt to life's exigencies, finding ways that are acceptable within one's family to handle id strivings. It develops continuously throughout one's lifetime but most rapidly in childhood, starting in earliest infancy (cf. Hartmann, 1958). The ego operates according to the reality principle and is the seedbed of *secondary process thought* (sequential, logical, reality-oriented types of cognition). It thus mediates between the demands of the id and the constraints of reality and ethics. It has both conscious and unconscious aspects. The conscious ones are similar to what most of us mean when we use the term "self" or "I," while the unconscious aspects include defensive processes like repression, displacement, rationalization, and sublimation. With the structural theory, analytic therapists had a new language for making sense of some kinds of character pathology; namely, that everyone develops ego defenses that are adaptive within his or her childhood setting but may turn out to be maladaptive later in the adult world beyond the family.

One important aspect of this model for both diagnosis and therapy is the portrayal of the ego as having a range of operations, from deeply unconscious (e.g., primitive feeling reactions to events, counteracted by a powerful defense like denial) to fully conscious. During the process of psychoanalytic treatment, it was noted, the "observing ego," the part of the self that is conscious and rational and can comment on emotional experience, makes an alliance with the practitioner to understand the total self together, while the "experiencing ego" holds a more visceral sense of what is going on in the therapy relationship. This "therapeutic split in the ego" (Sterba, 1934) was seen as a necessary condition of effective analytic therapy. If the patient was unable to talk from an observing position about less rational, more "gut-level" emotional reactions, the first task of the therapist was to help the patient develop that capacity. The presence or absence of an observing ego became of paramount diagnostic value, since the existence of a symptom or problem that was dystonic (alien) to the observing ego was found to be treatable much faster than a similar-looking problem that the patient had never regarded as

noteworthy. This insight persists among analytic diagnosticians in the language of whether a problem or personality style is "ego alien" or "ego syntonic."

The basic role of the ego in perceiving and adapting to reality is the source of the useful psychoanalytic phrase "ego strength," meaning the person's capacity to acknowledge reality, even when it is extremely unpleasant, without resorting to more primitive defenses like denial. Over the years of the development of psychoanalytic clinical theory, a distinction emerged between the more archaic and the more mature defenses, the former characterized by the psychological avoidance or radical distortion of disturbing facts of life, and the latter involving more of an accommodation to reality.

Another important clinical assumption that flowed from the ego psychology movement was the belief that psychological health involved not only having *mature* defenses but also being able to use a *variety* of defensive processes (cf. Shapiro, 1965). In other words, it was recognized that the person who habitually reacts to every stress with, say, projection, or with rationalization, is not as well off psychologically as the person who uses different ways of coping, depending on circumstances. Concepts like "rigidity" of personality and "character armor" (W. Reich, 1933) express this idea that mental health has something to do with emotional flexibility.

Freud coined the term *superego* for the part of the self that oversees things, especially from a moral perspective.* Roughly synonymous with "conscience," the superego is the part of the self that congratulates us for doing our best and criticizes us when we fall short of our own standards. It is a part of the ego, although it is experientially felt as separate from it. Freud believed that the superego was formed mainly during the oedipal period, through identification with parental values, but most contemporary analysts regard it as originating much earlier in primitive infantile notions of good and bad.

The superego is, like the ego to which it belongs, partly conscious and partly unconscious. Again, the assessment of whether an inappropriately punitive superego was experienced by the patient as ego alien or ego syntonic was eventually understood to have important prognostic implications. The client who announces that she is evil because she has had bad thoughts about her father is a very different kind of person from the one who reports that a part of her seems to *feel* she is evil when she entertains such thoughts. Both may be depressive,

*Note that Freud wrote in simple, non-jargon-laden language: Id, ego, and superego translate as "it," "me," and "above me." Few contemporary psychoanalytic theorists, it is sad to note, write with anything like his grace and stylistic simplicity.

self-attacking people, but the magnitude of the first woman's problem is so much greater than that of the second that it warrants a different level of classification.

