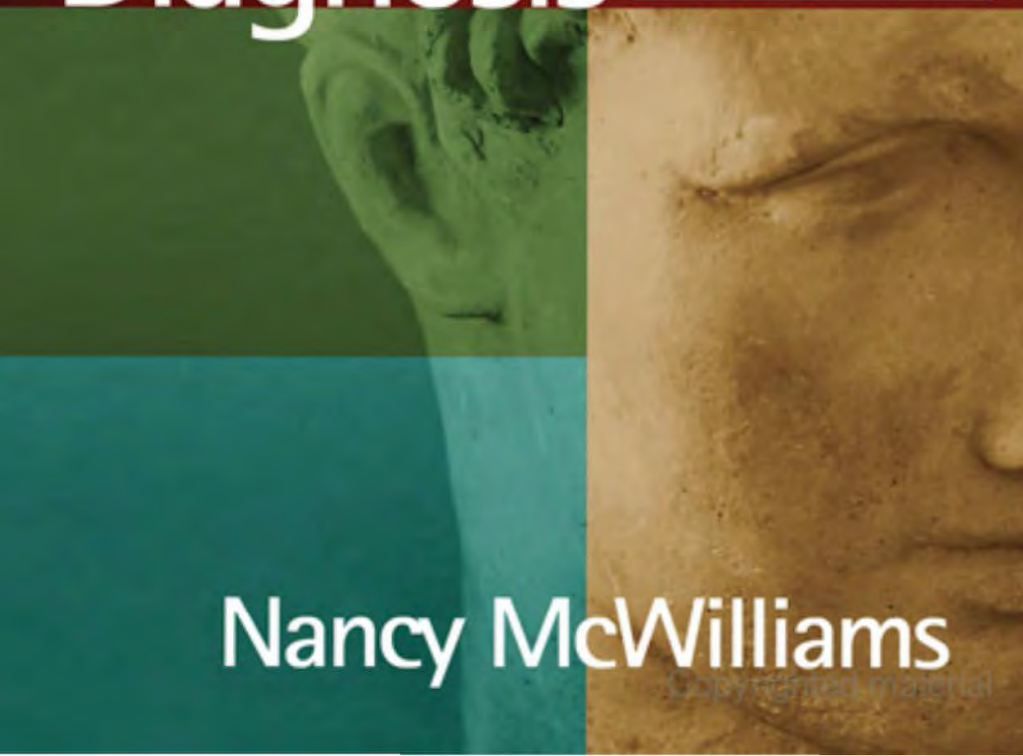
Understanding Personality Structure in the Clinical Process

Psychoanalytic Diagnosis

second edition



Nancy McWilliams

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In grateful memory
Howard Gordon Riley
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About the Author

Nancy McWilliams, PhD, teaches in the Graduate School of Applied and Professional Psychology at Rutgers, The State University of New Jersey, and has a private practice in Flemington, New Jersey. She is a former president of the Division of Psychoanalysis (39) of the American Psychological Association and is on the editorial board of *Psychoanalytic Psychology*. Dr. McWilliams's books have been translated into 14 languages, and she has lectured widely both nationally and internationally. She is a recipient of honors including the Rosalee Weiss Award for contributions to practice from the Division of Independent Practitioners of the American Psychological Association; Honorary Membership in the American Psychoanalytic Association; and the Robert S. Wallerstein Visiting Scholar Lectureship in Psychotherapy and Psychoanalysis at the University of California, San Francisco. A graduate of the National Psychological Association for Psychoanalysis, Dr. McWilliams is also affiliated with the Center for Psychoanalysis and Psychotherapy of New Jersey and the National Training Program of the National Institute for the Psychotherapies in New York City.

Preface

When I originally wrote *Psychoanalytic Diagnosis*, I knew from my experience as a teacher that students and early-career psychotherapists needed exposure to the inferential, dimensional, contextual, biopsychosocial kind of diagnosis that had preceded the era inaugurated by the 1980 publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) of the American Psychiatric Association. In particular, I wanted to keep alive the sensibility that represented decades of clinical experience and conversation, in which human beings have been seen as complex wholes rather than as collections of comorbid symptoms. I also saw how confusing it was, even to psychodynamically oriented students, to try to master the bewildering diversity of language, metaphor, and theoretical emphasis that comprises the psychoanalytic tradition. The need for a synthesis of the sprawling and contentious history of analytic theory, as it pertains to understanding one's individual patients, was evident.

In the early 1990s I was also nourishing a faint hope that the book would have some influence on mental health policy and on our culturally shared conception of psychotherapy, which were beginning to be transformed in disturbing ways. No such luck: The breadth and depth of change since then have been stunning. For a host of interacting reasons, psychodynamic—and even broadly humanistic (see Cain, 2010)—ways of understanding and treating people have become devalued, and the likelihood that a patient with significant character pathology, the hallmark of most psychodynamic treatment, will find genuine, lasting help in the mental health system has, in my view, plummeted. As the cognitive-behavioral movement continues to develop, some of its practitioners have

become as upset with these developments as analytic therapists have been; my CBT-oriented colleague Milton Spett recently complained (e-mail communication, May 28, 2010), in reaction to this trend, "We treat patients, not disorders."

Political and economic forces account for much of this change (see Mayes & Horwitz, 2005, for the political history of the paradigm shift in the area of mental illness "from broad, etiologically defined entities that were continuous with normality to symptom-based, categorical diseases" [p. 249]). At least in the United States, corporate interests—most notably those of insurance companies and the pharmaceutical industry—have sweepingly reshaped and thus redefined psychotherapy in line with their aims: maximized profits. In the service of short-term cost control, there has been a reversal of decades-long progress in helping individuals with complex personality problems—not because we lack skill in helping them, but because insurers, having marketed their managed-care plans to employers with the claim that they would provide "comprehensive" mental health coverage, later declined arbitrarily to cover Axis II conditions.

Meanwhile, drug companies have a substantial stake in construing psychological problems as discrete, reified illnesses so that they can market medications that treat each condition. Consequently, the emphasis is no longer on the deep healing of pervasive personal struggles, but on the circumscribed effort to change behaviors that interfere with smooth functioning in work or school. When I wrote the first edition of this book, I did not realize how much graver the prognosis for person-oriented (as opposed to symptom-oriented) therapy would become in the years after its publication (see McWilliams, 2005a, for a more detailed lament).

The climate in which therapists in my country currently practice is much more inclement than in 1994. Contemporary practitioners are besieged with suffering people who need intensive, long-term care (Can anyone convincingly argue that psychopathology is *decreasing* in the context of contemporary social, political, economic, and technological changes?). They may be expected to see patients every 2 weeks, or even less frequently, and to carry caseloads so large that genuine connection with and concern for one's individual clients is impossible. They are overwhelmed with paperwork, with efforts to justify even the most unambitious treatment to anonymous employees of insurance companies, with translating their efforts to help clients build agentic selves into slogans such as "progress on target behaviors." Official "diagnosis" under such pressures can often be cynical in spirit and thus in function, as clinicians label patients in ways that will permit insurance coverage and yet stigmatize them as little as possible.

Ironically, the current state of affairs makes it more rather than less important for psychotherapists to have a heuristic but scientifically enlightened sense of the overall psychology of each patient. If one wants to have a short-term impact, one had better have some expedited basis for predicting whether a person will react to a sympathetic comment with relief, with devaluation of the therapist, or with a devastating sense of not being understood. Hence, there is an even greater need now than in 1994 to reassert the value of personality diagnosis that is inferential, contextual, dimensional, and appreciative of the subjective experience of the patient. My role in developing the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006) attests to this concern, but in that document, what could be said about any type or level of personality organization was limited to a few paragraphs, whereas here I can elaborate more fully.

An indirect source of the widespread contemporary devaluation of the psychoanalytic tradition may be the expanding gulf between academics and therapists. Some degree of tension between these two groups has always existed, largely because of the different sensibilities of the individuals attracted to one role or the other. But the chasm has been greatly enlarged by increased pressures on academics to pursue grants and quickly amass research publications. Even those professors who would like to have a small practice would be foolish to do so in the current academic climate, especially while seeking tenure. As a result, few academics know what it feels like to work intensively with severely and/or complexly troubled individuals. The researcher–practitioner gulf has also been inadvertently widened by the growth of professional schools of psychology, where aspiring therapists have little opportunity for mutually enriching exchange with mentors involved in research.

One result of this wider fissure is that psychodynamic formulations of personality and psychopathology, which emerged more from clinical experience and naturalistic observation than from the laboratories of academic psychologists, have too often been portrayed to university students as archaic, irrelevant, and empirically discredited. Although decades of research on analytic concepts are typically ignored when current critics idealize specific evidence-based treatments—in their 1985 and 1996 books, Fisher and Greenberg reviewed over 2,500 such studies—the paucity of randomized controlled trials of open-ended psychodynamic therapy has cost us dearly. In addition, the arrogance of many analysts in the heyday of psychoanalysis, especially their belief that what they experienced with each patient was too idiosyncratic to be researchable, contributed to negative stereotypes held by nonclinical colleagues.

Even now, when some exemplary empirical work has shown the effectiveness of analytic treatments (e.g., Leichsenring & Rabung,

2008; Shedler, 2010), we are left with the self-defeating political legacy of many analysts' contempt for research on the analytic process. The increasing shaping of clinical psychology into a positivist "science," the cost-containment efforts by insurance companies, the economic interests of the pharmaceutical industry, and the dismissive reaction of some analysts to outcome research of any kind have generated the "perfect storm" leading to the devaluation of psychodynamic psychology and psychotherapy.

Contemporary misfortunes aside, there are additional spurs to the revision of this book. Since its original publication, cognitive and affective neuroscientists have begun to illuminate genetic, physiological, and chemical bases of psychological states. Research on infancy, especially on attachment, the conceptual baby of the psychoanalyst John Bowlby, has added new angles of vision to our understanding of the development of personality. The relational movement has inspired a significant paradigm shift within large sections of the psychoanalytic community. Cognitive and behavioral therapists, as their movement has matured and their practitioners have worked with more complex patients, are developing personality concepts that are remarkably similar to older psychoanalytic ones. And my own learning continues. I know more now about Sullivanian, neo-Kleinian, and Lacanian theories than I knew in 1994. I have had the benefit of critiques from teachers who have assigned *Psychoanalytic Diagnosis*, from the students they have taught, and from fellow practitioners who have read it. And I have had 20 more years of clinical experience since I first envisioned the book.

I was not entirely surprised by the success in North America of the first edition: I suspected as I was writing it that I was far from the only person who felt the lack of such a text for students of psychotherapy. But its international reception has astonished me, especially its warm welcome by therapists in countries as diverse as Romania, Korea, Denmark, Iran, Panama, China, New Zealand, and South Africa. Its popularity in my own country has brought me invitations to speak in unexpected mental health subcultures (e.g., to Air Force psychiatrists, evangelical pastoral counselors, prison psychologists, and addictions specialists), and its impact beyond North American borders has introduced me to therapists throughout the world, who have taught me about the personality dynamics they most commonly face. In Russia, it was suggested to me that the national character is masochistic; in Sweden, schizoid; in Poland, posttraumatic; in Australia, counterdependent; in Italy, hysterical. In Turkey, therapists working in traditional villages described patients who sound remarkably like the sexually inhibited women treated by Freud, a version of hysterical personality that has virtually disappeared from contemporary Western cultures. This exposure to psy-

chotherapy around the world has been a heady experience, one that I hope has enriched this revision.

At the urging of colleagues working in more traditional and collectivist cultures where emotional suffering is often expressed via the body (e.g., with Native American groups and in East and South Asian communities), I have expanded the section on somatization and suggested the utility of the concept of a personality type organized around that defense. I have revised my review of defenses, including somatizing, acting out, and sexualization with the more primary mechanisms. For reasons of length, and to avoid contributing to any tendency to pathologize people from cultures where somatization is normative, I decided against devoting a full chapter to somatizing personalities. Readers hoping to learn more about treating those who regularly and problematically become physically ill, and about others whose personalities are not covered here (e.g., sadistic and sadomasochistic, phobic and counterphobic, dependent and counterdependent, passive–aggressive, and chronically anxious people), will find help in the PDM.

In some parts of this second edition, I have changed very little, beyond trying to tighten up the writing, in observance of the principle "If it works, don't fix it." In others, there has been a more ambitious overhaul in light of new empirical findings and new theoretical perspectives. Psychoanalytic developmental observations have gone way beyond Mahler, and contemporary neuroscience has begun identifying clinically relevant brain processes that previously we could describe only metaphorically. Researchers in attachment have extended our understanding of relationship and have minted terms (e.g., "mentalization," "reflective functioning") that capture processes central to overall mental health. Neuroscientists have corrected some of our mistaken beliefs (e.g., that thought precedes affect or that memory of extreme trauma is retrievable [Solms & Turnbull, 2002]) and have greatly expanded our knowledge of temperament, drive, impulse, affect, and cognition. Some randomized controlled trials have been done on psychoanalytically informed treatments, and new meta-analyses have been conducted on existing studies.

I have retained, however, many references to older literature, both clinical and empirical. Personality by its nature is a fairly stable phenomenon, and there is a wealth of disciplined and useful observations about it from decades ago that I would rather honor than ignore. I have never shared the typically American assumption that the "newest" thing is self-evidently better than everything that came before it; in fact, given realistic pressures on current intellectuals, and given the narrowness of much professional training, it seems unlikely that current work can always be as thoughtful and far-reaching as that of writers who inhabited a less frantic, less driven era.

Acknowledgments

In the first edition of *Psychoanalytic Diagnosis*, I thanked my clients and virtually my entire community of colleagues. It is even truer now that this book is a product of a whole "climate of opinion" (to steal W. H. Auden's moving image of Freud). I emphasized in that volume that my organization of personality levels and types was not "my" taxonomy but my best effort at representing mainstream psychoanalytic ideas. At this point, given current controversies among analysts about whether diagnosis itself is valuable (the topic of a 2009 online colloquium of the International Association for Relational Psychoanalysis and Psychotherapy), I cannot presume to represent the diagnostic center of gravity of the psychoanalytic movement. And yet this book encompasses far more than my own thinking. For several years I have been asking practitioner audiences to e-mail me with criticisms of any statements in the first edition that do not fit their clinical experience. A great number of therapists, including many who practice in other countries and in settings very different from mine, have written to say that this conceptualization supports their own clinical experience. Some have taken me up on the invitation to criticize, and I have integrated many of their suggestions when rewriting various chapters.

Beyond those I named in 1994, there are too many people to enumerate here who have contributed to this revision. But I should single out Richard Chefetz, who spent many hours critiquing the chapter on dissociation and educating me about contemporary findings in traumatology. I am also grateful to Daniel Gaztembide (and to Brenna Bry, my department chair—a radical Skinnerian who appreciates psychoanalysis—who astutely assigned him to me as a "work-study" student). Dan-

iel sent me regular briefs about relevant research and theory. For his psychoanalytic wisdom and his fine ear for tone, I have depended, as always, on my friend Kerry Gordon. For his eagle eye in spotting typos, I thank Tim Paterson. Finally, for their friendship and candor, I want to acknowledge some colleagues who have influenced me in the years since the first edition: Neil Altman, Sandra Bem, Louis Berger, Ghislaine Boulanger, the late Stanley Greenspan, Judith Hyde, Deborah Luepnitz, William MacGillivray, David Pincus, Jan Resnick, Henry Seiden, Jonathan Shedler, Mark Siegert, Joyce Slochower, Robert Wallerstein, Bryant Welch, and Drew Westen. And thanks to the many unacknowledged others whose ideas have found their way into this book. My mistakes and misunderstandings are my own.

Contents

Introduction

Most of what follows is accumulated psychoanalytic wisdom. It is my own synthesis of that wisdom, however, and reflects my idiosyncratic conclusions, interpretations, and extrapolations. The organization of character possibilities along two axes, for example, which seems to me so clearly inferable from psychoanalytic theories and metaphors, may seem contrived to analysts who visualize the varieties of human personality in other images, along other spectra. I can only respond that this graphic depiction has been of value in my experiences acquainting relatively unprepared students with the welter of analytic concepts that have developed over more than a century.

The main object of this book is to enhance practice, not to resolve any of the conceptual and philosophical problems with which the psychoanalytic literature is replete. I am more interested in being pedagogically useful than in being indisputably "right." A recurrent emphasis in the chapters that follow concerns the relationship between psychodynamic formulations and the art of psychotherapy. Beyond conveying certain basic therapeutic attitudes, including curiosity, respect, compassion, devotion, integrity, and the willingness to admit mistakes and limitations (see McWilliams, 2004), I do not believe in teaching a particular "technique" in the absence of trying to understand the psychology of the person to whom one is applying the technique.

Readers may have encountered the argument that psychoanalytic ideas are irrelevant to the deeply distressed, to people with crushing reality challenges, to minorities, addicts, the poor, and others. If this book succeeds in conveying the richness and particularity of analyti-

cally informed therapies, it will correct that misconception, even though the two axes on which I organize diagnostic information comprise only some of what it is helpful to know about any client.

A COMMENT ON TERMINOLOGY

A strikingly cyclical effort to sanitize speech has contributed to widespread misunderstanding of the psychoanalytic tradition. Over time, whatever the original intentions of those people who coined any specific psychological term, labels for certain conditions ineluctably come to have a negative connotation. Language that was invented to be simply descriptive—in fact, invented to replace previous value-laden words—develops an evaluative cast and is applied, especially by lay people, in ways that pathologize. Certain topics seem inherently unsettling to human beings, and however carefully we try to talk about them in nonjudgmental language, the words we use to do so attain a pejorative tone over the years.

Today's "antisocial personality disorder," as a case in point, was in 1835 termed "moral insanity." Later it became "psychopathy," then "sociopathy." Each change was intended to give a descriptive, noncensorious label to a disturbing phenomenon. Yet the power of that phenomenon to disturb eventually contaminated each word that was invented to keep the concept out of the realm of moralization. Something similar occurred in the successive transformations of "inversion" to "deviation" to "homosexuality" to being "gay" to being "queer," and yet people who are bothered by same-sex erotics still use the terms "gay" and "queer" to devalue. It will probably happen with the shift from "retarded" to "developmentally challenged." Any phenomenon that tends to trouble people, for whatever reason, seems to instigate this futile chasing after nonstigmatizing language. It occurs with nonpsychological terms also; for example, it is endemic in controversies about political correctness. One outcome of this doomed project to sanitize language is that the older a psychological tradition is, the more negative, judgmental, and quaint its terminology sounds. The swift consumption, distortion, and prejudicial application of psychoanalytic terms, within the mental health professions and outside them, have been a bane of the psychodynamic tradition.

Paradoxically, another burden to the reputation of psychoanalysis has been its appeal. As concepts get popularized, they acquire not only judgmental meanings but also simplistic ones. I assume it would be hard for a reader who is new to psychoanalysis to come upon the adjective "masochistic," for instance, without reacting to the label as a judgment

that the person so depicted loves pain and suffering. Such a reaction is understandable but ignorant; the history of the psychoanalytic concept of masochism abounds with humane, insightful, useful, nonreductionistic observations about why some people repeatedly involve themselves in activities painful to them despite often heroic conscious efforts to do otherwise. The same can be said for many other terms that have been grabbed up by both nonanalytic clinicians and the literate public, and then bruited about with glib or condescending conviction about their meaning.

Concepts also get watered down as they come into common use. The term "trauma," as popularly used, has lost its catastrophic overtones and can frequently be heard meaning "discomfort" or "injury." "Depression" has come to be indistinguishable from brief periods of the blues (Horowitz & Wakefield, 2007). The term "panic disorder" had to be invented in order to restore to our ear the connotations of the older, perfectly useful phrases "anxiety neurosis" and "anxiety attack" once the word "anxiety" had been applied to everything from how one feels at a business lunch to how one would feel in front of a firing squad.

Given all this, I have struggled over how to present some of the material in this book. On a personal level, I try to observe the current preferences of groups as to how they should be identified and to respect the sensibilities of patients who object to certain diagnostic labels. Where current DSM terminology has become the norm for discussing a particular phenomenon, I use it unless it obscures older, richer concepts. But at a scholarly level, it seems an exercise in futility to continue to rename things rather than to use their existing names. Substituting "self-defeating" for "masochistic" or "histrionic" for "hysterical" may be preferred by those who want to avoid terms that contain psychodynamic assumptions, but such changes make less sense for those of us who think analytically and assume the operation of unconscious processes in character formation.

My somewhat ambivalent conclusion about the language to be used in this book has been to employ mostly traditional psychoanalytic nomenclature, alternating occasionally, in the hope of reducing the clanking weight of professional jargon, with more recent, roughly equivalent terms. Since I am trying to raise the consciousness of my audience about the rationale for each label that has come to denote a character attribute, I will generally rely on familiar psychoanalytic language and try to make it user-friendly. To the reader without a psychodynamic background, this may lend an anachronistic or even inferred judgmental tone to the text, but I can only ask such a person to try to suspend criticism temporarily and give the analytic tradition the benefit of the doubt while trying to consider the possible utility of the concepts covered.

A COMMENT ON TONE

Nearly everything one can say about individual character patterns and meanings, even in the context of accepting a general psychoanalytic approach, is disputable. Many concepts central to analytic thinking have not only not been systematically researched and validated, they are inherently so resistant to being operationalized and manipulated that it is difficult to imagine how they even could be empirically tested (see Fisher & Greenberg, 1985). Many scholars prefer to place psychoanalysis within the hermeneutic rather than the scientific tradition, partly because of this resistance of much of the subject matter to investigation by the scientific method as it has come to be defined by many contemporary academic psychologists.

I have erred in the direction of oversimplifying rather than obfuscating, of stating some ideas in a more sweeping way than many thoughtful professionals would consider warranted. This text is aimed at beginning practitioners, and I have no wish to increase the anxiety that inevitably suffuses the process of becoming a therapist by introducing endless complexity. In this second edition, however, in light of recent concern in the field about essentialism and absolutistic pronouncement, I have tried to tame any tendencies toward universalizing. All of us learn soon enough, from the unpredictable nuances of each therapy relationship into which we extend ourselves, how pale are even our most elegant and satisfying formulations next to the mystery that is human nature. Hence, I trust and encourage my readers to outgrow my constructions.

Part I

CONCEPTUAL ISSUES

INTRODUCTION TO PART I

The following six chapters contain a rationale for character diagnosis, a review of some major psychoanalytic theories and their respective contributions to models of personality structure, an exploration of individual differences that have been widely understood as embodying different maturational challenges, commentary on the therapeutic implications of such issues, and an exposition of defenses as they relate to character structure. Together these chapters provide a way of thinking about the consistencies in an individual that we think of as his or her personality.

This section culminates in the representation of diagnostic possibilities along a biaxial grid. Although this schema, like any attempt to generalize, is both arbitrary and oversimplified, I have found it useful in introducing therapists to central dynamic formulations and their clinical value. I believe that this way of construing personality is implicit in much of the psychoanalytic literature. Occasionally, a similar formulation has been explicit (e.g., M. H. Stone, 1980, who also included an axis for genetic tendencies). Other analysts have provided other visual representations of diagnostic possibilities (e.g., Blanck & Blanck, 1974, pp. 114–117; Greenspan, 1981, pp. 234–237; Horner, 1990, p. 23; Kernberg, 1984, p. 29; Kohut, 1971, p. 9).

Especially in the past two decades, researchers studying infants, patterns of relationship, trauma, and neuroscience have inspired new ways of thinking about personality differences. My diagram can incorporate

many of their findings, but some conceptualizations emerging from contemporary empirical studies represent significantly different angles of vision. My aim is not to dispute other organizations of developmental, structural, and temperamental concepts but to offer a synthesized and streamlined image for newcomers to this confusing field.

1

Why Diagnose?

For many people, including some therapists, "diagnosis" is a dirty word. We have all seen the misuse of psychodiagnostic formulations: The complex person gets flippantly oversimplified by the interviewer who is anxious about uncertainty; the anguished person gets linguistically distanced by the clinician who cannot bear to feel the pain; the troublesome person gets punished with a pathologizing label. Racism, sexism, heterosexism, classism, and numerous other prejudices can be (and have often been) handily fortified by nosology. Currently in the United States, where insurance companies allot specific numbers of sessions for specific diagnostic categories, often in defiance of a therapist's judgment, the assessment process is especially subject to corruption.

One objection to diagnosing is the view that diagnostic terms are inevitably pejorative. Paul Wachtel (personal communication, March 14, 2009) recently referred to diagnoses, for example, as "insults with a fancy pedigree." Jane Hall writes that "labels are for clothes, not people" (1998, p. 46). Seasoned therapists often make such comments, but I suspect that in their own training it was helpful for them to have language that generalized about individual differences and their implications for treatment. Once one has learned to see clinical patterns that have been observed for decades, one can throw away the book and savor individual uniqueness. Diagnostic terms can be used objectifyingly and insultingly, but if I succeed in conveying individual differences respectfully, readers will not recruit diagnostic terms in the service of feeling superior to others. Instead, they will have a rudimentary language for mentalizing

different subjective possibilities, a critical aspect of both personal and professional growth.

The abuse of diagnostic language is easily demonstrated. That something can be abused, however, is not a legitimate argument for discarding it. All kinds of evil can be wreaked in the name of worthy ideals—love, patriotism, Christianity, whatever—through no fault of the original vision but because of its perversion. The important question is, Does the careful, nonabusive application of psychodiagnostic concepts increase a client's chances of being helped?

There are at least five interrelated advantages of the diagnostic enterprise when pursued sensitively and with adequate training: (1) its usefulness for treatment planning, (2) its implications for prognosis, (3) its contribution to protecting consumers of mental health services, (4) its value in enabling the therapist to convey empathy, and (5) its role in reducing the probability that certain easily frightened people will flee from treatment. In addition, there are fringe benefits to the diagnostic process that indirectly facilitate therapy.

By the diagnostic process, I mean that except in crises, the initial sessions with a client should be spent gathering extensive objective and subjective information. My own habit (see McWilliams, 1999) is to devote the first meeting with a patient to the details of the presenting problem and its background. At the end of that session I check on the person's comfort with the prospect of our working together. Then I explain that I can understand more fully if I can see the problem in a broader context, and I get agreement to take a complete history during our next meeting. In that session I reiterate that I will be asking lots of questions, request permission to take confidential notes, and say that the client is free not to answer any question that feels uncomfortable (this rarely happens, but people seem to appreciate the comment).

I am unconvinced by the argument that simply allowing a relationship to develop will create a climate of trust in which all pertinent material will eventually surface. Once the patient feels close to the therapist, it may become harder, not easier, for him or her to bring up certain aspects of personal history or behavior. Alcoholics Anonymous (AA) meetings are full of people who spent years in therapy, or consulted a bevy of professionals, without ever having been asked about substance use. For those who associate a diagnostic session with images of authoritarianism and holier-than-thou detachment, let me stress that there is no reason an in-depth interview cannot be conducted in an atmosphere of sincere respect and egalitarianism (cf. Hite, 1996). Patients are usually grateful for professional thoroughness. One woman I interviewed who had seen several previous therapists remarked "No one has ever been this interested in me!"

PSYCHOANALYTIC DIAGNOSIS VERSUS DESCRIPTIVE PSYCHIATRIC DIAGNOSIS

Even more than when I wrote the first edition of this book, psychiatric descriptive diagnosis, the basis of the DSM and ICD systems, has become normative—so much so that the DSM is regularly dubbed the ("bible" of mental health, and students are trained in it as if it possesses some self-evident epistemic status. Although inferential/contextual/dimensional/subjectively attuned diagnosis can coexist with descriptive psychiatric diagnosis (Gabbard, 2005; PDM Task Force, 2006), the kind of assessment described in this book has become more the exception than the rule. I view this state of affairs with alarm. Let me mention briefly, with reference to the DSM, my reservations about descriptive and categorical diagnosis. Some of these may be quieted when DSM-5 appears, but I expect that the overall consequences of our having deferred to a categorical, trait-based taxonomy since 1980 will persist for some time.

First, the DSM lacks an implicit definition of mental health or emotional wellness. Psychoanalytic clinical experience, in contrast, assumes that beyond helping patients to change problematic behaviors and mental states, therapists try to help them to accept themselves with their limitations and to improve their overall resiliency, sense of agency, tolerance of a wide range of thoughts and affects, self-continuity, realistic self-esteem, capacity for intimacy, moral sensibilities, and awareness of others as having separate subjectivities. Because people who lack these capacities cannot yet imagine them, such patients rarely complain about their absence; they just want to feel better. They may come for treatment complaining of a specific Axis I disorder, but their problems may go far beyond those symptoms.

Second, despite the fact that a sincere effort to increase validity and reliability inspired those editions, the validity and reliability of the post-1980 DSMs have been disappointing (see Herzig & Licht, 2006). The attempt to redefine psychopathology in ways that facilitate some kinds of research has inadvertently produced descriptions of clinical syndromes that are artificially discrete and fail to capture patients' complex experiences. While the effort to expunge the psychoanalytic bias that pervaded DSM-II is understandable now that other powerful ways to conceptualize psychopathology exist, the deemphasis on the client's subjective experience of symptoms has produced a flat, experience-distant version of mental suffering that represents clinical phenomena about as well as the description of the key, tempo, and length of a musical composition represents the music itself. This critique applies especially to the personality disorders section of the DSM, but it also applies to its treatment of experiences such as anxiety and depression, the diagnosis

of which involves externally observable phenomena such as racing heartbeat or changes in eating and sleeping patterns rather than whether the anxiety is about separation or annihilation, or the depression is anaclitic or introjective (Blatt, 2004)—aspects that are critical to clinical understanding and help.

Third, although the DSM system is often called a "medical model" of psychopathology, no physician would equate the remission of symptoms with the cure of disease. The reification of "disorder" categories, in defiance of much clinical experience, has had significant unintended negative consequences. The assumption that psychological problems are best viewed as discrete symptom syndromes has encouraged insurance firms and governments to specify the lowest common denominator of change and insist that this is all they will cover, even when it is clear that the presenting complaints are the tip of an emotional iceberg that will cause trouble in the future if ignored. The categorical approach has also benefited pharmaceutical companies, who have an interest in an ever-increasing list of discrete "disorders" for which they can market specific drugs.

Fourth, many of the decisions about what to include in post-1980 DSMs, and where to include it, seem in retrospect to have been arbitrary, inconsistent, and influenced by contributors' ties to pharmaceutical companies. For example, all phenomena involving mood were put in the Mood Disorders section, and the time-honored diagnosis of depressive personality disappeared. The result has been the misperception of many personality problems as discrete episodes of a mood disorder. Another example: If one reads carefully the DSM descriptions of some Axis I disorders that are seen as chronic and pervasive (e.g., generalized anxiety disorder, somataform disorder), it is not clear why these are not considered personality disorders.

Even when the rationale for including or excluding a condition is clear and defensible, the result can seem arbitrary from a clinician's perspective. From DSM-III on, a criterion for inclusion has been that there has to be research data on a given disorder. This sounds reasonable, but it has led to some strange results. While there was enough empirical research on dissociative personalities by 1980 to warrant the DSM category of multiple personality disorder, later renamed dissociative identity disorder, there was very little research on childhood dissociation. And so, despite the fact that there is wide agreement among clinicians who treat dissociative adults that one does not develop a dissociative identity without having had a dissociative disorder in childhood, there is (as I write this in 2010) no DSM diagnosis for dissociative children. In science, naturalistic observation typically precedes testable hypotheses. New psychopathologies (e.g., Internet addiction, especially to pornogra-

phy, a version of compulsivity unknown before technology permitted it) are observed by clinicians before they can be researched. The dismissal of clinical experience from significant influence on post-1980 editions of the DSM has created these kinds of dilemmas.

Finally, I want to comment on a subtle social effect of categorical diagnosis: It may contribute to a form of self-estrangement, a reification of self-states for which one implicitly disowns responsibility. "I have social phobia" is a more alienated, less self-inhabited way of saying "I am a painfully shy person." When its patent on Prozac expired, Eli Lilly put the same recipe into a pink pill, named it Serafem, and created a new "illness": premenstrual dysphoric disorder (PMDD) (Cosgrove, 2010). Many women become irritable when premenstrual, but it is one thing to say "I'm sorry I'm kind of cranky today; my period is due" and another to announce "I *have* PMDD." It seems to me that the former owns one's behavior, increases the likelihood of warm connection with others, and acknowledges that life is sometimes difficult, while the latter implies that one has a treatable ailment, distances others from one's experience, and supports an infantile belief that everything can be fixed. Maybe this is just my idiosyncratic perspective, but I find this inconspicuous shift in communal assumptions troubling.

TREATMENT PLANNING

Treatment planning is the traditional rationale for diagnosis. It assumes a parallel between psychotherapy and medical treatment, and in medicine the relationship between diagnosis and therapy is (ideally) straightforward. This parallel sometimes obtains in psychotherapy and sometimes does not. It is easy to see the value of a good diagnosis for conditions for which a specific, consensually endorsed treatment approach exists. Examples include the diagnosis of substance abuse (implication: make psychotherapy contingent on chemical detoxification and rehabilitation) and bipolar illness (implication: provide both individual therapy and medication).

Although a number of focused interventions for characterological problems have been developed over the past 15 years, the most common prescription for personality disorders is still long-term psychoanalytic therapy. But analytic treatments, including psychoanalysis, are not uniform procedures applied inflexibly regardless of the patient's personality. Even the most classical analyst will be more careful of boundaries with a hysterical patient, more pursuant of affect with an obsessive person, more tolerant of silence with a schizoid client. Efforts by a therapist to be empathic do not guarantee that what a particular client will experience

is empathy—one has to infer something about the person's individual psychology to know what can help him or her feel known and accepted. Advances in the understanding of people with psychotic disorders (e.g., Read, Mosher, & Bentall, 2004) and borderline conditions (e.g., Bateman & Fonagy, 2004; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Steiner, 1993) have led to treatment approaches that are not "classical analysis" but are rooted in psychodynamic ideas. To use them, one must first recognize one's client as recurrently struggling with psychotic or borderline states, respectively.

It is common for research purposes to define therapies, analytic and otherwise, as specific technical procedures. Therapists themselves, in contrast, may define what they do as offering opportunities for intimate new emotional learning in which "technique" is secondary to the healing potential of the relationship itself. Analytic therapies are not monolithic activities foisted in a procrustean way on everyone. A good diagnostic formulation will inform the therapist's choices in the crucial areas of style of relatedness, tone of interventions, and topics of initial focus. With the increased practice of cognitive-behavioral therapies (CBT), we are starting to see approaches to working with serious disturbances of personality that have been developed by practitioners of that orientation (e.g., Linehan, 1993; Young, Klosko, & Weishaar, 2003). In response to their own clinical experiences with individuality and complexity, CBT clinicians are now writing about case formulation (e.g., Persons, 2008) for largely the same reasons I did. I hope this book will be useful to them, as well as to my psychoanalytic colleagues.

PROGNOSTIC IMPLICATIONS

The practitioner who expects from a patient with an obsessive character the same rate of progress achievable with a person who suddenly developed an intrusive obsession is risking a painful fall. An appreciation of differences in depth and extensivity of personality problems benefits the clinician as well as the patient. DSM categories sometimes contain implications about the gravity and eventual prognosis of a particular condition—the organization of information along axes was a move in this direction—but sometimes they simply allow for consensually accepted classification with no implicit information about what one can expect from the therapy process.

A main theme in this book is the futility of making a diagnosis based on the manifest problem alone. A phobia in someone with a depressive or narcissistic personality is a different phenomenon from a phobia in a characterologically phobic person. One reason psychodiagnosis has a

bad name in some quarters is that it has been done badly; people have simply attached a label to the patient's presenting complaint. It is also impossible to do good research on different diagnostic entities if they are being defined strictly by their manifest appearance. As with any computer analysis, if garbage goes in, garbage comes out.

A strength of the psychoanalytic tradition is its appreciation of the differences between a stress-related symptom and a problem inhering in personality. (This was not always true. Freud originally made few distinctions between characterologically hysterical individuals and people with other psychologies who had a hysterical reaction, or between what would now be considered an obsessive person at a borderline level of functioning and a person with an obsessional neurosis.) A bulimic woman who develops her eating disorder as a first-year college student and who recognizes her behavior as driven and self-destructive is a very different patient from a woman who has had binge–purge cycles since elementary school and who considers her behavior reasonable. Both would meet the DSM criteria for bulimia, but one could reasonably expect the first client to change her behavior within a few weeks, while a realistic goal for the second would be that after a year or so she would clearly see the costs of her eating disorder and the need for change.

CONSUMER PROTECTION

Conscientious diagnostic practices encourage ethical communication between practitioners and their potential clients, a kind of "truth in advertising." On the basis of a careful assessment, one can tell the patient something about what to expect and thereby avoid promising too much or giving glib misdirection. I have found that few people are upset upon being told, for example, that given their history and current challenges, psychotherapy can be expected to take a long time before yielding dependable, internally experienced change. Mostly seem encouraged that the therapist appreciates the depth of their problem and is willing to make a commitment to travel the distance. Margaret Little (1990) felt relief when an analyst to whom she had gone for a consultation commented to her, "But you're very ill!"

A recent patient of mine, a psychologically sophisticated man who had seen several people before me for what he considered severe obsessive tendencies, confronted me: "So you're the diagnosis maven; how do you have me categorized?" I took a deep breath and responded, "I guess what most hits me between the eyes is the degree of paranoia that you struggle with." "Thank God somebody finally got that," he responded. For those few clients who demand a miracle cure and lack the desire or

ability to make the commitment it would take to make genuine change, honest feedback about diagnosis allows them to withdraw gracefully and not waste their own time and the practitioner's looking for magic.

Therapists working under conditions in which only short-term therapy is possible can be tempted to believe, and to convey to their patients, that brief therapy is the treatment of choice. Short-term therapy is, in fact, sometimes preferable for genuinely therapeutic reasons, but therapists should resist the human tendency to make a virtue out of a necessity. A good assessment will give the interviewer information about how likely it is that a short-term approach will significantly help a particular person. It is honest, though painful to both parties, to admit to limitation. The alternative, to make oneself and/or the client believe that one can do effective treatment with anyone despite obvious external constraints, contributes to self-blame in both participants ("What's the matter with me that we haven't made the progress we're supposed to have made in six sessions?"). Converse clinical situations used to be common: In the era some call the golden age of psychoanalysis, many people stayed in therapy for years when they may have been better off at a drug treatment center or in a support group or with therapy and medication. A careful diagnostic evaluation reduces the likelihood that someone will spend inordinate time in a professional relationship from which he or she is deriving little benefit.

THE COMMUNICATION OF EMPATHY

The term "empathy" has been somewhat diluted by overuse. Still, there is no other word that connotes the "feeling with" rather than "feeling for" that constituted the original reason for distinguishing between empathy and sympathy (or "compassion," "pity," "concern," and similar terms that imply a degree of defensive distancing from the suffering person). "Empathy" is often misused to mean warm, accepting, sympathetic reactions to the client no matter what he or she is conveying emotionally. I use the term throughout this book in its literal sense of the capacity to feel emotionally something like what the other person is feeling.

My patients who are therapists themselves often express brutal self-criticism about their "lack of empathy" when they are having a hostile or frightened reaction to a client. They wish they did not feel such disturbing affects; it is unpleasant to acknowledge that therapeutic work can include primitive levels of hatred and misery that no one warned us about when we decided to go into the business of helping people. Clinicians in this condition may be actually suffering from high rather than low levels of empathy, for if they are really feeling *with* a patient, they

are feeling his or her hostility, terror, misery, and other wretched states of mind. Affects of people in therapy can be intensely negative, and they induce in others anything but a warm response. That one should try not to act on the basis of such emotional reactions is obvious even to a completely untrained person. What is less obvious is that such reactions are of great value. They may be critical to making a diagnosis that allows one to find a way to address a client's unhappiness that will be received as genuinely tuned in rather than as rote compassion, professionally dispensed regardless of the unique identity of the person in the other chair.

Someone who strikes an interviewer as manipulative, for example, may have, among other possibilities, an essentially hysterical character or a psychopathic personality. A therapeutic response would depend on the clinician's hypothesis. With a hysterically organized person, one might help by commenting on the client's feelings of fear and powerlessness. With the psychopathic person, one might instead convey a wry appreciation for the client's skills as a con artist. If the therapist has not gone beyond the "manipulative" label to a deeper inference, it is unlikely that he or she will be able to offer the client any deep hope of being understood. If one overgeneralizes—seeing all manipulative clients as hysterics, or, alternatively, as psychopaths—one will make therapeutic contact only part of the time. A person with hysterical dynamics may feel devastated to be misunderstood as executing a cynical power play when feeling desperately in need of comfort for the frightened child within; a psychopathic person will have nothing but contempt for the therapist who misses the centrality of a penchant for "getting over" on others.

Another instance of the value of diagnosis in enabling the therapist to convey empathy involves the common situation of a patient with a borderline personality organization contacting an emergency service with a threat of suicide. Emergency mental health workers are ordinarily trained in a generic crisis-intervention model (ask about the plan, the means, and their lethality), and that model usually serves them well. Yet people with borderline psychologies tend to talk suicide not when they want to die but when they are feeling what Masterson (1976) aptly called "abandonment depression." They need to counteract their panic and despair with the sense that someone cares about how bad they feel. Often, they learned growing up that no one pays attention to your feelings unless you are threatening mayhem. Assessment of suicidal intent only exasperates them, since the interviewer is, in terms of the patients' not-very-conscious subjective experience, distracted by the *content* of their threat when they feel desperate to talk about its *context.*

A clinician's effort to follow standard crisis-intervention procedures without a diagnostic sensibility can be countertherapeutic, even danger-

ous, since it can frustrate borderline patients to the point of feeling that to be heard, they must demonstrate rather than discuss suicidal feelings. It also leaves the therapist hating the client, since the person seems to be asking for help and then rejecting the helper's earnest efforts to give it (Frank et al., 1952). Emergency workers trained in identifying borderline clients become adept at responding to the painful affects behind the suicidal threat rather than doing an immediate suicide inventory; paradoxically, they probably prevent more self-destructive acts than colleagues who automatically evaluate suicidality. They may also have fewer demoralizing experiences of hating clients for "not cooperating" or "not being truthful."

FORESTALLING FLIGHTS FROM TREATMENT

A related issue involves keeping the skittish patient in treatment. Many people seek out professional help and then become frightened that attachment to the therapist represents a grave danger. Those with hypomanic personalities, for example, because early experiences of depending on others came out disastrously, tend to bolt from relationships as soon as the therapist's warmth stimulates their dependent longings. Counterdependent people, whose self-esteem requires denial of their need for care, may also rationalize running from treatment when an attachment forms, because they feel humiliated when implicitly acknowledging the emotional importance of another person. Experienced interviewers may know by the end of an initial meeting whether they are dealing with someone whose character presses for flight. It can be reassuring to hypomanic or counterdependent patients for the therapist to note how hard it may be for them to find the courage to stay in therapy. The statement rings true, and it also increases the probability that they can resist temptations to flee.

FRINGE BENEFITS

People are more comfortable when they sense that their interviewer is at ease. A therapeutic relationship is likely to get off to a good start if the client feels the clinician's curiosity, relative lack of anxiety, and conviction that the appropriate treatment can begin once the patient is better understood. A therapist who feels pressure to begin *doing therapy* before having come to a good provisional understanding of the patient's personal psychology is, like a driver with some sense of direction but no road map, going to suffer needless anxiety. (Of course, one *is* doing therapy

during a diagnostic evaluation; the process itself contributes to a working alliance without which treatment is an empty ritual. But the formal agreement about how the parties will proceed, and what the boundaries and respective responsibilities of the participants will be, should derive from a diagnostic formulation.) The patient will feel the anxiety and will wonder about the practitioner's competence. This self-replicating cycle can lead to all sorts of basically iatrogenic problems.

The diagnostic process also gives both participants something to do before the client feels safe enough to open up spontaneously without the comforting structure of being questioned. Therapists may underestimate the importance of this settling-in process, during which they may learn things that will become hard for the patient to expose later in treatment. Most adults can answer questions about their sexual practices or eating patterns or substance use with relative frankness when talking to someone who is still a stranger, but once the therapist has started to feel familiar and intimate (perhaps like one's mother) the words flow anything but easily. When a parental transference has heated up, the client may be encouraged to push on by remembering that in an early meeting with this person whose condemnation is now feared, all kinds of intimate matters were shared without incurring shock or disapproval. The patient's contrasting experiences of the therapist during the diagnostic phase and later phases of treatment calls attention to the fact that the transference *is* a transference (i.e., not a fully accurate or complete reading of the therapist's personality), an insight that may eventually be crucial to the person's understanding of what he or she typically projects into relationships.

One source of some therapists' discomfort with diagnosis may be fear of misdiagnosis. Fortunately, an initial formulation does not have to be "right" to provide many of the benefits mentioned here. A diagnostic hypothesis has a way of grounding the interviewer in a focused, low-anxiety activity whether or not it turns out to be supported by later clinical evidence. Given human complexity and professional fallibility, formulation is always tentative and should be acknowledged as such. Patients are often grateful for the clinician's avoidance of pretension and demonstration of care in considering different possibilities.

Finally, a positive side effect of diagnosis is its role in maintaining the therapist's self-esteem. Among the occupational hazards of a therapeutic career are feelings of fraudulence, worries about treatment failures, and burnout. These processes are greatly accelerated by unrealistic expectations. Practitioner demoralization and emotional withdrawal have far-reaching implications both for affected clinicians and for those who have come to depend on them. If one knows that one's depressed patient has a borderline rather than a neurotic-level personality struc-

ture, one will not be surprised if during the second year of treatment he or she makes a suicide gesture. Once borderline clients start to have real hope of change, they often panic and flirt with suicide in an effort to protect themselves from the devastation they would feel if they let themselves hope and then were traumatically disappointed. Issues surrounding this kind of crisis can be discussed and mastered (e.g., in terms of the felt dangers of hope and disappointment just mentioned, guilt toward original love objects over the transfer of emotional investment from them to the therapist, and related magical fantasies that one can expiate such guilt by a ritual attempt to die), providing emotional relief to both client and therapist.

I have seen many gifted, devoted therapists lose confidence and find rationalizations for getting rid of an ostensibly suicidal patient at precisely the moment when the person is expressing, in an identifiably provocative borderline way, how important and effective the treatment is becoming. Typically, in the session preceding the suicide gesture the patient expressed trust or hope for the first time, and the therapist became excited after so much arduous work with a difficult, oppositional client. Then with the parasuicidal behavior the therapist's own hopes crumble. The former excitement is reframed as illusory and self-serving, and the patient's self-destructive act is taken as evidence that the therapeutic prospects are nil after all. Recriminations abound: "Maybe my Psych 101 teacher was right that psychoanalytic therapy is a waste of time." "Maybe I should transfer this person to a therapist of the other gender." "Maybe I should ask a biologically oriented psychiatrist to take over the case." "Maybe I should transfer the patient to the Chronic Group." Therapists, whose personalities are often rather depressive (Hyde, 2009), are quick to turn any apparent setback into self-censure. Sufficient diagnostic facility can make a dent in this propensity, allowing realistic hope to prevail and keeping one in the clinical trenches.

LIMITS TO THE UTILITY OF DIAGNOSIS

As a person who does predominantly long-term, open-ended therapy, I find that careful assessment is most important at two points: (1) at the beginning of treatment, for the reasons given above; and (2) at times of crisis or stalemate, when a rethinking of the kind of dynamics I face may hold the key to effective changes in focus. Once I have a good feel for a person, and the work is going well, I stop thinking diagnostically and simply immerse myself in the unique relationship that unfolds between me and the client. If I find myself preoccupied with issues of diagnosis in an ongoing way, I suspect myself of defending against being fully present

with the patient's pain. Diagnosis can, like anything else, be used as a defense against anxiety about the unknown.

Finally, I should mention that people exist for whom the existing developmental and typological categories of personality are at best a poor fit. When any label obscures more than it illuminates, the practitioner is better off discarding it and relying on common sense and human decency, like the lost sailor who throws away a useless navigational chart and reverts to orienting by a few familiar stars. And even when a diagnostic formulation is a good match to a particular patient, there are such wide disparities among people on dimensions other than their level of organization and defensive style that empathy and healing may be best pursued via attunement to some of these. A deeply religious person of any personality type will need first for the therapist to demonstrate respect for his or her depth of conviction (see Lovinger, 1984); diagnosis-influenced interventions may be of value, but only secondarily. Similarly, it is sometimes more important, at least in the early phases of therapeutic engagement, to consider the emotional implications of someone's age, race, ethnicity, class background, physical disability, political attitudes, or sexual orientation than it is to appreciate that client's personality type.

Diagnosis should not be applied beyond its usefulness. 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 even our most thoughtful 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.

SUGGESTIONS FOR FURTHER READING

My favorite book on interviewing, mostly because of its tone, remains Harry Stack Sullivan's *The Psychiatric Interview* (1954). 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 was greatly influenced by the work of MacKinnon and Michels (1971), whose basic premises are similar to the ones informing this text. They finally issued, with Buckley, a revised edition of their classic tome in 2006 (now available in paperback). In *Psychodynamic Psychiatry in Clinical Practice*, Glen Gabbard (2005) has masterfully integrated dynamic and structural diagnosis with the DSM. For a well-written synthesis of empirical work on personality, applied to the area

of clinical practice, I recommend Jefferson Singer's *Personality and Psychotherapy* (2005).

Kernberg's *Severe Personality Disorders* (1984) contains a short but comprehensive section on the structural interview. Most beginning therapists find Kernberg hard to read, but his writing here is pellucid. My own book on case formulation (McWilliams, 1999) complements this volume by systematically considering aspects of clinical assessment other than level and type of personality organization, and my later book on psychotherapy (McWilliams, 2004) reviews the sensibilities that underlie psychoanalytic approaches to helping people. Mary Beth Peebles-Kleiger's *Beginnings* (2002), similarly based on long clinical experience, is excellent. So is Tracy Eells's (2007) more research-based text on formulation. For an empirical measure of inner capacities of the whole person that therapists need to evaluate, consider the Shedler–Westen Assessment Procedure (SWAP) (Shedler & Westen, 2010; Westen & Shedler, 1999a, 1999b). Finally, the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006) fills in many gaps left by this book.

2

Psychoanalytic Character Diagnosis

Classical psychoanalytic theory approached personality in two different ways, each deriving from an early 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 maturational 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.

These two explanatory sets are the basic elements of my own visualization of character possibilities. I try to show also how relational models in psychoanalysis (British object relations theory, American interpersonal psychoanalysis, self psychology, and contemporary relational ideas) can illuminate aspects of character organization. In addition, my understanding of personality has been enriched by less clinically influential psychodynamic formulations such as Jung's (1954) archetypes, Henry Murray's "personology" (e.g., 1938), Silvan Tomkins's (1995) "script theory," control–mastery theory (e.g., Silberschatz, 2005), and recent empirical work, especially attachment research and cognitive and affective neuroscience.

Readers may note that I am applying to the diagnostic enterprise several different paradigms within psychoanalysis that can be seen as mutually exclusive or essentially contradictory. Because this book is intended for therapists, and because I am temperamentally more of a synthesizer than a critic or distinction maker (I share this sensibility with other clinical writers such as Fred Pine [1985, 1990] and Lawrence Josephs [1992]), I have avoided arguing for the scientific or heuristic superiority of any one paradigm. I am not minimizing the value 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 conceptually problematic in some way.

Every new development in clinical theory offers practitioners a fresh way of trying to communicate to troubled people their wish to understand and help. Effective 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 sources than to become ideologically wedded to one or two favored theories and techniques. Some analysts adhere to dogma, but this stance has not enriched our clinical theory, nor has it contributed to the esteem in which our field is held by those who value humility and who appreciate ambiguity and complexity (cf. Goldberg, 1990a).

Different clients have a way of making different models relevant: One person stimulates in the therapist reflections on Kernberg's ideas; another sounds like a personality 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; Atwood & Stolorow, 1993) have shed light on the emotional processes underlying theories of personality by studying how the central themes in the theorist's life become the issues of focus in that person's theories of personality formation, psychopathology, and psychotherapy. Thus, it is not surprising that we have so many alternative conceptions. And even if some of them are logically at odds, I would argue that they are not phenomenologically so; they may apply differentially to different individuals and different character types.

Having stated my own biases and predilections, I now offer a brief, highly oversimplified summary of diagnostically salient models within the psychoanalytic tradition. I hope they will give therapists with minimal exposure to psychoanalytic theory a basis for comprehending the categories that are second nature for analytically trained therapists.

CLASSICAL FREUDIAN DRIVE THEORY AND ITS DEVELOPMENTAL TILT

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. Freud theorized that in infancy and early childhood, the person's natural dispositions concern basic survival issues, which are 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 his or her 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 is 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.

Lest this oversimplified account sound entirely fanciful, I should note that the theory did not spring full-blown from Freud's fevered imagination; there was an accretion of observations that influenced and supported it, collected not only by Freud but also by his colleagues. In Wilhelm Reich's *Character Analysis* (1933), the drive theory approach to personality diagnosis reached its zenith. Although Reich's language sounds archaic to contemporary ears, the book is full of fascinating insights about character types, and its observations may still strike a chord in sympathetic readers. Ultimately, the effort to construe character entirely on the basis of instinctual fixation proved disappointing; no analyst I know currently relies on a drive-based fixation model. Still, the field retains the developmental sensibility that the Freudian construct set in motion.

One echo of the original drive model is the continuing tendency of psychodynamic practitioners to think in terms of maturational processes and to understand psychopathology in terms of arrest or conflict at a particular phase. Efforts of contemporary psychoanalytic researchers to rethink the whole concept of standard developmental stages (see Lichtenberg, 2004; D. N. Stern, 2000) have inspired enthusiasm for less linear, less universalizing models, but these new ways of thinking coexist with general tendencies to view patients' problems in terms of some aborted 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 the interpersonal and intrapsychic tasks of each phase received considerable attention. Although Erikson's work (e.g., 1950) is usually seen as in the ego psychology tradition, his developmental stage theory echoes many assumptions in Freud's drive model. One of Erikson's most appealing additions to Freudian theory was his renaming of the stages in an effort to modify Freud's biologism. The oral phase became understood by its condition of total dependency in which the establishment of basic trust (or lack of trust) is at stake. 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 involves 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 ("ini-

tiative vs. guilt") and a sense of pleasure in identification with one's love objects.

Erikson, influenced by experiences such as having lived with Native American Hopi tribes, extended the idea of developmental phases and tasks throughout the lifespan and across cultures. In the 1950s, Harry Stack Sullivan (e.g., 1953) offered another stage theory (of predictable childhood "epochs"), one that stressed communicative achievements such as speech and play rather than drive satisfaction. 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 subphases of the separation–individuation process, a task that reaches its initial resolution by about age 3, was a further step in conceptualizing elements relevant to eventual personality structure. Her theory is basically object relational, but its implicit assumptions of fixation owe a debt to Freud's developmental model. Mahler broke down Freud's oral and anal stages 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 subphases of "hatching," "practicing," "rapprochement," and "on the way to object constancy") to a condition of relative psychological separation and individuation.

Other clinically relevant developmental observations emerged from British analysts. Melanie Klein (1946) wrote about the infant's shift from the "paranoid–schizoid position" to the "depressive position." In the former, the baby has not yet fully appreciated the separateness of other people, while in the latter, he or she has come to understand that the caregiver is outside the child's omnipotent control and has a separate mind. Thomas Ogden (1989) later posited a developmentally earlier "autistic-contiguous position," a "sensory-dominated, presymbolic area of experience in which the most primitive form of meaning is generated on the basis of the organization of sensory impressions, particularly at the skin surface" (p. 4). He emphasized how, in addition to viewing these positions as progressively more mature stages of development, we need to appreciate that we all move back and forth among them from moment to moment.

Such contributions were greeted eagerly by therapists. With the post-Freudian stage theories, they had fresh ways of understanding how their patients had gotten "stuck" and could appreciate otherwise puzzling shifts in self-states. 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, they could wonder to patients whether their predicaments reflected family processes that had made it difficult for them to feel security or autonomy or pleasure in their identifications (Erikson), or suggest that fate had handed them a childhood devoid of the crucially important preadolescent "chum" (Sullivan), or comment that their mother's hospitalization when they were 2 had overwhelmed the rapprochement process normal for that age and necessary for optimal separation (Mahler), or observe that in the moment, they were feeling a primitive terror because the therapist had interrupted their thought processes (Ogden).

More recently, Peter Fonagy and his colleagues (e.g., Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1996) have offered a model of the development of a mature sense of self and reality characterized by a capacity to "mentalize" the motives of others. Mentalization resembles what philosophers have called "theory of mind" and what Klein called the depressive position: the appreciation of the separate subjective lives of others. He observed that children move from an early "mode of psychic equivalence," in which the internal world and external reality are equated, to a "pretend mode" around age 2, in which the internal world is decoupled from the external world but is not governed by its realities (the era of imaginary friends), and the achievement of the capacity for mentalization and reflective functioning around ages 4 or 5, in which the two modes are integrated and fantasy is clearly distinguished from actuality. I talk more about this formulation in Chapter 3 in connection with borderline personality organization.

For therapists, such 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 we all generate about our more incomprehensible qualities ("I'm bad," "I'm ugly," "I'm lazy and undisciplined," "I'm just inherently rejectable," "I'm dangerous," etc.). And clinicians could keep their own sanity better when they ran into otherwise incomprehensible responses to their attempts to understand and help. For example, a client's sudden verbal assault on the therapist could be seen as a temporary retreat into the paranoid–schizoid position.

Many contemporary commentators have noted that our propensity to construe problems in developmental terms is too reductive and only questionably supported by clinical and empirical evidence. L. Mayes (2001, p. 1062), for example, notes that "maps that orient us to the developmental terrain are quite useful, but such maps should not be taken literally." Others have pointed to different patterns of psycho-

logical development in non-Western cultures (e.g., Bucci, 2002; Roland, 2003). Contemporary developmental psychologists (e.g., Fischer & Bidell, 1998) are leery of simple stage formulas, given that development is a dynamic, ever-shifting process. As my colleague Deirdre Kramer has noted (personal communication, July 20, 2010), it is probably more accurate to speak of a "range of developmental possibilities" than "a" developmental "level."

Still, the tendency of therapists to see psychological phenomena as residues of normal maturational challenges persists—perhaps reflecting the fact that developmental models have both an elegant simplicity and an overall humanity that appeals to us. There is a generosity of spirit, a kind of "There but for fortune go I" quality, to believing there is an archetypal, progressive, universal pattern of development, and that under unfortunate circumstances, any of us could have gotten stuck at any of its phases. It is not a sufficient explanation for personality differences, but it feels like an important *part* of the picture. One of the axes on which I have aligned diagnostic data contains this developmental bias in the form of relatively undifferentiated (symbiotic–psychotic), separation–individuation (borderline), and oedipal (neurotic) levels of personality organization.

EGO PSYCHOLOGY

With the publication of *The Ego and the Id* (1923), Freud introduced his structural model, launching a new theoretical era. Analysts shifted their interest from the contents of the unconscious to the processes by which those contents are kept out of consciousness. Arlow and Brenner (1964) have argued cogently for the greater explanatory power of the structural theory, but there were also practical clinical reasons for therapists to welcome the changes of focus from id to ego and from deeply unconscious material to the wishes, fears, and fantasies that are closer to consciousness and accessible if one works 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," 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 archaic kind of cognition,

which survives in the language of dreams, jokes, and hallucinations, "primary process" thought. Contemporary neuroscientists might locate the id in the amygdala, the ancient part of the brain involved in primitive emotional functioning.

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 resistance his ideas provoked in the post-Victorian era.)

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 and culture to handle id strivings. It develops continuously throughout one's lifetime but most rapidly in childhood, starting in earliest infancy (Hartmann, 1958). The Freudian ego operates according to the reality principle and is the seedbed of sequential, logical, reality-oriented cognition or "secondary process" thought. 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. The concept of the ego is relatively compatible with contemporary knowledge of the prefrontal cortex and its functions.

With the structural theory, analytic therapists had a new language for making sense of some kinds of character pathology; namely, that we all develop ego defenses that are adaptive within our particular childhood setting but that may turn out to be maladaptive later in the larger world. An 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., a powerful reaction of denial to emotionally disturbing events) to fully conscious. During psychoanalytic treatment, it was noted, the "observing ego," the part of the patient's self that is conscious and rational and can comment on emotional experience, allies with the therapist 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 therapy. If the patient is unable to talk from an observing position about less rational, more "gut-level" emotional reactions, the first task of the therapist is to help the patient develop that

capacity. Observation of the presence or absence of an observing ego became of paramount diagnostic value, because the existence of a symptom or problem that is 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 practitioners 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 phrase "ego strength," meaning a person's capacity to acknowledge reality, even when it is extremely unpleasant, without resorting to more primitive defenses such as denial (Bellak, Hurvich, & Gediman, 1973). 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 (Vaillant, 1992; Vaillant, Bond, & Vaillant, 1986).

Another clinical contribution of the ego psychology movement was the conclusion that psychological health involves not only having mature defenses but also being able to use a variety of defenses (cf. D. 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 one 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. (Note that Freud wrote in simple, non-jargon-laden language: Id, ego, and superego translate as "it," "me," and "above me," respectively [see Bettelheim, 1983]. Few contemporary psychoanalytic theorists write with anything like his grace and simplicity.) 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 often felt as a separate internal voice. 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 from which it arises, partly conscious and partly unconscious. Again, the assessment of whether an inappropriately punitive superego is 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 has a significantly different psychology 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, self-attacking people, but the magnitude of the first woman's problem is so much greater than that of the second that it was considered to warrant a different level of classification.

There was considerable clinical benefit to the development of the concept of the superego. Therapy went beyond simply trying to make conscious what had been unconscious. The therapist and client could view their work as also involving superego repair. A common therapeutic aim, especially throughout the early 20th century, when many middle-class adults had been reared in ways that fostered unduly 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 are not put into action). Psychoanalysis as a movement—and Freud as a person—was emphatically not hedonistic, but the taming of tyrannical superegos was one of its frequent goals. In practice, this tended to encourage more rather than less ethical behavior, since people with condemnatory superegos frequently behave in defiance of them, especially in states of intoxication or in situations in which they can rationalize acting out. We were learning that efforts to expose the operations of the id, to bring a person's unconscious life into the light of day, have little therapeutic benefit if the patient regards such illumination as exposing his or her personal 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 and other dysphoric affects. The idea that a primary function of the ego is 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 explicated in Anna Freud's *The Ego and the Mechanisms of Defense* (1936).

Sigmund Freud's original ideas had included the notion that anxious reactions are *caused by* defenses, most notably repression (unconsciously motivated forgetting). Bottled-up feelings were seen as tensions that press for discharge, tensions that are experienced as anxiety. When Freud made the shift to the structural theory, he reversed himself, deciding that repression is a *response* to anxiety, and that it is only one of

several ways human beings try to avoid an unbearable degree of irrational fear. He began construing psychopathology as a state in which a defensive effort has not worked, where the anxiety is felt in spite of one's habitual means of warding it off, or where the behavior that masks the anxiety is self-destructive. In Chapters 5 and 6 I elaborate on the defenses, the ones identified by Sigmund and Anna Freud, as well as by other analysts and researchers.

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 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 about inferred primitive phenomena. Object relations theorists struggled with how to put preverbal, prerational processes into rationally mediated words. Although they shared his respect for the power of unconscious dynamics, they disputed Freud on certain key 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 goes with 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 Freud's structural theory. People with an object relations orientation put their emphasis not on what drive had been mishandled in a person's childhood, or on what developmental phase had been poorly negotiated, or on what ego defenses had predominated. Rather, the emphasis was on what the main love 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 live on in the unconscious lives of adults. In

the object relations tradition, oedipal issues loom less large than themes of safety and agency, and separation and individuation.

The term "object relations" is unfortunate, since "object" in psychoanalese usually means "person." It derives from Freud's early explication of instinctual drives as having a source (some bodily tension), an aim (some 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 has remained in use despite its unattractive, mechanistic connotations because of this derivation and also because there are instances in which an important "object" 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.).

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 (1982) and others who knew Freud have stated that he 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 identified themselves as "interpersonal psychoanalysts." These theorists, who included Harry Stack Sullivan, Erich Fromm, Karen Horney, Clara Thompson, Otto Will, Frieda Fromm-Reichmann, and Harold Searles were, like their European colleagues, trying to work 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. Both groups deemphasized the therapist's role as conveyer of insight and concentrated more on the importance of establishing emotional safety. Fromm-Reichmann (1950) famously observed that "The patient needs an experience, not an explanation."

Freud had shifted 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. Emphasizing the value of the patient's exorcising an internal image of a problematic parent by seeing that image in the analyst and defying it, he noted that "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 a central tenet of contemporary analytic therapists (Blagys & Hilsenroth, 2000). It is also supported by considerable empirical work on psychotherapy outcome (Norcross, 2002; Strupp, 1989; Wampold, 2001; Zuroff & Blatt, 2006) and seems to apply to nonpsychodynamic as well as psychodynamic therapies (Shedler, 2010).

Object relational concepts allowed therapists to extend their empathy into the 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 is 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 milestone, not just a psychosexual one, in that it represents a victory over infantile egocentrism for a child to understand that two other people (the parents, in the classical paradigm) may relate to each other in ways that do not involve the child.

Concepts from the European object relations theorists and the American interpersonalists heralded significant advances in treatment because the psychologies of many clients, especially those suffering from more serious 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 may 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 (L. Stone, 1954). Therapists could now listen for the voices 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 stable patterns of behaving like, or unconsciously inducing others to behave like, the experienced objects of early childhood. The "stable instability" of the borderline client (Schmideberg, 1947; Kernberg, 1975) became 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 more ways of understanding what was happening in therapy, especially when an observing ego could not be accessed. For example, when a disturbed patient would launch into a paranoid diatribe, the therapist could make sense of it as a re-creation 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 object 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 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 a benign, 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 now diagnose as borderline or traumatized or personality disordered 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 useful 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," 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, wondering whether someone in his family had not listened to him very carefully:

He seemed to assume I didn't remember any of the main figures in his current life. He protested angrily, insisting that his parents had been very interested in him—especially his mother. He then commenced a long defense of her, during which I began, without 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 daydream 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 an enhancer of my own reputation. Racker (1968) would call this countertransference complementary, since my emotional state seemed to parallel 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. In the initial 1 to 2 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. Since the first edition of this book, there has been an explosion of neuroscientific understanding of infant development (Beebe & Lachmann, 1994; Sasso, 2008)—right-brain-to-right-brain communication (Fosha, 2005; Schore, 2003a, 2003b; Trevarthen & Aitken, 1994), the role of mirror neurons (Olds, 2006; Rizzolatti & Craighero, 2004) and the way the brains of both client and therapist change in intimate emotional connection, including therapy (Kandel, 1999; Tronick, 2003)—fulfilling Freud's (1895) hope that one day we would have chemical and neurological explanations for what he could describe only in metaphors.

Before we had functional magnetic resonance imaging (fMRI) studies, analytic theories created hypothetical structures to describe those processes, assuming that in making contact, we draw on early infantile knowledge that both predates and transcends the formal, logical interactions we easily put into words. The phenomenon of parallel process (Ekstein & Wallerstein, 1958), the understanding of which presumes the same emotional and preverbal sources, has been extensively documented in the clinical literature on supervision. The transformation of countertransference from obstacle to asset is one of the most critical contributions of object relations theory (see Ehrenberg, 1992; Maroda, 1991).

SELF PSYCHOLOGY

Theory influences practice, and 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, many practitioners were reporting that their patients' problems were not well described in the language of the existing 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 explanatory power one would want from a good theory.

Rather than seeming full of stormy, primitive introjects, as object relations theory described so well, many mid-century patients were reporting feelings of emptiness—they seemed 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 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 recognition from outside sources, such patients were regarded by analytically oriented people as having core problems with narcissism, even when they did not fit the stereotype of the "phallic" narcissistic character (arrogant, vain, charming) that W. Reich (1933) had delineated. They evoked a countertransference note-

worthy not for its intensity, but for boredom, impatience, and vague irritation. People treating such clients reported that they felt insignificant, invisible, and either devalued or overvalued by them. The therapist could not feel appreciated as a real other person trying to help, but instead seemed to be regarded as a replaceable source of the client's 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. From a traditional standpoint, they often did not appear flagrantly "sick" (they had impulse control, ego strength, interpersonal stability), but they nevertheless felt little pleasure in their lives and little realistic pride in themselves. Some practitioners considered them untreatable, since it is a 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 hallmarks.

Within psychoanalysis, Heinz Kohut formulated a new theory of the self: its development, possible distortion, and treatment. He emphasized 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 body of work, its influence on other writers (e.g., George Atwood, Sheldon Bach, Michael Basch, James Fosshage, Arnold Goldberg, Alice Miller, Andrew Morrison, Donna Orange, Paul and Anna Ornstein, Estelle Shane, Robert Stolorow, Ernest Wolf), and the general

tone it set for rethinking psychological issues had important implications for diagnosis. 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, 1990b). Interviewers could understand patients more completely by asking, in addition to 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 men may be clinically depressed, with virtually identical vegetative signs (sleep problems, appetite disturbance, tearfulness, psychomotor retardation, etc.), yet have radically disparate subjective experiences. One 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 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. 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.

Diagnostic discrimination between the first kind of depression ("melancholia" in the early psychoanalytic literature and "introjective depression" more recently [Blatt, 2008]) and the second, a more narcissistically depleted state of mind (Blatt's "anaclitic" depression), is a critical one for very practical reasons. The man with the first kind of depressive experience 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 man with the second kind of subjective experience will be 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 such discriminations later, but the point here is that self psychological frames of reference have had significant diagnostic value.

THE CONTEMPORARY RELATIONAL MOVEMENT

Winnicott (1952) stated, provocatively and memorably, that there is no such thing as a baby. He meant that there is an interpersonal *system* of a baby and a caregiver, as the baby cannot exist except in a specific context of care. Similarly, recent psychoanalytic theorists have challenged the assumption that there is such a thing as a discrete, stable, separate personality; they prefer to conceive of a series of self-states that arise in different interpersonal contexts. The most important recent theoretical innovations were set in motion by a 1983 text by Jay Greenberg and Steven Mitchell that contrasted drive and ego psychological models with relational theories (interpersonal, object relational, self psychological). Since that time, there has been a remarkable shift of conceptualization of the clinical process, generally dubbed the "relational turn" (S. A. Mitchell, 1988), in which the inevitably intersubjective nature of the clinical situation has been emphasized.

Scholars such as Louis Aron, Jessica Benjamin, Philip Bromberg, Jodie Davies, Adrienne Harris, Irwin Hoffman, Owen Renik, and Donnell Stern have challenged prior notions that the therapist's objectivity or emotional neutrality is either possible or desirable, and have emphasized the contributions to the clinical situation of the unconscious life of the therapist as well as that of the patient. Despite its obvious asymmetricality, the relationship that any therapist–client pair experiences is seen as mutual and co-constructed (Aron, 1996), and the analyst is assumed not to be an objective "knower" but a codiscoverer of the patient's psychology as it contributes to inevitable two-person enactments of the client's major interpersonal themes.

Relational psychoanalysts have been more interested in therapeutic *process* than in hypothesized structures such as character; in fact, many explicitly worry that talking about personality as a patterned, fixed phenomenon ignores the evidence for our ongoing construction of experience and for self-experiences that are more state dependent than personality driven. Still, their paradigm shift has affected how we think about personality and its implications for practice. By deconstructing prior conceits that analysts can somehow observe patients antiseptically (according to Heisenberg [1927], even electrons cannot not be studied without the act of observation affecting what is observed), relational analysts opened the door to appreciating the personality contributions of the therapist as well as the patient in the understanding of what is going on between them in therapy.

In response to the clinical challenges presented by people with histories of emotional and sexual abuse, much relational thinking has returned to the early Freudian focus on trauma, but with an emphasis

on dissociative rather than repressive processes. The contributions of relational analysts, along with advances in neuroscience and child development research, have changed some of our assumptions about psychic structure, especially in contexts that promote dissociation. I talk about this in more detail in Chapter 15.

From the perspective of personality diagnosis, perhaps the most important contributions of analysts in the relational movement include their sensitivity to unformulated experience (D. B. Stern, 1997, 2009), social construction of meaning (Hoffman, 1998), multiple self-states (Bromberg, 1991, 1998), and dissociation (Davies & Frawley, 1994), all ways of thinking about self-experience that imply more fluidity and unfinishedness than traditional theory assumed. Given the speed of social and technological change over the past quarter-century, it is not surprising that a major theoretical position has emerged in which impermanence and the collaborative construction of experience are foundational assumptions.

OTHER PSYCHOANALYTIC CONTRIBUTIONS TO PERSONALITY ASSESSMENT

In addition to drive, ego psychology, object relations, self, and relational 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 (1938); the "modern psychoanalysis" of Spotnitz (1976, 1985); the "script theory" of Tomkins (1995); the "control–mastery" theory of Sampson and Weiss (Weiss, 1993); evolutionary biology models (e.g., Slavin & Kriegman, 1990), contemporary gender theory (e.g., A. Harris, 2008), and the work of Jacques Lacan (Fink, 1999, 2007). I refer to some of these paradigms in subsequent chapters. I cannot resist noting my prediction in the first edition of this book that psychoanalysts would soon apply chaos theory (nonlinear general systems theory) to clinical issues, a prophecy that has since been realized (Seligman, 2005).

In concluding this chapter, I want to stress that analytic theories emphasize themes and dynamisms, not traits; that is why the word "dynamic" continues to apply. 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 modern 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 naiveté 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 recklessly. 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 several major clinical paradigms within psychoanalysis: drive theory, ego psychology, object relations theory, self psychology, and the contemporary relational sensibility. I have emphasized their respective implications for conceptualizing character, with attention to the clinical inferences that can be drawn from seeing people through these different lenses. I have also noted other influences on dynamic ideas about character structure and implications for therapy. 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, I think the best way to get a sense of the early Freud and of his 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 Psycho-Analysis* (1938) gives a synopsis of his later theory, but I find it too condensed and dry; Bettelheim's *Freud and Man's*

Soul (1983) is a good corrective. Freud's *The Psychopathology of Everyday Life* (1901) remains an easy and entertaining read for those who have not been exposed to his remarkable mind. Michael Kahn's *Basic Freud* (2002) is an unusually user-friendly text on core psychoanalytic ideas. For an interesting exploration of personality types in the Jungian tradition, see Dougherty and West's *The Matrix and Meaning of Character* (2007).

For a fascinating and readable overview of the history and politics of psychoanalytic theories, see Jeremy Safran's *Psychoanalysis and Psychoanalytic Therapies* (in press). For a summary of ego psychology concepts and their relevance to practice, see the Blancks' *Ego Psychology* (1974). Guntrip's *Psychoanalytic Theory, Therapy, and the Self* (1971), 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 American interpersonalists.

For self psychological sources, Kohut's *The Analysis of the Self* (1971) is almost impenetrable to beginners, but *The Restoration of the Self* (1977) is easier going. E. S. Wolf's *Treating the Self* (1988) accessibly translates the theory into practice. Stolorow and Atwood's *Contexts of Being* (1992) is a readable introduction to the intersubjective view. Lawrence Joseph's *Character Structure and the Organization of the Self* (1992) helpfully synthesizes psychoanalytic personality theory with self and relational constructs and their clinical implications, as do Fred Pine's integrative books (1985, 1990).

For an introduction to control–mastery theory, see George Silberschatz's *Transformative Relationships* (2005). To read seminal papers in the relational movement, go to Mitchell and Aron's *Relational Psychoanalysis* (1999); Paul Wachtel (2008) has written an integrative text from this perspective. For a readable overview of the major psychoanalytic theories, I strongly recommend Mitchell and Black's *Freud and Beyond* (1995). For coverage of empirical contributions to psychoanalytic personality theory, there are several excellent reviews in the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006). Morris Eagle (2011) has recently published a brilliant historical review and critique of evolving psychoanalytic theory. For a vivid exposure to how a practicing analyst applies theory (especially Winnicott, Lacan, and Klein) to practice, read Deborah Luepnitz's (2002) account of five cases in *Schopenhauer's Porcupines*, a gem of a book that is as absorbing as a good novel.

3

Developmental Levels of Personality Organization

This chapter focuses on what many analysts have seen as the maturational issues embedded in a person's character—the unfinished or impeded business of early psychological development: what Freud called fixation and what later analysts called developmental arrest. In much analytic writing about personality, it has been assumed that the earlier the developmental obstacle, the more disturbed the person. This belief is a great oversimplification and in some ways is simply wrong (see Fischer & Bidell, 1998; Westen, 1990). But for purposes of introducing a way to think about character that can be clinically helpful, I lay out the traditional overview as well as more recent efforts to account for general differences in psychological health and personality structure.

Historically, analysts have conceived of a continuum of overall mental functioning, from more disturbed to healthier. They have explicitly or implicitly construed individual personality as organized at a particular developmental level and structured by the individual's characteristic defensive style. The first dimension conceptualizes a person's degree of healthy psychological growth or pathology (psychotic, borderline, neurotic, "normal"); the second identifies his or her type of character (paranoid, depressive, schizoid, etc.).

A close friend of mine, a man with no experience in psychotherapy, who cannot imagine why anyone would go into a field where one spends hour upon hour listening to other people's problems, was trying to

understand my interest in writing this book. "It's simple for me," he commented. "I have just two categories for people: (1) nuts and (2) not nuts." I responded that in psychoanalytic theory, which assumes that everyone is to some degree irrational, we also have two basic attributions: (1) How nuts? and (2) Nuts in what particular way? As I mentioned in Chapter 2, although contemporary analysts conceive the phases through which young children pass in less drive-defined ways than Freud did, many of their theories continue to reflect his conclusion that current psychological preoccupations reflect infantile precursors, and that interactions in our earliest years set up the template for how we later assimilate experience.

Conceptualizing someone's unmet developmental challenges can help in understanding that person. Interestingly, the same three phases of early psychological organization keep reappearing in psychoanalytic developmental theories: (1) the first year and a half to 2 years (Freud's oral phase), (2) the period from 18 to 24 months to about 3 years (Freud's anal phase), and (3) the time between 3 or 4 and about 6 (Freud's oedipal period). The approximateness of these ages reflects individual differences; the sequence seems to be the same whether a child is precocious or late blooming. Many theorists have discussed these phases, variously emphasizing drive and defense, ego development, or images of self and other that characterize them. Some have stressed behavioral issues of the stages, others have addressed cognition, still others the child's affective maturation.

Many scholars (e.g., Lyons-Ruth, 1991; D. N. Stern, 2000) have critiqued stage theories in light of infant research, which has illuminated far more competence in early infancy than most developmental models assume and connects difficulties to parental attachment behaviors rather than presumed developmental phases. Analysts of a postmodern bent (e.g., Corbett, 2001; Fairfield, 2001) point out that models of "normal development" contain implicit cultural prescriptions, inevitably contributing to images of an in-group that is fine and an out-group that is not. Despite these limitations, I think that some notion of expectable psychological stages will survive in our conceptual formulations, as there is something that invites clinical empathy in the idea that we all go through a similar process of growth. In the following, I draw mostly on the ideas of Erikson, Mahler, and Fonagy to explicate the developmental aspect of psychoanalytic diagnosis.

It has never been empirically demonstrated that people with a lot of "oral" qualities have more severe degrees of psychopathology than those with central dynamics that earlier analysts would have regarded as either anal or oedipal, even though Freud's naming of the first three stages of development by these inferred drive concepts has a lot of

intuitive appeal and correlates to some degree with *type* of personality (depressive people at any level of health or pathology tend to manifest orality; the preoccupations of compulsive people are notoriously anal—see Chapter 13—whether or not their compulsivity causes them major problems).

Yet there is substantial clinical commentary (e.g., Volkan, 1995) and increasing empirical research (e.g., Fonagy, Gergely, Jurist, & Target, 2002; L. Silverman, Lachmann, & Milich, 1982), supporting a correlation between, on the one hand, one's level of ego development and self–other differentiation, and, on the other, the health or pathology of one's personality. To a certain extent this correlation is definitional and therefore tautological; that is, assessing primitive levels of ego development and object relations is like saying an interviewee is "sick," whereas seeing someone as obsessive or schizoid is not necessarily assigning pathology. But this way of conceptualizing psychological wellness versus disturbance according to categories from ego psychology and the later relational theories has profound clinical implications across different character types. A brief history of psychoanalytic attempts to make diagnostic distinctions between people based on the extent or "depth" of their difficulties rather than their type of personality follows.

HISTORICAL CONTEXT: DIAGNOSING LEVEL OF CHARACTER PATHOLOGY

Before the advent of descriptive psychiatry in the 19th century, certain forms of mental disturbance that occurred with any frequency in what was considered the "civilized world" were recognized, and most observers presumably made distinctions between the sane and the insane, much as my nonpsychological friend distinguishes between "nuts" and "not nuts." Sane people agreed more or less about what constitutes reality; insane people deviated from this consensus.

Men and women with hysterical conditions (which included what today would be diagnosed as posttraumatic problems), phobias, obsessions, compulsions, and nonpsychotic manic and depressive symptoms were understood to have psychological difficulties that fall short of complete insanity. People with hallucinations, delusions, and thought disorders were regarded as insane. People we would today call antisocial were diagnosed with "moral insanity" (Prichard, 1835) but were considered mentally in touch with reality. This rather crude taxonomy survives in the categories of our legal system, which puts emphasis on whether the person accused of a crime was able to assess reality at the time of its commission.

Kraepelinian Diagnosis: Neurosis versus Psychosis

Emil Kraepelin (1856–1926) is usually cited as the father of contemporary diagnostic classification. Kraepelin observed mental patients carefully, with the aim of identifying general syndromes that share common characteristics. In addition, he developed theories about the etiologies of those conditions, at least to the extent of regarding their origins as either exogenous and treatable or endogenous and incurable (Kraepelin, 1913). (Interestingly, he put severe bipolar illness ["manic–depressive psychosis"] in the former category and schizophrenia ["dementia praecox"—believed to be an organic deterioration of the brain] in the latter.) The "lunatic" began to be understood as a person afflicted with one of several possible documented illnesses.

Freud went beyond description and simple levels of deduction into more inferential formulations; his developing theory posited complex epigenetic explanations as preferable to Kraepelin's basic internal–external versions of causality. Still, Freud tended to view psychopathology by the Kraepelinian categories then available. He would describe a man troubled by obsessions (e.g., his patient the "Wolf Man" [Freud, 1918; Gardiner, 1971]), as having an obsessive–compulsive neurosis. By the end of his career, Freud began to discriminate between an obsessional neurosis in an otherwise nonobsessive person and an obsession that was part of an obsessive–compulsive character. But it was later analysts (e.g., Eissler, 1953; Horner, 1990) who made the distinctions that are the subject of this chapter, among (1) the obsessive person who is virtually delusional, who uses ruminative thoughts to ward off psychotic decompensation; (2) the person whose obsessing is part of a borderline personality structure (as in the "Wolf Man"); and (3) the obsessive person with a neurotic-to-normal personality organization.

Before the category of "borderline" emerged in the middle of the 20th century, analytically influenced therapists followed Freud in differentiating only between neurotic and psychotic levels of pathology, the former being distinguished by a general appreciation of reality and the latter by a loss of contact with it. A neurotic woman knew at some level that her problem was in her own head; the psychotic one believed it was the world that was out of kilter. When Freud developed the structural model of the mind, this distinction took on the quality of a comment on a person's psychological infrastructure: Neurotic people were viewed as suffering because their ego defenses were too automatic and inflexible, cutting them off from id energies that could be put to creative use; psychotic ones suffered because their ego defenses were too weak, leaving them helplessly overwhelmed by primitive material from the id.

The neurotic-versus-psychotic distinction had important clinical implications. The gist of these, considered in light of Freud's structural model, was that therapy with a neurotic person should involve weakening the defenses and getting access to the id so that its energies may be released for more constructive activity. In contrast, therapy with a psychotic person should aim at strengthening defenses, covering over primitive preoccupations, influencing realistically stressful circumstances so that they are less upsetting, encouraging reality testing, and pushing the bubbling id back into unconsciousness. It was as if the neurotic person were like a pot on the stove with the lid on too tight, making the therapist's job to let some steam escape, while the psychotic pot was boiling over, necessitating that the therapist get the lid back on and turn down the heat.

It became common for supervisors to recommend that with healthier patients, one should attack the defenses, whereas with people suffering from schizophrenia and other psychoses, one should support them. With the advent of antipsychotic drugs, this formulation lent itself to a widespread tendency not only to medicate—often the compassionate response to psychotic levels of anxiety—but also to assume that medication would do the covering over and would be needed on a lifetime basis. Therapists were advised not to do any "uncovering" with a potentially psychotic person: That might disturb the fragile defenses and send the client over the edge again. This way of conceptualizing degree of pathology is not without usefulness; it has opened the door to the development of different therapeutic approaches for different kinds of difficulties. But it falls short of a comprehensive and clinically nuanced ideal. Any theory oversimplifies, but this neurotic-versus-psychotic division, even with Freud's elegant structural underpinnings and their therapeutic implications, offered only a start at a useful inferential diagnosis.

Ego Psychology Diagnosis: Symptom Neurosis, Neurotic Character, Psychosis

In the psychoanalytic community, in addition to a distinction between neurosis and psychosis, differentiations of *extent* of maladaptation, not simply *type* of psychopathology, gradually began to appear within the neurotic category. The first clinically important one was Wilhelm Reich's (1933) discrimination between "symptom neuroses" and "character neuroses." Therapists were learning that it was useful to distinguish between a person with a discrete neurosis and one with a character permeated by neurotic patterns. This distinction lives on in the DSM, in which conditions labeled "disorder" tend to be those that analysts have called neuroses, and conditions labeled "personality disorder" resemble the old analytic concept of neurotic character.

To assess whether they were dealing with a symptom neurosis or a character problem, therapists were trained to pursue the following kinds of information when interviewing a person with neurotic complaints:

1. Is there an identifiable precipitant of the difficulty, or has it existed to some degree as long as the patient can remember?
2. Has there been a dramatic increase in the patient's anxiety, especially pertaining to the neurotic symptoms, or has there been only an incremental worsening of the person's overall state of feeling?
3. Is the patient self-referred, or did others (relatives, friends, the legal system) send him or her for treatment?
4. Are the person's symptoms ego alien (seen by him or her as problematic and irrational) or are they ego syntonic (regarded as the only and obvious way the patient can imagine reacting to current life circumstances)?
5. Is the person's capacity to get some perspective on his or her problems (the "observing ego") adequate to develop an alliance with the therapist against the problematic symptom, or does the patient seem to regard the interviewer as either a potential attacker or a magic rescuer?

The former alternative in each of the above possibilities was presumptive evidence of a symptom problem, the latter of a character problem (Nunberg, 1955). The significance of this distinction lay in its implications for treatment and prognosis. If it was a symptom neurosis that the client suffered (equivalent to "Axis I disorder without comorbid personality disorder"), then one suspected that something in the person's current life had activated an unconscious conflict and that the patient was now using maladaptive mechanisms to cope with it—methods that may have been the best available solution in childhood but that were now creating more problems than they were solving. The therapist's task would be to determine the conflict, help the patient understand and process the emotions connected to it, and develop new resolutions of it. The prognosis was favorable, and treatment might be relatively short (cf. Menninger, 1963). One could expect a climate of mutuality during therapy, in which strong transference (and countertransference) reactions might appear, but usually in the context of an even stronger degree of cooperation.

If the patient's difficulties amounted to a character neurosis or personality problem, then the therapeutic task would be more complicated, demanding, and time consuming, and the prognosis more guarded. This is only common sense, of course, in that trying to foster personality

change obviously poses more challenges than helping someone get rid of a maladaptive response to a specific stress. But analytic theory went beyond common sense in specifying ways in which work on a person's basic character would differ from work with a symptom not embedded in personality.

First, one could not take for granted that what the patient wanted (immediate relief from suffering) and what the therapist saw as necessary for the patient's eventual recovery and resistance to future difficulties (modification of personality) could be seen by the patient as compatible. In instances when the patient's aims and the analyst's conception of what was ultimately needed were at variance, the analyst's educative role became critical. One had to start by trying to convey to the patient how the therapist saw the problem; that is, "making ego alien what has been ego syntonic." For example, a 30-year-old accountant once came to me looking to "achieve more balance" in his life. Raised to be the hope of his family, with a mission to compensate for his father's failed ambitions, he was hardworking to the point of drivenness. He feared that he was missing precious years with his young children, whom he might enjoy if only he could stop pushing himself relentlessly to produce at work. He wanted me to develop a "program" with him in which he agreed to spend a certain amount of time per day exercising, a certain amount playing with his kids, a certain amount working on a hobby, and so forth. The proposed program included designated space for volunteer work, watching television, cooking, doing housework, and making love to his wife.

In the meeting that followed our initial interview, he brought in a sample schedule detailing such changes. He felt that if I could get him to put this program into effect, his problems would be solved. My first task was to try to suggest that this solution was part of the problem: He approached therapy with the same drivenness he was complaining about and pursued the serenity he knew he needed as if it were another job to do. I told him he was very good at *doing*, but he evidently had had little experience with just *being*. While he grasped this notion intellectually, he had no emotionally salient memory of a less compulsive approach to life, and he regarded me with a mixture of hope and skepticism. Although simply telling his story had provided some short-term relief of his depression, I saw him as having to get used to the fact that to avoid this kind of misery in the future, he would need to bring into conscious awareness and to rethink some of the major assumptions that had governed his life.

Second, in working with someone whose character was fundamentally neurotic, one could not take for granted an immediate "working alliance" (Greenson, 1967). Instead, one would have to create the condi-

tions under which it could develop. The concept of the working or therapeutic alliance refers to the collaborative dimension of the work between therapist and client, the cooperation that endures in spite of the strong and often negative emotions that may surface during treatment. Empirically, a solid working alliance is associated with good outcome (Safran & Muran, 2000), and its establishment (or restoration after a rupture) takes precedence over other aims.

Patients with symptom neuroses feel on the side of the therapist in opposing a problematic *part* of the self. They rarely require a long period to develop a shared perspective. In contrast, those whose problems are complexly interwoven with their personality may easily feel alone and under attack. When the therapist raises questions about lifelong, ego-syntonic patterns, their whole identity may feel assaulted. Distrust is inevitable and must be patiently endured by both parties until the therapist has earned the client's confidence. With some patients, this process of building an alliance can take more than a year. Trying too quickly to take on what the therapist sees as obvious problems may damage the alliance and impede the process of change.

Third, therapy sessions with someone with a character rather than a symptom problem could be expected to be less exciting, less surprising, less dramatic. Whatever the therapist's and patient's fantasies about unearthing vivid repressed memories or unconscious conflicts, they would have to content themselves with a more prosaic process, the painstaking unraveling of all the threads that had created the emotional knot that the patient had until now believed was just the way things had to be, and the slow working out of new ways of thinking and handling feelings.

In the development of personality disorders, as opposed to the appearance of neurotic reactions to particular current stresses, there are long patterns of identification, learning, and reinforcement. Where the etiology is traumatic, "strain trauma" (Kris, 1956) is implicated, rather than the "shock trauma" (one unassimilated, unmourned injury) celebrated in Hollywood's early, enthusiastic portrayals of psychoanalytic treatment (see, e.g., Hitchcock's *Spellbound*). As a consequence, one could expect that in the therapy of character neuroses, both parties would have to deal with occasional boredom, impatience, irritability, and demoralization—the patient by expressing them without fear of criticism and the therapist by mining such feelings for empathy with the patient's struggle with a difficult, protracted task.