Again, there was a lot of clinical benefit to the development of the concept of the superego. Therapy went beyond simply trying to make the patient's unconscious conscious; the practitioner could view the therapeutic task as also involving the modification of the client's superego. A common therapeutic aim, especially throughout the first half of the 20th century, when adults in the middle and upper-middle classes tended to have been reared in ways that produced unreasonably harsh superegos, was helping one's patients reevaluate overly stringent moral standards (e.g., antisexual strictures or internal chastisement for thoughts, feelings, and fantasies that were universal). Psychoanalysis as a movement—and Freud in particular—was emphatically not hedonistic, but the modification of inhumanly harsh superegos was one of its frequent goals. In practice, this tended to encourage more rather than less ethical behavior by patients, since people with condemnatory superegos frequently behave in defiance of them, especially in states of intoxication or in situations in which acting out can be rationalized. Efforts to expose the operations of the id, to bring a person's unconscious life into the light of day, had little therapeutic benefit if the patient reacted to such illumination as revealing evidence of his or her depravity.

Ego psychology's achievement in describing processes that are now subsumed under the general rubric of "defense" is centrally relevant to character diagnosis. Just as we may attempt to understand people in terms of the developmental phase that exemplifies their current struggle, we can sort them out according to their characteristic modes of handling anxiety. The idea that a primary function of the ego was to defend the self against anxiety arising from either powerful instinctual strivings (the id), upsetting reality experiences (the ego), or guilt feelings and associated fantasies (the superego) was most elegantly elaborated in Anna Freud's (1936) *The Ego and the Mechanisms of Defense*.

Sigmund Freud's original ideas had included the notion that anxious reactions were *caused* by defenses, most notably repression (motivated forgetting). Bottled-up feelings were seen as causing inner tension that pressed for discharge, experienced as anxiety. When Freud made the shift to the structural theory he reversed himself, deciding that repression was a *response* to anxiety, and that it was only one of several ways in which human beings try to avoid an unbearable sense of irrational fear. He began construing psychopathology as a state in which a defensive effort had not worked, where the anxiety was felt

despite the operation of one's habitual means of handling it, or where the behavior that masked the anxiety was self-destructive.

In Chapters 5 and 6 I shall cover the defenses, the ones identified by Sigmund and Anna Freud as well as by others, including some preverbal, archaic processes first elucidated by Melanie Klein. This summary will provide enough background for the subsequent portrayal of different character types.

THE OBJECT RELATIONS TRADITION

As the ego psychologists were mapping out a theoretical understanding of patients whose psychological processes were illuminated by the structural model, some theorists in Europe, especially in England, were looking at different kinds of unconscious processes and their manifestations. Some, like Klein (e.g., 1932, 1957), worked both with children and with patients whom Freud had regarded as too disturbed to be suitable for analysis.* These representatives of the "British School" of psychoanalysis were finding that they needed another language to describe the processes they observed. Their work was controversial for many years, partly due to the personalities, loyalties, and convictions of those involved, and partly because it is hard to write persuasively about inferred primitive phenomena. Object relations theorists struggled with how to put preverbal, prerational processes into words governed by reason. Although their respect for the power of unconscious dynamics made them clearly analytic, they disputed Freud on certain central issues.

W. R. D. Fairbairn (e.g., 1954), for example, rejected Freud's biologism outright, proposing that people do not seek drive satisfaction so much as they seek relationships. In other words, a baby is not so much focused on *getting mother's milk* as it is on having the experience of *being nursed*, with the sense of warmth and attachment that is part of that experience. Psychoanalysts influenced by Sandor Ferenczi (such as Michael and Alice Balint, sometimes referred to as belonging to the "Hungarian School" of psychoanalysis) pursued the study of primary experiences of love, loneliness, creativity, and integrity of self that do not fit neatly within the confines of the structural theory. People in this orientation put their emphasis not so much on what drive had been mishandled in a person's childhood, or on what developmental

*Freud was more conservative than many of his successors about the power of analytic therapy to effect significant changes, especially in those suffering from psychotic illnesses.

phase had been poorly negotiated, or on what ego defenses had predominated. Rather, the emphasis was on what the main objects* in the child's world had been like, how they had been experienced,† how they and felt aspects of them had been internalized, and how internal images and representations of them lived on in the unconscious lives of adults. In the object relations tradition, oedipal issues loom less large than themes of separation and individuation. Interestingly, the work of Otto Rank (e.g., 1929, 1945) presaged much of the object relations work that came after his time. However, because Rank left the analytic mainstream after his painful break with Freud, many of his most important observations had to be rediscovered (Menaker, 1982).