This distinction between neurotic symptoms and neurotic personality remains important, even in instances where one cannot do the long-term work (e.g., D. Shapiro, 1989) that character change requires. If one understands one's patient's inflexible personality issues, one can often

find some way of making a short-term impact that avoids the person's feeling misunderstood or attacked. For example, knowing that a woman has a central psychopathic streak alerts the therapist that in trying to interfere with some damaging pattern, it is better to appeal to her pride than to her assumed concern for others.

For a long time, the categories of symptom neurosis, character neurosis, and psychosis constituted the main constructs by which we understood personality differences on the dimension of severity of disorder. A neurosis was the least serious condition, a personality disorder more serious, and a psychotic disturbance quite grave. These formulations maintained the old distinction between sane and insane, with the sane category including two possibilities: neurotic reactions and neurotically structured personalities. Over time, however, it became apparent that such an overall scheme of classification was both incomplete and misleading.

One drawback of this taxonomy is its implication that all character problems are more pathological than all neuroses. One can still discern such an assumption in the DSM, in which the criteria for diagnosing most personality disorders include significant impairments in functioning. And yet some stress-related neurotic reactions are more crippling to a person's capacity to cope than, say, some hysterical and obsessional personality disorders. A man I know suffers from agoraphobia, ego alien but severe. He has warm relations with friends, enjoys his family, and works productively at home, but he never leaves his house. I see his life as more constricted and deadened than that of many people with personality disorders and even psychoses.

To complicate the issue still further, there is also a problem in the other direction: Some character disturbances seem to be much more severe and primitive in quality than anything that could reasonably be called "neurotic." One can see that there is no way in such a linear, three-part classification to differentiate between distortions of character that are mildly incapacitating and those that involve fairly dire consequences. A problem can be characterological and of any level of severity. The line between benign personality "traits" or "styles" and mild personality "disorders" is quite blurry. On the other end of the continuum, some character disorders have been understood for a long time as involving such substantial deformities of the ego that they are closer to psychosis than neurosis. Psychopathy and malignant forms of narcissistic personality organization, for example, have long been recognized as variants of human individuality, but until fairly recently, they have tended to be considered as somewhat outside the scope of possible therapeutic intervention and not easily placed on a neurotic–character disordered–psychotic continuum.

Object Relations Diagnosis: The Delineation of Borderline Conditions

Even in the late 19th century, some psychiatrists were identifying patients who seemed to inhabit a psychological "borderland" (Rosse, 1890) between sanity and insanity. By the middle of the 20th century, other ideas about personality organization suggesting a middle ground between neurosis and psychosis began to appear. Adolph Stein (1938) noted that people with qualities he called "borderline" got worse rather than better in standard psychoanalytic treatment. Helene Deutsch (1942) proposed the concept of the "as-if personality" for a subgroup of people we would now see as narcissistic or borderline, and Hoch and Polatin (1949) made a case for the category of "pseudoneurotic schizophrenia."

By the middle 1950s, the mental health community had followed these innovators in noting the limitations of the neurosis-versus-psychosis model. Numerous analysts began complaining about clients who seemed character disordered, but in a peculiarly chaotic way. Because they rarely or never reported hallucinations or delusions, they could not be considered psychotic, but they also lacked the consistency of neurotic-level patients, and they seemed to be miserable on a much grander and less comprehensible scale than neurotics. In treatment, they could become temporarily psychotic—convinced, for example, that their therapist was *exactly like* their mother, yet outside the consulting room there was an odd stability to their instability. In other words, they were too sane to be considered crazy, and too crazy to be considered sane. Therapists began suggesting new diagnostic labels that captured the quality of these people who lived on the border between neurosis and psychosis. In 1953, Knight published a thoughtful essay about "borderline states." In the same decade, T. F. Main (1957) was referring to similar pathology in hospitalized patients as "The Ailment." In 1964, Frosch suggested the diagnostic category of "psychotic character."

In 1968, Roy Grinker and his colleagues (Grinker, Werble, & Drye, 1968) did a seminal study documenting a "borderline syndrome" inhering in personality, with a range of severity from the border with the neuroses to the border with the psychoses. Gunderson and Singer (e.g., 1975) continued to subject the concept to empirical scrutiny, and eventually, via both research and clinical findings, and thanks to the elucidation of writers such as Kernberg (1975, 1976), Masterson (1976), and M. H. Stone (1980, 1986), the concept of a borderline level of personality organization attained widespread acceptance in the psychoanalytic community.

By 1980, the term had been sufficiently researched to appear in the DSM (DSM-III; American Psychiatric Association, 1980) as a personal-

ity disorder. This development has had mixed effects: It has legitimated a valuable psychoanalytic concept but at the price of losing its original meaning as a *level of functioning*. The concept of borderline psychology represented in the DSM drew heavily on the work of Gunderson (e.g., 1984), who had studied a group that most analysts would have diagnosed as having a hysterical or histrionic psychology at the borderline level. Kernberg (1984), one of the originators of the concept, began having to differentiate between "borderline personality organization" (BPO) and the DSM's "borderline personality disorder" (BPD).

I am probably fighting a losing battle in trying to preserve the original meaning of the term "borderline" (as I did, for example, in the Personality section of the *Psychodynamic Diagnostic Manual* [PDM Task Force, 2006]), but I think a lot has been sacrificed in equating the term with a particular character type. The concept of "borderline" as a level of psychological functioning had evolved over decades of clinical experience, coming to be generally viewed as a stable instability on the border between the neurotic and psychotic ranges, characterized by lack of identity integration and reliance on primitive defenses without overall loss of reality testing (Kernberg, 1975). I worry that with the DSM definition having become accepted, we are losing a way of talking about, say, obsessional or schizoid people at the borderline level (e.g., the "quiet borderline" patient of Sherwood & Cohen, 1994). If all our empirical research on borderline phenomena applies narrowly to the more self-dramatizing, histrionic version of borderline-level personality organization, we are left in the dark about the etiology and treatment of other personality disorders at the borderline level.

By the second half of the 20th century, many therapists struggling to help clients that we now see as borderline found themselves drawing inspiration and validation from writings of analysts in the British object relations movement and the American interpersonal group, who looked at patients' experiences with key figures in childhood. These theorists emphasized the patient's experience of relationship: Was the person preoccupied with symbiotic issues, separation–individuation themes, or highly individuated competitive and identificatory motifs? Erikson's (1950) reworking of Freud's three infantile stages in terms of the child's interpersonal task made a significant clinical impact, in that patients could be conceptualized as fixated at either primary dependency issues (trust vs. mistrust), secondary separation–individuation issues (autonomy vs. shame and doubt), or more advanced levels of identification (initiative vs. guilt).

These developmental-stage concepts made sense of the differences therapists were noticing among psychotic-, borderline-, and neurotic-level patients: People in a psychotic state seemed fixated at an unindi-

viduated level in which they could not differentiate between what was inside and what was outside themselves; people in a borderline condition were construed as fixated in dyadic struggles between total enmeshment, which they feared would obliterate their identity, and total isolation, which they equated with traumatic abandonment; and people with neurotic difficulties were understood as having accomplished separation and individuation but as having run into conflicts between, for example, things they wished for and things they feared, the prototype for which was the oedipal drama. This way of thinking made sense of numerous puzzling and demoralizing clinical challenges. It accounted for why one woman with phobias seemed to be clinging to sanity by a thread, while another was oddly stable in her phobic instability, and yet a third woman was, despite having a phobia, otherwise a paragon of mental health.

By the late 20th century there was, both within the psychoanalytic tradition and outside it, a vast literature on borderline psychopathology, showing a bewildering divergence of conclusions about its etiology. Some investigators (e.g., M. H. Stone, 1977) emphasized constitutional and neurological predispositions; some (e.g., G. Adler, 1985; Masterson, 1972, 1976) focused on developmental failures, especially in the separation–individuation phase described by Mahler (1971); some (e.g., Kernberg, 1975) conjectured about aberrant parent–child interaction at an earlier phase of infantile development; some (e.g., Mandelbaum, 1977; Rinsley, 1982) pointed to poor boundaries between members in dysfunctional family systems; and some (e.g., McWilliams, 1979; Westen, 1993) made sociological speculations. Others (e.g., Meissner, 1984, 1988) were integrative of many of these perspectives. With advances in attachment research (e.g., Ainsworth, Blehar, Waters, & Wall, 1978), some writers began to conjecture about the infantile attachment styles that correlated later with borderline psychology. By the 1990s, more and more people were writing about how trauma, especially incest, plays a bigger role in the development of borderline dynamics than had previously been suspected (e.g., Wolf & Alpert, 1991).

Recent empirical studies of borderline personality, most of them using the DSM definition, have looked at all these aspects. There is some evidence for constitutional predispositions (Gunderson & Lyons-Ruth, 2008; Siever & Weinstein, 2009); some for misattuned parenting around attachment and separation issues (Fonagy, Target, Gergeley, Allen, & Bateman, 2003; Nickell, Waudby, & Trull, 2002); and some for the role of trauma, especially relational trauma in early attachment (Schore, 2002) but also later experiences of sexual abuse (Herman, 1992). It is probable that all these factors play a role, that borderline psychology is not a single entity and is multidetermined, like most other complex psychological phenomena. Current psychoanalytic writing,

especially about borderline dynamics, has drawn heavily on empirical findings in the areas of infant development, attachment, and trauma. One consequence has been a significant paradigm shift, as unquestioned notions of fixation at a normative developmental phase have been challenged by evidence for different experiences of attachment and for the destructive effects of recurrent trauma even long after the preschool years.

Whatever the etiology of borderline personality organization, and it probably differs from person to person, clinicians of diverse perspectives have attained a surprisingly reliable consensus on the clinical manifestations of problems in the borderline range. Especially when an interviewer is trained in what information, subjective as well as objective, should be observed and pursued, the diagnosis of borderline level of character structure may be readily confirmed or disconfirmed (e.g., through Kernberg's [1984] structural interview or the later, more carefully empirically validated instrument of his colleagues, the Structured Interview for Personality Organization [STIPO; Stern, Caligor, Roose, & Clarkin, 2004]).

Despite the complexity of the etiologies of borderline conditions, I think it can still be useful to view people with a vulnerability to psychosis as unconsciously preoccupied with the issues of the early symbiotic phase (especially trust), people with borderline personality organization as focused on separation–individuation themes, and those with neurotic structure as more "oedipal" or capable of experiencing conflicts that feel more internal to them. The most prevalent kind of anxiety for people in the psychotic range is fear of annihilation (Hurvich, 2003), evidently an activation of the brain's FEAR system (Panksepp, 1998) that evolved to protect against predation; the central anxiety for people in the borderline range is separation anxiety or the activation of Panksepp's PANIC system that deals with early attachment needs; anxiety in neurotic people tends to involve more unconscious conflict, especially fear of enacting guilty wishes.

OVERVIEW OF THE NEUROTIC–BORDERLINE–PSYCHOTIC SPECTRUM

In the following sections, I discuss neurotic, borderline, and psychotic levels of character structure in terms of favored defenses, level of identity integration, adequacy of reality testing, capacity to observe one's pathology, nature of one's primary conflict, and transference and countertransference. I focus on how these abstractions manifest themselves as discernible behaviors and communications in an initial interview or

in an ongoing treatment. In Chapter 4 I explore implications of these discriminations for the conduct and prognosis of therapy. Again, I want to emphasize that these levels of organization are somewhat artificial, that we can all find in ourselves issues from every level, and that viewing one's client as organized at one or another of the levels should not distract a therapist from the person's individuality and areas of strength.

Characteristics of Neurotic-Level Personality Structure

It is an irony that the term "neurotic" is now reserved by most analysts for people so emotionally healthy that they are considered rare and unusually gratifying clients. In Freud's time, the word was applied to most nonorganic, nonschizophrenic, nonpsychopathic, and nonmanic–depressive patients—that is, to a large class of individuals with emotional distress short of psychosis. We now see many of the people Freud called neurotic as having borderline or even psychotic features ("hysteria" was understood to include hallucinatory experiences that clearly cross the border into unreality). The more we have learned about the depth of certain problems, and their stubborn enmeshment within the matrix of a person's character, the more we currently reserve the term "neurotic" to denote a high level of capacity to function despite emotional suffering.

People whose personalities would be described by many contemporary analysts as organized at an essentially neurotic level rely primarily on the more mature or second-order defenses. While they also use primitive defenses, these are not nearly so prominent in their overall functioning and are evident mostly in times of unusual stress. While the presence of primitive defenses does not rule out the diagnosis of neurotic level of character structure, the absence of mature defenses does. Traditionally, the psychoanalytic literature noted that healthier people use repression as their basic defense, in preference to more indiscriminate solutions to conflict such as denial, splitting, projective identification, and other more archaic mechanisms.

Myerson (1991) has described how empathic parenting allows a young child to experience intense affects without having to hang on to infantile ways of dealing with them. As the child grows up, these powerful and often painful states of mind are put away and forgotten rather than continually reexperienced and then denied, split off, or projected. They may reemerge in long-term, intensive analysis, when analyst and client together, under the conditions of safety that evoke a "transference neurosis," peel back layers of repression; but ordinarily, overwhelming affects and primitive ways of handling them are not characteristic of persons in the neurotic range. And even in deep psychoanalytic treat-

ment, the neurotic-level client maintains some more rational, objective capacities in the middle of whatever emotional storms and associated distortions occur.

People with healthier character structure strike the interviewer as having a somewhat integrated sense of identity (Erikson, 1968). Their behavior shows some consistency, and their inner experience is of continuity of self through time. When asked to describe themselves, they are not at a loss for words, nor do they respond one-dimensionally; they can usually delineate their overall temperament, values, tastes, habits, convictions, virtues, and shortcomings with a sense of their long-range stability. They feel a sense of continuity with the child they used to be and can project themselves into the future as well. When asked to describe important others, such as their parents or lovers, their characterizations tend to be multifaceted and appreciative of the complex yet coherent set of qualities that constitutes anyone's personality.

Neurotic-level people are ordinarily in solid touch with what most of the world calls "reality." Not only are they strangers to hallucinatory or delusional misinterpretations of experience (except under conditions of chemical or organic influence, or posttraumatic flashback), they also strike the interviewer or therapist as having comparatively little need to misunderstand things in order to assimilate them. Patient and therapist live subjectively in more or less the same world. Typically, the therapist feels no compelling emotional pressure to be complicit in seeing life through a lens that feels distorting. Some portion of what has brought a neurotic patient for help is seen by him or her as odd; in other words, much of the psychopathology of neurotically organized people is ego alien or capable of being addressed so that it becomes so.

People in the neurotic range show early in therapy a capacity for what Sterba (1934) called the "therapeutic split" between the observing and the experiencing parts of the self. Even when their difficulties are somewhat ego syntonic, neurotic-level people do not seem to demand the interviewer's implicit validation of their ways of perceiving. For example, a paranoid man who is organized neurotically will be willing to consider the possibility that his suspicions derive from an internal disposition to emphasize the destructive intent of others. Contrastingly, paranoid patients at the borderline or psychotic level will put intense pressure on the therapist to join their conviction that their difficulties are external in origin; for example, to agree that others may be out to get them. Without such validation, they worry that they are not safe with the therapist.

Similarly, compulsive people in the neurotic range may say that their repetitive rituals are crazy but that they feel anxiety if they neglect them. Compulsive borderline and psychotic people sincerely believe themselves to be protected in some elemental way by acting on their compulsions

and have often developed elaborate rationalizations for them. A neurotic-level patient will share a therapist's assumption that the compulsive behaviors are in some realistic sense unnecessary, but a borderline or psychotic patient may privately worry that the practitioner who questions the rituals is deficient in either common sense or moral decency. A neurotic woman with a cleaning compulsion will be embarrassed to admit how frequently she launders the sheets, while a borderline or psychotic one will feel that anyone who washes the bedding less regularly is unclean.

Sometimes years can go by in treatment before a borderline or psychotic person will even mention a compulsion or phobia or obsession—in the patient's view there is nothing unusual about it. I worked with one borderline client for more than 10 years before she casually mentioned an elaborate, time-consuming morning ritual to "clear her sinuses" that she considered part of ordinary good hygiene. Another borderline woman, who had never mentioned bulimia in her abundance of even more distressing symptoms, dropped the comment, after 5 years in therapy, "By the way, I notice I'm not puking anymore." She had not previously thought to regard that part of her behavioral repertoire as consequential.

Their histories and their behavior in the interview situation give evidence that neurotic-level people have more or less successfully traversed Erikson's first two stages, basic trust and basic autonomy, and that they have made at least some progress toward identity integration and a sense of initiative. They tend to seek therapy not because of problems in essential security or agency, but because they keep running into conflicts between what they want and obstacles to attaining it that they suspect are of their own making. Freud's contention that the proper goal of therapy is the removal of inhibitions against love and work applies to this group; some neurotic-level people are also looking to expand their capacity for solitude and play.

Being in the presence of someone at the healthier end of the continuum of character pathology feels generally benign. The counterpart of the patient's possession of a sound observing ego is the therapist's experience of a sound working alliance. Often from the very first session, the therapist of a neurotic client feels that he or she and the patient are on the same side and that their mutual antagonist is a problematic *part* of the patient. The sociologist Edgar Z. Friedenberg (1959) compared this alliance to the experience of two young men tinkering with a car: one the expert, the other an interested learner. In addition, whatever the valence of the therapist's countertransference, positive or negative, it tends not to feel overwhelming. The neurotic-level client engenders in the listener neither the wish to kill nor the compulsion to save.

Characteristics of Psychotic-Level Personality Structure

At the psychotic end of the spectrum, people are much more internally desperate and disorganized. Interviewing a deeply disturbed patient can range from being a participant in a pleasant, low-key discussion to being the recipient of a homicidal attack. Especially before the advent of antipsychotic drugs in the 1950s, few therapists had the natural intuitive talent and emotional stamina to be significantly therapeutic to those in psychotic states. One of the finest achievements of the psychoanalytic tradition has been its inference of some order in the apparent chaos of people who are easy to dismiss as hopelessly and incomprehensibly crazy, and its consequent offer of ways to understand and mitigate severe mental suffering (Arieti, 1974; Buckley, 1988; De Waelhens & Ver Eecke, 2000; Eigen, 1986; Ogden, 1989; Robbins, 1993; Searles, 1965; Silver, 1989; Silver & Cantor, 1990; Spotnitz, 1985; Volkan, 1995).

It is not difficult to diagnose patients who are in an overt state of psychosis: they express hallucinations, delusions, and ideas of reference, and their thinking strikes the listener as illogical. There are many people walking around, however, whose basic psychotic-level internal confusion does not surface conspicuously unless they are under considerable stress. The knowledge that one is dealing with a "compensated" schizophrenic, or a currently nonsuicidal depressive who may be subject to periodic delusional yearnings to die, can make the difference between preventing and precipitating disaster. Having carried out or supervised the long-term treatment of many extremely difficult, sometimes putatively "untreatable" cases, I am convinced that devoted therapists do significant prevention. We preempt psychotic breaks, prevent suicides and homicides, and keep people out of hospitals. (These critical effects of therapy go mostly undocumented; no one can prove that he or she prevented a calamity, and critics tend to argue that if one claims to have forestalled a psychotic break, the patient was not really at risk of psychosis in the first place.)

I share with many analysts the view that it is also useful to conceive of some people who may never become diagnosably psychotic as nevertheless living in a symbiotic–psychotic internal world or, in Klein's (e.g., 1946) terms, in a consistently "paranoid–schizoid" state. They function, sometimes quite effectively, but they strike one as confused and deeply terrified, and their thinking feels disorganized or paranoid. One man I worked with, for example, told me with palpable dread that he would never return to a particular gym to exercise: "*Three times* someone has moved my things, so it's obvious that I'm not wanted there." Another used to switch topics abruptly whenever he was becoming very sad. I commented on this, and he said, "Oh yeah, I know I do that." I asked

him what his understanding of the pattern was, expecting him to say something like "I'm not ready to go there," or "It hurts too much," or "I don't want to start crying." But what he said, in a tone suggesting it was self-evident, was "Well, I can see I'm hurting you!" He saw sympathetic sadness on my face and could not imagine he was not damaging me.

To understand the subjective world of psychotic-level clients, one must first appreciate the defenses they tend to use. I will expand on these in Chapter 5; at this point I am simply listing them: withdrawal, denial, omnipotent control, primitive idealization and devaluation, primitive forms of projection and introjection, splitting, extreme dissociation, acting out, and somatization. These processes are preverbal and prerational; they protect one against a level of "nameless dread" (Bion, 1967) so overwhelming that even the frightening distortions that the defenses themselves may create are a lesser evil than that state of terror. As Fromm-Reichmann (1950) noted, people who struggle with psychosis have a core, immobilizing dread of their fantasied superhuman potential for destructiveness.

Second, people whose personalities are organized at an essentially psychotic level have grave difficulties with identity—so much so that they may not be fully sure *that* they exist, much less whether their existence is satisfying. They are deeply confused about who they are, and they usually struggle with such basic issues of self-definition as body concept, age, gender, and sexual orientation. "How do I know who I am?" or even "How do I know that I exist?" are not uncommon questions for psychotically organized people to ask in earnest. They cannot depend on a sense of continuity of identity in themselves and do not experience others as having continuity of self either: They live in fear of "malevolent transformations" (Sullivan, 1953) that will turn a trusted person abruptly into a sadistic persecutor. When asked to describe themselves or other important people in their lives, they tend to be vague, tangential, concrete, or observably distorting.

Often in rather subtle ways, one feels that a patient with an essentially psychotic personality is not anchored in reality. Although most of us have vestiges of magical beliefs (e.g., the idea that saying something positive will jinx a situation), careful investigation will reveal that such attitudes are not ego alien to psychotic-level individuals. They are often confused by and estranged from the assumptions about "reality" that are conventional within their culture. Although they may be preternaturally attuned to the underlying affect in any situation, they often do not know how to interpret its meaning and may assign highly self-referential significance to it.

For example, a very paranoid patient I worked with for a long time, whose sanity was often at risk, had an uncanny feel for my emotional

state. She would read it accurately but then attach to her perception of it the primitive preoccupations she had about her own essential goodness or badness, as in "You look irritated. It must be because you think I'm a bad mother." Or "You look bored. I must have offended you last week by leaving the session 5 minutes early." It took her years to feel safe enough to tell me that was how she was interpreting my expressions, and several more years to transform the conviction "Evil people are going to kill me because they hate my lifestyle" into "I feel guilty about some aspects of my life."

People with psychotic tendencies have trouble getting perspective on their psychological problems. They lack the "reflective functioning" that Fonagy and Target (1996) have identified as critical to cognitive maturation. This deficit may be related to the well-documented difficulties that schizophrenic people have with abstraction (Kasanin, 1944). Those whose mental health history has given them enough jargon to *sound* like good self-observers (e.g., "I know I tend to overreact" or even "My schizophrenia interferes with my judgment") may reveal to a sensitive interviewer that in an effort to reduce anxiety they are compliantly parroting what they have been told about themselves. One patient of mine had had so many intakes at psychiatric hospitals during which she had been asked (in a mental status evaluation that helps determine whether the patient is capable of abstract thought) to give the meaning of the proverb "A bird in the hand is worth two in the bush" that she had asked an acquaintance what it meant and memorized the answer (she proudly offered this explanation when I commented in an interested way on the automatic quality of her response).

Early psychoanalytic formulations about the difficulties that psychotic people have in getting perspective on their realistic troubles stressed energic aspects of their dilemma; that is, they were expending so much energy fighting off existential terror that none was left to use in the service of coping with reality. Ego psychology models emphasized the psychotic person's lack of internal differentiation between id, ego, and superego, and between observing and experiencing aspects of the ego. Students of psychosis influenced by interpersonal, object relations, and self psychology theories (e.g., Atwood, Orange, & Stolorow, 2002) have referred to boundary confusion between inside and outside experience, and to deficits in attachment that make it subjectively too dangerous for the psychotic person to enter the same assumptive world as the interviewer.

Recently, in light of fMRI studies showing similarities between effects of trauma on the developing brain and the biological abnormalities found in the brains of individuals diagnosed with schizophrenia, John Read and his colleagues (Read, Perry, Moskowitz, & Connolly,

2001) have argued for a traumatic etiology of schizophrenia. A full account of the lack of "observing ego" in psychotic-level clients probably includes all these perspectives as well as genetic, biochemical, and situational contributants. The critical thing for therapists to appreciate is that close to the surface in people with psychotic-level psychologies, one finds both mortal fear and dire confusion.

The nature of the primary conflict in people with a potential for psychosis is literally existential: life versus death, existence versus obliteration, safety versus terror. Their dreams are full of stark images of death and destruction. "To be or not to be" is their recurrent theme. Laing (1965) eloquently depicted them as suffering "ontological insecurity." Psychoanalytically influenced studies of the families of schizophrenic people in the 1950s and 1960s consistently reported patterns of emotional communication in which the psychotic child received subtle messages to the effect that he or she was not a separate person but an extension of someone else (Bateson, Jackson, Haley, & Weakland, 1956; Lidz, 1973; Mischler & Waxier, 1968; Singer & Wynne, 1965a, 1965b). Although the discovery of the major tranquilizers has diverted attention from more strictly psychological investigations of psychotic processes, no one has yet presented evidence controverting the observation that the psychotic person is deeply unconvinced of his or her right to a separate existence, or may even be unfamiliar with the sense of existing at all.

Despite their unusual and even frightening aspects, patients in the psychotic range may induce a positive countertransference. This reaction differs a bit from warm countertransference reactions to neurotic-level clients: One may feel more subjective omnipotence, parental protectiveness, and deep soul-level empathy toward psychotic people than toward neurotic ones. The phrase "the lovable schizophrenic" was for a long time in vogue as an expression of the solicitous attitude that mental health personnel often feel toward their most severely troubled patients. (The implicit contrast group here, as I discuss below, is the borderline population.) Psychotic people are so desperate for respect and hope that they may be deferential and grateful to any therapist who does more than classify and medicate them. Their gratitude is naturally touching.

People with psychotic tendencies are particularly appreciative of sincerity. A recovered schizophrenic woman once told me she could forgive even serious failings in a therapist if she saw them as "honest mistakes." Psychotic-level clients may also appreciate educative efforts and may respond with relief to the normalization or reframing of their preoccupations. These dispositions, along with their propensity for fusion and idealization, can make the therapist feel strong and benevolent. The downside of these patients' poignant dependence on our care is the bur-

den of psychological responsibility they inevitably impose. In fact, the countertransference with psychotic-level people is remarkably like normal maternal feelings toward infants under a year and a half: They are wonderful in their attachment and terrifying in their needs. They are not yet oppositional and irritating, but they also tax one's resources to the limit. I should not work with a schizophrenic, a supervisor once told me, unless I was prepared to be eaten alive.

This "consuming" feature of their psychology is one reason that many therapists prefer not to work with individuals with schizophrenia and other psychoses. In addition, as Karon (1992) has noted, the access of psychotic patients to deeply upsetting realities that the rest of us would prefer to ignore is often too much for us. In particular, they see our flaws and limitations with stunning clarity. Other reasons for their relative unpopularity as patients despite their appealing qualities probably include therapists' lack of adequate training in psychotherapy with psychotics (Karon, 2003; Silver, 2003), economic pressures that breed rationalizations about limited approaches or "management" instead of therapy (Whitaker, 2002), and personal dispositions not to work toward relatively modest treatment goals in contrast to what can be achieved with a neurotic-level person. But as I stress in the next chapter, it can be effective and rewarding to work with clients in the psychotic range if one is realistic about the nature of their psychological difficulties.

Characteristics of Borderline Personality Organization

One of the most striking features of people with borderline personality organization is their use of primitive defenses. Because they rely on such archaic and global operations as denial, projective identification, and splitting, when they are regressed they can be hard to distinguish from psychotic patients. An important difference between borderline and psychotic people, though, is that when a therapist confronts a borderline patient on using a primitive mode of experiencing, the patient will show at least a temporary responsiveness. When the therapist makes a similar comment to a psychotically organized person, he or she will likely become further agitated.

As an illustration, consider the defense of primitive devaluation. Being devalued is a familiar and painful experience to any therapist. Devaluation is an unconscious strategy that is often intended to preserve self-esteem, but which does so at the expense of learning. An effort to address that defense might go something like "You certainly love to cherish all my defects. Maybe that protects you from admitting that you might need my help. Perhaps you would be feeling 'one down' or ashamed if you weren't always putting me down, and you're trying to

avoid that feeling." A borderline patient might scorn such an interpretation, or grudgingly admit it, or receive it silently, but in any event, he or she would give some indications of reduced anxiety. A psychotic person would react with increased anxiety, since to someone in existential terror, devaluation of the power of the therapist may be the only psychological means by which he or she feels protected from obliteration. The therapist's discussing it as if it were optional would be extremely frightening.

Borderline patients are in some ways similar to and in others different from psychotic people on the dimension of identity integration. Their experience of self is likely to be full of inconsistency and discontinuity. When asked to describe their personalities, they may, like psychotic-level patients, be at a loss. And when asked to describe important people in their lives, they may respond with anything but three-dimensional, evocative descriptions of recognizable human beings. "My mother? She's just a regular mother, I guess" is a typical response. They often give global, dismissive descriptions such as "An alcoholic. That's all." Unlike patients with psychosis, they rarely sound concrete or tangential to the point of being bizarre, but they do tend to dismiss the therapist's interest in the complexities of themselves and others. Fonagy (2000) writes that borderline clients are insecurely attached and lack the "reflective function" that finds meaning in their own behavior and that of others. They cannot "mentalize"; that is, they cannot appreciate the separate subjectivities of other people. In philosophical terms, they lack a theory of mind.

Clients in the borderline range may become hostile when confronted with the limited continuity of their identity. One of my patients flew into a full-blown fury at a questionnaire she was given as a standard intake procedure in a clinic. It had a sentence-completion section in which the client was asked to fill in blanks like "I am the kind of person who _____." "How can anybody know what to do with this shit?" she raged. (Some years and countless sessions later she mused, "*Now* I could fill in that form. I wonder why I went ballistic about it.") In general, borderline patients have trouble with affect tolerance and regulation, and quickly go to anger in situations where others might feel shame or envy or sadness or some other more nuanced affect.

In two ways, the relation of borderline patients to their own identity is different from that of psychotic people. First, the sense of inconsistency and discontinuity that people with borderline organization suffer lacks the degree of existential terror of the schizophrenic. Borderline patients may have identity confusion, but they know they exist. Second, people with psychotic tendencies are much less likely than borderline patients to react with hostility to questions about identity of self and others. They

are too worried about losing their sense of ongoing being, consistent or not, to resent the interviewer's focus on that problem.

Despite these distinctions, both borderline and psychotic people, unlike neurotics, rely heavily on primitive defenses and suffer a basic defect in the sense of self. The dimension of experience on which the two groups differ substantially is reality testing. Borderline clients, when interviewed thoughtfully, demonstrate an appreciation of reality no matter how crazy or florid their symptoms look. It used to be standard psychiatric practice to assess the degree of the patient's "insight into illness" in order to discriminate between psychotic and nonpsychotic states. Because a borderline patient may relentlessly deny psychopathology yet still show a level of discrimination about what is real or conventional that distinguishes him or her from a psychotic peer, Kernberg (1975) proposed that "adequacy of reality testing" be substituted for that criterion.

To make a differential diagnosis between borderline and psychotic levels of organization, Kernberg (1984) advises investigating the person's appreciation of conventional notions of reality by picking out some unusual feature of his or her self-presentation, commenting on it and asking if the patient is aware that others might find that feature peculiar (e.g., "I notice that you have a tattoo on your cheek that says 'Death!' Can you understand how that might seem unusual to me or others?"). The borderline person will acknowledge that the feature is unconventional and that outsiders might not understand its significance. The psychotic person is likely to become frightened and confused because the sense that he or she is not understood is deeply disturbing. These differing reactions, which Kernberg and his coworkers (e.g., Kernberg, Yeomans, Clarkin, & Levy, 2008) have explored both clinically and via empirical research, may be viewed as support for psychoanalytic assumptions about the centrality of separation–individuation issues for people with borderline pathology as contrasted with unconscious deficits in self–other differentiation in psychosis.

The capacity of someone at the borderline level to observe his or her own pathology—at least the aspects of it that impress an external observer—is quite limited. People with borderline psychologies come to therapy for complaints such as panic attacks or depression or illnesses that a physician has insisted are related to "stress," or they arrive at the therapist's office at the urging of an acquaintance or family member, but they rarely come with the agenda of changing their personalities in directions that outsiders readily see as advantageous. Even in recent years, when they are apt to know they "have BPD" and can endorse the DSM criteria for diagnosing it, they still lack a sense of what it would be like to be different. Having never had any other kind of character, they

have little emotional basis for knowing how it would feel to have identity integration, mature defenses, the capacity to defer gratification, a tolerance for ambivalence and ambiguity, or an ability to regulate affects. They just want to stop hurting or to get some critic off their back.

In nonregressed states, because their reality testing is fine and because they may present themselves in ways that compel our empathy, they do not look particularly "sick." Sometimes it is only after therapy has proceeded for a while that one realizes that a given patient has a borderline structure. Usually the first clue is that interventions that the therapist intends to be helpful are received as attacks. In other words, the therapist keeps assuming a capacity for reflective functioning that the patient mostly lacks. (In older language, the therapist is trying to talk with an observing ego, something the client cannot access, especially when upset.) The patient knows only that some aspect of the self is being criticized. The therapist keeps trying to forge the kind of alliance that is possible with neurotic-level patients and keeps coming to grief in the effort.

Eventually, one learns that one must first just weather the affective storms that seem to keep raging, while trying to behave in ways that the patient will experience as different from whatever influences have shaped such a troubled and help-resistant person. Only *after* therapy has brought about some structural change will the patient be different enough to begin to understand what the therapist is trying to work toward. This may take a long time—sometimes 2 years in my experience—but it is of comfort that in the meantime, the most disabling borderline behaviors may disappear. Clarkin and Levy (2003) describe significant symptom reduction after 1 year of transference-focused therapy. Still, the work will typically have been tumultuous and frustrating to both parties.

Masterson (1976) has vividly depicted, and others with different viewpoints report similar observations, how borderline clients seem caught in a dilemma: When they feel close to another person, they panic because they fear engulfment and total control; when they are alone, they feel traumatically abandoned. This central conflict of their emotional experience results in their going back and forth in relationships, including the therapy relationship, in which neither closeness nor distance is comfortable. Living with such a basic conflict, one that does not respond immediately to interpretive efforts, is exhausting for borderline patients, their friends, their families, and their therapists. They are famous among emergency psychiatric service workers, at whose door they frequently appear talking suicide, for manifesting "help seeking–help rejecting behavior."

Masterson saw borderline patients as fixated at the rapprochement subphase of the separation–individuation process (Mahler, 1972b), when

the child has attained some autonomy yet still needs reassurance that a caregiver remains available and powerful. This drama unfolds around age 2, when children typically alternate between rejecting mother's help ("I can do it myself!") and dissolving in tears at her knees. Masterson (1976) believed that borderline patients have had mothers who discouraged them from separating in the first place or neglected them when they needed to regress after attaining some independence. Whether or not his ideas about etiology are correct, his observations about the borderline person's entrapment in dilemmas of separation and individuation help make sense of the changing, demanding, and often confusing qualities of borderline patients.

Transferences in borderline clients tend to be strong, unambivalent, and resistant to ordinary kinds of intervention. The therapist may be perceived as all good or all bad. If a well-intentioned but clinically naive therapist tries to interpret transference as one would with a neurotic person (e.g., "Perhaps what you're feeling toward me is something you felt toward your father"), he or she will find that no relief or helpful sense of insight follows; in fact, often the client will simply agree that the therapist is actually behaving like the earlier object. Also, it is not uncommon for a borderline person in one state of mind to perceive the therapist as godlike in power and virtue, and in another (which may appear a day later) as weak and contemptible.

Not surprisingly, countertransference reactions with borderline clients tend to be strong and upsetting. Even when positive (e.g., dominated by fantasies of rescuing the devastated patient), they may have a disturbing, consuming quality. Analysts in hospital settings (Gabbard, 1986; Kernberg, 1981) have noted that with some borderline patients, staff tend to be either oversolicitous (seeing them as deprived, weak, and in need of extra love to grow) or punitive (seeing them as demanding, manipulative, and in need of limits). Inpatient personnel frequently find themselves divided into opposing camps when treatment plans for borderline clients are discussed (Gunderson, 1984; Main, 1957). Outpatient practitioners may move internally between one position and the other, mirroring each side of the client's conflict at different times. It is not unusual for the therapist to feel like the exasperated mother of a 2-year-old who will not accept help yet collapses in frustration without it.

SUMMARY

This chapter has given a cursory overview of evolving efforts to describe different realms of character organization. From Kraepelinian distinctions between the sane and the insane, through early psychoanalytic

conceptions of symptom versus character neuroses, to taxonomies that emphasize either neurotic-level, borderline, or psychotic-level structure, to characterizing clients in terms of attachment pattern and traumatic influences, therapists have sought to account for the varying reactions of their individual clients to their efforts to be of help. I have argued that the assessment of a person's central preoccupation (security, autonomy, or identity), characteristic experience of anxiety (annihilation anxiety; separation anxiety; or more specific fears of punishment, injury, and loss of control), primary developmental conflict (symbiotic, separation–individuation, or oedipal), object relational capacities (monadic, dyadic, or triadic), and sense of self (overwhelmed, embattled, or responsible) constitutes one useful dimension of psychoanalytic diagnosis.

SUGGESTIONS FOR FURTHER READING

Phyllis and Robert Tyson (1990) have made a helpful synthesis of traditional psychoanalytic developmental theory through the late 20th century. Two classic books by Gertrude and Rubin Blanck (1979, 1986) have sections on the connection between development and diagnosis. Clinicians who treat children will find Stanley Greenspan's *Developmentally Based Psychotherapy* (1997) useful. For a contemporary book connecting recent developmental research with clinical practice, especially with borderline clients, I recommend *Affect Regulation, Mentalization, and the Development of the Self* (Fonagy et al., 2002), a comprehensive tome that is thankfully available in paperback. For a recent, readable self psychologically influenced account of psychological development, I suggest Russell Meares's *Intimacy and Alienation: Memory, Trauma, and Personal Being* (2002).

For a classical exegesis of the difference between neurotic symptom and neurotic character, the chapter on "Character Disorders" in Fenichel's *The Psychoanalytic Theory of Neurosis* (1945) is the standard. More recently, Josephs (1992) and Akhtar (1992) have published integrative books that pursue at a more advanced level some of the characterological issues introduced here. For a study in the Kleinian tradition of the clinical implications of different levels of development, Steiner's *Psychic Retreats* (1993) is brilliant but may be difficult for beginning therapists.

For classic analytic articles about personality organization, New York University Press has put out fine collections of papers on character neurosis (Lax, 1989), psychosis (Buckley, 1988), and borderline conditions (M. H. Stone, 1986). For a phenomenological appreciation of psychosis, Laing's *The Divided Self* (1965) remains unmatched. Eigen's

The Psychotic Core (1986) is difficult but rewarding. Elyn Saks's (2008) memoir of living with schizophrenia gives a moving yet witty close-up of psychotic experience and also of the potential for individuals with psychotic dynamics, when given good medical and psychological care, to live rich, generative lives.

The literature on borderline conditions is so abundant and diverse as to be overwhelming, but recent contributions by Kernberg and his colleagues (e.g., Clarkin, Yeomans, & Kernberg, 2006) and Fonagy and his colleagues (Bateman & Fonagy, 2004) usefully consider classical formulations in light of recent research and connect their ideas to treatment. For a readable book that values a categorical rather than dimensional definition of borderline psychology and has synthesized a vast amount of research in the tradition of John Gunderson, I recommend Paris's *Treatment of Borderline Personality Disorder* (2008).

Since the first edition of this book there has been an explosion of clinical and empirical literature on attachment. The struggles of borderline patients have been described in Wallin's *Attachment in Psychotherapy* (2007) and in Mikulincer and Shaver's *Attachment in Adulthood* (2007) in terms of severe attachment anxiety. For application of trauma research and theory to the experience of patients who are diagnosed as borderline, Judith Herman's *Trauma and Recovery* (1992) is probably the best place to start. See also the suggestions at the end of Chapter 15.

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Implications of Developmental Levels of Organization

Like politics, psychotherapy is the art of the possible. One advantage of conceptualizing each client developmentally is that one can derive a sense of what is reasonably expectable, with optimal treatment, for each one. Just as a physician expects a healthy person to recover faster and more completely from an illness than a sickly one, or as a teacher assumes that an intelligent student will master more material than a slow one, a therapist should have different expectations for people with different levels of character development. Realistic goals protect patients from demoralization and therapists from burnout.

It was easier to write the first edition of this chapter; in the early 1990s there was something closer to a psychoanalytic consensus about what approach is appropriate for each level of personality organization. Since that time, several things have occurred. Analysts in the relational movement have challenged many aspects of traditional technique—especially its assumptions about the analyst's capacity for objectivity and neutrality. They have also questioned the value of any generalizations about character structure and have revised our understandings of the patient–therapist dyad to put the emphasis on what the two parties construct together rather than on what the therapist does for or to the patient. The two-person model of the therapeutic process has gone mainstream and has influenced even those who think more traditionally. It will probably be evident, even in this book with its one-person focus on patients' individual psychologies, that relational analysts have greatly influenced my thinking.

At the same time, several specific therapies for borderline personality organization have been developed, and psychoanalytic theorists no longer dominate professional conversations about how to understand borderline phenomena. Marsha Linehan, the architect of dialectical behavior therapy (e.g., 1993), has frequently acknowledged her debt to Otto Kernberg, but the treatment she created reflects both cognitive-behavioral concepts and some Zen Buddhist ideas, not assumptions about a dynamic unconscious. Jeffrey Young's schema therapy (e.g., Rafaeli, Bernstein, & Young, 2010), which also derives from cognitive-behavioral psychology with some psychodynamic influences, has been applied to borderline-level personality disorders. In the specifically psychoanalytic realm, where Kernberg's original notion of expressive therapy once predominated, we have seen the development of several specific, research-tested treatments: Kernberg's transference-focused psychotherapy (Clarkin, Yeomans, & Kernberg, 2006) and Fonagy's mentalization-based therapy (Bateman & Fonagy, 2004) being the best known.

Finally, the International Society for the Psychological Treatments of Schizophrenia has brought together therapists interested in psychotherapy with psychotic patients, and their synergy has added new elements to what we know about treating severely troubled people. Even more than in 1994, our mental health culture tends to overstate the pharmaceutical needs of people with psychoses and to understate their need for therapy. I think there is greater urgency now than in earlier decades to pass on our knowledge about effective talk therapy for those who suffer the most.

I start, as before, with considerations about treating neurotic-level clients, then those in the psychotic range, and finally those in the borderline spectrum. Even though the story has become more complicated, I think it is still useful to note clinical implications of levels of severity. I cannot do justice to the subtleties of specific approaches, but I try to present enough of a feel for how to work, depending on a person's inferred developmental challenges, that I demonstrate the value of assessing these levels. The goal of any dynamic therapy is to help each client with the maturational task that is most compelling for that person—whether that is the full flowering of one's creativity or the attainment of some minimal awareness that one exists and deserves to stay alive.

THERAPY WITH NEUROTIC-LEVEL PATIENTS

It used to be commonly claimed that psychoanalytic therapy is unsuited to anyone but the "worried well." The kernel of truth in this view

is that psychoanalysis *as a specific treatment* works best with articulate neurotic-level clients who have the ambitious goal of character change and/or deep self-knowledge. The arrangements that define classical Freudian analysis (frequent sessions, free association, use of the couch, attention to transference and resistance, open-ended contract) work less well for other patients—although early in the psychoanalytic movement, before modified approaches were developed, analysis was attempted with a wide array of clients. Also, the session frequency that Freud had recommended (originally six, then five times a week; later four or even three) made traditional analysis affordable only by people of some means.

That psychoanalytic therapy works faster and goes further with already advantaged people can be compared to the responses of healthy people to medical care or bright people to education. There are many reasons why it is easier to do analytic therapy with healthier patients than with borderline or psychotic individuals. In Eriksonian terms, one can assume basic trust, considerable autonomy, and a reliable sense of identity. Treatment goals may include removing unconscious obstacles to full gratification in the areas of love, work, and play. Freud equated psychoanalytic "cure" with freedom, and in the Platonic tradition, he believed it is truth that ultimately makes us free. A search for difficult truths about the self is possible for neurotic-level people because their self-esteem is resilient enough to tolerate some unpleasant discoveries. Accordingly, Theodor Reik (1948) used to say that the primary requisite to conduct or undergo analysis is moral courage.

Psychoanalysis and Open-Ended Psychoanalytic Therapies

Neurotic-level patients quickly establish with the therapist a working alliance in which the clinician and the observing part of the client are allies in accessing previously unconscious or disavowed defenses, feelings, fantasies, beliefs, conflicts, and strivings. If the patient is seeking a thorough understanding of his or her personality, with the goal of the greatest possible degree of growth and change, intensive analysis should be considered. Lately, students in psychoanalytic training constitute the majority of patients willing at the outset to make the three-or-four-sessions-per-week commitment that analysis dictates (usually because their training institute requires it), but some patients who are not in the mental health field decide after a period of less intensive therapy that they want to "go deeper" and move from analytically oriented treatment (twice a week or less) into analysis. In the United States, this is happening less frequently, not because of lack of interest, but because of insurance companies' unwillingness to fund intensive treatments.

The fact that psychoanalysis may go on for years does not obviate the fact that, perhaps especially with healthier persons, symptomatic and behavioral improvement may happen quickly. But people have a feel for the difference between behavior change that is possible in spite of one's psychology and behavior change that has come to feel congruent with one's insides. To move from the first to the second is one reason people may choose to stay in analytic treatment for the long haul. An analogy would be the difference that a man addicted to alcohol feels between early sobriety, during which he struggles minute by minute to resist the temptation to drink, and later recovery, when he no longer feels the urge. The behavior of not drinking is the same in early and late sobriety, but the underpinnings of it change. It may have taken years of AA meetings and unremitting discipline to alter old patterns, habits, and beliefs, but to the recovering alcoholic the shift from a barely controlled compulsion to indifference toward alcohol is a priceless achievement.

For neurotic-level people who are unable or unwilling to take on the commitment of time, money, and emotional energy involved in intensive analysis, psychoanalytic (or "psychodynamic") therapy, which developed as a modification of classical analysis in the direction of being more specifically problem focused, may be the treatment of choice. Patient and therapist meet for fewer than three sessions a week, usually face-to-face. The therapist is less encouraging of emotional regression and more active in pointing out themes and patterns that patients who come more frequently tend to notice by themselves. Both psychoanalysis and modified psychoanalytic therapies have been referred to as "uncovering" or "exploratory" or "expressive" treatments because the invitation to the client is to be as open as possible, to focus on feelings, and to try to push past defensiveness. Sometimes they have been also called "insight-oriented" therapies, in reference to the analytic assumption that self-knowledge reduces conflict and promotes growth.

Short-Term Treatments and Nonpsychodynamic Therapies

Patients in the neurotic range are also often good candidates for short-term analytic therapies (Bellak & Small, 1978; Davanloo, 1980; Fosha, 2000; Malan, 1963; Mann, 1973; Messer & Warren, 1995; Sifneos, 1992). Intensive focusing on a conflict area can be overwhelming to someone with a borderline or psychotic structure; in contrast, a neurotic-level person may find it stimulating and productive. Similarly, higher-functioning clients tend to do well in analytically informed group and family modes of treatment, while borderline and psychotic people often do not. (Lower-functioning clients absorb so much of the emotional energy of the group or family unit that the other parties get hope-

lessly torn between resentment at their always being center stage and guilt about that resentment, as the more troubled person is obviously suffering so much.)

In fact, virtually any approach to therapy will be helpful to most clients in the neurotic range. In CBT therapy they tend to do any homework the therapist suggests, and with biologically oriented psychiatrists, they may willingly take the medicines they are prescribed. They have had enough experiences with loving people that they assume benevolence in the therapist and try to cooperate. They are, understandably, popular clients. One of the reasons for the prestige that once attended classical analysis may be that people with the requisites to be analysands are readily responsive to and appreciative of their treatment. They are good advertisements for their analysts, unlike borderline people, for example, who may—even when they may be improving in therapy—disparage their therapists ruthlessly to outsiders or idealize them in such a cloying way that everyone in their circle of friends thinks they have been taken in by a master charlatan.

Most psychodynamic writers feel that intensive psychoanalysis offers neurotically organized people the greatest ultimate benefits and that anyone with the resources to undergo in-depth, high-frequency treatment, especially someone in young adulthood with years ahead to reap the psychological rewards, would be well advised to do so. I share this opinion, having benefited all my adult life from a good early classical analysis. It is also true, however, that a person in the neurotic range can benefit from all sorts of different experiences and can extract psychological growth even from some conditions that others might find disabling.

THERAPY WITH PATIENTS IN THE PSYCHOTIC RANGE

Probably the most important thing to understand about people with psychotic illnesses or psychotic-level psychologies is that they are terrified. It is no accident that many drugs that are helpful for schizophrenic conditions are major antianxiety agents; the person with a vulnerability to psychotic disorganization lacks a basic sense of security in the world and is ready to believe that annihilation is imminent. Adopting any approach that permits a lot of ambiguity, as does traditional analytic therapy with neurotics, is like throwing gasoline into the flame of psychotic-level terror. Consequently, the treatment of choice with psychotic-level patients has generally been framed as "supportive therapy," an approach that emphasizes active support of the patient's dignity, self-esteem, ego strength, and need for information and guidance.

All therapy is supportive, but in the ego psychology tradition the phrase has had a narrower meaning, reflecting the experience of several decades of psychodynamic work with more deeply disturbed people (Alanen, Gonzalez de Chavez, Silver, & Martindale, 2009; Arieti, 1974; Eigen, 1986; Federn, 1952; Fromm-Reichmann, 1950; Jacobson, 1967; Karon & VandenBos, 1981; Klein, 1940, 1945; Lidz, 1973; Little, 1981; Pinsker, 1997; Rockland, 1992; Rosenfeld, 1947; Searles, 1965; Segal, 1950; Selzer, Sullivan, Carsky, & Terkelson, 1989; Silver, 2003; Sullivan, 1962; R. S. Wallerstein, 1986). It is generally agreed that there is a continuum from supportive through expressive (or "uncovering," or "exploratory") therapy (Friedman, 2006), in which at the uncovering end one encourages full expression of intrapsychic conflict, leading to insight and resolution, while at the supportive end one tries to "support the ego in its struggle to contain, or repress intrapsychic conflicts and to suppress their symptomatic expression" (R. S. Wallerstein, 2002, p. 143). Much of what I cover in this section can apply to work with any patient but is particularly critical to working with more disturbed people.

Explicit Safety, Respect, Honesty

The first aspect of supportive work I should mention is the therapist's demonstration of trustworthiness. The fact that psychotic-level people are often compliant does not mean that they trust. In fact, their compliance may mean quite the opposite: It may express their fear that authorities will kill them for being separate, for having their own will. The therapist needs to keep in mind that it is important not to act in ways that reinforce the primitive images of hostile and omnipotent authority with which psychotic-level people are tormented. To prove that one is a safe object is not so easy. With a neurotic-level person in a paranoid state, it may be enough to interpret the transference, that is, to comment on how the patient is mixing one up with some negative person from the past or some projected negative part of the self. Interpretation of this sort is useless with severely disturbed people; in fact, they are likely to consider it a diabolical evasion.

Instead, one must repeatedly counteract the patient's most frightening expectations. A facial expression that conveys respect is enough to make a neurotic-level patient comfortable, but with a person at risk for psychosis, one must demonstrate much more actively one's acceptance of the patient as a morally equal human colleague. This might include simple communications such as asking such clients to tell you if it gets too warm or too cold in the office, asking their opinions about a new painting, creating opportunities for them to demonstrate areas of personal expertise, or commenting on the creative and positive aspects of

even their most bizarre symptoms. In this context, Karon (1989) has provided a pertinent example:

> Therapeutically, it is often useful to tell the patient, "That is a brilliant explanation." The patient is generally startled that any professional would take his or her ideas seriously. "You mean you think it is right?" If, as is usually the case, the therapist believes that the patient can tolerate it, the therapist might usefully say, "No, but that is because I know some things about the human mind which you don't know yet, and I'll tell you if you're interested. But given what you do know, that is a brilliant explanation." With such a nonhumiliating approach to the patient, it is often possible to get the most suspicious paranoid to consider what might be going on and its real meaning as an attempt to solve the terrifying dilemmas of his or her symptoms and life history. (p. 180)

Another aspect of demonstrating that one is trustworthy is behaving with unwavering honesty. Anyone experienced with schizophrenic clients can attest to their attunement to affective nuance and their need to know that their therapist is emotionally truthful. Psychotic-level people require much more emotional self-disclosure than other patients; without it, they may stew in their worst fantasies. This is an area where supportive therapy diverges from traditional analytic therapy with neurotic-level people. With healthier people, one may avoid emotional revelations so that the patient can notice and explore what his or her fantasies are about the therapist's affective state. With more troubled clients, one must be willing to be known.

Take irritation, for example. It is natural for the therapist to feel irritated with any patient at various points, especially when the person seems to be behaving self-destructively. A perception that one's therapist looks annoyed would be upsetting to any client, but it is mortally terrifying to more deeply troubled ones. If a neurotic-level person asks, "Are you mad at me?" one helpful response would be something along the lines of "What are your thoughts and feelings about what it would mean if I were mad at you?" If the same query is made by a potentially psychotic patient, the therapeutic reply might be "You're very perceptive. I guess I am feeling a little irritation. I'm a bit frustrated that I can't seem to help you as fast as I would like. What was your reason for asking?"

Notice that with the supportive approach, one still invites the patient to explore his or her perceptions, but only after a potentially inhibiting apprehension has been directly counteracted by specific information. In the example above, the therapist has also explicitly expressed respect for the patient's accurate perception, thus supporting his or her realistically based self-esteem, and has implicitly counteracted primitive fantasies of the therapist's dangerous omnipotence by connecting anger with ordi-

nary human limitation rather than with talionic destruction. No one who finds it uncomfortable to admit to baser human motives should work with people in the psychotic range; they can smell hypocrisy, and it literally makes them crazy.

Along these lines, it is important with a psychotic-level patient to give explicit rationales for one's way of working, rationales that will make emotional sense to the person. Higher-functioning people are often therapy-savvy, and if any arrangement does not seem reasonable to them, they will usually ask about it. Take the fee, for example. With neurotic patients, regardless of how many fantasies they have about what money means to you and to them, there is rarely a need to go into why one charges what one does. It was part of the original contract, and the reasonable part of the healthier patient understands that this is a relationship where a fee is charged for services rendered.

Psychotically vulnerable people, in contrast, can have all kinds of secret and very peculiar ideas about the meaning of money exchange—not in the form of fantasies that coexist with more rational notions, but as their private conviction. One of my more psychotically organized patients told me after several months that he believed that if I really wanted to help him, I would see him for free, and that any other basis for our relationship was corrupt. He was cooperating with me, he explained, because maybe if he could work his way enough into my affections, I would treat him simply out of love and thereby heal his deep conviction of unlovability. This kind of thinking in symbiotically preoccupied people is far from rare and has to be addressed directly. "Analyzing" it as one would do with a neurotic-level person will not be helpful because the belief is syntonic, not a buried vestige of infantile forms of thought.

Hence, if one is asked about the fee by a patient with these fantasies, one might say something like, "I charge what I do because this is the way I earn my living, helping people with emotional problems. Also, I have learned that when I charge less than this, I find myself feeling resentful, and I don't believe I can be fully helpful when I'm in a state of resentment." This is not only useful education about how the world works and about the essentially reciprocal nature of psychotherapy—which is in itself corrective to the more fused, enmeshed conceptions of relationship held by more disturbed people—but it is also emotionally honest and will consequently be received with relief even if the patient still thinks the fee is unnecessary or too high.

My own style with most psychotic-level people is quite self-disclosing. I have been known to talk about my family, my personal history, my opinions—anything to put the person at ease with me as an ordinary human being. Such an approach is controversial; not every therapist is temperamentally comfortable with exposure. It also has certain hazards,

not the least of which is that some aspect of the therapist's revealed person will incite a psychotic response in the patient. My rationale lies in the contrast between symbiotically organized people and more individuated ones. The former have such total, encompassing transferences that they can only learn about their distortions of reality when reality is painted in stark colors in front of them, whereas the latter have subtle and unconscious transferences that may surface only when the therapist is more opaque.

The terror of the patient that he or she is in the hands of a powerful, distant, and perhaps persecutory Other is so great that the benefits of being more open may outweigh the risks. And if some revelation provokes a psychotic response, it can be addressed; nondisclosure certainly provokes its share of psychotic upset anyway. In fact, occasional disasters are inevitable in work with more disturbed people and cannot be avoided by the "right" technique. Once I sent a paranoid young man into a full-scale delusion about my intent to murder him because I absentmindedly swatted a bug ("You killed a living thing!") in his presence.

Another way one may have to demonstrate basic concern, and thereby trustworthiness, is by extending oneself to help in a more specific, problem-solving way than would be warranted in psychotherapy with healthier persons. Advice is ordinarily not given to healthier clients, as it implicitly infantilizes a person with a sense of agency. Karon and VandenBos (1981) discuss the value of practical advice to the patient about counteracting insomnia. One may have to take a position on the patient's behalf on certain matters. For instance, "I think it's important that you go to your sister's funeral. I know it won't be easy, but I'm afraid if you avoid it you'll always fault yourself, and you won't have another chance. I'll be here afterward to help you cope with any upset you feel." One may have to advocate for the patient with agencies and social authorities.

The reader will have picked up by now that with psychotic-level people one must relate in a more authoritative (not authoritarian) way than with higher-functioning patients. By behaving like a professional expert but a human equal, the therapist can make frightened clients feel safer. The egalitarian tone is nonhumiliating; the sense of authority reassures them that the therapist is strong enough to withstand their fantasied destructiveness. Naturally, the issues on which one takes an authoritative stand must be ones in which the therapist is genuinely confident. Eventually, as they progress in treatment, even very disturbed people will develop enough security in the relationship to express a difference of opinion, and the therapist can take pride in having fostered the evolution of some genuine psychological independence.

Education

A related aspect of supportive therapy is the therapist's educative role. Individuals in the psychotic range have areas of great cognitive confusion, especially about emotions and fantasies. Older research into family dynamics in schizophrenia (Bateson et al., 1956; Lidz, 1973; Mischler & Waxler, 1968; Singer & Wynne, 1965a, 1965b) suggest that many psychotic people grew up in systems in which baffling, paralyzing emotional language was used. Family members may have talked about love while acting hatefully, claimed to represent the client's feelings while unwittingly distorting them, and so forth. As a result, psychosis-prone people often need explicit education about what feelings are, how they are natural reactions, how they differ from actions, how everyone weaves them into fantasies, and how universal are the concerns that the psychotically organized person believes constitute his or her idiosyncratic and warped drama. In many vulnerable people, feelings are not so much unconscious as they are fundamentally unformulated (D. B. Stern, 1997).

One component of the educative process is normalization. The active solicitation of all the client's concerns and then the reframing of frightening thoughts and feelings as natural aspects of being an emotionally responsive human being are vital to work with more disturbed people. For example, a psychotically bipolar woman became agitated on finding herself admiring my legs as I opened a window; she worried that this meant she was a lesbian. With a less fragile person, I would have asked her to associate to that worry, assuming that her anxiety about sexual orientation was tolerable and would lead to interesting discoveries about disowned aspects of herself. With this woman, however, I remarked warmly that I felt complimented (she looked frightened, as if expecting me to be horrified by the prospect of her attraction), and I went on to say that as far as I could tell on the basis of her history she was not essentially a lesbian, although everyone has some sexual feelings toward people of both genders, and that the only way she might differ from others in having noticed this idea in herself is that some people have a knack for automatically keeping such perceptions unconscious. I recast her worry as being another instance of her greater sensitivity to her inner life and to emotional subtlety than most people have, and I reiterated that my role with her included my trying to help her become comfortable with the fact that she was often in touch with aspects of universal human psychology that many people keep out of awareness.

In this work, one draws on accumulated clinical wisdom, generalizing to the patient what therapists have learned about human psychology. Early conceptions of psychosis as a state of defenselessness, contrasting with the overdefendedness of neurotic people, contributed to the devel-

opment of this difference in technique. (We now understand psychotic-level people as having defenses, but very primitive ones that cannot be analyzed without making the client feel bereft of one of his or her few means of feeling less frightened.) Psychotically inclined people become traumatically overstimulated by primary process material and often can reduce their upset from that material only by having it normalized.

For example, a young man I treated briefly for a psychotic reaction to his father's death confessed that he sometimes believed that he had become his father: his self had died, and his father had taken over his body. He was having recurrent dreams in which monsters pursued him, turned into his father, and tried to kill him, and he was genuinely terrified that the dead man, who had been a difficult and punitive parent in life, was capable of invading his body from the grave. I assured him that this was a natural though not always conscious fantasy that people have after bereavement, told him he could expect to lose that feeling as the mourning period progressed, and explained that his belief that his father inhabited his body was expressing numerous natural responses to the death of a parent. First, it indicated denial that his father was dead—a normal phase of grief; second, it expressed his own survivor guilt, handled by the fantasy that he rather than his father had died; third, it was an attempt to reduce anxiety, in that if his father was in his body, he was not somewhere else planning to murder his son for the sin of outliving him.

This kind of active, educative stance is vital to the emotional equilibrium of a psychotically anxious person because it mitigates the terror that he or she harbors about going crazy. It also welcomes the client into a world of greater psychological complexity and implicitly invites him or her to "join the human race." Many people with psychotic tendencies have been placed since early childhood in the sick role, first by their families and later by other social systems that define them as oddballs. Consequently, they come to treatment expecting that a therapist will be similarly impressed by their lack of sanity. Interventions that embrace rather than stigmatize are relievingly corrective and can have a self-fulfilling effect. In educative conversations it is more important to convey a general expectation of eventual understanding than to be completely accurate. Since one never does understand perfectly, it is also important to modify one's authoritative tone with some qualifications about such explanations being a "best guess" or "provisional understanding."

This style of intervention was first developed for children whose primitive preoccupations coexisted with fears of regression (B. Bornstein, 1949) and has variously been called "reconstruction upward" (Greenson, 1967; R. M. Loewenstein, 1951), "interpreting upward" (Horner, 1990), and simply "interpreting up." These phrases imply a contrast with the

kind of interpretation helpful to neurotic-level patients, by which one works "from surface to depth" (Fenichel, 1941), addressing whatever defense is closest to conscious understanding. In interpreting up, one directly plumbs the depths, names their contents, and explains why that material would have been set off by the patient's life experiences. Oddly, this essential aspect of psychodynamic work with frightened patients is seldom spelled out in books on technique.

Identification of Triggers

A third principle of supportive therapy involves attention to feelings and stresses rather than defenses. For example, when working with more disturbed people we frequently have to sit through extended paranoid tirades when the patient is upset. It is tempting, in the face of an assault on the senses of a psychotic degree of fear and hatred, to try to explain away the projective defense or to contrast the client's distortions with the therapist's view of reality, but either of those strategies is likely to make the patient worry that the therapist is secretly in league with the persecutors. Yet just witnessing a disorganized psychotic outburst seems hardly therapeutic. So what is one to do?

First, one waits until the patient pauses for breath. It is better to wait too long than not long enough (this may mean sitting quietly and nodding sympathetically for most of the session), reminding oneself that at least the patient now trusts you enough to express uncensored feelings. Second, one makes a comment something like "You seem more upset than usual today," with no implication that the content of the upset is crazy. Finally, one tries to help the client figure out what set off this intensity of feeling. Often, the source of the distress is only peripherally related to the topic of the rant; it may be, for example, some life circumstance involving a separation (the client's child is entering kindergarten, or a brother announced his engagement, or the therapist mentioned vacation plans). Then one empathizes actively with how disconcerting separations can be.

In this process, one must sometimes tolerate the odd role of accepting what the therapist sees as the person's distortions, and occasionally, as most strikingly dramatized in Robert Lindner's (1955) entertaining essay, "The Jet-Propelled Couch," one must even actively accept the patient's frame of reference. Sometimes only in being joined this way will the patient feel sufficiently understood to accept later reflections (cf. Federn, 1952). The school of "Modern Psychoanalysis" (Spotnitz, 1985) has raised this style of therapy to a high art. Originally labeled "paradigmatic psychoanalysis" (Coleman & Nelson, 1957), this approach has a lot in common with later "paradoxical intervention" techniques favored

by some family systems therapists. Joining is not as cynical as it may seem, as there is always some truth in even the most paranoid constructions.

Some examples of joining: A woman storms into her therapist's office, accusing him of involvement in a plot to kill her. Rather than questioning the existence of the plot or suggesting that she is projecting her own murderous wishes, the therapist says, "I'm sorry! If I've been connected with such a plot, I wasn't aware of it. What's going on?" A man falls into a miserable silence and when prodded confesses that he is responsible for the carnage in the Middle East. The therapist responds, "It must be terrible to carry that burden of guilt. In what way are you responsible?" Or a patient confides that the therapist's colleague and friend, the ward nurse, tried to poison him. The therapist says, "How awful. Why do you suppose she is mad enough at you to try to kill you?"

Note that in all these instances, the therapist does not express agreement with the patient's interpretations of events, but neither does he or she inflict the wound to the patient's pride of dismissing them. And most important, the therapist invites further discussion. Usually, once the client lets off enough steam, a less terrifying understanding will gradually replace more paranoid attributions. Sometimes the therapist can assist this process by gently asking about alternative explanations of the patient's perceptions, but only after giving the client time for self-expression. Often by the end of the session, the patient feels reoriented and leaves in a more composed state.

By now it is probably evident how different psychoanalytic work with psychotic-level people is from therapy with neurotic individuals. Not everyone has the temperament to do this kind of work comfortably—it is facilitated by both counterphobia and a sense of personal power that is alien to the personalities of many therapists; those without such qualities may be better off in other areas of mental health service. One of the most important things to learn in one's training is which kinds of people one enjoys and treats effectively, and which kinds one should refer.

Therapy with psychotic and potentially psychotic people has different aims and satisfactions from therapy with healthier clients. Despite some prejudice against it in the name of cost cutting (a position I see as comparable to arguing that cancer patients should receive aspirin), psychotherapy with psychotic people is effective (Gottdiener, 2002, 2006; Gottdeiner & Haslam, 2002; Silver, 2003) and may be gratefully received (see, e.g., A Recovering Patient, 1986; Saks, 2008). By the mid-1990s, cognitive-behavioral therapists (e.g., Hagarty et al., 1995) were describing effective work with psychotic patients characterized by education, support, and skills training—an approach that in practice seems

pretty similar to psychoanalytic supportive treatment. Therapy with the severely disturbed can be lifesaving; expertise in it is much rarer than expertise treating healthier people; it is intellectually and emotionally stimulating; it nourishes one's creativity. At the same time, it can be depleting, confusing, and discouraging, and it inevitably confronts one with the limits on one's capacities to effect dramatic transformations.

In closing this section, I offer the following rules from Ann-Louise Silver (2003, p. 331) for working with people with psychoses:

1. If you cannot help the patient, do no harm. Consequently,
2. Use physical force only to prevent a patient from harming him or herself or someone else, never as punishment, or "negative reinforcement."
3. Never humiliate your patient.
4. Get as accurate a case history as possible. Don't limit yourself to a few hours or even a few sessions.
5. Encourage work and social relations.
6. Most centrally, do your best to understand your patient as an individual human being.

THERAPY WITH BORDERLINE PATIENTS

The term "borderline," used as a level of organization, encompasses great diversity. Not only is a depressive person with borderline character structure quite different from a narcissistic or hysterical or paranoid borderline person, but there is a wide range of severity within the borderline spectrum, extending from the border with the neuroses to the border with the psychoses (Grinker et al., 1968)—somewhat arbitrary borders to begin with. The closer a person's psychology is to neurotic, the more positively he or she will respond to a more "uncovering" kind of treatment, whereas clients who border on psychosis will react better to a more supportive style. We are not unidimensional; every neurotic-level person has some borderline tendencies, and vice versa. But in general, people with a borderline level of personality organization need highly structured therapies. In what follows I mention some cognitive and behavioral approaches along with psychodynamic ones, as in practice, there are significant similarities across treatment approaches.

The aim of therapy for people with borderline psychologies is the development of an integrated, dependable, complex, and positively valued sense of self. Along with this goes the evolution of a capacity to love other people fully despite their flaws and contradictions and the ability to tolerate and regulate a wide range of emotions. A gradual movement

from capricious reactivity to steady reliance on one's perceptions, feelings, and values is possible for borderline people, despite the difficulties they present to therapists, especially in the early part of treatment.

Theorists with different explanatory constructions about borderline personality structure have emphasized different aspects of treatment. Originally, it was widely seen as a developmental arrest (e.g., Adler & Buie, 1979; Balint, 1968; Blanck & Blanck, 1986; Giovacchini & Boyer, 1982; Masterson, 1976; Meissner, 1988; Pine, 1985; Searles, 1986; Stolorow, Brandchaft, & Atwood, 1987) in interaction with a constitutional temperament (Gabbard, 1991; Kernberg, 1975; M. H. Stone, 1981). More recently, it has been viewed as a result of trauma (e.g., Briere, 1992; C. A. Ross, 2000), especially attachment trauma (Blatt & Levy, 2003). These theories are not mutually exclusive; "borderline personality" is a complex concept and probably multiply determined.

Although the generalizability of most empirical studies of therapy for people with borderline psychologies is limited to those meeting DSM criteria for BPD, research on treatments for borderline conditions has been encouraging and has given empirical support to several approaches. Linehan's dialectical behavior therapy (e.g., 1993) is often cited as "the" evidence-based therapy for BPD, but there have also been methodologically rigorous studies (e.g., Bateman & Fonagy, 2004; Levy et al., 2006) of both Fonagy's mentalization-based therapy (MBT) and Kernberg's transference-focused psychotherapy (TFP)—the latter being the manualized version of the "expressive therapy" denoted in this book's first edition. Recently, Young's schema-focused therapy (SFT—whence the three-letter acronym rule?!) has been empirically tested (van Asselt et al., 2008). Differing views of etiology and differing therapy traditions naturally lead to different treatments, and there is sufficient controversy in the literature on treating borderline clients that a few paragraphs cannot address all the divergences. Still, it is remarkable how much practical consensus, despite varied theoretical languages and etiological assumptions, there is about overall principles of treatment, some of which I summarize here (cf. Paris, 2008).

Safeguarding Boundaries and Tolerating Emotional Intensity

Although borderline patients have more capacity to trust than psychotically organized people do, and thus rarely require the therapist's continual demonstration that they are safe in the consulting room, they may take up to several years to develop the kind of therapeutic alliance that a neurotic client may feel within minutes of meeting the therapist. By definition, the borderline client lacks an integrated observing ego that sees things more or less as the therapist does; instead, he or she is subject to

shifting chaotically between different ego states, with no capacity yet for putting disparate attitudes together. Whereas the psychotic person tends to fuse psychologically with the clinician and the neurotic one to keep a clear separate identity, the borderline person alternates—confusingly to self and others—between symbiotic attachment and hostile, isolated separateness. Both states are upsetting: One raises the specter of engulfment, the other of desertion.

Given this instability of ego state, a critical dimension of treatment with borderline patients is the establishment of the consistent conditions of the therapy—what Langs (1973) has called the therapeutic frame. This includes not only arrangements as to time and fee but may also involve numerous other decisions about the boundaries of the relationship that rarely come up with other clients. All the mainstream therapies for BPD have mechanisms (contracts, consequences, rules of the treatment, ways to limit self-destructiveness) to maintain treatment via explicit boundary conditions. One can be more flexible with either neurotic- or psychotic-level patients.

Common concerns of borderline clients include "Can I call you at home?" "What if I'm suicidal?" "Will you break confidentiality for any reason?" "How late can I cancel a session without being charged?" "Can I sleep on the floor in your waiting room?" "Will you write my professor and say I was too stressed out to take the exam?" Some of these issues are articulated as questions; others come up in enacted form (e.g., one finds the client sleeping on the waiting room floor). The possibilities for boundary struggles are limitless with people in the borderline range, and the critical thing for the therapist to know is not so much *what* conditions should be set (these may vary according to the patient's personality, the therapist's preferences, and the situation) but *that* they must be set, consistently observed, and enforced by specific sanctions if the patient fails to respect them. It is disturbing to people with separation–individuation issues to be indulged rather than contained, much as it is to adolescents whose parents do not insist on responsible behavior. Without explicit limits, they tend to escalate until they find the ones that have been unstated.

Borderline-level clients will often react with anger to the practitioner's boundaries, but two therapeutic messages will be received nonetheless: (1) the therapist regards the patient as a grown-up and has confidence in his or her ability to tolerate frustration, and (2) the therapist refuses to be exploited and is therefore a model of self-respect. Often, the histories of people in the borderline range give evidence of their having had ample exposure to the opposite messages; they have been indulged when regressed (and usually ignored when acting more mature), and they have been expected to be exploitable and allowed to exploit.

When I first began practicing, I was struck by the amount of deprivation and trauma in the histories of borderline clients. I tended to see them as hungry and needy more than as aggressive and angry and I would extend myself beyond my usual limits in the hope of making up for their hardships. I learned that the more I gave, the more they regressed, and the more I became resentful. I eventually learned to adhere to my frame, however harsh it might seem in the moment. I would not let sessions run over, for example, even when the patient had just gone into a state of intense grief. Instead, I learned to end the session gently but firmly at the regular time and then to listen in the next meeting for the person's anger at having been kicked out. When borderline patients could tell me off about my rigid, selfish rules, I noticed that they did a lot better than when I was trying to put them into a state of gratitude for my generosity—an inherently infantilizing position.

Therapists new to work with borderline patients often wonder when all the preconditions of therapy will finally be worked out, a working alliance created, and the actual therapy begun. It may be painful to realize that all the work with the conditions of treatment *is* the therapy. The beginner wonders when the borderline patient will "calm down." The intensity of borderline patients will characterize the work throughout, and it is critical that the therapist be able to tolerate or "contain" that intensity, even when it involves verbal attacks on the therapist (Bion, 1962; Charles, 2004). Once a neurotic-type alliance is achieved, the patient by definition will have taken a giant step developmentally. It is disconcerting to spend so much time on boundary issues, especially when they stimulate over-the-top reactivity, with people who are often bright, talented, and articulate, and with whom one naturally wants to get on to other things. Niggling over limits is scarcely what we envisioned as constituting therapy when we went into this field. Thus, people working with their first borderline clients may suffer periodic fits of doubt about their competence.

Even for patients who are attracted to psychoanalysis and who want to "go deep," face-to-face therapy is generally better for borderline clients. Although not as subject to overwhelming transferences as psychotically vulnerable people are, they have more than enough anxiety without the therapist's being out of their line of vision. Seeing the therapist's facial affect may also be critical for the recovery of more difficult patients. In videotaped therapies with clients who had had prior treatment failures, Krause and his colleagues (e.g., Anstadt, Merten, Ullrich, & Krause, 1997) found that irrespective of the therapist's orientation, improvement correlated with the client's seeing a "nonmatching" affect on the therapist's face. For example, when the client's face showed shame, the therapist's might show anger that someone had shamed the client; when

there was fear on the client's face, the therapist's might show curiosity about the fear). Also, again because intensity needs no encouragement in borderline clients, only unusual circumstances (such as the need for increased support during withdrawal from an addiction) would warrant scheduling borderline clients at a frequency of more than three times a week, as in classical analysis.

Voicing Contrasting Feeling States

A second thing to attend to with borderline clients is one's way of speaking. With neurotic patients, one's comments may be infrequent, with the goal of being impactful when they occur ("less is more"). One can talk with healthier clients in a pithy, emotionally blunt way (Colby, 1951; Fenichel, 1941; Hammer, 1968), noting the underside of some conflict in which the client is aware of only one feeling. For example, a woman in the neurotic range may be gushing about a friend with whom she is in a somewhat competitive situation in a way that suggests she is not in touch with any negative affects. The therapist may say something along the lines of "But you'd also like to kill her." Or a man may be going on about how independent and free spirited he is; the therapist may comment, "And yet you are always worried about what I think of you."

In these cases, the respective neurotic clients will know that the therapist has revealed a part of their subjective experience that they had been keeping out of consciousness. Because they can appreciate that the clinician is not being reductive, is not claiming that the disowned attitude is their *real* feeling and that their conscious ideas were illusory, they may feel expanded in their awareness as a result of the interpretation. They feel understood, even if slightly wounded. But borderline clients to whom one talks this way will feel criticized and diminished, because unless the statement is phrased differently, the main message that will be received is "You're utterly wrong about what you really feel." This response derives from their tendency to be in one or another self-state rather than in a frame of mind that can experience and tolerate ambivalence and ambiguity.

For these reasons, it is common for beginning therapists to think they are expressing solicitous understanding and to find that the borderline person reacts as if attacked. One way around this problem is to appreciate that the borderline client lacks the reflective capacity to process an interpretation as additional information about the self, and that consequently one must provide that function within the interpretation. So one would have a better chance of being heard as empathic if one said, "I can see how much Mary means to you. Is it possible, though, that there is also a part of you—a part that you would not act upon of

course—that would like to get rid of her because she's in some ways in competition with you?" Or, "You certainly have established that you have a very independent, self-reliant streak. It's interesting that it seems to coexist with some opposite tendencies, like a sensitivity to what I think of you." Such interventions lack the punch and beauty of an economy of words, but given the particular psychological problems of borderline people, they are much more likely than more trenchant formulations to be taken in as intended.

Interpreting Primitive Defenses

A third feature of effective psychoanalytic therapy with patients in the borderline range is the interpretation of primitive defenses as they appear in the relationship. This work is not different in principle from ego psychological work with neurotic-level people: one analyzes defensive processes as they appear in the transference. But because the defenses of a borderline person are so primal, and because they may come across as entirely different in different ego states, the analysis of their defenses requires a special approach.

With borderline clients, it is rarely helpful to make "genetic" (historical) interpretations, in which a transference reaction is linked to feelings that belonged to a figure from the patient's past. With neurotic-level clients, one can get a lot of mileage out of a comment like "Perhaps you're feeling so angry at me because you're experiencing me as like your mother." The patient may agree, notice the differences between the therapist and the mother, and get interested in other instances in which this association might have been operating. With borderline patients, reactions can vary from "So what?" (meaning, "You're a lot like my mother, so why wouldn't I react that way?") to "How's that supposed to be useful?" (meaning, "You're just talking party-line shrink talk now. When are you going to get down to helping me?") to "Right!" (meaning, "Finally you're getting the picture. The problem is my mother, and I want you to change her!"). Such reactions can leave a beginning therapist bewildered, disarmed, and deskilled, especially if genetic interpretations were a helpful aspect of the therapist's personal experience in psychotherapy.

What can be interpreted with borderline clients is the here-and-now emotional situation. For example, when anger permeates the therapeutic dyad, it is likely that the patient's defense is not displacement or straightforward projection, as it would be in the above example of the neurotic person with the mother transference; instead, the patient may be using projective identification. He or she is trying to unload the feeling of "bad me" (Sullivan, 1953) and the associated affect of rage by putting them

on the therapist, but the transfer of image and affect is not "clean"; the client retains feelings of badness and anger despite the projection. This is the painful price paid by the borderline person, and inevitably shared by the therapist, for inadequate psychological separation.

Here is a critical difference between borderline clients and both psychotic and neurotic ones. The psychotic client is sufficiently out of touch with reality not to care whether a projection "fits." The neurotic person has an observing ego capable of noticing that he or she is projecting. Borderline patients cannot quite succeed in getting rid of the feeling being projected. They cannot take an attitude of indifference about how realistic the projected material is because unlike psychotics, they have intact reality testing. And they cannot relegate it to the unconscious part of the ego because, unlike neurotics, they switch states rather than using repression. So they keep feeling whatever is projected, along with the need to *make it fit* so that they will not feel crazy. The therapist gets the client's anger (or other strong affect), and as the client tries to make the projection fit by insisting that he or she is angry *because the therapist is hostile*, also begins to feel a rage at being misunderstood. Soon, the therapist *is* hostile. Such transactions account for the bad reputation borderline clients have among many mental health professionals, even though they are not always unpleasant people and are usually responsive to good treatment.

The kind of interpretation that may reach a borderline person in such a predicament is something like "You seem to have a conviction that you are bad. You're angry about that, and you're handling that anger by saying that I am the one who is bad, and that it's my anger that causes yours. Could you imagine that both you and I could be some combination of good and bad and that that wouldn't have to be such a big deal?" This is an example of a here-and-now confrontation of a primitive defense. It represents an effort by the therapist, one that will have to be repeated in different forms for months at best, to help the patient shift from a psychology in which everything is black or white, all or nothing, to one in which diverse good and bad aspects of the self, and a range of emotions, are all consolidated within an overall identity. This kind of intervention does not come easily to most people, but fortunately, it improves with practice.

Getting Supervision from the Patient

A fourth dimension of work with borderline clients that I have found valuable is asking the patient's help in resolving the either/or dilemmas into which the therapist is typically put. This technique, by which one in effect gets the patient to be one's supervisor, relates to the all-or-nothing

way in which borderline people construe things. They tend to evoke in a therapist the sense that there are two mutually exclusive options for responding to a given situation, and that both would be wrong, for different reasons. Usually there is a test involved (Weiss, 1993) in which if the therapist acts one way, he or she will fail according to one polarity of the patient's conflict, and if the other alternative is chosen, there will be an equal failure of the opposite sort.

For example, I once treated a 22-year-old man with an alcoholic father, who seemed not to notice his existence, and an overinvolved, anxious, intrusive mother, who took over her son's life to the extent of picking out his clothes each day. (I had met the parents and was thus in a position to know more about the real people who had influenced this man than one often knows with borderline clients.) As the therapy progressed, this patient would stop speaking for increasing amounts of time during our sessions. At first, it seemed as if he simply needed the space to get his thoughts together, but as the silences stretched out to 15 and then 20 minutes at a time, I felt that something less benign was going on and that I would be remiss in not addressing it.

If this patient had been in the neurotic range, I would have reminded him of his agreement to keep talking about whatever was on his mind and explored with him what was getting in the way of his willingness to do that; in other words, I would have done simple resistance analysis. But with this young man I could feel that something more primitive was going on, involving counterpoised terrors of engulfment and abandonment, and I knew we did not have enough of a working alliance for me to approach his silence as I would with a healthier person. If I remained quiet, I was fairly sure he would feel hurtfully neglected, as by his father; yet if I spoke, I suspected he would experience me as taking over, like his mother. My quandary at this juncture probably mirrored his sense that he would be damned if he did talk and damned if he didn't.

After trying for a while to figure out which intervention would be the lesser evil, it occurred to me to ask him to help me solve the problem. At least that way, whatever came out of our interaction would have an element of his autonomy in it. So I asked him how he wanted me to respond when he went into a long silence. He answered that he guessed he wanted me to ask him questions and to draw him out. I then commented that I would be glad to do that, but that he should know that I might be way off base in my pursuit of what he was thinking about since when he was quiet, I had no idea what was on his mind. (There had been evidence in the dreams and fantasies he had reported, while still talking, that he believed that others, like the fantasied omniscient mother of early infancy, could read his mind. I wanted to send a contrary and more realistic message.)

He brightened up and on that basis changed his mind, deciding I should wait until he felt ready to talk. He then came for three sessions in a row in which he greeted me cheerfully, sat down, said nothing for 45 minutes, then departed politely when I said our time was up. Interestingly, whereas I had been in a miserable internal state before I got him to supervise me in this way, I was at peace with his silence afterward. A couple of years later, he was able to tell me that my willingness to take his direction marked the beginning of his ability to feel like a separate person in the presence of someone else. This approach thus reduces the therapist's immediate uneasiness; more important, it models an acceptance of uncertainty, affirms the patient's dignity and creativity, and reminds both parties nonjudgmentally of the cooperative nature of the work.

It is important in such interventions to talk from the perspective of one's one own motives rather than the patient's inferred motives. The value of "I-statements" is as great here as when one argues with a lover or friend. There is a huge difference between being on the receiving end of "You're putting me in a bind" or "You're setting it up so that whatever I do is wrong" and hearing "I'm trying to do right by you as your therapist, and I find myself feeling in a bind. I worry that if I do X, I'll be unhelpful in one direction, and if I do Y, I'll disappoint you in another."

Promoting Individuation and Discouraging Regression

People with borderline psychologies need empathy as much as anyone else, but their mood changes and ego-state fluctuations make it hard for clinicians to know how and when to convey it. Because they tend to evoke loving countertransferences when they are depressed or frightened, and hateful ones when they act antagonistically, one may find oneself inadvertently rewarding them for regression and punishing them for individuation. Therapists trained to work with neurotic-level patients by fostering a contained regression may, out of habit, evoke some of the least healthy responses of borderline clients. An appreciation of their psychology helps us to act somewhat counterintuitively; that is, to be relatively nonresponsive to states of subjective helplessness and to show appreciation for assertiveness—even when it takes the form of angry opposition.

As I mentioned in Chapter 3, Masterson (1976) noted that when borderline clients, whose mothers he saw as having rewarded their clinging, are in a regressed, dependent relationship, they feel safe. When alone, they suffer an anguished desperation that he called "abandonment depression." His observations comport with those of researchers

in attachment (e.g., M. Main, 1995), who have related some insecure attachment patterns to an anxious, autonomy-impeding mothering style. Because separateness is eventually empowering, Masterson urged therapists to behave with borderline patients conversely from the way their mothers purportedly had; namely, to confront regressive and self-destructive behaviors actively (e.g., "Why would you want to pick up men at bars?") and to endorse empathically any efforts toward autonomy and competence (e.g., "I'm glad to see you can tell me off when I make you angry"). He advised us not to reward the clinging that gives the patient no basis for self-esteem, and to take pains to see the forward-moving, adaptive elements in even aggravating manifestations of self-assertion. At first such a posture may feel a bit contrived, but as one sees clients respond, it may become more integrated and authentic to one's therapeutic style.

Interpreting during Quiescence

Pine (1985) contributed an important dictum to our literature on working with clients who struggle over separation and individuation: "Strike when the iron is cold." With many neurotic-level people, the best time to make interpretations is when the patient is in a state of emotional arousal, so that the content of the therapist's observation is not intellectualized and the affective power of the issues being addressed is unmistakable. With borderline clients, the opposite consideration applies, because when they are in a state of heightened emotionality, they are too upset to take anything in. One can comment on what happened in their rage or panic or desperate regression, but only after that state is over and they are internally reassured of having recovered from such a disturbing intensity of feeling.

Thus one might say to a borderline patient, "I was thinking. What you're talking about now, your tendency to feel murderous envy and to attack people when you're in that state ... was something like that part of your outburst at me last week? It felt as if whatever I offered you, you had to destroy it." In a state of emotional repose, a borderline client may be willing—even relieved—to hear that the therapist has named such a dynamic and tried to understand it. But in a state of intense feeling, the patient may receive such a comment not only as condemnation but also as an effort to dismiss passionately held attitudes as if they were contemptible. Telling someone in the throes of an envious rage that he or she is trying to destroy the therapist may increase the person's helpless fury and shame over having such raw impulses. Talking about it later may be fruitful.

Respecting Countertransference Data

A final aspect of the implications of a borderline diagnosis for psychotherapy concerns the central role of the therapist's understanding of countertransference. Much more than neurotic-level people, borderline clients communicate through powerful and unverbalized affect transmission, probably via the early right-brain-to-right-brain communication characteristic of parents and infants (Schore, 2003a). By this I mean that even though they may talk freely in therapy, the most vital communications they send are often not in the content of their words but in the "background music" of their emotional state. The intuitive, affective, and imaginal responses of therapists when sitting with a borderline patient can often provide better data about the essence of what is going on between the two people than either cognitive reflection on the content of the patient's communication or recourse to ideas on theory and technique.

When one suddenly feels bored, or in a rage, or panicky, or overwhelmed with the wish to rescue, or diverted by sexual images, something is probably going on that says something important about the client's internal state. For example, a paranoid man, in treatment with a young woman, is in a state of self-righteous indignation about mistreatment by some authority. The therapist notices that she feels weak, small, fearful of the patient's criticism, and distracted by fantasies of being attacked. She should consider the possibility that what she is feeling is a split-off, disowned part of the patient that is being projected into her in an almost physical way. If that idea seems reasonable after some reflection, it may be therapeutic (to both parties!) for her to say something like "I know that you are in touch with feeling angry and energized, but I think there may also be a part of you that feels weak, anxious, and fearful of being attacked."

This area of the informational value of countertransference is a tricky one. Not every passing thought and emotion that one feels in the presence of a borderline patient was "put" there by the patient. At our worst, we can do harm in the name of concepts like projective identification and co-construction; I have even heard of therapists getting into hassles with borderline clients over whose "fault" it is that the therapist is having strong reactions. I do not want to feed anyone's rationalizations in this direction. Decades of clinical work suggests that countertransference, like transference, is a mixture of internally generated and externally stimulated material, sometimes weighted more in one direction, sometimes more in the other (Gill, 1983; Jacobs, 1991; Roland, 1981; Sandler, 1976; Tansey & Burke, 1989). In our therapeutic role we

should be insightful about our own dynamics and take responsibility for our reactions, even when they are being provoked by a patient's incursions on our equanimity. And even interpretations that we feel sure are valid should be offered in a way that invites clients to take issue if they disagree.

The extreme converse attitude, that one should regard countertransference as solely one's "own stuff," can also be inimical to clinical progress. Some psychoanalytic supervisors put so much stress on their students' understanding of their own dynamics that they foster a distracting degree of self-consciousness. No emotional energy is left over for reflecting on what can be learned about the patient from one's responses. A kind of navel gazing comes to substitute for real relatedness, and people of talent and compassion become reluctant to trust what are often excellent natural instincts because they fear they are acting something out. If in the above example, for instance, the therapist had handled her countertransference with self-examination alone, reflecting on how she has a vulnerability to feeling small and frightened in the presence of angry men who remind her of her critical father, there would be little to do therapeutically with such an insight. It might help her to contain defensive reactions, an achievement not to be disdained, but it would not guide the therapist toward what she could actively do to help the patient. The worst thing that can happen if we mistake our own feelings for a client's is that we will be wrong, and if interpretations are made in a tone of hypothesis rather than pronouncement, the patient will be glad to point out our errors.

Different writers emphasize different aspects of tone with borderline patients. My own style, one that fits my own personality, is to be more emotionally "real" with borderline patients than with neurotic-level ones. Trying to act "neutral" with them, especially when they are self-harming, tends to sound stiff and false. For example, a therapist has been working for weeks to reduce a young woman's tendency for self-harm and is just beginning to see progress. Then the client comes in, smiles coyly, and says, "Well, I know we've been working on this, but I cut myself again." Or "I know you think I should always use condoms, but I did have unprotected sex with a guy this week that I met in a bar. I don't think he's HIV positive, though; he seems nice. Are you angry at me?" At such points, a hot rage may start to burn in one's gut.

I have learned that it is not helpful to say, as if one could be dispassionate, "So tell me about your fantasies about my reaction," as one might with a neurotic-level person who had acted out and feared disapproval. Instead, it is better to say something like "Well, you know it's my job to try to help you be less self-destructive, so when I hear that you've

been *more* self-destructive, it does get to me. What's it like for you when I get irritated at your behavior?" As Karen Maroda (1999) has emphasized, it does not usually close the patient down when the therapist is able to show some emotion—especially borderline patients, who know they are difficult.