Freud's own work was not inhospitable to the development and elaboration of object relations theory. His appreciation of the importance of the child's actual and experienced infantile objects comes through in his concept of the "family romance," in his recognition of how different the oedipal phase could be for the child depending on the personalities of the parents, and also in his increasing emphasis on relationship factors in treatment. Richard Sterba, one of the last analysts who knew Freud well, has commented (1982) on how much object relations theory has enriched Freud's original observations, implying that Freud would have welcomed this direction in psychoanalysis.

By the middle of the 20th century, object relational formulations from the British and Hungarian schools were paralleled to a striking degree by developments among therapists in the United States who

*The term "object relations" is unfortunate, since "object" in psychoanalese usually means "person." It derives from Freud's early explication of instincts as having a *source* (some bodily tension), an *aim* (some kind of biological satisfaction), and an *object* (typically a person, since the drives Freud saw as central to one's psychology were the sexual and aggressive ones). This phrase remains in use despite its unattractive, mechanistic connotations because of this derivation and also because there are instances in which an important "object" to someone is a nonhuman attachment (e.g., the American flag to a patriot; footwear to a shoe fetishist) or is *part* of a human being (the mother's breast, the father's smile, the sister's voice, etc.).

†The reason analysts distinguish between actual objects and the child's experience of them is that children, especially infants, may misperceive important family figures and their motives, and retain an internalization of the misperception. For example, a girl whose father goes off to war when she is 2 years old will inevitably experience him as having rejected and abandoned her, and she may later cling internally to the belief that she was not very important to him. Alternatively, a boy may see a grandmother as a virtual saint because she was warm to him, yet the same grandmother may realistically be a destructive person who acted out her competition with her daughter in ways that undermined the boy's mother and foiled the mother's attempts to attach affectionately to her son. His internal objects will include a loving grandmother and a cold rejecting mother.

identified themselves as "interpersonal psychoanalysts." These theorists, who included Harry Stack Sullivan, Erich Fromm, Karen Horney, Clara Thompson, Otto Will, Frieda Fromm-Reichmann, and others were, like their European colleagues, trying to work psychodynamically with more seriously disturbed patients. They differed from object relations analysts across the Atlantic mainly in the extent to which they emphasized the internalized nature of early object relations: The American-based therapists tended to put less stress on the stubbornly persisting unconscious images of early objects and aspects of objects.

Freud had made a shift toward an interpersonal theory of treatment when he stopped regarding his patients' transferences as distortions to be explained away and began seeing them as offering the emotional context necessary for healing: "It is impossible to destroy anyone *in absentia* or *in effigie*" (1912, p. 108). The conviction that the emotional connection between therapist and client constitutes the most vital curative factor in therapy is widely held by contemporary practitioners who identify themselves as relational in orientation. It is also supported by considerable empirical work on psychotherapy outcome (Strupp, 1989).

Relational concepts allowed therapists to extend their empathy into the subtle area of how their clients experienced interpersonal connection. They might be in a state of psychological fusion with another person, in which self and object are emotionally indistinguishable. They might be in a dyadic space, where the object was felt as either for them or against them. Or they might see others as fully independent of themselves. The child's movement from experiential symbiosis (early infancy) through me-versus-you struggles (age 2 or so) through more complex identifications (age 3 and up) became more salient in this theory than the oral, anal, and oedipal preoccupations of those stages. The oedipal phase was appreciated as a *cognitive* developmental milestone, not just as a psychosexual one, in that it is a substantial leap—a victory over infantile egocentrism—to be able to understand that two other people (one's parents, in the classical paradigm) might be relating *to each other* in a way that had little to do with the self.

The appearance of concepts from the European object relations theorists and from the interpersonalists in the United States heralded significant advances in treatment because the psychologies of many clients, especially those suffering from more debilitating kinds of psychopathology, are not easily construed in terms of id, ego, and superego. Instead of having an integrated ego with a self-observing function, such persons seem to have different "ego states," conditions of mind in which they feel and behave one way, often contrasting with the way they feel and behave at other times. In the grip of these states, they

appear to have no capacity to think objectively about what is going on in themselves, and they may insist that their current emotional experience is natural and inevitable given their situation.

Clinicians trying to help these difficult patients learn that treatment goes better if one can figure out which internal parent or other important early object is being activated at any given time, rather than trying to relate to them as if there is a consistent "self" with mature defenses that can be engaged. Thus, the arrival of the object relations point of view had significant implications for extending the scope and range of treatment (see L. Stone, 1954). Therapists could now listen for the attitudes of "introjects," those internalized others who had influenced the child and lived on in the adult, and from whom the client had not yet achieved a satisfactory psychological separation.

Within this formulation, character could be seen as reasonably predictable patterns of behaving like, or unconsciously inducing others to behave like, the experienced objects of early childhood. The "stable instability" of the borderline personality (Kernberg, 1975) had become more theoretically comprehensible and hence more clinically addressable. With the metaphors and models of object relations theory, filtered through the therapist's internal images and emotional reactions to the patient's communications, a practitioner now had additional means of understanding what was happening in therapy, especially when an observing ego could not be accessed. For example, when a disturbed patient would launch a paranoid diatribe, the therapist could make sense of it as a recreation of the patient's having felt relentlessly and unfairly criticized as a child.

A new appreciation of *countertransference* evolved in the psychoanalytic community, reflecting therapists' accumulating clinical knowledge and exposure to the work of relational theorists writing about their internal responses to patients. In the United States, Harold Searles distinguished himself for frank depictions of normal countertransference storms, as in his 1959 article on efforts of psychotic people to drive therapists crazy. In Britain, D. W. Winnicott was one of the bravest self-disclosers, as in his justly famous 1949 article "Hate in the Countertransference." Freud had regarded strong emotional reactions to patients as evidence of the analyst's incomplete self-knowledge and inability to maintain an affectively positive, physicianly attitude toward the other person in the room. In gradual contrast to this appealingly rational position, analysts working with psychotic clients and with those we would now consider borderline were finding that one of their best vehicles for comprehending these overwhelmed, disorganized, desperate, tormented people was their own intense countertransferential response to them.

In this vein, Heinrich Racker (1968), a South American analyst influenced by Klein, offered the clinically invaluable categories of *concordant* and *complementary countertransferences*. The former term refers to the therapist's feeling (empathically) what the patient as a child had felt in relation to an early object; the latter connotes the therapist's feeling (unempathically, from the viewpoint of the client) what the object had felt toward the child.

For example, one of my patients once seemed to be going nowhere for several sessions. I noticed that every time he mentioned someone, he would attach a sort of verbal "footnote" to his commentary, such as "Marge is the secretary on the third floor that I eat lunch with on Tuesdays"—even if he had often talked about Marge before. I commented on this habit of his, wondering whether someone in his family had not listened to him very carefully: He assumed I didn't remember any of the important figures in his current life.

He protested angrily. His parents were *very* interested in him—especially his mother, he volunteered. He then commenced a long defense of her, during which I began, without even really noticing it, to get very bored. Suddenly, I realized I had not heard a thing he had said for several minutes. I was off in a fantasy about how I would present my work with him as a case study to some eminent colleagues, and how my account of this treatment would impress them with my skill. As I pulled myself out of this narcissistic reverie and started listening again, I was fascinated to hear that he was saying, in the context of defending his mother against the charge of lack of attentiveness, that every time he was in a play in elementary school, she would make the most elaborate costume of any mother in the grade, would rehearse every line of dialogue with him over and over, and would sit in the front row on the day of the performance, radiating pride.