A book on diagnosing individuals takes by definition a one-person perspective of trying to understand what is consistent about the patient in *any* relationship. And I have argued, contra some relational arguments, that this is a valuable perspective (cf. Chodorow, 2010). But in treatment, it is important to remember the psychological equivalent of the Heisenberg principle: When we are observing something, we are part of what is being observed. When we are with a patient, we are relating to a person *as he or she exists in the situation of being with us.* What we are learning about the emotional brain, about right-brain-to-right-brain communication, about the intersubjective nature of all interaction, reveals that the image of any person as an autonomous individual whom one is "objectively" observing is a fiction (Wachtel, 2010). The fact that all relationships are co-constructed means that one must own one's own contribution to whatever goes on. Attunement to that fact may be particularly important with borderline clients, who struggle with humiliation and may be relieved by the therapist's sharing responsibility for what goes on in the dyad.

This concludes what I can say in a primer about implications of developmental level for treatment. I have only scratched the surface. If this were a treatise on technique per se, each level would merit at least a chapter, or better yet, would be the subject of its own book. And as if the above issues were not complex enough, let me now introduce the topic of the interaction of developmental and typological categories of personality structure and their complex relationship.

INTERACTION OF MATURATIONAL AND TYPOLOGICAL DIMENSIONS OF CHARACTER

Figure 4.1 sets out visually the ways in which many analytically oriented therapists implicitly map out their patients' personality structures. The developmental axis, though divided into the three main categories of organization, is actually a continuum, with differences of degree that gradually become great enough to warrant conceptualization as differences of kind. We all fluctuate in terms of our maturational state; under enough stress an optimally healthy person can have a temporary psychotic reaction; and even the most delusional schizophrenic has moments of utter lucidity. Many of the typological categories that cross

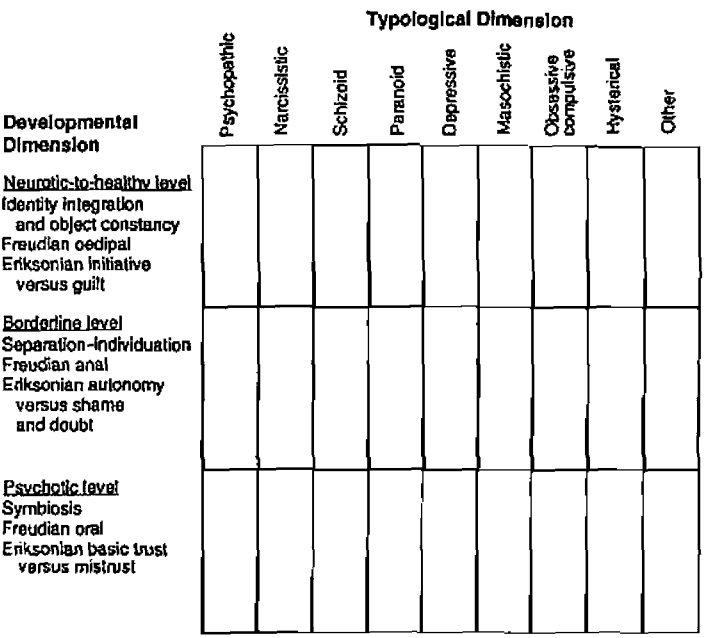

FIGURE 4.1. Developmental and typological dimensions of personality.

the maturational axis should be familiar, even though they will not be discussed systematically until later in this book. In Chapters 5 and 6 I cover in detail the concept of defense, since the personality configurations on the typological axis represent the habitual use of one defense or one cluster of defenses.

In every category on the horizontal axis, there is a range of character pathology from the psychotic to the neurotic–healthy areas. Yet people are not evenly distributed along all points of each continuum. Those categories that represent the habitual use of a more primitive defense will "load" more toward the psychotic end of the continuum; paranoid people, for example, who by definition depend on denial and projection, will be more common at the lower rather than at the upper end of the developmental axis. Those typological categories representing reliance on more mature defenses will load more toward the neurotic pole; a greater proportion of obsessional people, for example, will be at the neurotic end of the obsessive dimension than at the psychotic pole. Most character patterns that are maladaptive enough to be considered a

DSM personality *disorder*, rather than just a personality *style*, are likely to be in the borderline range.

Anyone's life experience with a diversity of human beings gives evidence that it is possible for someone to have a high degree of ego development and identity integration and still handle anxieties with a primitive defense. Again taking the case of people with significant paranoia, most of us can think of individuals whose personalities are distinctly paranoid but who have good ego strength, clarity about their existence as individuated human beings, an elaborated and consolidated identity, and enduring relationships. They often find a home in professions like detective work or covert operations in which their paranoid tendencies work to advantage. The fact that healthier paranoid people do not usually seek psychotherapy (a fact intrinsically related to their paranoia) does not mean that they are not out there. The frequency with which people seek therapy and thereby get into mental health statistics is not the same across different types of personality because the categories reflect important differences in areas like one's disposition to trust, inclination to hope, willingness to part with money for nonmaterial benefits, and so forth.

Correspondingly, ordinary life experience also suggests that it is possible for people to rely centrally on a "mature" defense like intellectualization and nevertheless have poor reality testing, inadequate separateness, limited identity integration, and unsatisfying object relationships. Thus, whereas healthier obsessive people may be easier to find than those with psychotic leanings, any intake worker in an inpatient facility has seen people whose penchant for intellectualizing has crossed the line into delusion.

It is often more important clinically to have a sense of a client's overall developmental level than it is to identify his or her most appropriate typological descriptor. Since flexibility of defense is one aspect of psychological health, people in the higher ranges rarely exemplify one pure personality type. But both areas of assessment are important, as will be exemplified in certain instances of differential diagnosis that I cover in Chapters 7 through 15.

SUMMARY

The subject of this chapter has been the implications for therapy of whether a given client is mainly neurotic, psychotic, or borderline characterologically. Neurotic-level people are usually good candidates for either psychoanalysis or traditional exploratory therapies; their ego strength also makes them responsive to many other kinds of intervention.

Patients at a symbiotic–psychotic level usually need supportive therapy, characterized by, among other things, an emphasis on safety, respect, honesty, education, and attention to the effects of particular stresses.

Patients at a borderline level are most helped by modes of working in which boundaries are fastidiously maintained, contrasting ego states named, and primitive defenses interpreted. The patient's help may be solicited to resolve impasses. Interventions that are useful to borderline patients discourage regression and support individuation. The therapist builds understanding during periods of quiescence and respects information contained in countertransference.

Finally, character structure was diagrammed on two axes in order to illustrate graphically the principle of appreciating both developmental and typological dimensions of personality.

SUGGESTIONS FOR FURTHER READING

The standard text on classical psychoanalysis with neurotic-level people is still Greenson's *The Technique and Practice of Psychoanalysis* (1967). Schafer's *The Analytic Attitude* (1983) articulates aspects of therapy that conventional books leave out. Among the texts on therapy that try to be generic across levels of character organization, I recommend those by Fromm-Reichmann (1950), Hedges (1992), Pine (1985), Charles (2004), and my own text (McWilliams, 2004). The most readable book on therapy across developmental levels from an object relations perspective is probably Horner's *Psychoanalytic Object Relations Therapy* (1991). E. S. Wolf's *Treating the Self* (1988) gives a particularly useful self psychology perspective. Good relationally oriented texts include Maroda's *Psychodynamic Techniques* (2010) and Safran's research-based primer (in press).

The best writing I know of about working with psychotic-level patients—and good sources in this area are much scarcer—includes work by Arieti (1955), Searles (1965), Lidz (1973), Karon and VandenBos (1981), Selzer and his colleagues (1989), and Geekie and Read (2009). The text by Alanen and colleagues (2009) is a good overview of psychotherapy with schizophrenia. The long-standing need for comprehensive books on supportive therapy has been filled by Rockland (1992) and Pinsker (1997). For a moving account of recovery from schizophrenia from the patient's perspective, see the classic *I Never Promised You a Rose Garden*, by Hannah Green (1964), the pseudonym of the still-healthy Joanne Greenberg, who was treated by Freida Fromm-Reichmann.

The literature on the therapies for borderline personality organization is confusing because of the diversity of approaches to conceptualizing borderline clients. Hartocollis's (1977) edited volume is useful for the historical context of the concept. Among the more classic psychoanalytic contributions to technique, Masterson's work, which has the virtue of being gracefully written, is perhaps best summarized in his 1976 book. G. Adler's (1985) contribution is a readable overview of a more self psychologically influenced way of understanding and treating people in this group.

Kernberg's research group (Clarkin et al., 2006) has published a comprehensive manual on transference-focused therapy, with emphasis on primitive defenses, especially splitting. Bateman and Fonagy's *Mentalization-Based Treatment for Borderline Personality Disorders* (2004) similarly synthesizes knowledge gleaned from a long program of research and practice, with emphasis on cognitive and attachment deficits. Linehan's cognitive-behavioral work (e.g., 1993), which emphasizes the affect dimension of borderline experience, is accessibly written and clinically useful by therapists of all orientations.

5

Primary Defensive Processes

In this chapter and the next, I cover the major common defenses. The concept of defense has been central to psychoanalytic character diagnosis. The major diagnostic categories that have been used by analytic therapists to denote personality types refer implicitly to the persistent operation in an individual of a specific defense or constellation of defenses. Thus, a diagnostic label is a kind of shorthand for a person's habitual defensive pattern.

The term "defense" is in many ways unfortunate. What we refer to as defenses in adults begin as global, inevitable, adaptive ways of experiencing the world. Freud is responsible for originally observing and naming some of these processes; his choice of the term "defense" reflects at least two aspects of his thinking. First, he was fond of military metaphors. When he was trying to make psychoanalysis palatable to a skeptical public, he frequently made analogies, for pedagogical purposes, comparing psychological operations to army tactical maneuvers, or compromises over military objectives, or battles with complex outcomes.

Second, when he first encountered the most dramatic and memorable examples of processes that we now call defenses (repression, conversion, dissociation) he saw them when they were operating in their defensive function. The emotionally damaged, predominantly hysterical people he first became fascinated by were trying to avoid reexperiencing what they feared would be unbearable pain. They were doing so, Freud observed, at a high cost to their overall functioning. Ultimately it would be better for them to feel fully the overwhelming emotions they were afraid of, thereby liberating their energies for getting on with their lives.

Thus, the earliest context in which the defenses were talked about was one in which the doctor's task was to diminish their power.

Construed that way, the therapeutic value of weakening or breaking down a person's maladaptive defenses was self-evident. Unfortunately, in the climate of excitement surrounding Freud's early observations, the idea that defenses are somehow by nature maladaptive spread among the lay public, and the word acquired an undeservedly negative cast. Calling someone "defensive" is universally understood to be a criticism. Analysts also use the word in that way in ordinary speech, but when they are discussing defense mechanisms in a scholarly, theoretical way, they do not necessarily assume that anything pathological is going on when a defense is operating. In fact, analytically influenced therapists have sometimes understood certain problems, notably psychotic and close-to-psychotic "decompensations," as evidence of insufficient defenses.

The phenomena that we refer to as defenses have many benign functions. They begin as healthy, creative adaptations, and they continue to work adaptively throughout life. When they are operating to protect the self against threat, they are discernible as "defenses," a label that seems under those circumstances to fit. The person using a defense is generally trying unconsciously to accomplish one or both of the following: (1) the avoidance or management of some powerful, threatening feeling, usually anxiety but sometimes overwhelming grief, shame, envy, and other disorganizing emotional experiences; and (2) the maintenance of self-esteem. The ego psychologists emphasized the function of defenses in dealing with anxiety; object relations theorists, who focus on attachment and separation, introduced the understanding that defenses operate against grief as well; and self psychologists have stressed the role of defenses in the effort to maintain a strong, consistent, positively valued sense of self. Analysts in the relational movement have emphasized the shared nature of defenses that emerge in couples and systems.

Psychoanalysts assume, although this is seldom explicitly stated, that we all have preferred defenses that have become integral to our individual styles of coping. This preferential and automatic reliance on a particular defense or set of defenses is the result of a complex interaction among at least four factors: (1) one's constitutional temperament, (2) the nature of the stresses that one suffered in early childhood, (3) the defenses modeled—and sometimes explicitly taught—by parents and other significant figures, and (4) the experienced consequences of using particular defenses (in the language of learning theory, reinforcement effects). In psychodynamic parlance, the unconscious choice of one's favorite modes of coping is "overdetermined," expressing the cardinal analytic principle of "multiple function" (Waelder, 1960).

Defenses have been extensively researched. Phoebe Cramer (2008) has reviewed empirical findings supporting seven core psychoanalytic observations; namely, that defenses (1) function outside of awareness; (2) develop in predictable order as children mature; (3) are present in normal personality; (4) become increasingly used in times of stress; (5) reduce the conscious experience of negative emotions; (6) operate via the autonomic nervous system; and (7) when used excessively, are associated with psychopathology. Substantial agreement exists among psychoanalytic scholars that some defenses are less developmentally mature than others (Cramer, 1991; Laughlin, 1970; Vaillant et al., 1986). Cramer (2006) has demonstrated, for example, that denial occurs very early, projection develops later, and identification arrives still later (though I discuss here the archaic precursors of both projection and identification as primary defensive processes). In general, defenses that are referred to as "primary" or "immature" or "primitive" or "lower order" involve the boundary between the self and the outer world. Those conceived as "secondary" or "more mature" or "advanced" or "higher order" deal with internal boundaries, such as those between the ego or superego and the id, or between the observing and the experiencing parts of the ego.

Primitive defenses operate in a global, undifferentiated way in a person's total sensorium, fusing cognitive, affective, and behavioral dimensions, whereas more advanced ones make specific transformations of thought, feeling, sensation, or behavior, or some combination of these. The conceptual division between more archaic and higher-order defenses is somewhat arbitrary. Ever since Kernberg (e.g., 1976) called attention to borderline clients' use of archaic forms of projection and introjection (a precursor of identification), however, many therapists have followed him in identifying the following defenses as intrinsically "primitive": withdrawal, denial, omnipotent control, primitive idealization and devaluation, projective and introjective identification, and splitting. In 1994 I suggested adding extreme forms of dissociation to that list. And now, based on the work of Vaillant (e.g., Vaillant et al., 1986) and other researchers with which I was not so familiar in 1994, and at the suggestion of several colleagues, I have added somatization, acting out, and sexualization to the more primitive defenses. There are mature expressions of those processes, but that is also true of some other lower-order defenses, such as primitive idealization and withdrawal.

To be considered primary, a defense typically has two qualities associated with the preverbal phase of development: a lack of attainment of the reality principle (see Chapter 2) and a lack of appreciation of the separateness and constancy of those outside the self. For example, denial is thought to be a manifestation of a more primitive process than

repression. For something to be repressed, it has to have been known in some way and then consigned to unconsciousness. Denial is an instant, nonreflective process. "This is not happening" is a more magical way of dealing with something unpleasant than "This happened, but I'll forget about it because it's too painful."

Similarly, the defense mechanism known as "splitting," in which a person segregates experiences into all-good and all-bad categories, with no room for ambiguity and ambivalence, is considered primitive because it is believed to derive from a time before the child has developed object constancy. The perception of mother when one feels gratified is thought to be an overall sense of "good mother," whereas the perception of the same person when one is frustrated is "bad mother." Before the infant is mature enough to appreciate the reality that it is the same person in each situation, one whose presence sometimes feels good and sometimes feels bad, we assume each experience has a kind of total, discrete, defining quality. In contrast, a defense like rationalization is considered mature because it requires some sophisticated verbal and thinking skills and more attunement to reality for a person to make up reasonable explanations that justify a feeling.

Many defensive processes have more primitive and more mature forms. For example, "idealization" can denote an unquestioning, worshipful conviction that another person is perfect, or it can refer to a subtle, subdued sense that someone is special or admirable despite some visible limitations. "Withdrawal" can refer to the full renunciation of reality in favor of a psychotic state of mind, or it can refer to a mild tendency to deal with stress by daydreaming. For this chapter on primitive defenses, I have called a defense "extreme" if it also has more mature manifestations.

The so-called primitive defenses are ways we believe the infant naturally perceives the world. These ways of experiencing live on in all of us, whether or not we have significant psychopathology; we all deny, we all split, we all have omnipotent strivings. Such processes pose a problem only if we lack more mature psychological skills or if these defenses are used to the exclusion of possible others. Most of us also supplement them with more sophisticated means of processing anxiety and assimilating a complex and disturbing reality. *It is the absence of mature defenses, not the presence of primitive ones, that characterizes borderline or psychotic structure.*

It is much harder to describe the primitive defenses than the more advanced ones. The fact that they are preverbal, prelogical, comprehensive, imaginal, and magical (part of primary process thought) make them extremely hard to represent in prose; in fact, the representation of preverbal processes in words is to some degree an oxymoron. The

following summary gives an overview of those defenses that are conventionally understood as primary.

EXTREME WITHDRAWAL

An infant who is overstimulated or distressed will often simply fall asleep. Withdrawal into a different state of consciousness is an automatic, self-protective response that one sees in the tiniest of human beings. Adult versions of the same process can be observed in people who retreat from social or interpersonal situations, substituting the stimulation of their internal fantasy world for the stresses of relating to others. A propensity to use chemicals to alter one's consciousness can also be considered a kind of withdrawal. Some professionals, including contributors to recent editions of the DSM, prefer the term "autistic fantasy" to withdrawal; this label refers to a specific version of the general tendency to shrink from personal contact.

Some babies are temperamentally more inclined than others toward this way of responding to stress; observers of infants have sometimes noted that it is the babies who are especially sensitive who are most likely to withdraw. People with this constitutionally impressionable disposition may generate a rich internal fantasy life and regard the external world as problematic or affectively impoverished. Experiences of emotional intrusion or impingement by caregivers and other early objects can reinforce withdrawal; conversely, neglect and isolation can also foster that reaction by leaving a child dependent on what he or she can generate internally for stimulation. Schizoid personality styles are the characterological outcome of reliance on the defense of withdrawal.

The obvious disadvantage of withdrawal is that it removes the person from active participation in interpersonal problem solving. People with schizoid partners are frequently at a loss as to how to get them to show some kind of emotional responsiveness. "He just fiddles with the TV remote control and refuses to answer me" is a typical complaint. People who chronically withdraw into their own minds try the patience of those who love them by their resistance to engaging on a feeling level. Those with serious emotional disturbance are hard to help because of their apparent indifference to the mental health workers who try to win their attention and attachment.

The main advantage of withdrawal as a defensive strategy is that while it involves a psychological escape from reality, it requires little distortion of it. People who depend on withdrawal console themselves not by misunderstanding the world but by retreating from it. Consequently, they may be unusually sensitive, often to the great surprise of

those who write them off as dull nonparticipants. And despite their lack of a disposition to express their own feelings, they may be highly perceptive of feelings in others. On the healthier end of the schizoid scale, one finds people of remarkable creativity: artists, writers, theoretical scientists, philosophers, religious mystics, and other highly talented onlookers whose capacity to stand aside from ordinary convention gives them a unique capacity for original commentary.

DENIAL

Another early way in which infants can handle unpleasant experiences is by refusing to accept that they are happening. Denial lives on automatically in all of us as our first reaction to any catastrophe; the initial response of individuals who are informed of the death of someone important to them is typically "Oh, no!" This reaction is the shadow of an archaic process rooted in the child's egocentrism, in which a prelogical conviction that "If I don't acknowledge it, it isn't happening" governs experience. It was processes like this one that prompted Selma Fraiberg to title her classic popular book on early childhood *The Magic Years* (1959).

Examples of people for whom denial is a bedrock defense are the Pollyana-like individuals who insist that everything is always fine and for the best. The parents of one of my patients continued to have one child after another even after three of their offspring had died from what any parents not in a state of denial would have realized was a genetically implicated affliction. They refused to mourn for the dead children, ignored the suffering of their two healthy sons, resisted advice to get genetic counseling, and insisted that their condition represented the will of God, who knew what was best for them. Experiences of rapture and overwhelming exhilaration, especially when they occur in situations in which most people would perceive some negative aspects to their circumstances, are similarly assumed to reflect the operation of denial.

Most of us occasionally use denial, with the worthy aim of making life less unpleasant, and many people use it frequently in dealing with specific stresses. A person whose feelings get hurt in situations in which it is inappropriate or unwise to cry is more likely to deny the hurt feelings than to acknowledge them fully and inhibit the crying response consciously. In crises or emergencies, a capacity to deny emotionally that one's survival is at risk can be lifesaving: Denial may permit the most realistically effective and even heroic actions. Every war brings tales of those who "kept their heads" in terrifying, life-threatening conditions, and saved themselves and their fellows.

Less benignly, denial can contribute to the contrary outcome. An acquaintance of mine refuses to get annual Pap smears, as if by ignoring the possibility of cancer she can magically avoid it. Spouses who deny that their abusive partner is dangerous, alcoholics who insist they have no drinking problem, mothers who ignore the evidence of sexual molestation of their daughters, elderly people who will not give up a driver's license despite obvious impairment—all are familiar examples of denial at its worst. This psychoanalytic concept has made its way more or less undistorted into everyday language, partly because the word "denial" is, like "withdrawal," not jargonized and partly because it is a concept of singular significance to 12-step programs and other enterprises that attempt to confront people on their use of this defense and thereby help them out of whatever hell it has created for them.

A component of denial can be found in the operation of most of the more mature defenses. Take, for instance, the consoling belief that the person who rejected you really desired you but was not ready for a full commitment. Such a conclusion includes denial that one was rejected as well as the more sophisticated excuse-making activity that we refer to as rationalization. Similarly, the defense of reaction formation, in which an emotion is turned into its opposite (e.g., hatred into love), constitutes a specific and more complex type of denial of the feeling being defended against than a simple refusal to feel that emotion.

The clearest example of psychopathology defined by the use of denial is mania. In manic states, people may deny to an astonishing degree their physical limitations, their need for sleep, their financial exigencies, their personal weaknesses, even their mortality. Where depression makes the painful facts of life supremely unignorable, mania makes them seem insignificant. Analysts may refer to those who use denial as their main defense as hypomanic (the "hypo" prefix, meaning "a little" or "somewhat," distinguishes them from those who suffer full manic episodes). They have also been termed "cyclothymic" ("alternating emotion"), because of their tendency to cycle between manic and depressed moods, usually short of diagnosable bipolar illness. We understand this oscillation as the repetitive use of denial followed by its inevitable collapse as the person becomes exhausted in the manic condition. Although this personality diagnosis has not been in the DSM since its second edition because of a decision to put all mood-related phenomena into a "mood disorders" section, it is described in the PDM and in Chapter 11.

As with most primitive defenses, unmodified denial in adults is usually cause for concern. Nonetheless, mildly hypomanic people can be delightful. Many comedians and entertainers show the quick wit, the elevated energy, the playfulness with words, and the infectious high spirits that characterize those who successfully screen out and transform

painful affects for long periods of time. Yet the depressive underside of such people is often visible to their closer friends, and the psychological price exacted by their manic charm is often not hard to see.

OMNIPOTENT CONTROL

For the newborn, the world and the self are felt more or less as one. Fonagy's research (Fonagy et al., 2003) suggests that infants live for about 18 months in a mental state of "psychic equivalence," in which the external world is felt as isomorphic with the internal one. Piaget recognized this phenomenon (e.g., 1937) in his concept of "primary egocentrism" (a cognitive phase roughly equivalent to Freud's [1914b] "primary narcissism," during which primary process thought prevails). It may be that the source of all events is understood by the newborn as internal in some way; that is, if the infant is cold, and a caregiver perceives this and provides warmth, the baby has some preverbal experience of its having magically elicited the warmth. The awareness that there is a locus of control in separate others, outside the self, has not yet developed.

A sense that one can influence one's surroundings, that one has agency, is a critical dimension of self-esteem, one that may begin with infantile and unrealistic but developmentally normal fantasies of omnipotence. It was Sandor Ferenczi (1913) who first called attention to the "stages in the development of a sense of reality." He noted that at the infantile stage of primary omnipotence or grandiosity, the fantasy that one controls the world is normal; that this naturally shifts, as the child matures, to a phase of secondary or derived omnipotence in which one or more caregivers are believed to be all-powerful; and that eventually, the maturing child comes to terms with the unattractive fact that no one's potency is unlimited. A precondition for the mature adult attitude that one's power is not boundless may be, paradoxically, the opposite emotional experience in infancy: a secure enough early life that one can freely enjoy the developmentally appropriate illusions of, first, one's own omnipotence, and second, that of those on whom one depends.

Some healthy residues of the sense of infantile omnipotence remain in all of us and contribute to feelings of competence and effectiveness in life. There is a natural kind of "high" that we feel when we effectively exert our will. Anyone who has ever "had a hunch" about impending luck and then won some kind of gamble knows how delicious is the sense of omnipotent control. The conviction that individuals can do anything they set their mind to is a piece of American ideology that flies in the face

of common sense and most human experience, but it nonetheless can be a powerfully positive and self-fulfilling fiction.

For some people, the need to feel a sense of omnipotent control, and to interpret experiences as resulting from their own unfettered power, remains compelling. If one's personality is organized around seeking and enjoying the sense that one has effectively exercised one's power, with all other practical and ethical concerns relegated to secondary importance, one's personality is in the psychopathic range ("sociopathic" and "antisocial" are terms of later origin). Psychopathy and criminality are overlapping but not equivalent categories (Hare, 1999). Nonprofessionals frequently assume that most criminals are psychopaths and vice versa. Yet many people who rarely break the law have personalities driven by the defense of omnipotent control, as in the corporate "snakes in suits" described by Babiak and Hare (2007). They use conscious manipulation as a primary way of avoiding anxiety and maintaining self-esteem.

"Getting over on" others is a central preoccupation and pleasure of individuals whose personalities are dominated by omnipotent control (Bursten, 1973a). Such people are common in enterprises that require guile, a love of stimulation or danger, and a willingness to subordinate other concerns to the central objective of making one's influence felt. They can be found in leadership roles in business, in politics, in covert operations, among cult leaders and evangelists, in the advertising and entertainment industries, and in other walks of life where the potential to wield raw power is high. Once when I was consulting at a military base, making myself available for anyone who wanted to confer on a question within my expertise, the commander of the base wanted an hour with me. His question was "How can we prevent psychopaths from becoming generals?"

EXTREME IDEALIZATION AND DEVALUATION

Ferenczi's formulation about how early fantasies of omnipotence of the self are gradually replaced by fantasies of the omnipotence of one's caregivers continues to be valuable. One can see how fervently a young child would need to believe that Mommy or Daddy can protect him or her from all the dangers of life. As we get older, we forget how frightening it is to children to confront for the first time the realities of hostility, vulnerability to illness and harm, mortality, and other terrors (C. Brenner, 1982). One way that youngsters cushion themselves against these overwhelming fears is to believe that someone, some benevolent, all-powerful

authority, is in charge. (In fact, this wish to believe that the people who are running the world are somehow more inherently wise and powerful than ordinary, fallible human beings lives on in most of us and can be inferred by our degree of upset whenever events remind us that such a construction is only a wish.)

The conviction of young children that their mother or father is capable of superhuman acts is the great blessing and curse of parenthood. It is an undisputed advantage in the boo-boo curing department, and there is nothing more touching than a child's total and loving trust, but in other ways it creates in parents a barely controllable exasperation. I remember one of my daughters, then about 2½, throwing a full-scale tantrum when I tried to explain that I could not make it stop raining so that she could go swimming.

We all idealize. We carry remnants of the need to impute special value and power to people on whom we depend emotionally. Normal idealization is an essential component of mature love (Bergmann, 1987). And the developing tendency over time to deidealize or devalue those to whom we have childhood attachments seems to be a normal and important part of the separation–individuation process. It would be unusual for an 18-year-old to leave home feeling it is a much better place than the life that awaits. In some people, however, the need to idealize seems relatively unmodified from infancy. Their behavior shows evidence of the survival of archaic and rather desperate efforts to counteract internal terror by the conviction that some attachment figure is omnipotent, omniscient, and omnibenevolent, and that through psychological merger with this wonderful Other, they are safe. They also hope to be free of shame: A by-product of idealization and the associated belief in perfection is that imperfections in the self are harder to bear; fusion with an idealized object is an attractive remedy.

Longings for the omnipotent caregiver naturally appear in people's religious convictions; more problematically, they are evident in phenomena like the insistence that one's lover is perfect, one's personal guru is infallible, one's school is the best, one's taste is unassailable, one's government is incapable of error, and similar illusions. People in cults have been known to die rather than devalue a leader who has become crazy. In general, the more dependent one is or feels, the greater the temptation to idealize. Numerous female friends have announced to me during pregnancy, a time of awesome confrontation with personal vulnerability, that their obstetrician is "wonderful" or "the best in the field."

People who live their lives seeking to *rank* all aspects of the human condition according to how comparatively valuable they are, and who

appear motivated by a search for perfection through merger with idealized objects, efforts to perfect the self, and tendencies to contrast the self with devalued alternatives, have narcissistic personalities. While other aspects of narcissistic organization have been emphasized in much of the psychoanalytic literature, a structural way of construing the psychology of such people is in terms of their habitual recourse to primitive idealization and devaluation. Their need for constant reassurance of their attractiveness, power, fame, and value to others (i.e., perfection) results from depending on these defenses. Self-esteem strivings in people who need to idealize and devalue are contaminated by the idea that one must perfect the self rather than accept it.

Primitive devaluation is the inevitable downside of the need to idealize. Since nothing in human life is perfect, archaic modes of idealization are doomed to disappointment. The more an object is idealized, the more radical the devaluation to which it will eventually be subject. The bigger one's illusions, the harder they fall. Clinicians working with narcissistic people can ruefully attest to the damage that may ensue when the client who has thought that a therapist can walk on water decides instead that the therapist cannot walk and chew gum at the same time. Treatment relationships with narcissistic clients are notoriously subject to sudden rupture when the patient becomes disenchanted. However sweet it can feel to be the object of total idealization, it is nevertheless onerous, both because of the irritating aspects of being treated as if we can stop the rain and because we have learned the hard way that being put on a pedestal is only the precursor to being knocked off. My colleague Jamie Walkup (personal communication, May 1992) adds that it is also a straitjacket, tempting the therapist to deny normal ignorance, to find intolerable the modest goals of help and assistance, and to think that only one's best performance is "typical."

In ordinary life, one can see analogues of this process in the degree of hate and rage that can be aimed at those who seemed to promise much and then failed to deliver. The man who believed that his wife's oncologist was the only cancer specialist who could cure her is the one most likely to initiate a lawsuit if death eventually defeats the doctor. Some people spend their lives running from one intimate relationship to the next, in recurrent cycles of idealization and disillusionment, trading the current partner in for a new model every time he or she turns out to be a human being. The modification of primitive idealization is a legitimate goal of all long-term psychoanalytic therapy, but that enterprise has particular relevance in work with narcissistic clients because of the degree of unhappiness in their lives and in those of the people who try to love them.

PROJECTION, INTROJECTION, AND PROJECTIVE IDENTIFICATION

I am combining the discussion of two of the most primitive defensive processes, projection and introjection, because they represent opposite sides of the same psychological coin. In both projection and introjection, there is a permeated psychological boundary between the self and the world. As mentioned earlier, in normal infancy, before the child has developed a sense of which experiences come from inside and which ones have their sources outside the self, we assume that there is a generalized sense of "I" being equivalent to "the world." A baby with colic probably has the experience of "Hurt!" rather than "Something inside me hurts." The infant cannot yet distinguish between an internally located pain like colic and an externally caused discomfort like pressure from diapers that are too tight. From this era of relative undifferentiation come the processes that later, in their defensive function, we refer to as projection and introjection. When these processes work together, they are considered one defense, called projective identification. Some writers (e.g., Scharff, 1992) distinguish between projective and introjective identification, but similar processes are at work in each kind of operation.

Projection is the process whereby what is inside is misunderstood as coming from outside. In its benign and mature forms, it is the basis for empathy. Since no one is ever able to get inside the mind of another person, we must use our capacity to project our own experience in order to understand someone else's subjective world. Intuition, leaps of nonverbal synchronicity, and peak experiences of mystical union with another person or group involve a projection of the self into the other, with powerful emotional rewards to both parties. People in love are well known for reading one another's minds in ways that they themselves cannot account for logically.

In its malignant forms, projection breeds dangerous misunderstanding and untold interpersonal damage. When the projected attitudes seriously distort the object on whom they are projected, or when what is projected consists of disowned and highly negative parts of the self, all kinds of difficulties can ensue. Others resent being misperceived and may retaliate when treated, for example, as judgmental, envious, or persecutory (attitudes that are among the most common of those that tend to be ignored in the self and ascribed to others). A person who uses projection as his or her main way of understanding the world and coping with life, and who denies or disavows what is being projected, can be said to have a paranoid character.

I should note that paranoia has nothing inherently to do with suspiciousness (which may be based on realistic, unprojected observation and experience, or may derive from posttraumatic vigilance), nor with whether or not an attribution is accurate. The fact that a projection "fits" does not make it any less a projection; and although it is easier to spot a projection when the attribution does *not* fit, it is also possible that there is some other, nondefensive reason for a misunderstanding of someone else's motives. Popular misuse of the word "paranoid" has wrongly equated it with "fearful" or "unreasonably suspicious," much to the detriment of precision in language, even though it is true that what people project is usually unpleasant stuff to which they then may react with fear and distrust (see McWilliams, 2010).

Introjection is the process whereby what is outside is misunderstood as coming from inside. In its benign forms, it amounts to a primitive identification with important others. Young children take in all kinds of attitudes, affects, and behaviors of significant people in their lives. The process is so subtle as to be mysterious, although recent studies of mirror neurons and other brain processes are starting to shed light on it. Long before a child can make a subjectively voluntary decision to be like Mommy or Daddy, he or she seems to have "swallowed" them in some primal way.

In its problematic forms, introjection can, like projection, be highly destructive. The most striking examples of pathological introjection involve the process that has been labeled, somewhat inappropriately in view of its primitivity, "identification with the aggressor" (A. Freud, 1936). It is well known, from both naturalistic observations (e.g., Bettelheim, 1960) and empirical research (e.g., Milgram, 1963), that under conditions of fear or abuse, people will try to master their fright and pain by taking on qualities of their abusers. "I'm not the helpless victim; I'm the powerful perpetrator" seems to be the unconscious attraction to this defense. This mechanism crosses all diagnostic boundaries but is particularly evident in characterological dispositions toward sadism, explosivity, and what is often misleadingly called impulsivity.

Introjection is also implicated in some kinds of depressive psychology (Blatt, 1974, 2004). When we are deeply attached to people, we introject them, and their representations inside us become a part of our identity ("I am Tom's son, Mary's husband, Sue's father, Dan's friend," etc.). If we lose someone whose image we have internalized, whether by death, separation, or rejection, not only do we feel that our environment is poorer for that person's absence in our lives but we also feel that we are somehow diminished, that a part of our self has died. An emptiness or sense of void comes to dominate our inner world. We may also, in an effort to feel some sense of power rather than helpless loss, become pre-

occupied with the question of what failure or sin of ours drove the person away. The critical, attacking voice of a lost object can live on in us as a way of keeping that person internally alive. When mourning is avoided, unconscious self-criticism thus takes its place. Freud (1917a) beautifully described the process of mourning as a slow coming to terms with this condition of loss, in which "the shadow of the object fell upon the ego" (p. 249). A person who is unable over time to separate internally from a loved one whose image has been introjected, who consequently fails to invest emotionally in other people (the function of the grieving process), will continue to feel diminished, unworthy, depleted, and bereft.

Similarly, children in destructive families prefer to believe there is something wrong with them (preserving hope that by changing, they can improve their lot), than to take in the terrifying fact that they are dependent on negligent or abusive caregivers. Fairbairn (1943) called this process the "moral defense," noting that it is "better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" (pp. 66–67). If one regularly uses introjection to reduce anxiety and maintain continuity in the self, keeping psychological ties to unrewarding objects of one's earlier life, one can reasonably be considered characterologically depressive.

Melanie Klein (1946) was the first analyst to write about a defensive process that she found to be ubiquitous in more disturbed patients, which she called "projective identification." This fusion of projective and introjective mechanisms has been compactly described by Ogden (1982):

> In projective identification, not only does the patient view the therapist in a distorted way that is determined by the patient's past object relations; in addition, pressure is exerted on the therapist to experience himself in a way that is congruent with the patient's unconscious fantasy. (pp. 2–3)

In other words, the patient both projects internal objects and gets the person on whom they are projected to behave like those objects, as if the target person had those same introjects. Projective identification is a difficult abstraction, one that has inspired much controversy in the analytic literature (e.g., S. A. Mitchell, 1997). My own understanding of the term involves the ideas implied in the previous paragraph; that is, projection and introjection each have a continuum of forms, running from primitive to advanced (cf. Kernberg, 1976), and at the primitive end, those processes are fused because of their similar confusion of inside and outside. This fusion is what we call projective identification. In Chapter 4 I discussed briefly the operation of projective identification in psychotic and borderline states.

To illustrate how that process differs from mature projection, consider the contrast between the following hypothetical statements from two young men who have come for an intake interview:

PATIENT A: (*somewhat apologetically*) I know I have no reason to believe you're critical of me, but I can't help thinking that you are.

PATIENT B: (*in an accusatory tone*) You shrinks all love to sit back and judge people, and I don't give a shit what you think!

Let us assume that in reality, the therapist began the session with a genuinely friendly, interested, nonjudgmental attitude toward each client. The content of what is bothering each man is similar; both are worried that the therapist is taking a harsh, evaluative stance. Both are projecting an internalized critical object onto the therapist. Three aspects of their respective communications, however, make them very different from each other.

First, Patient A shows evidence of the capacity for self-reflection (observing ego, reflective functioning), the ability to see that his fantasy may not necessarily conform to reality; his projection is ego alien. Patient B, on the other hand, experiences what is projected as an accurate depiction of the therapist's state of mind; his projection is ego syntonic. In fact, he believes in the reality of his attribution so absolutely that he is already launching a counterattack against the assault that he is certain the therapist is planning. The fusion of cognitive, affective, and behavioral dimensions of experience typical of primitive processes is discernible here.

Second, these patients differ in the extent to which their projective process has successfully done the job for which the defense was called upon, namely, to get rid of a troublesome feeling. Patient A has ejected the critical attitude and presumably feels some relief in reporting it, while Patient B both projects it and keeps it. He ascribes a critical attitude to the other person, yet that does not relieve him of feeling censorious himself. Kernberg (1975) has described this aspect of projective identification as "maintaining empathy" with what has been projected.

Finally, these patients' respective communications will likely have very different emotional effects. The therapist will find it easy to like Patient A and will readily form a working alliance. With Patient B, however, the therapist will rapidly begin feeling like exactly the sort of person the patient is already convinced he is sitting with: uncaring, ready to judge, and disinclined to exert the energy it will take to try to care about this man. In other words, the countertransference toward the first man

will be positive and mild, while toward the second it will be negative and intense.

The late Bertram Cohen once explained the "self-fulfilling prophecy" quality of projective identification to me as a natural consequence of a person's being disturbed enough to have very primitive *but not psychotic* perceptions. A woman who is invested in staying anchored in reality will feel less crazy if she can induce in someone else the feelings she is convinced the other person already has. A frankly psychotic woman will not care whether her projection "fits," and will therefore spare others the pressure to confirm its appropriateness and hence her sanity.

Projective identification is a particularly powerful and challenging operation, one that strains the therapist's capacities. While all the defenses in this section are considered primitive, this one, along with splitting, which I discuss next, has a special reputation for causing headaches to clinicians. When one is caught in the patient's certainty about how the therapist "really" feels, along with the patient's unrelenting struggle to induce just those feelings, it is hard to withstand the emotional barrage. Moreover, since all of us share in the predicament of being human, and hence contain already within ourselves all the different emotions, defenses, and attitudes that get projected onto us, there is always some truth in the projective identifier's belief. It can be very confusing to figure out in the heat of the clinical moment where the patient's defense ends and the therapist's psychology begins. Perhaps the capacity of this defense to threaten the therapist's confidence in his or her own mental health accounts for the fact that projective identification, along with splitting, is implicated in borderline personality organization. In particular, because the projective piece of it is so powerful, it is associated with borderline levels of paranoid personality.

Contrary to professional popular opinion, however, projective identification is not used exclusively by people whose character is essentially borderline. There are numerous subtle and benign ways that the process operates in everyday life irrespective of psychopathology. For example, when what is projected and identified with involves the loving, joyful affects, a contagion of good feeling can occur in a group. Even when what is projected and identified with is negative, as long as the process is not relentless, intense, and unmodulated by other interpersonal processes of a more mature sort, it is not unduly harmful. There has been a tendency in recent American psychoanalysis to reframe the unconscious as an intersubjectively shared phenomenon rather than as one's individual "stuff" (see Aron, 1996, or Zeddies, 2000, on the relational unconscious) and also to see it as creative and positive rather than as Freud's seething cauldron of dangerous desire (Eigen, 2004; Grotstein,

2000; Newirth, 2003; Safran, 2006). The positive aspects of projective identification are implicit in such formulations.

SPLITTING OF THE EGO

Splitting of the ego, usually referred to simply as "splitting," is the other interpersonally powerful process that is understood as deriving from a preverbal time, before the infant can appreciate that his or her caregivers have good and bad qualities and are associated with good and bad experiences. We can observe in 2-year-olds a need to organize their perceptions by assigning good and bad valences to everything in their world. That tendency, along with a sense of the difference between big and little (adult and child, respectively), is one of the primary ways in which young human beings organize experience. Before one has object constancy, one cannot have ambivalence, since ambivalence implies opposite feelings toward a constant object. Instead, one can be in either a good or a bad ego state toward an object in one's world.

In everyday adult life, splitting remains a powerful and appealing way to make sense of complex experiences, especially when they are confusing or threatening. Political scientists can attest to how attractive it is for any unhappy group to develop a sense of a clearly evil enemy, against which the good insiders must struggle. Manichean visions of good versus evil, God versus the devil, cowboys versus Indians, the free world against the terrorists, the lone whistle-blower against the hateful bureaucracy, and so on, have pervaded the mythology of contemporary Western culture. Comparably split images can be found in the folklore and organizing beliefs of any society.

The mechanism of splitting can be very effective in its defensive functions of reducing anxiety and maintaining self-esteem. Of course, splitting always involves distortion, and therein lies its danger. Scholarly studies of the "authoritarian personality" (Adorno, Frenkl-Brunswick, Levinson, & Sanford, 1950) in the post–World War II era explored the far-reaching social consequences of the use of splitting (not by that name) to make sense of the world and one's place in it. The authors of the original study on authoritarianism believed that certain right-wing beliefs were particularly likely to be associated with this kind of inflexibility, but later commentators established that left-wing and liberal forms of authoritarianism also exist (see Brown, 1965).

Clinically, splitting is evident when a patient expresses one nonambivalent attitude and regards its opposite (the other side of what most of us would feel as ambivalence) as completely disconnected. For example, a borderline woman experiences her therapist as all good, in contrast

to the allegedly uncaring, hostile, stupid bureaucrats who work in the same setting. Or the therapist may suddenly become the target of undiluted rage, as the patient regards him or her as the personification of evil, neglect, or incompetence, when last week the therapist could do no wrong. If confronted with inconsistencies in his or her attributions, the client who splits will not find it arresting or worth pondering that someone who seemed so good has become so bad.

It is well known that in institutions like psychiatric hospitals and clinics, patients whose psychologies we describe as borderline not only split internally, they create (via projective identification) splits in the staff of the agency (G. Adler, 1972; Gunderson, 1984; Kernberg, 1981; T. F. Main, 1957; Stanton & Schwartz, 1954). Those mental health workers associated with a borderline client's care find themselves in repeated arguments in which some of them feel a powerful sympathy toward the patient and want to rescue and nurture, whereas the others feel an equally powerful antipathy and want to confront and set limits. This is one reason that splitting as a defense has a less than glowing reputation. Patients who use it as their customary way of organizing their experience tend to wear out their caregivers.

SOMATIZATION

When young children are not helped by their caregivers to state their feelings in words, they tend to express them in either depleted bodily states (illness) or action. Somatization is what analysts have called the process by which emotional states become expressed physically. Although it is common to conflate somatization with malingering, the somatic experience of being emotionally unwell in ways that are unverbalizable is not equivalent to pretending to be ill in order to extract sympathy or avoid a responsibility. Nor does it equate with a problem's being "all in your head." The brain is a part of one's physicality, not a detached overseer. Distinctions between body and mind, along with assumptions that the mind "controls" the body, have been long exposed as quaint myths of the Enlightenment era, with its smug assumption that "man" has natural dominion over nature, other animals, and his own body (cf. Meissner, 2006).

Our earliest reactions to the stresses of life are somatic, and many of these reactions remain basic to our responsiveness. The fight–flight–freeze response to stress seems pretty hard-wired. Blushing is an automatic aspect of the shame response. Under trauma, the brain is flooded with glucocorticoids, with multiple systemic consequences. The gastrointestinal system, the circulatory system, the immune system, the endo-

crine system, the skin, the breath, the heart—all get activated in different ways under emotional pressures. Part of maturation is the slow mastering of language to describe experiences that are originally felt as inchoate bodily arousal. If one has little help on making that transition, the automatic physical responses may be the only language one has for states of emotional activation (Gilleland, Suveg, Jacob, & Thomassin, 2009).