In my fantasy, I had become startlingly like the mother of his childhood years, interested in him mainly as a potential enhancer of my own reputation. Racker would call this countertransference complementary, since my emotional state paralleled that of one of the patient's significant childhood objects. If instead I had found myself feeling, presumably like the client as a child, that I was not really being attended to but was valued by him mainly for the ways I enhanced his self-esteem (an equally possible outcome of the emotional atmosphere between us), then my countertransference would be considered concordant.

This process of unconscious induction of attitudes comparable to those assimilated in earliest infancy can sound rather mystical. But there are ways of looking at such phenomena that may make them more comprehensible. Consider that in the initial one to two years of life, most communication between infant and others is nonverbal.

People relating to babies figure out what they need largely on the basis of intuitive, emotional reactions. Nonverbal communication can be remarkably powerful, as anyone who has ever taken care of a newborn, or been moved to tears by a melody, or fallen inexplicably in love can testify. Analytic theory assumes that we draw on our early infantile knowledge in all the realms of making contact that both predate and transcend the formal, logical interactions we find easy to put into words. The phenomenon of *parallel process* (Ekstein & Wallerstein, 1958), which draws from the same emotional and preverbal sources, has been extensively documented in the clinical literature on supervision.

This transformation of countertransference from obstacle to asset is one of the most significant contributions of object relations theory (see Ehrenberg, 1992). Over time, countertransference information has also become increasingly recognized as critical to an accurate assessment of personality structure. The diagnostic use of the interviewer's emotional responses to the client has not been stressed in most textbooks on diagnosis (with the pioneering exception of MacKinnon & Michels, 1971); there is still some squeamishness in the field about acknowledging the extent to which an attunement to "irrational" countertransference reactions should inform diagnosis. It is an aspect of assessment that I have tried to give its deserved amount of attention here.

SELF PSYCHOLOGY

Theory not only influences practice, it is also influenced by it. When enough therapists come up against aspects of psychology that do not seem to be adequately addressed by prevailing models, the time is ripe for a paradigm shift (Kuhn, 1970; Spence, 1987). By the 1960s, practitioners were reporting that their patients' problems were not always well described in the language of any of the then current analytic models; that is, the central complaints of many people seeking treatment were not reducible to either a problem managing an instinctual urge and its inhibitors (drive theory), or to the inflexible operation of particular defenses against anxiety (ego psychology), or to the activation of internal objects from which the patient had inadequately differentiated (object relations theory). Such processes might be inferable, but they lacked both the economy of explanation and the extent of explanatory power one would want from a good theory.

Rather than seeming full of stormy, primitive introjects, as object relations theory described so well, these people reported feeling

empty—devoid of internal objects rather than beleaguered by them. They lacked a sense of inner direction and dependable, orienting values, and they came to therapy to find some meaning in life. On the surface, they might look very self-assured, but internally they were in a constant search for reassurance that they were acceptable or admirable or valuable. Even among clients whose reported problems lay elsewhere, a sense of inner confusion about self-esteem and basic values could be discerned.

With their chronic need for mirroring from outside sources, such patients were regarded by analytically oriented people as essentially narcissistic, even when they did not fit the stereotype of the "phallic" narcissistic character (arrogant, vain, charming) that Reich had delineated. They induced a countertransference noteworthy not for its intensity, but for its boredom, impatience, and sense of vague irritation and futility in the interviewer. People treating such clients reported that they felt insignificant, invisible, and either devalued or overvalued by them. They could not feel appreciated as a real other person trying to help, but instead seemed to be regarded as a replaceable source of their clients' emotional inflation or deflation.

The disturbance of such people seemed to center in their sense of who they were, what their values were, and what maintained their self-esteem. They would sometimes say they did not know who they were or what really mattered to them, beyond getting reassured that they mattered. They often did not appear flagrantly "sick" from a traditional standpoint (they had impulse control, ego strength, interpersonal stability, etc.), but they nevertheless felt little pleasure in their lives and in who they were. Some analytic practitioners considered them untreatable, since it is a much more monumental task to help someone develop a self than it is to help him or her repair or reorient one that already exists. Others worked at finding new constructs through which these patients' suffering could be better conceptualized and hence more sensitively treated. Some stayed within existing psychodynamic models to do so (e.g., Erikson and Rollo May within ego psychology, Kernberg and Masterson within object relations); others went elsewhere. Carl Rogers (1951, 1961) went outside the psychoanalytic tradition altogether to develop a theory and therapy that made affirmation of the client's developing self and self-esteem its hallmark.