Analysts have long described somatizing patients as characterized by alexithymia, or lack of words for affect (Krystal, 1988, 1997; McDougall, 1989; Sifneos, 1973), an observation supported by a recent, comprehensive study by Mattila and colleagues (2008). Waldinger, Shulz, Barsky, and Ahern (2006) found that both insecure attachment and a childhood history of trauma are associated with somatization. Trauma has been implicated by a number of researchers (Reinhard, Wolf & Cozolino, 2010; Samelius, Wijma, Wingren, & Wijma, 2009; Zink, Klesges, Stevens, & Decker, 2009). Contrary to the assumptions of many, there is little empirical evidence for the reinforcement of somatization by parental responsiveness to it (Jellesma, Rieffe, Terwogt, & Westenburg, 2009). Rather, it seems to correlate with childhood fear, insecure attachment, and a less integrated sense of self (Evans et al., 2009; Tsao et al., 2009).

When life is hard to bear, the immune system can break down. I can recall (more clearly now than I could see at the time) several instances when I became ill during a period of emotional overload, and I have often heard friends and clients describe such tipping points in the face of particularly taxing events. Several studies have found that DSM-IV-defined somatization disorder co-occurs with the majority of personality disorders (Bornstein & Gold, 2008; Garcia-Campayo, Alda, Sobradiel, Olivan, & Pascual, 2007; Spitzer & Barnow, 2005), suggesting that somatization is common in more serious character pathology. People who regularly and characteristically respond to stress with illness may be conceptualized as having a somatizing personality (PDM Task Force, 2006). Although the DSM has never included characterological somatization in its listing of personality disorders, the DSM-IV description of "somatization disorder" describes individuals who have problems in multiple organ systems, over many years, under many different circumstances. This is pretty hard to differentiate conceptually from a personality disorder.

Most of us can think of acquaintances who respond to stress by getting sick. Therapists see many clients referred by physicians who have been defeated by a patient's chronic physical fragility, whom they have finally sent to see whether psychotherapy can help. We see others who come to us as a last resort because nothing else has successfully treated

their tension headaches or irritable colon or skin rashes or chronic pain. Expression of feelings is the ordinary currency of the psychoanalytic and humanistic therapies. Because somatizers suffer automatically and physically and lack the capacity for such expression, they can be difficult to help—especially when their physical suffering has been complicated by having encountered impatience, exasperation, and a sense of defeat in previous health professionals and therapists.

The conclusion that a person complaining to a therapist of physical pain or exhaustion is using the defense of somatization should not be reached unreflectively. For one thing, the stress of disease itself can cause a regressive reaction. People can get sick because they are unconsciously depressed; they can also get depressed because they are medically ill. In addition, some clients come from cultures in which it is normative to express psychological suffering by reference to bodily pain or malfunction. In traditions where the idiom of distress is physical, even psychologically mature individuals express their difficulties this way, and so the assumption of a primitive regressive process is unwarranted (Rao, Young, & Raguram, 2007; So, 2008).

ACTING OUT (DEFENSIVE ENACTMENT)

As noted above, the other way young children express unverbalizable states of mind is by acting them out. In the first edition of this book, I put acting out with the more mature defenses because in the chapter on primary defensive processes I was concentrating on the processes that Kernberg (1984) had explicated in connection with borderline and psychotic conditions. I think now that even though it characterizes healthy as well as more troubled individuals, it is a mistake to frame enactment as a second-order process: Putting into action what one lacks the words to express is by definition a preverbal operation. But I still want to issue my earlier caution: The label "acting out" gets applied to all kinds of behavior that the labeler happens not to like, often in a tone quite at odds with its original nonpejorative meaning. Most readers have probably heard the phrase bandied about disapprovingly and may not be aware of the more simply descriptive use of the term.

To my knowledge, the earliest uses of the phrase "acting out" occurred in psychoanalytic descriptions of patients' actions outside the analyst's office, when their behavior seemed to embody feelings toward the analyst that the person was unaware of having or was too anxious to let into awareness, especially in the analyst's presence (Freud, 1914b). Later on, the term became used more generally to describe behavior that

is driven by unconscious needs to master the anxiety associated with internally forbidden feelings and wishes, with powerfully upsetting fears and fantasies, and with traumatic memories (Aichhorn, 1936; Fenichel, 1945). Still later, the related term "enactment" was applied to the representation in action of experiences for which the affected person had never had words and could not formulate verbally (Bromberg, 1998; D. B. Stern, 1997). Analysts in the relational movement emphasize that enactments are inevitable in therapy, as the unconscious worlds of both patient and therapist create mutually enacted dynamics, which the therapist is responsible to turn into speech and reflection. With respect to the individual function of acting out as a defense, by enacting upsetting scenarios, the unconsciously anxious person turns passive into active, transforming a sense of helplessness and vulnerability into an experience of agency and power, no matter how negative the drama that is played out (cf. Weiss, 1993).

A teacher, whose relationship to her judgmental mother had left her both frightened of and deeply hungry for intimacy, began a sexual affair with a colleague named Nancy a few weeks after entering therapy with me. I suspected she was beginning to feel some wish for closeness with me, was unconsciously assuming that I (like her mother) would be scornful of her longings, and was handling her unconscious and forbidden strivings by acting out aspects of what she wished and feared with someone who bore my name. This kind of enactment, assuming my interpretation of it is accurate, happens frequently in analysis, especially with patients who have a childhood basis for fearing an authority's rejection of their needs and feelings.

"Acting out" or "enactment" thus properly refers to any behavior that is assumed to be an expression of transference attitudes that the patient does not yet feel safe enough, or emotionally articulate enough, to bring into treatment in words. It may also be used to label the process by which any attitude, in or out of treatment, may be discharged in action with the unconscious purpose of mastering overwhelming, unverbalizable affects that surround it. What is acted out may be predominantly self-destructive, or predominantly growth enhancing, or some of each; what makes it acting out is not its goodness or badness but the unconscious or dissociated nature of the feelings that propel the person into action and the compulsive, automatic way in which the acted-out behavior is undertaken. The current popularity of calling any unappreciated behavior—in obstreperous children, for example, or in rude acquaintances—"acting out" is psychoanalytically unjustified. The negative cast that the phrase has acquired may reflect the fact that beneficial kinds of acting out do not call attention to themselves in the way that destructive ones do.

Analysts have created several imposing labels depicting classes of behaviors that, when unconsciously motivated, fall under the general heading of acting out: exhibitionism, voyeurism, sadism, masochism, perversion, and all the "counter" terms ("counterphobia," "counter-dependency," "counterhostility"). I am not, by the way, implying that these processes are inherently negative or even inherently defensive. We have normal exhibitionistic and voyeuristic needs that are ordinarily discharged in socially acceptable ways of looking and being looked at. Our masochistic and sadistic strivings may find positive expression in acts of personal sacrifice or dominance, respectively. All these tendencies may be integrated into pleasurable sexual experiences. But when applied to specific acts that are understood as defensive, such terms assume underlying fear or other disavowed or unformulated negative feelings. Freud's early observation that we act out what we do not remember remains astute, especially if we assume that the reason we do not remember is that something very painful went along with the unremembered and now-enacted state.

To the extent that there is an identifiable population of persons who rely on acting out to deal with their psychological dilemmas, that group would fall into the category of impulsive personalities. This nomenclature is misleading, as it implies an uncomplicated readiness to do whatever one feels like doing at the moment. Much of what may look like spontaneous, uncomplicated impulsiveness is often unconsciously and very complexly driven behavior, behavior that is anything but innocently expressive and random. Hysterically organized people are famous for acting out unconscious sexual scenarios; addicted people of all kinds can be conceptualized as repeatedly acting out their relation to their preferred substance (in such cases, of course, chemical dependency can complicate what was already a psychological addiction); people with compulsions are by definition acting out when they succumb to internal pressure to engage in their particular compulsive acts; psychopathic people may be reenacting a complicated pattern of manipulation. Thus, the defense may be seen in many contrasting clinical presentations.

SEXUALIZATION (INSTINCTUALIZATION)

Sexualization usually takes an enacted form and might be considered a subtype of acting out. I have chosen to present it separately, though, partly because it is possible to sexualize without acting out (a process that is more accurately referred to as erotization) and partly because it is a concept of such general and interesting significance that it deserves some special attention.

Freud (1905) originally assumed that basic sexual energy, a force he called "libido," underlies virtually all human activity. (Later, impressed with the prevalence of human destructiveness, he decided that aggressive strivings are equally fundamental and motivating, but most of the language of his clinical theory derives from a time before that shift in his thinking.) One consequence of his biological, drive-based theory was his tendency to regard sexual behaviors as expressing a primary motivation, not a derivative and defensive one. Obviously, sexuality is a powerful basic dynamism in human beings, and much human sexual behavior amounts to relatively direct expressions of the reproductive imperative of our species. Clinical experience and research findings (see Celenza, 2006; Ogden, 1996; Panksepp, 2001; Stoller, 1968, 1975, 1980, 1985) over the decades since Freud's work, however, attest to how often sexual activity and fantasy are used defensively: to master anxiety, to restore self-esteem, to offset shame, or to distract from a sense of inner deadness.

People may sexualize any experience with the unconscious intention of converting terror or pain or other overwhelming sensation into excitement—a process that has also been referred to as instinctualization. Sexual arousal is a reliable means of feeling alive. A child's fear of death—by abandonment, abuse, or other dreaded calamity—can be mastered psychologically by turning a traumatic situation into a life-affirming one; many children masturbate to reduce anxiety. Studies of people with unusual sexual proclivities have often turned up infantile experiences that overwhelmed the child's capacity to cope and were consequently transformed into self-initiated sexualizations of the trauma. For example, Stoller's (e.g., 1975) work with sexually masochistic people, those for whom pain is a condition of sexual satisfaction, revealed that a significant number of them had suffered invasive and painful medical treatments as young children. At the other end of the sadomasochistic spectrum, rape is the sexualization of violence.

Most of us use sexualization to some degree to cope with and spice up troublesome aspects of life. There are some gender differences in what tends to be sexualized: For example, women are more apt to sexualize dependency and men to sexualize aggression. Some people sexualize money, some sexualize dirt, some sexualize power, and so on. Many of us sexualize the experience of learning; the erotic aura around talented teachers has been noted at least since the time of Socrates. Our tendency to erotize our reaction to anyone with superior power may explain why political figures and other celebrities are typically deluged with sexually available admirers, and why the potential for sexual corruption and exploitiveness is so great among the influential and famous.

The susceptibility of those in a relatively weak position to converting their envy, hostility, and fear of mistreatment into a sexual scenario, one in which they compensate for a relative lack of official power with recourse to a very personal erotic power, is one of the reasons we need laws and conventions protecting those who are structurally dependent on others (employees on employers, students on teachers, sergeants on lieutenants, patients on therapists). We all need to be discouraged not only from the possibility of crass exploitation by the authorities in our lives but also from the temptations created by our own defenses.

At the risk of belaboring a point that applies to all defensive processes, let me stress that sexualization is not inherently problematic or destructive. People's individual sexual fantasies, response patterns, and practices are probably more idiosyncratic than almost any other psychological aspect of their lives; what turns one person on erotically may leave another cold. If I happen to sexualize the experience of someone's handling my hair (even if the childhood genesis of my doing so was a defensive sexualizing of my mother's abusive hair yanking), and my sexual partner loves to run his or her fingers through it, I am not likely to go into psychotherapy. But if I sexualize the experience of being frightened by abusive males, and I have repeated affairs with men who beat me up, I might well seek help. As with every other defense, it is the context and consequences of its use in adulthood that determine whether it is reasonable to be regarded (by self and others) as a positive adaptation, an unremarkable habit, or a pathological affliction.

EXTREME DISSOCIATION

I have put extreme dissociation with the primary defenses here, both because it works so globally on the total personality and because many dissociated states are essentially psychotic. Since the first edition of this book, however, I have become increasingly sensitized to the range of dissociative reactions and the inadvisability of restricting our use of the term "dissociation" to the overwhelming, shock-trauma versions of the defense. In 1994 I wrote that dissociation seemed different from the other lower-order defenses because it is so clearly a response to severe trauma, from which many of us are thankfully spared while growing up (the other processes, in contrast, represent normal modes of operating that become problematic only if one hangs onto them too long or to the exclusion of other ways of dealing with reality). But I have come to agree with many contemporary relational analysts (e.g., Bromberg, 1998; Davies & Frawley, 1994; Howell, 2005) that it is a matter of degree that separates one person's pain from another's trauma, and that

dissociation exists on a continuum from normal and minor to aberrant and devastating.

Dissociation is a "normal" reaction to trauma. Any of us, if confronted with a catastrophe that overwhelms our capacity to cope, especially if it involves unbearable pain and/or terror, might dissociate. Out-of-body experiences during war, life-threatening disasters, and major surgery have been reported so often that only the most skeptical person can completely disregard the evidence for dissociative phenomena. People who undergo unbearable calamities at any age may dissociate (Boulanger, 2007; Grand, 2000); those who are repeatedly subject to horrific abuse as young children may come to dissociate as their habitual reaction to stress. Where this is true, the adult survivor is legitimately conceptualized as suffering from a chronic dissociative disorder, once labeled "multiple personality" and currently termed "dissociative identity disorder."

There has been an explosion of research and clinical reporting on dissociation and dissociative identity disorder in recent decades, all of which has underscored the fact that people who use dissociation as their primary defense exist in far greater numbers than anyone had previously suspected (see I. Brenner, 2001, 2004). Perhaps there has been an increase in the kind of horrific child abuse that creates dissociation, or perhaps some threshold of public awareness was crossed with the publication of *Sybil* (Schreiber, 1973) that has encouraged people who suspect that they may be regularly dissociating to show themselves sooner and in greater numbers to mental health professionals. Neuropsychoanalytic studies are beginning to describe what goes on in the brain in states of dissociation (Anderson & Gold, 2003; Bromberg, 2003).

The advantages of dissociating under unbearable conditions are obvious: The dissociating person cuts off pain, terror, horror, and conviction of imminent death. Anyone who has had an out-of-body experience when in mortal danger, and even those of us without such a dramatic basis for empathy, can readily understand a preference for being outside rather than inside the sense of impending obliteration. Occasional or mild dissociation may facilitate acts of singular courage. The great drawback of the defense, of course, is its tendency to operate automatically under conditions in which one's survival is not realistically at risk, and when more discriminating adaptations to threat would extract far less from one's overall functioning. Traumatized people may confuse ordinary stress with life-threatening circumstances, becoming immediately amnesic or totally different, much to their own confusion and that of others. Outsiders, unless they also have a traumatic history, rarely suspect dissociation when a friend suddenly forgets some major incident or appears inexplicably changed. Rather, they conclude that their

acquaintance is moody, or unstable, or a liar. There is thus a high interpersonal price paid by the habitual user of this defense.

SUMMARY

In this chapter I have described defenses that analysts conventionally consider primitive or primary: extreme withdrawal, denial, omnipotent control, extreme idealization and devaluation, primitive forms of projection and introjection, splitting, somatization, enactment, sexualization, and extreme forms of dissociation. I have reviewed the assumed normal origins of each defense and mentioned adaptive and maladaptive functions of each. I have also identified the personalities and syndromes associated with heavy reliance on each primary defense.

SUGGESTIONS FOR FURTHER READING

Primitive forms of projection and introjection have inspired a few worthy books (Grotstein, 1993; Ogden, 1982; Sandler, 1987; Scharff, 1992); other primary defenses tend to be discussed in different writers' speculations about psychic development. Klein's "Love, Guilt and Reparation" (1937) and "Envy and Gratitude" (1957) are highly illuminative of primitive processes and, unlike some of her work, not incomprehensible to beginning therapists. Balint (1968) was gifted in describing archaic dynamics in individuals; Bion (1959) was peerless at discerning their operation in groups. Grotstein's *Splitting and Projective Identification* (1993) is also a brilliant and useful exposition of these Kleinian concepts.

Phoebe Cramer's *Protecting the Self* (2006) reviews some fascinating studies of defenses and their development and offers empirical support for the longstanding psychoanalytic observation that maturation of defensive style is associated with psychological health, whereas reliance on more primitive defenses correlates with psychopathology. George Vaillant has devoted much of his remarkable career to the understanding of defensive processes; his 1992 book, *Ego Mechanisms of Defense*, is particularly useful to therapists.

6

Secondary Defensive Processes

Virtually any psychological process can be used defensively, and so no summary of the defenses can be complete. In analysis, even free association can be used defensively, to avoid certain topics. Anna Freud's seminal—*The Ego and the Mechanisms of Defense* (1936) covers denial, repression, reaction formation, displacement, rationalization, intellectualization, regression, reversal, turning against the self, identification with the aggressor, and sublimation. Laughlin (1970) delineated 22 major and 26 minor defense mechanisms, Vaillant and Vaillant (e.g., 1992) named 18, which they grouped according to inferred maturity, and the DSM-IV enumerates 31, also grouped by level. Cramer (2006) contrasts defense mechanism with deliberate coping strategies by noting the unconscious, automatic, nonintentional quality of defenses.

I describe here a selection of operations that is more extensive than Anna Freud's but less comprehensive than Laughlin's and Vaillant's lists. I have chosen the "mature," or "higher-order," defenses to be covered according to two criteria: (1) the frequency with which they are mentioned in psychoanalytic clinical literature and by practicing therapists, and (2) their relevance to particular character patterns. Anyone else's list would probably be different, would emphasize other aspects of defense, and would reflect another writer's distinctive take on analytic theory and practice.

REPRESSION

Repression was one of the first defenses to fascinate Freud, and it has enjoyed a long history of clinical and empirical investigation. The essence of repression is motivated forgetting or ignoring. Its implicit metaphor recalls the early drive model with its idea that impulses and affects press for release and have to be held in check by a dynamic force. Freud (1915b) wrote that "the essence of repression lies simply in turning something away, and keeping it at a distance, from the conscious" (p. 146). If either an internal disposition or an external circumstance is sufficiently upsetting or confusing, it may be deliberately consigned to unconsciousness. This process may apply to a total experience, to the affect connected with an experience, or to one's fantasies and wishes associated with it.

Not all difficulty in paying attention or remembering constitutes repression. Only when there is evidence that an idea or emotion or perception has become consciously inaccessible because of its power to upset are there grounds for assuming the operation of this defense. Other attentional and memory deficits may result from toxic or organic conditions, or simply from the ordinary mental sifting of the important from the trivial. (Now that I am in my sixties and regularly forgetting what I came upstairs for, it occurs to me that the Freudian theory that memory lapses are always dynamically provoked could only have been developed by a relatively young man.)

Freud saw the operation of repression in traumatic experiences such as rape or torture that the victim later cannot recall. Instances of what were once called the "war neuroses," now known as posttraumatic stress reactions, have been psychoanalytically explained by reference to the concept of repression. In such cases, a person is unable to remember at will certain horrifying, life-threatening events but may be troubled by intrusive flashbacks of them, a phenomenon to which Freud would have attached the colorful label "the return of the repressed." Our current knowledge of brain processes suggests that repression is not an accurate concept for such traumatic memory problems. We now know that under extreme stress, the functioning of the hippocampus, which stores episodic memory (the sense of "it happened to me; I was there"), is shut down by the glucocorticoids secreted during trauma. Thus, the episodic memory *is not laid down in the first place.* After a trauma there may be semantic memory (third-person facts after the event), procedural memory (physical experience of the event, or "body memory"), and emotional memory (feeling the emotions that were activated in the event when something, such as being in the place it happened, reminds one of it), but there may never be episodic memory (Solms & Turnbull,

2002). I say more about the clinical implications of these facts in Chapter 15.

Later analytic theory applied the term "repression" more to internally generated ideas than to trauma. This is the version of repression that has remained most useful to therapists. Repression is seen as the means by which children deal with developmentally normal but unrealizable and frightening strivings, such as the oedipal wish to destroy one parent and possess the other: They eventually relegate them to unconsciousness. One must have attained a sense of the wholeness and continuity of the self before one is capable of handling disturbing impulses by repression. For people whose early experiences did not foster identity integration, troublesome feelings tend to be handled with more primitive defenses, such as denial, projection, and splitting (Myerson, 1991).

A clinically inconsequential example of repression, the kind that Freud (1901) saw as part of the "psychopathology of everyday life," would be a speaker's momentarily forgetting the name of someone he or she is introducing, when there is evidence for the speaker's unconscious negative feeling toward that person. In the developmentally normal repressive processes that allow children to reject infantile love objects and seek partners outside the family, and in trivial (and often entertaining) instances of repression, one can see the adaptive nature of the process. If we were constantly aware of the whole panoply of our impulses, feelings, memories, images, and conflicts, we would be chronically overwhelmed. Like other defenses, repression becomes problematic only when it (1) fails to do its job of keeping disturbing ideas out of consciousness so that we can go about the business of accommodating to reality, or (2) gets in the way of certain positive aspects of living, or (3) operates to the exclusion of other more successful ways of coping. Overreliance upon repression, along with certain other defensive processes that often coexist with it, has classically been considered the hallmark of the hysterical personality.

Freud's early efforts to get hysterical patients to bring into consciousness both the traumatic events of their histories and the urges and feelings they had been raised to consider unacceptable yielded fascinating information (Breuer & Freud, 1893–1895). From working with this population Freud originally concluded, as I mentioned in Chapter 2, that repression causes anxiety. According to his original mechanistic model, the anxiety that is such a frequent concomitant of hysteria is caused by a repressive bottling up of drives and affects. These feelings press for discharge and hence cause a chronic state of tension (some irreverent commentators have called this the "coitus interruptus" theory of the relationship of repression to anxiety). Later, as Freud revised his theory in light of accumulating clinical observations, he reversed his version of cause and effect, regarding repression and other defense mechanisms as

the result rather than the cause of anxiety. In other words, preexisting irrational fear created the need to forget.

This later formulation of repression as an elemental defense of the ego, the automatic suppressor of countless anxieties that are simply inherent in living one's life, became standard psychoanalytic theory in the ego psychology era. Nevertheless, Freud's original postulation of repression as the *instigator* of anxiety is not without some intuitive appeal, in that excessive repression may ultimately cause as many problems as it solves. This process, labeled by Mowrer (1950) the "neurotic paradox," whereby attempts to quell one anxiety only generate others, is the core characteristic of what was once (in a much more comprehensive use of the term than is typical now) called neurosis. Along these lines, Theodor Reik used to contrast the emotionally healthy person, who can stand in front of the window at Tiffany's admiring the jewelry and tolerating a passing fantasy of stealing it, with the neurotic person, who looks in the window and runs in the opposite direction. When psychoanalysis first captured the imagination of the educated public, such popularized examples of the pathological operation of repressive defenses contributed to a widespread overvaluation of the goals of removing repression and shedding inhibitions, and also to the misunderstanding that these processes constitute the essence of all psychoanalytic therapies.

An element of repression is present in the operation of most of the higher-order defenses (although it is arguable that denial rather than repression is operating in instances in which it is unclear whether or not the person was originally aware of something before losing that knowledge). For example, in reaction formation, the turning of an attitude into its opposite, such as hate into love or idealization into contempt, the original emotion can be seen as repressed (or denied, depending on whether it was ever consciously felt). In isolation, the affect connected with an idea is repressed (or denied, as above). In reversal, there is a repression of the original scenario that is now being turned around. And so forth. Freud's original belief that repression was a sort of grandparent of all other defenses can be seen sympathetically in this light, despite current evidence that the processes described in Chapter 5 predate repression in the child by at least a year and a half. In Chapter 15 I discuss current analytic views that dissociation is a more basic defense than repression, but for purposes of this chapter, I am giving the more classical account.

REGRESSION

Regression is a relatively uncomplicated defense mechanism, familiar to every parent who has watched a child slide backward into the habits of a prior maturational stage when tired or hungry. Social and emotional

development does not progress in a straight line; there is a fluctuation to personal growth that becomes less dramatic as we age, but never entirely goes away. Almost anyone, if tired enough, will begin to whine. The "rapprochement subphase" of the separation–individuation process that Mahler (1972a, 1972b) described as a universal feature of the last part of every child's second year, when the toddler who has just declared independence from the mother goes back and hides under her skirt, is only one example of the tendency of human beings to cling to the familiar right after having achieved some new level of competence.

In long-term psychotherapy and psychoanalysis, this tendency is easy to observe. The patient who has finally summoned up the courage to try out a new way of behaving, especially if it involves new behavior toward the therapist (e.g., expressing criticism or anger, confiding masturbation fantasies, asking for a break on fees, or scheduling with more self-assertion than was permitted in childhood), will frequently revert to old habits of thought, feeling, and behavior in subsequent sessions. The therapist who does not appreciate the ebb and flow inherent in developmental change may be dismayed by this phenomenon (the countertransference may resemble the normal exasperation of a parent who finally succeeds in getting a young child to sleep through the night, and then gets a week of bedroom visits at 3:00 A.M.) until it becomes clear that despite the regressive dimension of the client's struggle, the overall direction of change is forward.

Strictly speaking, it is not regression when a person is aware of needing some extra comfort and asks to be held or reassured, nor is it regression when one deliberately seeks out a means—through competitive sports, for instance—of discharging primordial levels of drive. To qualify as a defense mechanism, the process must be unconscious. Thus, the woman who lapses unwittingly into compliant, little-girlish ways of relating right after realizing some ambition or the man who thoughtlessly lashes out at his wife just after attaining some new level of intimacy with her are regressing in the psychoanalytic meaning of the term, as their respective actions have not been consciously chosen. Somatization has often been seen as a type of regression, and it belongs there if the person has attained the capacity to put words to feelings and then backslides into a preverbal, somatizing state.

Some hypochondriacal people, those who drive physicians to distraction with a litany of vague and changing complaints that never respond to treatment, use regression to the sick role as a primary means of coping with upsetting aspects of their lives. By the time they are persuaded to consult a therapist, they have usually built up an additional and virtually impenetrable wall of defensiveness deriving from having repeatedly been treated like a spoiled child or willful attention seeker. They expect clini-

cians to try to expose them as malingerers. Consequently, the therapist whose client uses regression to the sick role as a favored defense must have almost superhuman reserves of tact and patience—all the more so if the patient's pattern of taking to the sickbed has been reinforced by other rewards of that position ("secondary gain").

Although one sometimes sees a client with both, hypochondriasis should not be confused with somatization. In the former, there is no disease process, despite the patient's worry or even conviction of illness. In the latter, there are diagnosable ailments related to stresses that the person somehow cannot process emotionally. Sometimes, of course, doctors are sure they are dealing with a hypochodriacal patient and eventually learn that the person has been suffering from an obscure, undiagnosed illness. Therapists have to take care to leave open a mental space for the possibility that a difficult client who seems clearly either hypochondriacal or somatizing may be ill with a systemic problem that has not been identified.

Hypochondria and other kinds of regression into relatively helpless and childlike modes of dealing with life can be a kind of cornerstone of a person's character. Where regression, with or without hypochondria, constitutes someone's core strategy for dealing with the challenges of living, he or she may be characterized as having an infantile personality. This category did not survive after the second edition of the DSM, but some analysts have lamented its disappearance.

ISOLATION OF AFFECT

One way in which people may deal with anxieties and other painful states of mind is by isolating feeling from knowing. More technically, the affective aspect of an experience or idea can be sequestered from its cognitive dimension. Isolation of affect can be of great value: Surgeons could not work effectively if they were constantly attuned to the physical agony of patients or to their own revulsion, distress, or sadism when cutting into someone's flesh; generals could not plan battle strategy if they were in continual touch with the graphic horrors of war; police officers could not investigate violent crimes without becoming unglued.

The "psychic numbing" that Lifton (1968) has described as a consequence of catastrophe exemplifies the operation of isolation of affect on a social level. Therapists who have worked with survivors of the Holocaust have been struck by their wooden descriptions of atrocities that defy the ordinary imagination. The political scientist Herman Kahn (1962) wrote an influential book on the probable outcome of a nuclear conflagration,

in which the most horrific consequences of atomic disaster were detailed in an almost jovial tone of detachment. With respect to its adaptive utility in extreme situations, isolation is a degree more discriminative than dissociation: The experience is not totally obliterated from conscious experience, but its emotional meaning is cut off.

Isolation can also become, by means of a certain style of child rearing mixing with a child of a certain temperament, a core defense in the absence of obvious trauma. We all know people who claim that they have no emotional responses to things about which the rest of us have powerful feelings; such people sometimes make a virtue out of the defense of isolation and idealize the condition of expressing only rational concerns. Our cultural tendency to admire the capacity to isolate affect from intellect is discernible in the widespread devotion of old *Star Trek* fans to the character of Mr. Spock, the Vulcan. The fact that isolation is appreciated as a defensive rather than a natural position is betrayed by the decision of the writers of that series to give Spock a latent emotional side, the contribution of his Earthling mother.

Many contemporary analysts consider isolation to be a subtype of dissociation. Analysts in the ego psychology tradition considered it the most primitive of the "intellectual defenses" and the basic unit of psychological operation in mechanisms like intellectualization, rationalization, and moralization. I consider these defenses separately in the following sections, but they have in common the relegation to unconsciousness of the personal, gut-level implications of any situation or idea or occurrence. When one's primary defense is isolation, and the pattern of one's life reflects the overvaluation of thinking and the underappreciation of feeling, one's character structure is considered obsessive.

INTELLECTUALIZATION

Intellectualization is the name given to a higher-order version of the isolation of affect from intellect. The person using isolation typically reports that he or she has no feelings, whereas the one who intellectualizes talks about feelings in a way that strikes the listener as emotionless. For example, the comment, "Well, naturally I have some anger about that," delivered in a casual, detached tone, suggests that while the idea of feeling anger is theoretically acceptable to the person, the actual expression of it is still inhibited. When patients in psychoanalysis are intellectualizing about their treatment, they tend to summarize their experiences on the couch in a tone that sounds more like a weather report on their psyche than a disclosure of something that has moved them. In the 2004 U.S. presidential campaign, Al Gore's wooden, perseverative lectures

contributed to his defeat; the public worries about defensiveness when a candidate seems to lack passion.

Intellectualization handles ordinary emotional overload in the same way that isolation handles traumatic overstimulation. It shows considerable ego strength for a person to be able to think rationally in a situation fraught with emotional meaning, and as long as the affective aspects of that circumstance are eventually processed with more emotional acknowledgment, the defense is operating effectively. Many people feel that they have made a maturational leap when they can intellectualize under stress rather than giving an impulsive, knee-jerk response. When someone seems unable to leave a defensively cognitive, anti-emotional position, however, even when provoked, others tend intuitively to consider him or her emotionally dishonest. Sex, banter, artistic expression, and other gratifying adult forms of play may be unnecessarily truncated in the person who has learned to depend on intellectualization to cope with life.

RATIONALIZATION

The defense of rationalization is so familiar that I hardly need to explicate it. Not only has this term seeped into common usage with a connotation similar to the one used in psychoanalytic writing, it is also a phenomenon that most of us find naturally entertaining—at least in others. "So convenient a thing it is to be a reasonable Creature," Benjamin Franklin remarked, "since it enables one to find or make a Reason for everything one has in mind to do" (quoted in K. Silverman, 1986, p. 39). Rationalization may come into play either when we fail to get something we had wanted, and we conclude in retrospect that it was actually not so desirable (sometimes called "sour grapes rationalization" after the Aesop fable of the fox and the grapes), or when something bad happens, and we decide that it was not so bad after all ("sweet lemon rationalization"). An example of the first kind would be the conclusion that the house we could not afford was too big for us anyway; an example of the second would be the popular rationalization of those who value education: "Well, it was a learning experience."

The more intelligent and creative a person is, the more likely it is that he or she is a good rationalizer. The defense operates benignly when it allows someone to make the best of a difficult situation with minimal resentment, but its drawback as a defensive strategy is that virtually anything can be—and has been—rationalized. People rarely admit to doing something just because it feels good; they prefer to surround their decisions with good reasons. Thus, the parent who hits a child rational-

izes aggression by allegedly doing it for the youngster's "own good"; the therapist who insensitively raises a patient's fee rationalizes greed by deciding that paying more will benefit the person's self-esteem; the serial dieter rationalizes vanity with an appeal to health.

MORALIZATION

Moralization is a close relative of rationalization. When one is rationalizing, one unconsciously seeks cognitively acceptable grounds for one's direction; when one is moralizing, one seeks ways to feel it is one's *duty* to pursue that course. Rationalization converts what the person already wants into reasonable language; moralization puts it into the realm of the justified or morally obligatory. Where the rationalizer talks about the "learning experience" that some disappointment provided, the moralizer will insist that it "builds character."

The self-righteous quality of this particular transformation of impulse makes others regard it as either amusing or vaguely unpleasant, although in certain social and political situations, leaders who exploit their constituents' wish to feel morally superior can produce mass moralization so effortlessly that the public that has been thus seduced hardly blinks. The belief of the colonialists that they were bringing higher standards of civilization to the people whose resources they were plundering is a good example of moralization. Adolf Hitler was able to indulge his own murderous fantasies by persuading an astounding number of followers that the obliteration of Jews and other devalued groups was necessary for the ethical and spiritual improvement of the human race. In the contemporary United States, abrogation of time-honored protections of human rights has been justified in the name of fighting terrorism.

At a less catastrophic level, most of us have witnessed someone who defended having savagely criticized a subordinate on the grounds that it is a supervisor's duty to be frank about an employee's failings. In doctoral oral defenses, hostile examiners have been known to make comments like "Would we be doing this student any favors by withholding the critique that this study deserves?" One of my friends, an interior decorator, moralized the vanity behind her decision to have an expensive facelift by explaining that alas, it was her obligation to present an appealing appearance to her customers. Bette Davis reported having been in conflict over her wish to continue her acting career during World War II, but she resolved her discomfort by noting, "But then I felt that's what the enemy wanted—to destroy and paralyze America. So I decided to keep on working" (quoted in Sorel, 1991, p. 75).

Moralization may be regarded as a developmentally advanced version of splitting. Although I have not seen it presented that way in the psychoanalytic literature, it makes sense that an inclination to moralize would be the natural later stage of the primitive tendency to make gross good–bad distinctions. While splitting occurs naturally in the child before there is an integrated self capable of ambivalence, moralization resolves, by recourse to principle, mixed feelings that the evolving self has become able to suffer. From moralization one can infer the operation of a superego, albeit usually a rigid and punitive one that requires a contrast group of "others," or "those people" who lack the ethical sensibilities of the moralizer.

Moralization is the main defense in a personality organization that has been called moral masochism (Reik, 1941). Some obsessive and compulsive people are also wedded to this defense. In psychotherapy, moralizers can create vexing dilemmas for clinicians, who find that when they confront certain self-defeating attitudes or behaviors, their patients regard them as deficient in virtue for not seeing the issue the same way they do. One patient of mine, an obsessive–compulsive man on the neurotic end of the borderline continuum, kept imploring me to make a moral judgment about his compulsive masturbation, with the hope that that would resolve his conflict about it. "How would you feel if I said I thought it was getting in the way of your going out and developing relationships with women?" I asked. "I'd feel criticized, deeply ashamed—I'd want to crawl in a hole," he responded. "How about if I said that given your repressive background, it was an achievement to have found any kind of sexual satisfaction, and your masturbation represents a forward-moving tendency in your sexual development?" I offered. "I'd think you were depraved."

Moralization thus illustrates the caveat that even though a given defense may be considered a "mature" mechanism, it can still be maddeningly impervious to therapeutic influence. Working with someone in the neurotic range whose character is defined by the chronic, inflexible use of a particular defensive strategy can be as arduous as working with overtly psychotic patients.

COMPARTMENTALIZATION

Compartmentalization is another of the intellectual defenses, probably more closely related to dissociative processes than to rationalization and moralization, although rationalization is often called on to support it. Like isolation of affect, it is on the more primitive side; its function is to permit two conflicting conditions to exist without conscious confu-

sion, guilt, shame, or anxiety. Whereas isolation involves a rift between cognition and emotion, in compartmentalization, there is a rift between incompatible cognitions. When someone compartmentalizes, he or she holds two or more ideas, attitudes, or behaviors that are essentially and definitionally in conflict, without appreciating the contradiction. To an observer, compartmentalization may be indistinguishable from hypocrisy.

Examples of everyday compartmentalization of which most of us are occasionally guilty include such simultaneous attitudes as a professed belief in the Golden Rule and also in the principle of looking out for Number One, espousing the importance of open communication while defending the position of not speaking to somebody, deploring prejudice yet savoring ethnic jokes. When compartmentalization occurs in organizations and cultures, it can be reinforced by group dynamics. In the United States, some politically powerful groups sincerely hold the incompatible beliefs that we can increase our commitment to national defense and yet not increase taxes.

As for individuals on the more pathological end of the compartmentalization continuum, there are people who are great humanitarians in the public sphere yet defend the abuse of their children in the privacy of their homes. Repeatedly, we see exposés of preachers or legislators who rail against sin while enthusiastically committing more than their share of it. More than one crusader against pornography has been found to have an extensive collection of erotica. Sin that is committed with a clear sense of guilt, or in a dissociated state at the time of commission, is not properly regarded as revealing the defense of "compartmentalization"; the term applies only if the discrepant activities or ideas are both accessible to consciousness. Upon confrontation, the person using compartmentalization will rationalize the contradictions away.

UNDOING

Just as moralization can be considered a more grown-up version of splitting, undoing can be regarded as the natural successor to omnipotent control. There is a magical quality about the defense that betrays its archaic origins, even though individuals engaging in defensive undoing can often be induced, via an appeal to their reflective capacities, to see the meaning of what amounts to superstitious behavior. "Undoing" is a term that means exactly what one would think: the unconscious effort to counterbalance some affect—usually guilt or shame—with an attitude or behavior that will magically erase it. An everyday example would be a spouse's arriving home with a gift that is intended to compensate for

last night's temper outburst. If that motive is conscious, we cannot technically call it undoing, but when undoers are not aware of their shame or guilt, and therefore cannot consciously own their wish to expiate it, the label applies.

Many religious rituals have an aspect of undoing. The effort to atone for sins, even those committed only in thought, may be a universal human impulse. Around the age when children can cognitively grasp the fact of death, one sees numerous magical rituals that have a component of undoing. The childhood game of avoiding cracks in the sidewalk lest one break mother's back is psychoanalytically comprehensible as the undoing of unconscious death wishes for the mother, which create more fear than they did before the concept of death had taken on a more mature meaning.. Omnipotent fantasies are discernible in the implicit belief expressed in this behavior that one's hostile feelings are dangerous: The thought is tantamount to the deed.

One of my patients used to give me flowers occasionally. As she was quite disturbed and would have experienced my rejecting such gifts, or even analyzing her disposition to give them, as a profound repudiation of her generous impulses, for a long time I did not attempt to explore with her the meaning of this behavior. Eventually, however, she was able to figure out herself that she tended to bring me bouquets when she had been unusually angry at me the previous session. "I guess they were really for your grave," she explained, grinning.

People who have a high degree of remorse for their past sins, mistakes, and failures, whether real, exaggerated, or committed only in thought, may make a lifetime project out of undoing. A 79-year-old, middle-class Caucasian woman whom I studied in connection with research on the psychology of characterological altruists (McWilliams, 1984) had for decades dedicated herself to the cause of equal justice for nonwhite people; her background included her having inadvertently insulted a woman of color, whom she had deeply loved, when she was about 9, something over which she was still miserable. Tomkins's (1964) study of committed abolitionists suggested a similar organization of personality around the defense of undoing.

When undoing is a central defense in a person's repertoire, and when acts that have the unconscious significance of expiating past crimes comprise the main support to the individual's self-esteem, we consider his or her personality to be compulsive. I want to stress here, since the terms "compulsion" and "compulsive" are so often associated with undesirable behaviors, that the concept of compulsivity is neutral as to moral content. In other words, one can be a compulsive drinker, but one can also be a compulsive humanitarian. Similarly, "obsessive" and "compulsive" are not necessarily pejorative terms when applied to personality

structure, even though those labels derive from attempts to understand pathological states of obsession and compulsion. The sufferer of ego-alien, persistent, unwanted thoughts (obsessions) or persistent, unwanted acts (compulsions) may be desperate for help. In contrast, a person happily obsessed with writing a novel or pleasurably engaged in compulsive gardening is hardly to be regarded as "sick." In describing character, which may be highly adaptive and healthy, "obsessive" applies to thinking styles; "compulsive" to acting modes of adaptation.

TURNING AGAINST THE SELF

Anna Freud (1936) tended to use simple, everyday language, as in her use of the term "turning against the self." The concept means what it sounds like: the redirecting of some negative affect or attitude from an external object toward the self. If one is critical of an authority whose goodwill seems essential to one's security, and if one thinks that person cannot tolerate criticism, one feels safer aiming the critical ideas inward. For children, who have no choice about where they live and who may pay a high price for offending a touchy caregiver, the defense of turning against the self can distract them from the much more upsetting fact that their well-being depends on an undependable adult (Fairbairn, 1954). However unpleasant it is to feel self-critical, it is emotionally preferable to acknowledging a realistic threat to one's survival under conditions in which one has no power to change things.

One of my patients spent her formative years living in the care of a suicidal mother and an on-again-off-again, self-centered father. Her family's security was so precarious that even at the subsistence level they were in trouble: Some of this woman's earliest memories concern her parents' being thrown out of their apartments for nonpayment of rent. Rather than feel chronic terror that her mother would kill herself and her father would disappear on some self-indulgent project—both of which were serious possibilities—she became adept at believing that if only she were a better person, her parents would give her their love and protection. This conviction, which had been adaptive in childhood, caused her continual suffering as an adult when she reacted to any unhappy circumstance with self-attack rather than with creative efforts to improve her situation. It took years of therapy for her to realize at an emotional level that she was no longer a powerless child in a dysfunctional family, whose only hope for a sense of efficacy lay in the project of improving herself internally.

Most of us retain some tendency to turn negative affects, attitudes, and perceptions against the self because of the illusion that the process

gives of our being more in control of upsetting situations than we may be. Turning against the self can be considered a more mature version of introjection. The external critic is not swallowed whole, as in introjection, but one identifies with the critical attitude to some degree. It is a popular defense among some healthier people who are aware of, and resistant to, temptations to deny or project unpleasant qualities. They prefer to err in the direction of considering that a problem is their fault rather than someone else's. Automatic and compulsive use of this defense is common in people with depressive personalities and in the relational version of characterological masochism.

DISPLACEMENT

Displacement is another defense that is popularly appreciated without much distortion of its technical psychoanalytic meaning. At the age of 11 one of my daughters, observing our dog attack its pull toy right after being scolded for misbehavior, commented, "Look at that! She's taking her anger out on the toy—just like people!" The term "displacement" refers to the redirection of a drive, emotion, preoccupation, or behavior from its initial or natural object to another because its original direction is for some reason anxiety ridden.

The classic cartoon about the man bawled out by his boss, who goes home and yells at his wife, who in turn scolds the kids, who kick the dog is a study in displacement. The "triangulation" emphasized by family therapists in the tradition of Murray Bowen (e.g., 1993) is a displacement phenomenon. I have noticed that in couples in which one partner is unfaithful, the other partner directs most of his or her reactive hatred not to the mate who has strayed but to the "other" woman or man. Tirades about "that home wrecker," implying that the partner was an innocent victim of a cynical seduction, seem to protect an already anguished person from risking any further threat to the relationship that might be created if the betrayed party's rage were aimed directly at the adulterous mate.

Lust can also be displaced; sexual fetishes seem explicable as the reorientation of erotic interest from a human being's genitals to some unconsciously related area, such as feet or even shoes. If events in a man's history have made vaginas seem dangerous, some other female-associated object may be substituted. Anxiety may itself be displaced; Freud's famous patient the "Wolf Man" was treated in his later years by Ruth Mack Brunswick for a morbid preoccupation with his nose that came to be understood as the displacement of frightening, mutilatory fantasies about his penis (Gardiner, 1971). When someone uses displace-

ment of anxiety from a fraught area to a specific object that symbolizes the dreaded phenomenon (e.g., a terror of spiders, which to that person have the unconscious significance of maternal engulfment, or a horror of knives, which the individual unconsciously equates with phallic penetration), he or she has a phobia (Nemiah, 1973).

When people have patterns of displaced, fearful preoccupations in many aspects of their lives, we consider their character to be phobic. Many people have one phobia, but therapists occasionally see patients who have agoraphobia, multiple other phobias, and a general phobic attitude. Phobic psychology differs from fears whose origins lie in trauma: If I avoid bridges because I once had a horrible accident on a bridge, my avoidance is a posttraumatic phenomenon. But if I steer clear of bridges because I am unconsciously symbolizing and displacing a normal fear (seeing a bridge as a symbol of major life transitions, of which the ultimate is the transition to the grave), and magically hoping that will protect me from aging and dying, I am phobic.

Certain lamentable cultural trends such as racism, sexism, heterosexism, and the general blaming of societal problems on disenfranchised groups that have little power to fight back contain a large element of displacement. So does the tendency toward scapegoating that one finds in most organizations and subcultures. Transference, in clinical as well as the extra-clinical manifestations of transference that Sullivan called "parataxic distortions," contains displacement (of feelings toward important early objects) as well as projection (of internal features of the self). Benign forms of displacement include the diverting of aggressive energy into creative activity—a great deal of housework gets done when people are in a snit about something—and the redirecting of erotic impulses from impossible or forbidden sexual objects toward an appropriate partner.

REACTION FORMATION

The defense of reaction formation is an intriguing phenomenon. Evidently, the human organism is capable of turning something into its polar opposite in order to render it less threatening. The traditional definition of reaction formation involves this conversion of a negative into a positive affect or vice versa. The transformation of hatred into love, or longing into contempt, or envy into attraction, for example, can be inferred from many common transactions.

Perhaps the earliest age at which the process is easily discernible is in a child's third or fourth year; by this time, if a new baby arrives, the displaced older sibling is likely to have enough ego strength to handle its

anger and jealousy by converting them into a conscious feeling of love toward the newborn. It is typical of reaction formation that some of the disowned affect "leaks through" the defense, such that observers can sense there is something a bit excessive or false in the conscious emotional disposition. With a preschool girl who has been displaced by a younger brother, for instance, there may be a distinct flavor of her "loving the baby to death": hugging him too hard, singing to him too loudly, bouncing him too aggressively, and so on. Most adult older siblings have been told a story about their pinching the new baby's cheeks until the child screamed, or offering some delicacy that was actually poisonous, or committing some similar transgression that was allegedly motivated by love.

A more accurate way to depict reaction formation than as the turning of an emotion into its opposite might be to note that it functions to deny ambivalence. It is a basic psychoanalytic premise that no disposition is totally unmixed. We can hate the person we love or resent the person to whom we feel grateful; our emotional situation does not reduce to one or the other position. (Freud felt that there is one exception to universal ambivalence—the love of a mother for a male baby—but one suspects his narcissism distorted his perception.) It is a common fear that analysts delight in exposing the fact that one *seems* to feel *x* but *really* feels *y*; in fact, we take the view that while one may feel *x*, one *also* (unconsciously, perhaps) feels *y*. In reaction formation, one persuades the self that all that is felt is one polarity of a complex emotional response.

From the example of the displaced sibling who finds a way to avoid feeling negative affects and to experience only positive ones, at an age when finer discriminations between shades of feeling and (more important) between feelings and actions are not yet maturationally possible, one can see how valuable such a defense can be. Other situations in which its operation is mostly benevolent include circumstances in which competitive feelings, which include both murderous and admiring components, lead a child to emulate a competent friend rather than to reject him or her. In adults one sees reaction formation, but ordinarily we assume that grown people would be better off acknowledging all aspects of their emotional reactions to any given situation and applying their inhibition to the domain of behavior rather than that of feeling.

Reaction formation is a favored defense in those psychopathologies in which hostile feelings and aggressive strivings are of paramount concern and are experienced as in danger of getting out of hand. Paranoid people, for instance, often feel only hatred and suspicion when the external observer suspects that they also feel longing and dependency; obsessive and compulsive people frequently believe that they have only respect and appreciation for the authorities that others suspect them of simultaneously resenting.

REVERSAL

Another way that one can cope with feelings that present a psychological threat to the self is by enacting a scenario that switches one's position from subject to object or vice versa. For example, if one feels that the yearning to be cared for by someone else is shameful or dangerous, one can vicariously satisfy one's own dependency needs by taking care of another person and unconsciously identifying with that person's gratification in being nurtured. This version of reversal is a time-honored device of therapists, who are often uncomfortable with their own dependency but happy to be depended upon.

As soon as children are old enough to play with dolls or "action figures" (as boys' dolls are currently marketed), they can be said to be using reversal. An advantage of reversal is that one can shift the power aspects of a transaction so that one is in the initiating rather than the responding role. Control–mastery theorists call this "passive-into-active transformation" (Silberschatz, 2005). The defense operates constructively when the scenario being reversed is a benign one and destructively when the reversed situation is intrinsically negative. In fraternity hazing and other abusive rites of passage, for instance, one's experience of persecution during one's own initiation is transformed later into a situation that is felt as positive by virtue of its being a switch from passive to active, from victim to victimizer.

Sometimes in clinical practice one encounters reversal being used in a way that challenges one's therapeutic resourcefulness. I worked for a long time with a man who had had a deeply depressed and alcoholic mother. Every morning as a boy, he would come into the kitchen to see her drooping over a cup of coffee, cigarette in hand, looking exhausted and miserable. His presenting problem was a vulnerability to depression that had originated in his unsatisfactory relationship with this miserable, potentially suicidal woman. When he would come in for a session, he would often scan my face and announce, "You sure look tired today" or "You certainly seem to be down in the dumps about something." Occasionally he was right, but more commonly I was in a good mood and struck by the inaccuracy of his observation. As time went on, I increasingly challenged his assumption about my fatigue or despondency, saying that I was not aware of feeling tired or depressed. Instead of finding this interesting, and using my comment as a springboard to understand what he was displacing or projecting, he would reverse roles with me psychologically, announcing that while I might think I was okay, I obviously was not; that he was an unusually sensitive observer of people, and he knew a depressed person when he saw one.

This man had essentially made himself the therapist and me the patient, thus reversing a situation that was very difficult for him. His childhood experience of unreliable maternal authority had not given him grounds for any emotional security in a role that invited him to depend, especially on a female object. In this case, although his use of reversal protected him from acknowledging some deeply disturbing feelings, it had had the unfortunate side effect of making it hard for him to be in relationships that were emotionally reciprocal. Part of the stimulus for his depressive symptoms was a series of failed friendships and love affairs in which his tendency to recreate the scenario of a needy child and empathically limited parent, with himself in the latter position, eventually rankled potential intimates.

One subject in my research on altruism (McWilliams, 1984) was an attractive, successful man in his 40s whose greatest satisfactions in life lay in his activity as a volunteer for an international agency that arranged for the adoption of hard-to-place children (some were of stigmatized ethnic origin, some had physical handicaps or deformities, and some suffered congenital diseases). In his words, "I can't describe the high I get when I hand the baby to the adoptive mother and know that a new life is beginning for that kid." His history included the sudden, shattering death of his mother when he was 2, followed by a short period of great distress, followed by his informal adoption by a housekeeper, who later married his father and became in every psychological sense his mother. Whenever he successfully arranged an adoption, he felt the elation of rescuing someone as he had been rescued (although until I worked with him, he had never made a conscious connection between his own background and his humanitarian concerns) and the relief that this time the situation was reversed: He was the rescuer, the one with the power, and it was the other party who was the helpless, needy child.

The reader may be noticing that as I discuss these higher-order defensive processes, there are no single personality types that reflect an overdependence on them. Psychologically healthier people tend not only to use more mature defenses, such as reversal, they also handle anxiety and other difficult emotional states by recourse to varying defensive modes. Consequently, they are less readily typed by one label.

IDENTIFICATION

It may seem odd for identification to be included in a list of defense mechanisms, since most of us consider the capacity to identify with another person, or with some aspect of another person, as a benign and nondefensive

tendency. That some kinds of identification have very few if any defensive components (e.g., the kind that psychologists with a social learning orientation have called "modeling" and that we currently attribute to mirror neurons) is well established, but psychoanalytic thinkers continue to regard many instances of identification as motivated by needs to avoid anxiety, grief, shame, or other painful affects; or to restore a threatened sense of self-cohesion and self-esteem. Like the other mature defensive processes, identification is a normal aspect of psychological development that becomes problematic only under certain circumstances.

Freud (1923) was the first to suggest a distinction between nondefensive and defensive identification by differentiating what he called "anaclitic" identification (from the Greek word meaning "to lean on") from "identification with the aggressor." The first type he considered to be motivated by an uncomplicated wish to be like a valued person ("Mommy is generous and comforting, and I want to be just like her"). The second he regarded as an equally automatic but defensively motivated solution to the problem of feeling threatened by the power of another person ("I'm afraid of Mommy's punishment for my hostile impulses; if I *become* her, her power will be inside rather than outside me"). Freud assumed that many acts of identification contain elements of both a straightforward taking in of what is loved and a defensive becoming like what is feared.

Analysts use the word "identification" to connote a mature level of deliberately, yet at least partly unconsciously, becoming like another person. This capacity evolves in a developmental line from the earliest infantile forms of introjection (or "incorporation"), which have the quality of swallowing the other person whole, to more subtle, discriminating, and subjectively voluntary processes of selectively taking on another person's characteristics (Cramer, 2006; Schafer, 1968). Identificatory potential is assumed to evolve and modify throughout life and to be the emotional basis of psychological growth and change. In fact, the opportunity that close relationships provide for mutually enriching identifications accounts for the value that analysts have traditionally placed on emotional intimacy. In a way that parallels how primitive projection transforms itself over the lifespan of an emotionally healthy person into a greater and greater capacity for empathy, archaic forms of identification gradually transmute to more and more discerning and nuanced ways to enrich the self by accumulating the qualities of admired others.

Freud's most familiar paradigm of defensive identification was the oedipal situation. In this famous scenario, the young child reaches an age, usually around 3, in which his wishes for exclusive possession of the mother run into the harsh fact of the father's claim on her love and physical availability (I am using the masculine pronoun because Freud's depiction of this process was based on his understanding of heterosex-

ual male children—something many analysts have critiqued). He fears that his father, whose superior power is obvious, will kill or maim him in retaliation for his own wishes to kill or maim his father, whom he views as a rival, and the child resolves the anxiety connected with such fantasies by identification ("Maybe I can't get rid of Father—whom I love anyway and don't really want to dispose of—or get Mother all to myself—which would also have its downside, but I could be like Father and grow up to have someone like Mother as my exclusive partner"). Freud felt that this fantasy, which he considered normal and universal, was the prototype for identification with the aggressor—in this case an imagined aggressor.

Identification is inherently a neutral process; it can have positive or negative effects depending on who is the object of the identification. A major part of the process of psychotherapy is the rethinking of old and now problematic identifications that were entered into automatically, resolved a conflict for the child at the time, and are now causing conflict in adulthood. For example, a minister that I worked with had survived the ordeal of having an abusive, alcoholic father and an ineffectual, phobic mother by emulating his tough Uncle Harry, a man who solved all interpersonal problems with his fists. This resolution was highly adaptive for my patient throughout his adolescence in a chaotic family in a series of hostile urban neighborhoods; he could deck anybody who got in his way, and as a result, nobody messed with him. This was how he relieved anxiety, discharged troubling feelings that were unwelcome in his home, restored his self-esteem, and guaranteed others' respect. In his later professional life, however, when he threatened to beat up several obnoxious church elders, he lost the respect of many in his congregation, who did not regard his behavior as consistent with a Christian sensibility. He presented himself for therapy knowing that he had to develop new ways of coping with stress, and as he came to understand the nature of his early identifications and the current price he paid for them, he did.

Because identification can seem to be a remedy for all the complexities of life, it may be used more frequently as a defense when a person is under emotional stress, especially of the sort that puts a strain on older subjective versions of who one is. Death or loss will predictably instigate identification, both with the absent love object and then with those who come to replace that person in the survivor's emotional world. The yearning of adolescents to find icons to emulate in their effort to address the complex demands of looming adulthood has been noted for centuries; in fact, the dissatisfaction of contemporary teenagers with the heroes now offered by Western culture has been connected by some psychoanalytic observers with the alarming increase in adolescent suicides over recent decades (e.g., Hendin, 1975).

Some people seem to identify more easily and reflexively than others, as if they are blotters for whatever psychological ink comes in their direction. Those who suffer from basic confusions of identity, of whatever severity, are at risk here, as anyone who has studied cult behavior can attest. Conversion experiences contain a heavy component of defensive identification. Even quite healthy people with some area of identity disturbance, such as a hysterically organized woman with unconscious feelings that her gender is a problem, can be more than usually subject to identifying with someone who gives the impression of having a better handle on life's difficulties.

The capacity of human beings to identify with new love objects is probably the main vehicle through which people recover from emotional suffering, and the main means by which psychotherapy of any kind achieves change. Repeatedly, research on the treatment process finds the emotional quality of the relationship between patient and therapist to be more highly correlated with outcome than any other specifiable factors (Norcross, 2002; Strupp, 1989; Wampold, 2001, 2010). In some recent analytic writing on the therapy process, relationship is stressed to such an extent that interpretation, once seen as the mainstay of psychological healing, may hardly be mentioned at all (e.g., Buechler, 2008; Fosha, 2005; Maroda, 2010; Safran, in press).

In psychoanalytic treatment, the patient's propensity to make identifications with the therapist is cherished for its reparative potential and is also safeguarded as far as possible from abuse. Practitioners, even those who recommend disclosing countertransference feelings under some circumstances, may try to avoid exploiting the patient's readiness to identify by exemplifying general qualities of human virtue (such as compassion, curiosity, tolerance of difference, and a sense of ultimate responsibility for one's behavior) while being reserved about showing specifics of their personal attributes, giving advice, or sharing particular opinions. Freud's (e.g., 1938) repeated warning to analysts to avoid falling into the temptation to present themselves in a grandiose way as saviors, healers, or prophets to their patients remains a guiding maxim in the field; narcissistic misuse of a patient's wish to identify remains a professional taboo—albeit one that, like other taboos, is probably broken much more frequently than most of us would admit.

SUBLIMATION

At one time, the concept of sublimation was widely understood among the educated public and represented a trendy way of looking at many different individual proclivities. Contemporarily, with the receding cen-

trality of drive theory in psychoanalytic thinking and the reduced familiarity with psychoanalytic theory generally, it is referred to less in psychoanalytic literature, and it is less appreciated popularly as a concept. The original idea was that sublimation was the "good" defense, the one that by definition represented a creative, healthful, socially acceptable or beneficial resolution of internal conflicts between primitive urges and inhibiting forces.

Sublimation was the label Freud (1905) originally gave to the expression of biologically based impulses (which to him included urges to suck, bite, mess, fight, copulate, look at others and be looked at by them, inflict injury, endure pain, protect the young, etc.) in a socially valuable form. For example, Freud would have said that a periodontist may be sublimating sadism; a performing artist, exhibitionism; a lawyer, the wish to kill one's enemies. Instinctual strivings, according to him, become influenced by the circumstances of one's individual childhood; certain drives or conflicts take on special salience and may be creatively directed into useful activities.

This defense was considered to be the healthiest means of resolving psychological predicaments for two reasons: first, it fosters behavior beneficial to the species; and second, it discharges the relevant impulse instead of wasting a lot of emotional energy either transforming it into something different (e.g., as reaction formation would do) or counteracting it with an opposing force (e.g., denial, repression). Such energy discharge was assumed to be inherently beneficial: it kept the human organism in proper homeostasis (Fenichel, 1945).

Sublimation remains a concept to which one finds references in the analytic literature when a writer is referring to someone's finding a creative and useful way to express problematic impulses and conflicts. In contrast to a common misunderstanding that the object of psychotherapy is to rid oneself of infantile strivings, the psychoanalytic position about health and growth includes the assumption that the infantile parts of our natures remain alive throughout adulthood. We do not have the choice to divest ourselves of them; we can only handle them in better or worse ways.

The goals of analytic therapy include the understanding of all aspects of the self, even the most primitive and disturbing ones, the development of compassion for oneself (and others, as one's need to project and displace one's previously disowned qualities lessens), and the expansion of one's freedom to resolve old conflicts in new ways. They do not include purging the self of its loathed aspects or obliterating primitive desires. That sublimation is considered the apogee of ego development says a great deal about the basic psychoanalytic attitude toward human beings and our inherent potentials and limits, and about the implicit values informing psychoanalytic diagnosis.

HUMOR

I have added humor to this list of more mature defenses because although it could be considered a subtype of sublimation, it is a particularly interesting one. Children start making jokes when very young (an 8-month-old baby I knew, who had just learned the concept of "hot," suddenly pulled her hand away from her mother's breast, yelled "hot!" and burst out laughing—clearly a deliberate witticism). Such jokes seem not defensive at all—some humor has the quality of sheer joy and playfulness. At the other end of the spectrum, the compulsion to be funny can be extremely defensive; most of us know someone who, when invited into a sincere conversation, cannot stop making jokes. A driven need to be constantly funny and to avoid feeling life's inevitable pain is a feature of hypomanic personality, a personality type that is most commonly found at the borderline level of severity.

Some humor clearly maximizes our capacity to tolerate psychological pain. The extreme version of this process is the "gallows humor" that has been noted for centuries as a mechanism for surviving life's grimmest realities. Much humor is defensive in a positive way, performing welcome functions such as holding objects of fear up to ridicule, acknowledging harsh realities with a light touch, transforming pain into pleasure. A sense of humor, especially a capacity to laugh at one's own idiosyncrasies, has long been considered a core element of mental health. The emergence of humor in a previously dour or anguished patient is often the first indication of significant internal change.

CONCLUDING COMMENTS

This concludes my review of defensive operations that are pertinent to understanding the organization of individual character. I should remind the reader here that this book is about personality *structure*, not just personality *disorders*. Even though its focus is on the clinical task of diagnosis, which presumes that the person coming for help is suffering in some way, we should remember that the problem for which help has been sought may not lie in the patient's basic character. It may, for example, be a response to some stress that would tax the reserves of anyone, with any kind of character structure.

But just how a person suffers will reflect his or her personality organization. And how someone else can help mitigate the suffering requires a sensitivity to personality differences. Cactus and ivy will both grow when given light and water, but the gardener who does not appreciate the differences between the two plants will not bring each to full flower.

An understanding of variation among people in their basic character is essential to effective psychotherapy whether or not the problem to be addressed is characterological. A therapeutic stance that is helpful to an obsessive person troubled by depression will differ from the one that helps another depressed client whose basic personality is more hysterically organized.

All of us have powerful childhood fears and yearnings, handle them with the best defensive strategies available at the time, and maintain these methods of coping as other demands replace the early scenarios of our lives. The object of a sensitive psychodiagnostic process is not to evaluate how "sick" someone is, or to determine which people are beyond the pale of what is socially defined as normal (McDougall, 1980), but to understand the particularity of a person's suffering and strength so that one can participate in mitigating the former and building on the latter.

In the following section, I describe the major psychodynamically significant personality types. There are many other ways of categorizing individual differences; the one that therapists have inherited originally organized people based on the kind of mental suffering to which they were prone. (It would be a fascinating project to interview people in other roles—hairdressers, bartenders, teachers, musicians, accountants—to learn about their generalizations for dividing up the human pie, as it is my sense that most groups generate lore about personality types relevant to the lens through which they view the human animal.) Each personality category, as I have mentioned, constitutes a characterological reliance on a defense or group of defenses. Each comprises a developmental range from people who are frankly psychotic to those who are mentally healthy exemplars of a particular psychological orientation. In what follows I cover subjective as well as objective aspects of working with someone with each personality type and, where possible, translate psychoanalytic generalities and abstractions into reportable clinical transactions.

SUMMARY

In this chapter I have covered the most common and clinically relevant of the secondary, or "higher-order," defenses: repression, regression, isolation, intellectualization, rationalization, moralization, compartmentalization, undoing, turning against the self, displacement, reaction formation, reversal, identification, sublimation, and humor. I have given adaptive and maladaptive examples of each and have noted related character types. Finally, in the service of transition to the next chapters, I made some general comments about the relationship of defense to personality.

SUGGESTIONS FOR FURTHER READING

As I mentioned at the end of Chapter 5, commentary on the defenses is usually embedded in other topics and is seldom the subject of a book. Anna Freud's (1936) and H. P. Laughlin's (1970, 1979) writings are the exceptions, and both are relatively easy to read. For the intrepid, Fenichel (1945) covered the topic with his usual thoroughness in Chapters 8 and 9 of *The Psychoanalytic Theory of Neurosis*. For excellent, empirically based overviews of defenses, try Vaillant's edited 1992 book, *Ego Mechanisms of Defense*, or Phoebe Cramer's 1991 and 2006 volumes, *The Development of Defense Mechanisms* and *Protecting the Self*, respectively.

Part II

TYPES OF CHARACTER ORGANIZATION

INTRODUCTION TO PART II

Each chapter in this section covers a major character type. I have chosen these types on the basis of the frequency with which they are encountered clinically and on the basis of my own clinical familiarity and confidence working with them. As I noted in the Preface, some personalities that I do not cover in this section are depicted in the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006).

Order of presentation is arbitrary, but overall, I have started with the least object related and ended with individuals who tend to strike therapists as powerful in their attachment, even though their specific attachment style may be problematic. With each personality I consider (1) drive, affect, and temperament; (2) adaptive and defensive ego functions; (3) early relational patterns that contribute to the development of the personality, become internalized, and repeat in later relationships; (4) experiences of the self, including conscious and unconscious ways one sees oneself, along with the ways one seeks self-esteem; (5) transference and countertransference outcomes of internal representations of self, others, and self–other patterns of interaction; (6) implications for treatment; and (7) considerations of differential diagnosis.

RATIONALE FOR CHAPTER ORGANIZATION

The first four categories I have taken from Pine (1990), who has summarized drive, ego, object relational, and self aspects of individual psychology as follows:

> Broadly speaking, under these four terms I am referring, respectively, to the domains of (a) drives, urges, wishes; (b) defense, adaptation, reality testing, and defects in the development of each; (c) relationships to significant others as experienced and as carried in memory; with whatever attendant distortions such experiences and memories may entail; and (d) subjective experience of self in relation to such phenomena as boundaries, esteem, authenticity, and agency. (p. 13)

Like Pine, I see these four perspectives as implicit in the psychoanalytic tradition and as useful for sorting out different aspects of psychological complexity.

I have added affect to Pine's first domain (cf. Isaacs, 1990; Kernberg, 1976; Spezzano, 1993; Tomkins, 1962, 1963, 1991, 1992). Because Freud subsumed emotion under drive (see Solms & Nersessian, 1999), a focus on affect per se has been slow to come to analytic theorizing. In a 2000 survey, however, Blagys and Hilsenroth found that psychodynamic clinicians consider work with affects to be definitional of their orientation. Analysts have long noted the therapeutic superiority of emotional over intellectual insight (see J. G. Allen, 1980); more recently, many theorists have put affect at the center of human psychology and the clinical process (e.g., Chodorow, 1999; Fosha, 2000, 2005; Maroda, 2010; D. Shapiro, 2002).

There have been countless scientific studies attesting to the powerful operation of unconscious affects (see Westen, 1999). Research during the last two decades into early experience and brain function (e.g., Damasio, 1994; Lichtenberg, 1989; Panksepp, 1999; Solms & Bucci, 2000) supports the need to differentiate and comprehend these implicit feelings if we are to understand personality differences. Rainer Krause's work (e.g., Anstadt et al., 1997) suggests that we all have a characteristic facial affect pattern—an emotional "fractal," or type and sequence of affective expression that is our unique emotional signature. It has thus become clear that stable personality differences include distinctive affect configurations.

I have also included temperament with drive and affect. The significance Freud attached to innate individual differences in areas like direction and strength of drive look prescient in the light of contemporary

genetic and neuroscientific findings and in the aftermath of decades of scholarship about temperament (Kagan, 1994). Because therapy orients itself to what is modifiable, a clinician may tend not to think much about inborn "givens," but what is hardwired is still valuable to understand. Appreciating someone's constitutional endowment contributes to reasonable goals and allows us to help a client accept and make new adaptations to what cannot be changed.

The next two topics under each type are intended to illuminate the interpersonal style of someone with that psychology and to suggest components of effective therapy with such a person. I discuss countertransference issues for both diagnostic and therapeutic reasons. Our emotional reactions contain important diagnostic information—often the only clues (especially in more disturbed patients) for differentiating between two character types with contrasting therapeutic requirements. In addition, countertransference information may prepare us for what we are going to feel working with any client; we can then improve our chances of handling our feelings effectively. I have included in these sections some ideas about passing what control–mastery theorists would regard as characteristic "tests" of patients with different types of personality (Weiss, 1993).

Finally, I have included a differential diagnosis section to alert readers to possible alternatives to what may seem an evident personality organization, especially when such differentiations have important therapeutic consequences. It can be disastrous, for example, to misunderstand a hysterical woman as fundamentally narcissistic, or a narcissistic man as essentially obsessive, or a person with pervasive dissociation as schizophrenic. And yet all of these mistakes are made all the time because the DSM checklist approach to diagnosis lends itself to such errors.

CHARACTER, CHARACTER PATHOLOGY, AND SITUATIONAL FACTORS

The following descriptions include both disturbed and healthy versions of each character type. Everyone has regularities of experiencing and coping that constitute a personality. In most of us, it is not "disordered." We all have features of several personality styles no matter which tendencies are paramount in us. Many people who do not fit neatly into one category are adequately described as a combination of two types of organization (e.g., paranoid–schizoid, depressive–masochistic). Assessment of someone's character structure, even in the absence of a personality

disorder, gives the therapist an idea of what will be assimilable by the client and what style of relatedness will catalyze the therapist's efforts to help. Even though no one's psychology corresponds point for point to a textbook description, most of us can be located in a general area that gives a clinician some orientation toward how to be therapeutic.

Dynamics are not pathology. It is reasonable to infer character pathology or personality disorder only when a person's patterns are so stereotypical that they prevent psychological growth and adaptation. An obsessive man organizes his life around thinking, finding self-esteem in creative acts of thought such as scholarship, logical analysis, detailed planning, and judicious decision making. A pathologically obsessive one ruminates unproductively, accomplishing no objective, realizing no ambition, hating himself for going in circles. A depressive woman finds satisfaction in taking care of others; a pathologically depressive one cannot take care of herself.

In addition to distinguishing between personality and personality disorder, it is important to distinguish between character and responsivity. Certain situations elicit aspects of anyone's personality that may be latent under other circumstances: losses bring out one's depressive side; battles for control breed obsessive ruminations; sexual exploitation evokes hysteria. The therapist should be careful to weigh the relative impact of situational factors and characterological ones. People who are in ongoing, unrelentingly stressful situations may look character disordered by external criteria, but their patterns may be more situational than internal. For example, employees or students in "paranoiagenic" institutional surroundings may seem to have stable traits that meet the DSM criteria for paranoid personality disorder, and yet those traits may disappear when they leave the setting and are no longer feeling humiliated, helpless, and unsafe (cf. Kernberg's [1986, 2006] observations about paranoiagenesis in psychoanalytic institutes).

A Chinese student who was seeing one of my colleagues had numerous narcissistic preoccupations: She was acutely sensitive to how she was perceived, spent considerable energy on maintaining her self-esteem, suffered envy of American students to whom everything seemed to come easily, and worried constantly about whether she "fit in." The genuine warmth with which she related to her therapist, however, and the affection in his countertransference, belied a conclusion that she had an essentially narcissistic personality. The stresses of adapting to a new community had exacerbated the latent concerns about acceptability, identity, and self-esteem with which anyone would struggle if culturally displaced. In addition to illustrating a caveat about confusing personality with reactivity, this example points to the critical value of subjective data.

LIMITS ON PERSONALITY CHANGE

Clinical experience suggests that although personality can be substantially modified by therapy, it cannot be transformed (the drive-theory homily for this observation was "You can change the economics but not the dynamics"). That is, a therapist can help a depressive client to be less destructively and intransigently depressive but cannot change that client into a hysterical or schizoid character. People maintain their "inner working models" (Fonagy, 2001): core internal scripts, conflicts, expectations, affects, and defenses. Yet with new experience and insight they may vastly expand their sense of agency and realistic self-esteem. The increased sense of freedom comes from mastery and choice in behavior that previously was automatic; the self-acceptance comes from understanding how they got their particular combination of tendencies. Whether or not a therapy contract includes an agreement to try to modify character, an appreciation of it may facilitate psychotherapy.

I have wanted this book to be comprehensive, but not so much so that it would weigh down the reader's book bag, expense account, or fortitude. This section gives in-depth descriptions of psychopathic, narcissistic, schizoid, paranoid, depressive, hypomanic, masochistic, obsessive, compulsive, hysterical, and dissociative personalities. As I noted previously, there are many other themes around which personality can be organized, but these are the configurations I know best. It is my impression that most of the personality types I have omitted are seen more commonly as melodic variations than as symphonic themes. For example, while people whose character is fundamentally and centrally sadistic are not unknown, they rarely come voluntarily to therapy. We are more likely to see sadism as part of another clinical picture, such as psychopathy or dissociation. Some people are passive–aggressive at the level of character, but more commonly, passive–aggressive tendencies are ancillary to other dynamics, including dependent, obsessive–compulsive, paranoid, and masochistic trends.

7

Psychopathic (Antisocial) Personalities

I begin discussing the typological categories of personality organization with what are probably the most unpopular and intimidating patients encountered in mental health practice, those who are essentially psychopathic. I am following Meloy (1988) in using the older term for this personality type. The term "antisocial" looks at the phenomenon from the outside, at what is externally visible, with an emphasis on the social consequences of this psychology, whereas I try here to explore the subjective experience and internal dynamics of psychopathic people.

Research has supported Kernberg's (1984) concept of a range of narcissistic conditions (disorders of the self), with extreme psychopathy on the far end (e.g., Gacano, Meloy, & Berg, 1992). Robert Hare (e.g., Hare et al., 1990) distinguishes true psychopaths from people with antisocial tendencies, using the term "psychopath" to denote only a fraction of the larger spectrum. This is a valuable distinction for research, and one that has had vital practical outcomes such as identifying job applicants who would be disastrous employees. For purposes of discussing dynamics that pervade the antisocial spectrum, however, I use the adjective "psychopathic" more loosely, as equivalent to "antisocial," and the noun "psychopathy" for the whole antisocial range. But unlike my practice in 1994 and in deference to Hare's differentiation, I use the noun "psychopath" only for the extreme version of this psychology, and I avoid using "sociopathic," as that term now suggests a dated distinction.

Although there is overwhelming evidence that extreme psychopaths are not treatable (M. H. Stone, 2000), it is possible to have a therapeutic influence on many individuals with antisocial tendencies. People whose personalities are structured along psychopathic lines range from extremely psychotic, disorganized, impulsive, sadistic people like Richard Chase (Biondi & Hecox, 1992; Ressler & Schactman, 1992), who randomly murdered, dismembered, and drank the blood of his victims (in the delusion that his own blood was poisoned, and he needed it to survive), to urbane, polished charmers like the characters depicted by Babiak and Hare (2007) in their chilling work on American corporate psychopaths: *Snakes in Suits*. The psychopathic continuum loads heavily in the borderline-to-psychotic direction, because conceptually, the diagnosis refers to a basic failure of human attachment and a reliance on very primitive defenses.

With Bursten (1973a), however, I would argue that there are people in the higher ranges whose personalities show more psychopathy than any other features and who are reasonably construed as high-level antisocial personalities. Such people have enough identity integration, reality testing, and capacity to use more mature defenses to be considered neither borderline nor psychotic, but their core ways of thinking and acting show an antisocial sensibility. Some highly successful people have had an essentially psychopathic outlook; assuming good-enough ego strength, ruthless indifference to others can make competitive achievements easier than they are for those who are capable of loyalty and thoughtfulness.

In 1939, Henderson differentiated between "passive–parasitic" psychopaths and aggressive violent ones. An example of the former would be a developer of a Ponzi scheme who seems to have a warm family and good friendships (at least until the scam is exposed). As a society, we seem to be more taken aback by this more subtle version of psychopathy than by its more aggressive manifestations, but the exploitive orientation toward others is the same. Bursten's (1973a) criterion for diagnosing a psychopathic person, that his or her organizing preoccupation is "getting over on" or consciously manipulating others, captures the essence of psychopathic psychology. Conceived this way, the diagnosis of characterological psychopathy has nothing to do with overt criminality and everything to do with internal motivation.

DRIVE, AFFECT, AND TEMPERAMENT IN PSYCHOPATHY

The fact that infants differ in temperament from birth (something any parent with more than two children always knew) has now been well

established scientifically (Kagan, 1994; Thomas, Chess, & Birch, 1968). Some areas in which infants have demonstrated innate variability include activity level, aggressivity, reactivity, consolability, and similar factors that might tilt development in a psychopathic direction. Early studies of twins and adoptees (e.g., Vandenberg, Singer, & Pauls, 1986) concluded that people who become antisocial may have more constitutional aggressivity than others. In the years since the first edition of this book, there has been an explosion of brain research showing that our prior assumptions about the separability of what is constitutional and what is learned was naive: Genetic dispositions can be skewed by early experience, genes can be turned on or off, brain chemicals are altered by experience, and everything interacts. In a well-designed longitudinal study, Caspi and colleagues (2002) found that people with a variation in the expression of a gene that breaks down norepinephrine and related neurotransmitters (the monoamine oxidase A [MAOA] variation that can have permanent effects on the X chromosome), are much more likely when subjected to maltreatment to develop violent and antisocial patterns (see Fonagy, 2003; Niehoff, 2003).

Early neglect, abuse, and maltreatment can affect the development of the orbitofrontal cortex, which seems to be the moral center of the brain (Damasio, 1994; Martens, 2002; Yu, 2006). Thus, the biological substrate for the high levels of affective and predatory aggression in antisocial people may not directly implicate their genetic heritage, but may still be essentially "hardwired" by the interaction of experience and genes. Antisocial personalities have low serotonin levels, of whatever origin (Coccaro, 1996), and diagnosed psychopaths have remarkably low reactivity of the autonomic nervous system (Intrator et al., 1997; Lykken, 1995), a fact that may explain their sensation-seeking and long-noted "failure to learn by experience" (Cleckley, 1941, p. 368).

Louth, Williamson, Alpert, Pouget, and Hare (1998) found that psychopaths have anomalies in the brain circuitry that underlie linguistic and affective processes, suggesting that extremely antisocial people have not learned about feelings in the relationally grounded way that most of us do. Instead, they acquire emotional speech as a kind of "second language" that is used to manipulate others rather than to express inner states. Psychopathic individuals have poor affect regulation and a higher-than-average threshold for pleasurable excitement (Kernberg, 2005). Whereas most of us can get emotional satisfaction from good music, loving sex, natural beauty, a clever joke, or a job well done, they may need a sharper, more jolting experience to feel alive.

As for the main feelings of psychopathic people, it is hard to specify them because of their inability to articulate emotion. They act instead of

talking. They seem to have a sense of basic arousal without the sense of having specific affects. When they do feel, what they experience may be either blind rage or manic exhilaration. In the section on relational patterns in this chapter, I suggest some reasons for what Modell (1975) first described as a "massive affect block." One way the treatment of psychopathic individuals differs markedly from therapy with people with other personalities is that the clinician cannot expect to make an alliance by reflecting the client's presumed feelings.

DEFENSIVE AND ADAPTIVE PROCESSES IN PSYCHOPATHY

The primary defense in psychopathic people is omnipotent control. They also use projective identification, dissociation, and acting out. The need to exert power takes precedence over all other aims. It defends against shame and, especially in brutal psychopaths, distracts others from seeing the sexual perversions that often underlie criminality (Ressler & Schactman, 1992). The psychopath's famous absence of conscience (Cleckley, 1941) evidences not only a defective superego (Johnson, 1949) but also a lack of primary attachments to other people. To the deeply antisocial person, the value of others reduces to their utility in allowing one to demonstrate clout.

Psychopathic people will brag outright about their con jobs, conquests, and scams if they think the listener can be thereby impressed with their power. There is nothing unconscious about this process; it is literally shameless. Law enforcement agents are repeatedly astounded at how readily criminals will confess to homicide yet will hide lesser offenses (sexual compulsions, taking a few dollars from a murder victim's handbag), evidently because these are seen as signs of weakness (N. Susalis, personal communication, May 7, 1993). Kernberg (1984) refers to the psychopath's "malignant grandiosity," a phrase that rings true to anyone who has experienced such a person's effort to triumph sadistically by sabotaging therapy.

It is important to distinguish between psychopathic manipulation and what is frequently labeled manipulation in hysterical and borderline patients. The former is a deliberate, syntonic attempt to use others; the latter makes others *feel* used, while the patient may be relatively unaware of a specific manipulative intent. As I noted in Chapter 4, I recommend restricting the term "manipulation" to the conscious, intentional psychopathic phenomenon. Hysterical and borderline patients may try to get their needs met by indirect means that exasperate others and provoke attributions of manipulation, but their behaviors have significantly different sources, and they are uncon-

sciously intended to maintain relationships rather than to use others indifferently.

Early observers noted, and more recent research confirms (Robins, Tipp, & Przybeck, 1991), that many psychopathic people—those who have escaped self-destruction and incarceration—"burn out" in middle age, often becoming surprisingly upright citizens. They may become more amenable to psychotherapy then and may benefit from it more than younger people with psychopathic psychologies. This change may reflect hormonal decreases that reduce internal pressures toward action, but it also may reflect the loss of physical power that occurs at midlife. As long as omnipotent defenses are unthwarted by limits, a person's motivation to develop more mature adaptations is minimal. Older adolescents and young adults of all personality types, especially healthy young men, typically have omnipotent feelings: death is far away, and the prerogatives of adulthood are at hand. Infantile grandiosity is reinforced. (I suspect that one reason psychopathy is more common in men is that females confront realistic limitation earlier: We are less physically strong; we live with the nuisance of menstruation and the danger of pregnancy; we are at greater risk of rape and physical abuse, and as primary caregivers, we are humbled by the discrepancy between our images of ideal maternal effectiveness and the emotional challenges of trying to rear civilized children.) But reality has a way of catching up with us, whatever our early advantages. By middle age, death is no longer an abstraction, physical strength has declined, reaction time is down, health cannot be taken for granted, and the long-term costs of hard living have begun to appear. These facts of life can have a maturing effect, interesting a person in less omnipotent adaptations.

As for projective identification, in psychopathic people a reliance on this process may reflect not only a developmental arrest and reliance on primitive defenses but also the consequences of their inarticulateness and emotional immaturity. Their inability and/or disinclination to express emotions verbally (except to manipulate) means that the only way they can get other people to understand what they are feeling is to evoke that feeling in them. The dissociative defenses of psychopaths are commonly noted but hard to evaluate in specific instances. Dissociative phenomena range from trivial instances of the minimizing of one's role in some blunder to total amnesia for a violent crime. Disavowal of personal responsibility, which may have a dissociative quality, is a critical diagnostic indicator of psychopathy; the batterer who explains that he and his lover had a "tiff" and he "guesses he lost his temper" or the seemingly contrite cheater who claims to have "used bad judgment in this instance" is showing characteristic minimization. Interviewers who pick this up should ask for specifics: "What exactly did you do when

you lost your temper?" or "What exactly did you judge wrong?" (usually the answer to the latter shows regret about getting caught, not remorse about cheating).

When a psychopathic person claims to have been emotionally dissociated or amnesic during some experience, especially during the perpetration of an offense, it is hard to tell whether the experience was in fact dissociated or whether words to this effect are a manipulative evasion of responsibility. Given the frequency of severe abuse in the histories of people diagnosed as antisocial, and given the causal relationship between abuse and dissociation, it would be unimaginable for dissociation not to be a frequent concomitant of a psychopathic personality. Still, the unreliability of accounts by antisocial people makes the topic a vexing one. I say more about this in the differential diagnosis section at the end of this chapter and in Chapter 15.

Acting out is virtually definitional of psychopathy. Not only do antisocial people have an internal goad toward action when aroused or upset, but they also have no experience of the increase in self-esteem that can come from control of impulse. Older clinical literature airs a controversy about whether psychopaths lack anxiety or whether their anxiety is invisible. Greenwald (1974) believed that they do feel anxious but that they act out so fast to relieve themselves of such a toxic feeling that the observer has no chance to see it (and they would never admit to anxiety if asked, as they would see it as "weak"). So far as we can investigate empirically, however, those who saw them as lacking anxiety were more accurate, at least with respect to true psychopaths: Their level of fear and upset tests way below that of nonpsychopathic people; they show no more reaction to a word like "rape" than to a word like "table" (Intrator et al., 1997), and they have virtually no startle response (Patrick, 1994). People with antisocial tendencies *who are healthy enough to participate in therapy* may have some anxiety, however (Gacano & Meloy, 1991; Gacano, Meloy, & Berg, 1992), and that anxiety may be a motivator that contributes to their capacity to benefit from treatment.

RELATIONAL PATTERNS IN PSYCHOPATHY

The childhoods of antisocial people are often rife with insecurity and chaos. Confusing amalgams of harsh discipline, overindulgence, and neglect have long been noted in the clinical literature (Abraham, 1935; Aichhorn, 1936; Akhtar, 1992; Bird, 2001; Greenacre, 1958; Redl & Wineman, 1951). Especially in the histories of violent psychopaths, one can find virtually no consistent, loving, protective influences. Weak, depressed, or masochistic mothers and explosive, inconsistent, or sadis-

tic fathers have been linked with psychopathy, as have alcoholism and other addiction in the family. Moves, losses, and family break-ups are common. Under unstable and frightening circumstances like these, the normal confidence in one's early omnipotent feelings and later in the power of others to protect the young self could not possibly develop normally. The absence of a sense of power at developmentally appropriate times may impel children in this predicament to spend the rest of their lives seeking confirmations of their omnipotence.

Even if they are aware of them, psychopathic people cannot acknowledge ordinary emotions because they associate them with weakness and vulnerability. It is probable that in their families of origin, no one helped them put words to emotional experiences. They have no concept of using language to state feelings and no internalized basis for knowing another role for speech. Clinical observations suggest that in their families, words were used mostly to control others. The deficits of their caregivers in responding to their emotional needs are related to another piece of clinical lore: Children who become psychopathic have often been indulged materially and deprived emotionally. The parents of an antisocial patient of mine used to get her extravagant gifts (a stereo, a car) when she seemed upset. It did not occur to them to draw her out and listen to her concerns. This kind of "generosity" is particularly destructive; in the case of my patient, it left her no way to formulate her lingering sense that there was something missing in her life.

The most penetrating recent psychoanalytic thinking about psychopathy (e.g., Kernberg, 2004; Meloy, 1997) emphasizes the failure (from whatever accidents of temperament and rearing) of attachment and consequent internalization. The antisocial person seems never to have attached psychologically, incorporated good objects, or identified with caregivers. He or she did not take love in and never loved. Instead, identification may have been with a "stranger selfobject" (Grotstein, 1982) experienced as predatory. Meloy (1988) writes of "a paucity of deep and unconscious identifications with, initially, the primary parent figure and ultimately the archetypal and guiding identifications with the society and culture and humankind in general" (p. 44).

Many an adoptive parent has learned the hard way that children from destitute orphanages or other profoundly negligent/abusive backgrounds can have attachment disorders that render them permanently unable to love, no matter how devoted their later care. Young children with such histories often show disorganized–disoriented attachment, or the apparent absence of an internalized, organized attachment strategy (D. Diamond, 2004; Main & Solomon, 1986), in which the object of attachment may also be a source of terror and rage, producing contradictory behaviors such as smiling at the mother and biting her. One

subtype of the disorganized–disoriented style is a disorganized–controlling style that shows up by age 6 in some maltreated children (Hesse & Main, 1999) that sounds consistent with long-time observations of psychopathic psychology.

An alternative origin of a character organized around omnipotent fantasies and antisocial behavior is a history in which parents or other important figures were deeply invested in the child's omnipotence and sent repeated messages that life should pose no limits on the prerogatives of a person so inherently entitled to exert dominance. Such parents, identifying with the child's defiance and acting out their own hatred of authority, tend to react with outrage when teachers, counselors, or law-enforcement agents try to set limits on their youngster. Like all character types, psychopathy can be "inherited" in that the child imitates the defensive solutions of the parents. When the main source of someone's characterological psychopathy is parental modeling and reinforcement of manipulative and entitled behavior, the prognosis is probably better than when the condition is rooted in chaos and negligence. At least the child of indulgent, corrupting parents has succeeded in identifying with *someone* and has some capacity to connect. It may be that this kind of family breeds healthier people with antisocial trends, and that more traumatic backgrounds breed more deeply disturbed individuals, including true or primary psychopaths.

THE PSYCHOPATHIC SELF

One biological substrate of a disposition toward psychopathy is a degree of aggression that would make a child difficult to calm, comfort, and mirror. Children who are innately hyperactive, demanding, distractible, and headstrong need much more active, energetic parenting than placid, easily consoled youngsters. They also arguably need much more direct involvement by a father figure than most preschoolers in Western societies get (Cath, 1986; M. J. Diamond, 2007; McWilliams, 2005a; J. Shapiro, Diamond, & Greenberg, 1995), and would probably benefit from additional caregivers as well. I have known highly aggressive children who were observably too much for one parent but who attached firmly if provided with enough stimulation and loving discipline. Given contemporary Western cultural assumptions that a single parent is adequate, we may be raising many more psychopaths in this part of the world than we would otherwise see.

Sociological conjectures aside, the condition of being viewed from day one as a problem child would make it very hard for a potential psychopath to find self-esteem via the normal route of feeling the caregivers'

love and pride. When outside objects fail, the only object to invest in emotionally is the self and its personal power. Self-representations may be polarized between the desired condition of personal omnipotence and the feared condition of desperate weakness. Aggressive and sadistic acts may stabilize the sense of self in a psychopathic person by both reducing unpleasant states of arousal and restoring self-esteem.

David Berkowitz, the "Son of Sam" serial killer, began his murders of women after learning that his biological mother was something of a slattern rather than the elevated figure of his imagination (Abrahamsen, 1985). An adoptee, he had attached his self-esteem to the fantasy of having a superior "real" mother, and when this illusion was shattered, he went on a rampage. Similar connections between a crime spree and some blow to grandiosity have been noted in many sensational cases, but observation of manipulative people in ordinary life suggests that this pattern in its essentials is not limited to psychopathic killers. Anyone whose fondest images of self reflect unrealistic notions of superiority, and who runs into evidence that he or she is only human, may attempt to restore self-esteem by exerting power.

In addition, the more chaotic the environment of a child, and the more exhausted or inadequate the caregivers, the more likely it is that the youngster will not run into effective limits and will not have to take seriously the consequences of impulsive actions. From a social learning theory point of view, grandiosity in a child would be the expectable result of an upbringing that lacks consistent discipline. The condition of having much more energy than one's caregiver would teach the lesson that one can ignore the needs of others, do whatever feels compelling at the time, and handle any adverse consequences by escaping, dissimulating, and seducing or bullying others.

One other feature of self-experience in the psychopathic patient that deserves mention is primitive envy, the wish to destroy that which one most desires (Klein, 1957). Although antisocial people rarely articulate envy, many of their behaviors demonstrate it. One probably cannot grow up unable to love without knowing that there is something out there that other people enjoy that one lacks. Active devaluation and depreciation of anything in the tenderer realms of human life are characteristic of antisocial people at all levels of severity; those in the psychotic range have been known to kill what attracts them. The serial killer Ted Bundy, for example, described his need to destroy pretty young women (who, others noted, resembled his mother) as a kind of "owning" them (Michaud & Aynesworth, 1983). The killers portrayed in Truman Capote's *In Cold Blood* (1965) exterminated a happy family "for no reason" except presumably that they were a happy family toward whom the exterminators could not bear to feel their consuming envy.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH PSYCHOPATHIC PATIENTS

The psychopathic person's basic transference to a therapist is a projection of his or her internal predation, the assumption that the clinician intends to use the patient for selfish purposes. Not having had any emotional experience with love and empathy, the antisocial patient has no way to understand the generous aspects of the therapist's interest and will try to figure out the practitioner's "angle." If the patient has reason to believe that the therapist can be used to promote some personal agenda (such as giving a good report to a judge or probation officer), he or she may be uncannily charming, so much so that an inexperienced clinician may be taken in.