Within psychoanalysis, Heinz Kohut formulated a new theory of the self: of its development, possible distortion, and treatment. He emphasized processes like the normal need to idealize and the implications for adult psychopathology when one grows up without objects that can be initially idealized and then gradually and nontraumatically deidealized. Kohut's contributions (e.g., 1971, 1977, 1984) proved

valuable not only to those who were looking for new ways to understand and help narcissistically impaired clients; they also furthered a general reorientation toward thinking about people in terms of self-structures, self-representations, self-images, and how one comes to depend on internal processes for self-esteem. An appreciation of the emptiness and pain of those without a reliable superego began to coexist with the compassion that analysts already felt for those whose superegos were excessively strict.

Kohut's work, its influence on other writers (e.g., Alice Miller, Robert Stolorow, George Atwood, Arnold Goldberg, Sheldon Bach, Paul and Anna Ornstein, Ernest Wolf), and the general tone it set for rethinking psychological issues had important diagnostic implications—despite the fact that among many self psychologists, as noted earlier, the traditional assessment–interview process is viewed with suspicion. This new way of conceptualizing clinical material added to analytic theory the language of self and encouraged evaluators to try to understand the dimension of self-experiences in people. Therapists began observing that even in patients not notable for their overall narcissism, one could see the operation of processes oriented toward supporting self-esteem, self-cohesion, and a sense of self-continuity—functions that had not been stressed in most earlier literature. Defenses were reconceptualized as existing not only to protect a person from anxiety about id, ego, and superego dangers but also to sustain a consistent, positively valued sense of self (Goldberg, 1990a). Interviewers could understand patients more completely by asking, in addition to the traditional questions about defense ("Of what is this person afraid? When afraid, what does this person do?" [Waelder, 1960]), "How vulnerable is this person's self-esteem? When it is threatened, what does he or she do?"

A clinical example may show why this addition to theory is useful. Two persons may be clinically depressed, with virtually identical vegetative signs (sleep problems, appetite disturbance, tearfulness, psychomotor retardation, etc.), yet have radically disparate subjective experiences. One is a man who feels *bad*, in the sense of morally deficient or evil. He is contemplating suicide because he believes that his existence only aggravates the problems of the world and that he would be doing the planet a favor by removing his corrupting influence from it. The other is a man who feels not morally bad but internally *empty*, defective, ugly. He also is considering suicide, not to improve the world, but because he sees no point in living. The former feels a piercing guilt, the latter a diffuse shame (cf. Blatt, 1974). In object relations terms, the first man is too full of internalized others telling him he is

bad; the second is too empty of internalizations that could give him any direction.

The diagnostic discrimination between the former kind of depression, once referred to in the psychoanalytic literature as "melancholia," and the second, a more narcissistically depleted state of mind, is a critical one for very practical reasons. The first kind of depressive client will not respond well to an overtly sympathetic, supportive tone in the interviewer; he will feel misunderstood as a person more deserving than *he* knows he really is, and he will get more depressed. The second kind of depressive man will be greatly relieved by the therapist's direct expression of concern and support; his emptiness will be temporarily filled, and the agony of his shame will be mitigated. I will have more to say about these kinds of discriminations later, but the point at hand is that the appearance of self psychology and its categories of analysis has had significant diagnostic value.

OTHER PSYCHOANALYTIC CONTRIBUTIONS TO PERSONALITY ASSESSMENT

In addition to drive, ego psychology, object relations, and self orientations, there are several other theories within a broad psychoanalytic framework that have affected our conceptualizations of character. They include, but are not limited to, the ideas of Jung, Adler, and Rank; the "personology" of Murray; the "modern psychoanalysis" of Spotnitz; the "transactional analysis" of Berne; the "script theory" of Tomkins; the "control–mastery" theory of Sampson and Weiss; and the evolutionary biology model of Slavin and Kriegman (1990). Many therapists draw from these perspectives as well as from the more general ones depicted above. I shall occasionally refer to some of these paradigms in subsequent chapters. By the time this book sees print, there will no doubt be an application of chaos theory to the field, providing another useful set of images and constructs to illuminate personality development, structure, function, and malfunction.

In concluding this chapter, I want to stress the importance of dynamic processes in character. Psychoanalytic theories emphasize dynamisms, not traits. It is the appreciation of oscillating patterns that makes analytic notions of character richer and more clinically germane than the lists of static attributes one finds in most assessment instruments and in compendia like the DSM. People become organized on *dimensions* that have significance for them, and they typically show characteristics expressing both polarities of any salient dimension.

Philip Slater (1970) captured this idea succinctly in a footnote commentary on contemporary literary criticism and biography:

> Generations of humanists have excited themselves and their readers by showing "contradictions" and "paradoxes" in some real or fictional person's character, simply because a trait and its opposite coexisted in the same person. But in fact traits and their opposites always coexist if the traits are of any intensity, and the whole tradition of cleverly ferreting out paradoxes of character depends upon the psychological naivete of the reader for its impact. (pp. 3n–4n)

Thus, people with conflicts about closeness can get upset by both closeness and distance. People who crave success the most hungrily are often the ones who sabotage it the most wrecklessly. The manic person is psychologically more similar to the depressive than to the schizoid individual; a compulsively promiscuous man has more in common with someone who resolved a sexual conflict by celibacy than with someone for whom sexuality is not problematic. People are complicated, but their intricacies are not random. Analytic theories offer us ways of helping our clients to make sense out of seemingly inexplicable ironies and absurdities in their lives, and to transform their vulnerabilites into strengths.

SUMMARY

I have briefly described the major current paradigms within psychoanalysis: drive theory, ego psychology, object relations theory, and self psychology approaches to understanding people. Their respective implications for conceptualizing character were emphasized, with attention to the clinical inferences that can be drawn from seeing people through these different lenses. I also noted other influences on dynamic ideas about character structure and their associated therapeutic approaches. This review could only hit the highlights of over a hundred years of intellectual ferment, controversy, and theory development.

SUGGESTIONS FOR FURTHER READING

For those who have never read him, the best way to get a sense of Freud, and of nascent drive theory, is to peruse *The Interpretation of*

Dreams (1900), skipping over the parts where he addresses contemporary controversies or develops grand metaphysical schemes. His "Outline of Psychoanalysis" (1938) gives a synopsis of his later theory, but I find it too condensed and dry; *Freud and Man's Soul* (Bettelheim, 1983) is a good corrective. Brenner's (1955) *An Elementary Textbook of Psychoanalysis* is comprehensive but authoritarian to the contemporary ear; I prefer Hall (1954).

Several more recent books give historical reviews of psychoanalytic clinical theory. The Blancks' (G. Blanck & R. Blanck, 1974) *Ego Psychology: Theory and Practice* has a particularly good one. Guntrip's (1971) *Psychoanalytic Theory, Therapy, and the Self*, a model of psychoanalytic humanitarianism, puts object relations theory in context, as does Symington's (1986) well-written study. Hughes (1989) has gracefully explicated Klein, Winnicott, and Fairbairn. Fromm-Reichmann (1950) and Levenson (1972) are excellent spokespeople for the American interpersonalists. Greenberg and Mitchell (1983) discerningly contrast drive–conflict models and relational ones.

For self psychological sources, Kohut's (1971) *The Analysis of the Self* is almost impenetrable to beginners, but *The Restoration of the Self* (1977) is easier going. Chessick's (1985) review and critical interpretation of the self psychology movement is quite helpful. Stolorow and Atwood's (1992) *Contexts of Being* is a readable introduction to the intersubjective view.

For an introduction to control–mastery theory, consider *How Psychotherapy Works* by Joseph Weiss (1993). The most concise and clear recent review of developments in psychoanalytic personality theory is probably Westen's (1990) essay in the *Handbook of Personality Theory and Research*. For integrationists, both of Fred Pine's recent books (1985, 1990) are outstanding.

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