The usual countertransference to the patient's preoccupation with using the therapist or outsmarting the therapist's presumably exploitive agenda is shock and resistance to the sense that one's essential identity as a helper is being eradicated. The naive practitioner may succumb to the temptation to try to prove helpful intent. When that fails, hostility, contempt, and moralistic outrage toward the psychopathic person are common reactions. These "unempathic" feelings in ordinarily compassionate people should be understood, paradoxically, as a kind of empathy with psychopathic psychology: The client is unable to care about the therapist, and the therapist finds it almost as hard to care about the client. Outright hatred of the patient is not uncommon, and is no cause for worry, since the capacity to hate is a kind of attachment (Bollas, 1987). If one can tolerate the experience of internal coldness and even hatred, one will get an unpleasant but useful glimpse of what it is like to be a psychopathically organized person.

Other common countertransference reactions are complementary rather than concordant (Racker, 1968; see Chapter 2) and chiefly involve fear of a peculiarly ominous kind. People who work with psychopaths frequently comment on their cold, remorseless eyes and worry that such patients have them "under their thumb" (Meloy, 1988). Eerie forebodings are common. Again, it is important that the clinician tolerate these upsetting reactions rather than try to deny or compensate for them, since minimizing the threat posed by a true sociopath is highly unwise (both realistically and because it may prompt the client to demonstrate his or her destructive power). Finally, the experience of being actively, even sadistically depreciated can provoke intense hostility or hopeless resignation in the clinician. Awareness that devaluing messages constitute a defense against envy is cold intellectual comfort in the face of a psychopath's unmitigated scorn, but it helps.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF PSYCHOPATHY

In light of the bad reputation of antisocial patients, I should say at the outset that I have known of many psychopathic people who were helped by psychotherapy. The therapist cannot be grandiose, however, about how much can be accomplished, and more than with individuals in other diagnostic categories, it is critical that a careful assessment be done to see whether or not any individual psychopathic patient is treatable. Some are so damaged, so dangerous, or so determined to destroy the therapist's aims that psychotherapy would be an exercise in futility and naiveté. Meloy (1988) makes a key distinction between the roles of evaluator and therapist, a discrimination that is unnecessary with patients of most other character types, since they lack the psychopath's aim of defeating the clinician. Meloy's explanation of the phenomenon of therapeutic nihilism (Lion, 1978) fits my own experience:

> It is the stereotypical judgment that all psychopathically disturbed individuals, or antisocial personality disorders, *as a class*, are untreatable by virtue of their diagnosis. Such a judgment ignores both individual differences and the continuous nature of severity of psychopathology. I have most commonly observed this reaction in public mental health clinicians who are assigned patients on referral from probation, parole, or the court; and assume, because of the coercive nature of the treatment referral, that ... any psychotherapeutic gain is impossible.
>
> Such reactions are often the product of attitudes that have been internalized as an "oral tradition" during training from senior, teaching clinicians. They are rarely the product of direct, individual experience. It is, in a sense, a mass retaliatory attitude where moral judgment impinges on professional assessment. The behavioral pathology of the psychopath, to devalue and dehumanize others, becomes the concordant identification of the clinician doing to the psychopath what the clinician perceives the psychopath doing to others. (Meloy, 1988, p. 325)

Karon and VandenBos (1981) made a comparable critique of the equally prevalent, empirically unsupported belief that schizophrenia is not treatable; psychopathic patients at a psychotic level of personality organization thus may have two strikes against them.

Attitudes about the inherent untreatability of all psychopathic individuals may also reflect the fact that in most training programs—even those that send their students into internship and practicum placements at jails, youth correctional facilities, and drug treatment centers that contain many psychopathic people—very little if any attention is paid

to the development of the skills appropriate for this group. When new therapists fail using approaches that are effective with other populations, they may blame the patient rather than the limitations of their training.

The assessment of treatability is beyond the scope of this text, but I recommend using Kernberg's structural interview (B. L. Stern et al., 2004) to evaluate whether psychotherapy should be undertaken with any particular psychopathic person. DSM-IV is not useful here. Its criteria for antisocial personality disorder were normed on prison inmates and developed with researchers rather than therapists in mind. With the exception of lack of remorse, DSM-IV criteria for assessing antisocial personality disorder are all factors that can be observed externally by the clinically untrained; they do not necessarily pick up critical internal, subjective states. Hence, they tend to overdiagnose people with backgrounds of poverty, oppression, and marginality (who may run afoul of authorities for many reasons other than their individual psychology) and to underdiagnose successful, socially prominent psychopaths. As I write this, it appears that in DSM-5, antisocial psychology will be reframed as on the narcissistic spectrum and may be defined more internally.

Once one has decided to work with a psychopathic person—or has realized that a current patient is significantly antisocial—the most critical feature of treatment is incorruptibility: of the therapist, the frame, and the conditions that make therapy possible. It is much better to err on the side of inflexibility than to show, in the hope that it will be seen as empathy, what the client will see as weakness. Psychopathic people do not understand empathy. They understand using people, and they will feel a sadistic triumph over, not a grateful appreciation for, a therapist who wavers from the boundaries of the treatment contract. Any behavior that can be interpreted as weakness and vulnerability probably will be. Anthony Hopkins gave a chilling portrayal of the psychopath's talent for finding someone's Achilles' heel in his character's manipulation of the detective played by Jodie Foster in *The Silence of the Lambs*. The writers of the television series *Dexter* have clearly done their homework; like the authors of *The Sopranos*, they have managed a plot device that allows the viewer to care about a lead character who has extreme *but not total* psychopathy. Dexter is capable of some attachment, but the portrayal of his internal world through his voiceover comments shows a lot about the emotional limitations of the significantly antisocial person.

It is unrealistic to expect love from antisocial people, but one can earn their respect by coming across as tough-minded and exacting. When I work with psychopathic patients, I insist on payment at the beginning of each session and send the client away in its absence—no matter how reasonable the explanation offered. Like most therapists who were

taught to bend over backward to consider the special needs of each client, I had to learn from experience that not bending at all is the right response to the needs of the antisocial patient. Early in therapy I do not analyze such patients' assumed motives for testing the solidity of the contract, I merely remind them that our deal was that they would pay up front, and I repeat that I will hold up my end of the deal—the application of my expertise to help them understand themselves better—if they hold up theirs.

Related to incorruptibility is uncompromising honesty: talking straight, keeping promises, making good on threats, and persistently addressing reality. Honesty includes the therapist's private admission of intense negative feelings toward the patient, both countertransferences and realistic perceptions of danger. If such reactions are denied, countertransferences may be acted out and legitimate fears may be minimized. To treat psychopathic clients we must make peace with our own antisocial tendencies so that we have a basis for identifying with the patient's psychology. With respect to money discussions, for example, we should nondefensively admit selfishness and greed when giving a rationale for the fee. Some therapists cannot work with psychopathic people, as they cannot find in themselves enough antisocial features to permit any sense of commonality.

Except for admissions like the above that legitimately pertain to the therapeutic contract, honesty does not mean disclosure; self-revelation will only be interpreted as frailty. Nor does it mean moralizing. When considering the patient's destructive actions, it is futile to invite the expression of assumed feelings of badness or guilt. The patient lacks a normal superego and probably committed the sins in order to feel good (omnipotent) rather than bad (weak). One must restrict oneself to addressing the possible realistic outcomes of amoral behavior. Probes into presumed struggles with conscience tend to evoke responses like the one attributed to Willie Sutton when he was asked why he robbed banks: "Because that's where the money is."

The therapist's unrelenting emphasis on the realistic risks of each grandiose design need not be humorless just because the matters at hand have serious consequences. One of my colleagues, a woman renowned for her talent with antisocial clients, reports the following banter with a court-remanded car thief:

> "The man was explaining to me how brilliant his scheme had been for the heist he had almost pulled off, how if only one little unforeseen thing hadn't happened, it would have been the perfect crime. As he talked, he was getting more and more excited and animated, and I agreed with some admiration that he had almost gotten away with the theft. It started to feel

like we were co-conspirators. Eventually, he got so carried away that he asked, 'Would you do something like that?'

"'No,' I answered.

"'Why not?' he asked, a little deflated.

"'Two reasons,' I said. 'First, there's always some little thing that can go wrong, even with a brilliant plan. Life isn't that controllable. And then I'd be in jail, or in a mental hospital involuntarily, like you are, talking to some shrink I didn't choose myself. And second, I wouldn't because I have something that you don't: a conscience.'

"'Yeah,' he said. 'You know how I could get one of those?'"

Of course, the first step in developing a conscience is to care about someone to the degree that that person's opinion matters. Without moralizing, the therapist moves the patient along toward more responsible behavior simply by being a consistent, nonpunitive, nonexploitable object. Harold Greenwald (1958, 1974), who worked with antisocial people in the Los Angeles underworld, described how he would connect with psychopaths in terms that they could understand. He reasoned that since power is the only quality antisocial people respect, power is the first thing the therapist must demonstrate. He gives the following instance of claiming his own power:

A pimp came to see me and started to discuss his way of life. He said, "You know I'm ashamed to show myself and so on, but after all, it's a pretty good way to live and most guys would want to live that way, you know, to live as a pimp. It's not bad—you get girls out hustling for you—why shouldn't you do it? Why shouldn't anybody do it?" I said, "You're a jerk." He asked why. I replied, "Look, I live off the earnings of call girls. I wrote a book about them; I got respect for it; I got famous from it; they made a movie out of it. I made much more money off call girls than you ever will, and you, you schmuck, you can get arrested any day and be sent to jail for ten years, whereas I get respect, honor, and admiration." This he could understand. He saw that somebody whom he considered similar to him had a superior way of accomplishing the same ends. (1974, p. 371)

Greenwald has his own free-wheeling but still essentially incorruptible style with psychopathic patients. He is not the only therapist who has discovered the utility of "outpsyching the psychopath" or "conning the con" as a way of demonstrating that he deserves respect. Like my colleague previously quoted, he can own enough psychopathic impulses in himself that he does not feel fully alienated from the emotional world of his clients. Tellingly, he reports that in the second or third year of intensive treatment with him, psychopathic patients often go into a serious, even psychotic depression. He sees this as evidence that they have started to care about him in a genuine way rather than as an object to

manipulate and, realizing this, they descend into a state of misery about their dependency. This depression, which only slowly lifts, compares in its essentials to Klein's (1935) description of the feelings of infants in the second 6 months of life, when the child makes the painful discovery that the mother exists as a separate person outside the baby's control.

In contrast with appropriate therapy with people of other diagnoses, the therapist of a psychopathic client may have to adopt an attitude of independent strength verging on indifference. I assume this applies to cognitive-behavioral therapies, some of which have shown promise with this population (M. H. Stone, 2000), as well as to analytically informed ones. One cannot seem emotionally invested in the patient's changing, because as soon as an antisocial person sees that need, he or she can sabotage psychotherapy to demonstrate the clinician's impotence. It is better to invest in simply increasing one's understanding, setting the tone that one will do one's job competently, and to communicate that it is up to the patient to take advantage of therapy or not. This principle is analogous to the lesson every police officer learns about investigating a crime: Never show the suspect that it is important to you to get a confession.

The most skilled interviewer of antisocial people I know was for a long time the chief of detectives in my town, a man with an exceptional record of evoking confessions—often movingly tearful ones—from rapists, child torturers, murderers, and serial killers. Listening to tapes of his interrogations, one is struck by his attitude of respect and his quiet conviction that even the most monstrous perpetrator has a need to tell someone the truth. The suspects' responsiveness to being treated with dignity is poignant—the more so in light of their knowledge that the interviewer's agenda is to prosecute. No one interrogated by him has ever complained of betrayal, even as he testifies against them in court on the basis of their confession. "He treated me fair," they report.

These phenomena raise the question of whether the fabled callousness of the psychopath is a response to environments that are either abusive (as was childhood, later replicated by a savage subculture) or incomprehensible (as is a therapist's wish to help). The fact that these perpetrators are palpably relieved to confess to someone who wants to incarcerate them suggests that even an incorrigible felon may have a primitive sense of accountability and can gain something from a relationship. The sadistic murderer Carl Panzram (Gaddis & Long, 1970) had a lifelong friendship with a prison guard who once showed him ordinary kindness. Rigorous tough-mindedness and rock-bottom respect seem to be a winning combination with antisocial people. (This observation does not equate to an argument for "leniency" toward dangerous criminals. Understanding that psychopathic people are human beings

who may be helped to some degree should not be confused with wishful thinking that therapy can transform a compulsive killer into a model of citizenship. The public needs protection from antisocial people whether or not their crimes are comprehensible psychodynamically and whether or not they can profit from a therapeutic relationship.)

The overall aim of work with a psychopathic individual is to help the patient move toward Klein's depressive position, in which others are seen as separate subjects worthy of concern (Kernberg, 1992). Over the course of treatment, as the psychopathic person's omnipotent control, projective identification, domination by envy, and self-destructive activities are dispassionately examined in an atmosphere of consistency and respect, the patient will in fact change. Any shift from using words to manipulate to using them for honest self-expression is a substantial achievement, one that may occur simply through the antisocial person's repeated exposure to someone with integrity. Any instance where the client inhibits an impulse and learns something about pride in self-control should be seen as a milestone. Since even a small movement toward human relatedness in a psychopath may prevent an immense amount of human suffering, such progress is worth every drop of sweat the practitioner secretes in its service.

DIFFERENTIAL DIAGNOSIS

It is not usually hard to spot the antisocial features in any client whose personality has a psychopathic component. Whether those features are central enough to define the person as characterologically psychopathic is a more subtle question. Psychologies that can easily be misunderstood as essentially antisocial include paranoid, dissociative, and narcissistic conditions. The behavior of addicted individuals often mimics psychopathy. In addition, some people with hysterical personalities become misdiagnosed as psychopathic, a topic I discuss in Chapter 14.

Psychopathic versus Paranoid Personality

There is considerable overlap between predominantly psychopathic psychologies and those that are more paranoid; many people have a lot of each sensibility. Both antisocial and paranoid people are highly concerned with issues of power, but from different perspectives. Unlike psychopaths, people with essentially paranoid character structure have profound guilt, the analysis of which is critical to their recovery from suffering. Thus, it is vital to assess with anyone who has both paranoid and psychopathic features which tendencies predominate.

Psychopathic versus Dissociative Personality

There is also considerable overlap between psychopathic and dissociative conditions. It is critical for an interviewer to evaluate whether a patient is a basically psychopathic person who uses some dissociative defenses or whether he or she has a dissociative psychology with one or more antisocial or persecutory alter personalities. The prognosis for the former kind of patient is guarded, whereas many essentially dissociative people, when accurately diagnosed, respond favorably to therapy. Unfortunately, this evaluation can be exceedingly difficult, even when done by an expert. Both primarily dissociative and primarily psychopathic people have a deep distrust of others, and for different reasons (terror of abuse vs. omnipotent triumph), both may dissimulate, comply superficially, and subvert the therapist.

I do not recommend trying to make this differential diagnosis when some important consequence hinges on it—for instance, when a man who has committed homicide may plead not guilty by reason of insanity if he can convince a professional that he has dissociative identity disorder. The differential diagnosis is hard enough without that complication, although regrettably, it is such a pivotal legal distinction that evaluators are working to develop procedures to make it more reliable. Even trained forensic psychologists have a tough time with these calls. I say more on this differential in Chapter 15.

Psychopathic versus Narcissistic Personality

Finally, there is a close connection between psychopathic and narcissistic conditions: there is a continuum from minor narcissism through malignant narcissism to outright psychopathy. Both predominantly narcissistic and predominantly psychopathic people have a subjectively empty internal world and a dependence on external events to provide self-esteem. The dimensional formulation, originally suggested by Kernberg (1984), has always made sense to me and now has enough recent research support that, as of the time I write, the authors of *DSM-5* are planning to put these disorders of self on one spectrum. But I would also suggest that antisocial and narcissistic people are different enough to warrant thinking in terms of a continuum for each.

Most psychopathic individuals do not idealize repetitively, and most narcissistic ones do not depend on omnipotent control. Many people have aspects of both character types, and self-inflation can characterize either one, but prognosis improves in inverse relation to the psychopathic pole. Because treatment considerations are quite different for the two groups (e.g., sympathetic mirroring comforts most narcissistic people

8

Narcissistic Personalities

The term "narcissistic" refers to people whose personalities are organized around maintaining their self-esteem by getting affirmation from outside themselves. All of us have vulnerabilities in our sense of who we are and how valuable we feel, and we try to run our lives so that we can feel good about ourselves. Our pride is enhanced by approval and injured by disapproval from significant others. In some of us, concerns with "narcissistic supplies," or supports to self-esteem, eclipse other issues to such an extent that we may be considered excessively self-preoccupied. Terms like "narcissistic personality" and "pathological narcissism" apply to this disproportionate degree of self-concern, not to ordinary responsiveness to approval and sensitivity to criticism.

Narcissism, normal as well as pathological, is a topic to which Freud (1914a) gave recurrent attention. He borrowed the term from the Greek myth of Narcissus, the youth who fell in love with his reflection in a pool of water and eventually died of a kind of longing that his image could never satisfy. Yet Freud had little to say about therapy for those in whom narcissistic concerns are central. Alfred Adler (e.g., 1927) and Otto Rank (e.g., 1929) both wrote on topics we would now include under narcissism, but their respective estrangements from Freud made their work unfamiliar to many therapists. Since the early psychoanalytic era, it has been noted that some people have problems with self-esteem that are hard to construe solely in terms of drives and unconscious conflicts, and are correspondingly hard to treat by reference to conflict-based models of therapy. A deficit model seems to fit their experience better: There is something missing from their inner lives.

Preoccupied with how they appear to others, narcissistically organized people may privately feel fraudulent and loveless. Ways of helping them to develop self-acceptance and to deepen their relationships awaited the expansion of dynamic psychology into areas that Freud had only begun to touch. Attention to concepts like basic security and identity (Erikson, 1950, 1968; Sullivan, 1953); the self as opposed to the more functionalist concept of the ego (Jacobson, 1964; Winnicott, 1960b); self-esteem regulation (A. Reich, 1960); attachment and separation (Bowlby, 1969, 1973; Spitz, 1965); developmental arrest and deficit (Kohut, 1971; Stolorow & Lachmann, 1978); shame (H. B. Lewis, 1971; Lynd, 1958; Morrison, 1989); and affect regulation, trauma, and attachment (Banai, Mikulincer, & Shaver, 2005; Schore, 2002) contributed to our understanding of narcissism.

As new theoretical areas were explored in the post-Freudian years, old areas were reworked, leading to improvements in treating narcissistic problems. Much ferment followed challenges by object relations theorists (Balint, 1960; Fairbairn, 1954; Horney, 1939) to Freud's concept of "primary narcissism," the assumption that the infant cathects (invests emotionally in) self before others. Thinkers who stressed primary *relatedness* understood narcissistic pathology not as fixation on normal infantile grandiosity but as compensatory for early disappointments in relationship. Around the same time, notions like containment (Bion, 1967), the holding environment (Modell, 1976; Winnicott, 1960b), and mirroring (Kohut, 1968; Winnicott, 1967) were redefining theories of therapy. These ideas were more applicable than earlier models of psychopathology and treatment to people for whom the continuity of a sense of self, and the feelings of reasonable worth attached to it, are fundamentally problematic.

It is also likely that when Freud was writing, narcissistic problems of the kind that are epidemic today were less common. Psychoanalytically influenced social theorists (e.g., Cushman, 1995; Fromm, 1947; Hendin, 1975; Lasch, 1978, 1984; Layton, 2004; Slater, 1970) have argued that the vicissitudes of contemporary life reinforce narcissistic concerns. The world changes rapidly; we move frequently; mass communications exploit our insecurities and pander to our vanity and greed; secularization dilutes the internal norms that religious traditions once provided. In mass societies and in times of rapid change, the immediate impression one makes may be more compelling than one's integrity and sincerity, qualities that are prized in smaller, more stable communities where people know each other well enough to make judgments based on someone's history and reputation. In the United States, a climate of narcissistic absorption may not be a particularly recent phenomenon. In 1831, Alexis de Tocqueville (2002) noted that a society that touts equal-

but antagonizes antisocial ones), despite the things they have in common and the number of people who have aspects of each orientation, it seems to me clinically useful to differentiate carefully between them.

Psychopathic Personality versus Addiction

People struggling with substance use disorders are notoriously manipulative and exploitive, as the addictive substance becomes more important to them than human relationships or personal integrity. Because of their antisocial *behavior*, observers commonly infer that their personalities are psychopathic. Although some addicted people may be characterologically antisocial, the personality organization of substance abusers cannot be inferred reliably until the interviewer has obtained reliable information about their behavior prior to their addiction or until they have been in recovery for a considerable length of time and their basic personality has emerged.

SUMMARY

In this chapter I portrayed the psychopathic personality as expressing an organizing need to feel one's effect on other people, to manipulate them, to "get over on" them. I summarized some constitutional predispositions to antisocial behaviors and mentioned the rage and mania that may briefly interrupt the affect block characteristic of antisocial persons. I discussed psychopathy in terms of the defenses of omnipotent control, projective identification, dissociation, and acting out; of object relations marked by instability, pandering, emotional misunderstanding, exploitation, and sometimes brutality; and a self-structure dominated by grandiose efforts to avoid a sense of weakness and envy. I mentioned putatively unempathic transference and countertransference reactions and stressed the importance of the therapist's incorruptibility, consistency, and self-conscious renunciation of the need to be seen as helpful. I differentiated psychopathic character from paranoid, dissociative, and narcissistic psychologies, and from the consequences of addiction.

SUGGESTIONS FOR FURTHER READING

Unfortunately, texts on psychotherapy as a general process rarely give psychopathic clients much attention, and there is a relative paucity of good analytic literature on this group. For an excellent collection of seminal psychoanalytic articles on psychopathy, I recommend Meloy's edited

collection, *The Mark of Cain* (2001). Bursten's study *The Manipulator* (1973a) and Meloy's *The Psychopathic Mind* (1988) are comprehensive and readable explorations with some attention to therapy issues. Akhtar also has a good chapter on the topic in *Broken Structures* (1992). Hare's *Without Conscience* (1999) is excellent, and his account with Babiak of *Snakes in Suits* (2007) is compelling.

ity of opportunity leaves citizens concerned with how to demonstrate their claim to special worth. Without a class system to provide visible levels of status, they try to accumulate observable evidence of their superiority, as inferiority would be equated with personal failure.

Many of Freud's patients suffered from too much internal commentary about their goodness or badness, a condition he came to depict as reflecting a "harsh superego." Contemporary clients, in contrast, often feel subjectively empty rather than full of critical internalizations; they worry that they "don't fit in" rather than that they are betraying their principles, and they may ruminate about observable assets such as beauty, fame, wealth, or the appearance of political correctness rather than more private aspects of their identity and integrity. Image replaces substance, and what Jung (1945) called the persona (the self one shows to the world) becomes more vivid and dependable than one's actual person.

Ernest Jones (1913) may have been the first analytic writer to describe the more overtly grandiose narcissistic person. He depicted a man characterized by exhibitionism, aloofness, emotional inaccessibility, fantasies of omnipotence, overvaluation of his creativity, and a tendency to be judgmental. He portrayed such individuals as on a continuum from psychotic to normal, commenting that "when such men become insane they are apt to express openly the delusion that they actually are God, and instances of the kind are to be met within every asylum" (p. 245). W. Reich (1933) devoted a section of *Character Analysis* to the "phallic–narcissistic character," represented as "self-assured ... arrogant ... energetic, often impressive in his bearing ... [who] will usually anticipate any impending attack with an attack of his own" (pp. 217–218). This familiar type appears in its essentials in the DSM-IV criteria for narcissistic personality disorder.

As psychoanalytic observations of personality continued, it became clear that the overtly grandiose personality was only one form of a "disorder of the self" (Kohut & Wolf, 1978). Current analytic conceptualization recognizes many different external manifestations of a core difficulty with identity and self-esteem. Bursten (1973b) suggested a typology of narcissistic personalities that includes craving, paranoid, manipulative, and phallic narcissistic subvarieties. Many have noted that in every vain, grandiose narcissist hides a self-conscious, shamefaced child, and in every depressed and self-critical narcissist lurks a grandiose vision of what that person should or could be (Meissner, 1979; A. Miller, 1975; Morrison, 1983). Repeatedly, the clinical literature has distinguished between two versions of narcissism, variously dubbed the "oblivious" versus the "hypervigilent" type (Gabbard, 1989), the overt versus the covert or "shy" type (Akhtar, 2000); the exhibitionistic versus the "closet" type (Masterson, 1993), and (my personal favorite)

the "thick-skinned" versus the "thin-skinned" type (Rosenfeld, 1987). Pharis (2004) has described a "virtuous narcissist," often an inspiring political figure, who accomplishes great things but quietly lets an associate take blame for any mistakes.

What narcissistic people of all appearances have in common is an inner sense of, and/or terror of, insufficiency, shame, weakness, and inferiority (Cooper, 1984). Their compensatory behaviors might diverge greatly yet still reveal similar preoccupations. Hence, individuals as different as Janis Joplin and Socrates's problematic student Alcibiades might be reasonably viewed as narcissistically organized.

DRIVE, AFFECT, AND TEMPERAMENT IN NARCISSISM

I am not aware of research on the topic of constitutional and temperamental contributions to narcissistic personality organization in adulthood. Unlike antisocial people, who pose obvious and costly problems to society and therefore prompt funding for scientific investigation into psychopathy, narcissistic individuals are quite diverse, often subtle in their pathology, and not so patently damaging. Successful narcissistic people (monetarily, socially, politically, militarily, or however their success is manifested) may be admired and emulated. The internal costs of narcissistic hunger for recognition are rarely visible to onlookers, and injuries done to others in the pursuit of narcissistically driven projects may be rationalized as trivial or necessary side effects of competence ("You can't make an omelet without breaking eggs"). Also, recognition of more subtle kinds of narcissism as treatable character problems is an achievement of only the past few decades.

Although Shedler and Westen's work (e.g., 2010) establishes that therapists are quite reliable in identifying narcissistic dynamics, most of our ideas about etiology are still untested, clinically generated hypotheses. One of these is that people at risk for developing a narcissistic character structure may be constitutionally more sensitive than others to unverbalized emotional messages. Specifically, narcissism has been associated with the kind of infant who seems preternaturally attuned to the unstated affects, attitudes, and expectations of others. Alice Miller (1975) suggested, for example, that many families contain one child whose natural intuitive talents are unconsciously exploited by his or her caregivers for the maintenance of their self-esteem and that this child grows up confused about whose life he or she is supposed to lead. Miller believed that such gifted children are more likely than untalented youngsters to be treated as "narcissistic extensions" of their caregivers and are hence more apt to become narcissistic adults.

On a different note, in discussing entitled, grandiose narcissistic clients, Kernberg (1970) has suggested that they may have either an innately strong aggressive drive or a constitutionally determined lack of tolerance for anxiety about aggressive impulses. Such dispositions would partially explain the lengths to which narcissistic people may go to avoid acknowledging their own drives and appetites: They may be scared of their power. Beyond these speculations, we know little about temperamental propensities that may contribute to a narcissistic character structure.

As for the main emotions associated with narcissistic personality organization, shame and envy are recurrently stressed in the clinical literature (e.g., Steiner, 2006). Feelings of shame and fears of being shamed pervade the subjective experience of narcissistic people. The early analysts underestimated the power of this emotional state, often mistaking it for guilt and making guilt-oriented interpretations that narcissistic patients found unempathic. Guilt is the conviction that one is sinful or has committed wrongdoings; it is easily conceptualized in terms of an internal critical parent or the superego. Shame is the sense of being *seen* as bad or wrong; the audience here is outside the self. Guilt carries with it a sense of an active potential for evil, whereas shame has connotations of helplessness, ugliness, and impotence.

The narcissistic person's vulnerability to envy is a related phenomenon, one that Melanie Klein's work illuminates (Segal, 1997). If I have an internal conviction that I am lacking in some way and that my inadequacies are at constant risk of exposure, I will be envious toward those who seem content or who have assets that I believe would make up for what I lack. Envy may also be the root of the much-noted judgmental quality of narcissistically organized persons, toward themselves and toward others. If I feel deficient and I perceive you as having it all, I may try to destroy what you have by deploring, scorning, or ridiculing it.

DEFENSIVE AND ADAPTIVE PROCESSES IN NARCISSISM

Narcissistically structured people may use a whole range of defenses, but the ones they depend on most fundamentally are idealization and devaluation. These processes are complementary, in that when the self is idealized, others are devalued, and vice versa. Kohut (1971) originally used the term "grandiose self" to capture the sense of self-aggrandizement and superiority that characterizes one polarity of the inner world of narcissistic people. This grandiosity may be felt internally, or it may be projected. There is a constant "ranking" process that narcissistic people use to address any issue that faces them: Who is the "best" doctor?

What is the "finest" preschool? Where is the "most rigorous" training? Realistic advantages and disadvantages may be completely overridden by concerns about comparative prestige.

For example, a woman I know was determined that her son would go to the "best" college. She took him to see several exclusive schools, pulled strings where she had any, and even wrote thank-you notes to deans of admission with whom he had interviewed. By mid-April, he had been accepted by several excellent colleges and universities, and he was on the waiting list at Yale. Her response was a sense of devastation that he had been rejected by Harvard. The young man elected to attend Princeton. Throughout his freshman year, his mother badgered Harvard to take him as a transfer student. Although he thrived at Princeton, when Harvard finally capitulated to his mother's relentless entreaties, there was no question about his destination.

The subordination of other concerns to issues of general valuation and devaluation is of note here. This mother knew that professors in her son's chosen field considered Harvard inferior to Princeton in that area; she also knew that Harvard undergraduates tend to receive less attention than those at Princeton; and she was aware that her son would suffer socially at Harvard for missing his freshman year there. Nevertheless, she persisted. Although she did not have a diagnosable narcissistic personality disorder, this woman used her son as a narcissistic extension in this instance because she had a defensive belief system that included the conviction that her own life would have been dramatically transformed had she gone to Radcliffe, the "sister" school to Harvard and the "best" school for women at the time she was applying to college.

In an instance where a parent's valuation and devaluation were characterological, a patient of mine, a college student with artistic and literary sensibilities, was told by his grandiose father that he would support his becoming a doctor (preferably) or a lawyer (if he proved untalented in the natural sciences), but nothing else. Medicine and law would bring in money and command respect; any other career would reflect badly on the family. Because this young man had been treated like a narcissistic extension his whole life, he saw nothing unusual in his father's position, which is culturally quite aberrant in the United States.

A related defensive position in which narcissistically motivated people are trapped concerns perfectionism. They hold themselves up to unrealistic ideals and either convince themselves that they have attained them (the grandiose outcome) or respond to their falling short by feeling inherently flawed rather than forgivably human (the depressive outcome). In therapy, they may have the ego-syntonic expectation that the point of undergoing treatment is to perfect the self rather than to understand it and to find more effective ways of handling its needs. The demand for

perfection is expressed in chronic criticism of self or others (depending on whether or not the devalued self is projected) and in an inability to find joy amid the ambiguities of human existence.

Sometimes narcissistic people handle their self-esteem problem by regarding someone else—a lover, a mentor, a hero—as perfect and then feeling inflated by identification with that person ("I am an appendage of So-and-so, who can do no wrong"). Some have lifelong patterns of idealizing someone and then sweeping that idol off the pedestal when an imperfection appears. Perfectionistic solutions to narcissistic dilemmas are inherently self-defeating: One creates exaggerated ideals to compensate for defects in the sense of self that are felt as so contemptible that nothing short of perfection will make up for them, and yet, since no one is perfect, the strategy is doomed, and the depreciated self emerges again.

RELATIONAL PATTERNS IN NARCISSISM

From this description of some of their dynamics, the reader has probably already concluded that relationships between narcissistic people and others are overly burdened with the self-esteem issues of the narcissistic party. Although it is rare for someone with a narcissistic personality disorder to come to therapy with the explicit agenda of becoming a better friend or family member or lover, it is not uncommon for clients with this problem, especially in midlife or later, to be aware that something is wrong in their interactions with others. One problem in helping them is conveying to them what it would be like to accept a person nonjudgmentally and nonexploitively, to love others as they are, without idealizing, and to express genuine feelings without shame. Narcissistic people may have no concept of such possibilities; the therapist's acceptance of them can become the prototype for their emotional understanding of intimacy.

Self psychologists have coined the term "selfobjects" for the people in our lives who support our self-esteem by their affirmation, admiration, and approval (see Basch, 1994). The term reflects the fact that individuals in that role function as objects outside the self and also as part of one's self-definition. By helping to modulate self-esteem, they augment what most of us also do internally. We all have selfobjects, and we need them. If we lose them we feel diminished, as if some vital piece of us has died. Yet reality and morality require that others be more than selfobjects, that we *recognize* them (Benjamin, 1988) in terms of who they are and what they need, not just in terms of what they do for us.

The narcissistic person needs selfobjects so greatly that other aspects of relationship pale, and may even be unimaginable, as they were to my

client whose father would not support his being anything but a doctor or lawyer. Thus, the most grievous cost of a narcissistic orientation is a stunted capacity to love. Despite the importance of other people to the equilibrium of a narcissistic person, his or her consuming need for reassurance about self-worth leaves no energy for others except in their function as selfobjects and narcissistic extensions. Hence, narcissistic people send confusing messages to their friends and families: Their need for others is deep, but their love for them is shallow. Symington (1993) believes that the ultimate cause of this deficit is a child's having repudiated, for whatever reason, the original emotional "lifegiver," with the long-term consequence of internal deadness and incapacity to find one's vitality.

Some theorize that people get this way by having been used as narcissistic appendages themselves. Narcissistic clients may have been vitally important to parents or other caregivers, not because of who they really were but because of the function they fulfilled. The confusing message that one is highly valued, but only for a particular role that one plays, makes children worry that if their real feelings, especially hostile or selfish ones, are visible, rejection or humiliation will follow. It fosters the development of what Winnicott (1960a) called the "false self," the presentation of what one has learned is acceptable. A crucial difference between the etiologies of psychopathy and narcissism may be that whereas antisocial psychology derives from overt abuse and neglect, narcissistic psychology springs from a particular kind of attention or even doting, in which support is given on the implicit condition that the child cooperate with a parent's narcissistic agenda.

I assume that most parents regard their children with a combination of narcissistic needs and true empathy. In moderation, children enjoy being treated as narcissistic extensions. Making parents feel proud, as if they also have been admired when their son or daughter gets recognition, is one of the sweeter pleasures of childhood. As usual, the issue is one of degree and balance: Does the child also get attention unrelated to whether the parent's aims are furthered? A markedly nonnarcissistic attitude toward offspring informs the remarks of a now-deceased friend of mine who reared 12 children during the 1930s, all of whom have turned out well despite borderline poverty and some painful losses:

> "Every time I'd get pregnant, I'd cry. I'd wonder where the money would come from, how I was going to nurse this child and take care of everything else. But around the fourth month I'd begin to feel life, and I'd get all excited, thinking, 'I can't wait till you come out and I find out who you are!' "

I quote this to contrast her sentiments with those of a prospective parent who "knows" who the child is going to be: Someone to be molded by the parent into a person who realizes all the parent's failed ambitions and brings reflected glory to the family.

A related aspect of the upbringing of people who become narcissistic is a family atmosphere of constant evaluation. If I have an agenda for a child that is vital to my own self-esteem, then every time that child disappoints me, I will be implicitly or explicitly critical. I doubt that anyone has ever brought up a child without criticism, but the background message that one is not good enough in some vague way is quite different from specific feedback on behaviors that offend. An evaluative atmosphere of perpetual praise and applause, which one finds in some families with narcissistic children, is equally damaging to the development of realistic self-esteem. The child is always aware of being judged, even if the verdict is positive. He or she knows on some level that there is a false quality to the attitude of constant admiration, and despite the conscious sense of entitlement that may issue from such a background, it creates a nagging worry that one is a bit of a fraud, undeserving of this adulation that seems tangential to who one really is. Fernando (1998) has argued that overindulgence of this kind is the primary etiology of pathological narcissism. Fiscalini (1993), noting different versions of narcissistic orientation, identified the shamed child, the spoiled child, and the special child as precursors of pathological narcissism in adulthood.

Thus we see again how certain character structures can be "inherited," though parents do not have to have narcissistic personalities themselves to rear a son or daughter who is disturbed narcissistically. Parents may have narcissistic needs toward a particular child (as in the case of the woman whose son had to go to Harvard) that set the stage for that child's not being able to discriminate between genuine feelings and efforts to please or impress others. What is a nonissue to one parent is a central one to another. We all want for our children the things we lacked, a harmless desire as long as we spare them any pressure to live their lives for our sakes.

Martha Wolfenstein gave us an interesting glimpse of narcissistic processes in a 1951 article "The Emergence of Fun Morality," depicting how liberal intellectual New Yorkers in the postwar era, having grown up during hard times, gave their children the message that they should feel bad about themselves if they were not *having fun*. People whose options were drastically curtailed by some disaster such as war or persecution are apt to send signals that their children should live the life they never had. Frequently, the children of traumatized parents grow up with some identity confusion and feelings of vague shame and emptiness (see Bergmann, 1985; Fogelman, 1988; Fogelman & Savran, 1979).

The communication that "unlike me, you can have it all" is particularly destructive, in that no one can have it all; every generation will face its own constraints. For self-esteem to be contingent on such an unrealistic goal is a crippling inheritance.

THE NARCISSISTIC SELF

I have already alluded to many of the self-experiences of people who are diagnosably narcissistic. They include a sense of vague falseness, shame, envy, emptiness or incompleteness, ugliness, and inferiority, or their compensatory counterparts: self-righteousness, pride, contempt, defensive self-sufficiency, vanity, and superiority. Kernberg (1975) describes such polarities as opposite ego states, grandiose (all-good) versus depleted (all-bad) definitions of self, which are the only options narcissistic persons have for organizing their inner experience. The sense of being "good enough" is not one of their internal categories.

Narcissistically structured people are aware at some level of their psychological fragility. They are afraid of falling apart, of precipitously losing their self-esteem or self-coherence (e.g., when criticized), and abruptly feeling like nobody rather than somebody (Goldberg, 1990b). They sense that their identity is too tenuous to hold together and weather some strain. Their fear of the fragmentation of their inner self is often displaced into a preoccupation with their physical health; thus, they are vulnerable to hypochondriacal preoccupations and morbid fears of death.

One subtle outcome of the perfectionism of narcissistic people is the avoidance of feelings and actions that express awareness of either personal fallibility or realistic dependence on others. In particular, remorse and gratitude are attitudes that narcissistic people tend to deny (McWilliams & Lependorf, 1990). Remorse about some personal error or injury includes an admission of defect, and gratitude for someone's help acknowledges one's need. Because narcissistic individuals try to build a sense of self on the illusion of not having failings and not being in need, they fear that the admission of guilt or dependency exposes something unacceptably shameful. Sincere apologies and heartfelt thanks, the behavioral expressions of remorse and gratitude, may thus be avoided or compromised in narcissistic people, to the great impoverishment of their relationships with others.

By definition, the assessment of narcissistic personality organization conveys that the client needs external affirmation in order to feel internal validity. Theorists diverge rather strikingly in whether they stress the grandiose or the depleted aspects of narcissistic self-experience, a

difference of emphasis central to the disagreement between Kernberg and Kohut on how to understand and treat narcissistic characters, about which I say more later. Disputes on this question go back at least as far as differences of opinion between Freud (1914b), who stressed the individual's primary love of self, and Alfred Adler (1927), who emphasized how narcissistic defenses compensate for feelings of inferiority. Which came first in the evolution of pathological narcissism, the grandiose self-state or the depleted, shamed one, may be the psychoanalytic equivalent of a chicken–egg riddle. From a phenomenological standpoint, these contrasting ego states are intimately connected, much as depression and mania are opposite sides of the same psychological coin.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH NARCISSISTIC PATIENTS

The transference environment with narcissistic clients feels qualitatively different from what one feels with clients who lack pathological narcissism. Even the highest-functioning, most cooperative person with a narcissistic character may contribute to an ambiance in the therapeutic relationship that contrasts sharply with the atmosphere that emerges between the therapist and other clients. Typically, the therapist first notices the patient's lack of interest in exploring the therapeutic relationship. The early psychoanalysts noted this and concluded that narcissistic patients did not have transferences because all their libidinal energy was directed toward the self; this was another basis for doubting that they were treatable. Contemporary analytic theory acknowledges that narcissistic clients do have transference reactions but of a different sort from those of other patients.

Inquiries into how the client is feeling toward the clinician may be received as distracting, annoying, or irrelevant to the client's concerns. It is not unusual for narcissistic patients to conclude that the therapist is asking about their experience of the therapeutic relationship out of conceit or a need for reassurance. (Such silent hypotheses may be projections, of course, even if true, but they tend to be unverbalized, and they can rarely be usefully addressed, at least early in treatment.) This does not mean that narcissistic patients lack strong reactions to the therapist. They may devalue or idealize intensely. Yet they are curiously uninterested in the meaning of those reactions and are genuinely confused about why the clinician is asking about them. Their transferences may be so ego syntonic as to be inaccessible to exploration. A narcissistic patient may believe he or she is devaluing the therapist because the therapist is objectively second-rate or idealizing the therapist because the therapist is

objectively wonderful. Efforts to make such reactions ego alien will usually fail, at least initially: The devalued practitioner who comments on the patient's critical attitude will be perceived as defensive, and the idealized one who comments on the patient's overvaluation will be further idealized as someone whose perfection includes an admirable humility.

Beginning therapists get a lot more devaluing transferences than idealizing ones. It may be some consolation for the misery one endures at being the object of subtle and relentless disparagement that being the recipient of a narcissistic idealizing transference is not much better. In both circumstances one may feel that one's realistic existence as a human being with some emotional intelligence, who is sincerely trying to help, has been extinguished. In fact, this countertransference sense of having been obliterated, of having been made invisible as a real person, is diagnostic of a probable narcissistic dynamic.

Related to these phenomena are countertransferences that include boredom, irritability, sleepiness, and a vague sense that nothing is happening in the treatment. A typical comment about a narcissistic client from a therapist in supervision: "She comes in every week, gives me the news of the week in review, critiques my clothing, dismisses all my interventions, and leaves. Why does she keep coming back? What is she getting out of this?" A strange sense that one does not quite exist in the room is common. Extreme drowsiness is perhaps the most unpleasant of the countertransference reactions to narcissistic patients; every time I experience this, I find myself generating biological explanations ("I didn't get enough sleep last night"; "I just ate a big lunch"; "I must be coming down with a cold"), and then once that patient is out the door and another one is inside, I am wide awake and interested. Occasionally one's countertransference to an idealizing person is a sense of grandiose expansion, of joining the patient in a mutual admiration society. But unless the therapist is also characterologically narcissistic, such reactions are both unconvincing and short-lived.

The psychoanalytic explanation for these phenomena relates to the special kind of transference characteristic of narcissistic people. Rather than projecting a discrete internal object such as a parent onto the therapist, they externalize an aspect of their self. Specifically, instead of feeling that the therapist is like mother or father (although sometimes one can see aspects of such transferences), the client projects either the grandiose or the devalued part of the self. The therapist thus becomes a container for the internal process of self-esteem maintenance. He or she is a selfobject, not a fully separate person who feels to the patient like a previously known, well-delineated figure from the past.

To be used for a self-esteem maintaining function rather than perceived as a separate person is disconcerting, even unnerving. The dehu-

manizing effect of the narcissistic person's attitude accounts for some of the negative countertransference reactions therapists have described in connection with treating such clients. Yet most therapists also report that they can tolerate, control, and derive empathy from such internal reactions once they understand them as comprehensible and expectable features of working with narcissistic patients. The disposition to feel flawed as a therapist is a virtually inevitable mirror of the patient's core worries about self-worth; it is relieving to substitute a revised clinical formulation for ruminations about what one is doing wrong.

Heinz Kohut and other analysts influenced by the self psychology movement (e.g., Bach, 1985; Buirski & Haglund, 2001; Rowe & MacIsaac, 1989; Stolorow, Brandchaft, & Atwood, 1987; E. S. Wolf, 1988) have described several subtypes of selfobject transferences that may appear in narcissistic patients, including mirroring, twinship, and alter-ego patterns, and many scholars have found parallels between these concepts and contemporary infant research (Basch, 1994). Although I cannot do justice to the complexity of such ideas here, readers who find that the description of narcissistic personality fits a patient they have previously been construing some other way may find it helpful to explore the language of self psychologists for conceptualizing their clients' experience.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF NARCISSISM

A therapist who is able to help a narcissistic person to find self-acceptance without either inflating the self or disparaging others has done a truly good deed, and a difficult one. A primary requisite for treating narcissistic pathology is patience: No one with a track record for influencing the psychology of narcissistic patients has done it very fast. Although modification of any kind of character structure is a long-term undertaking, the requirement of patience may be more keenly felt with narcissistic clients than with those of other character types because of one's having to endure countertransference reactions of boredom and demoralization.

Because there are competing theories of etiology and therapy, it is hard to summarize psychodynamic wisdom about treating narcissistic patients. Most arguments are variants on a complex disagreement between Kohut and Kernberg that appeared in the 1970s and 1980s. The gist of their respective positions was that Kohut (1971, 1977, 1984) saw pathological narcissism developmentally (the patient's maturation was going along normally and ran into some difficulties in the resolution

of normal needs to idealize and deidealize), while Kernberg (1975, 1976, 1984) viewed it structurally (something went askew very early, leaving the person with entrenched primitive defenses that differ in kind rather than in degree from normality: "Pathological narcissism reflects libidinal investment not in a normal integrated self-structure but in a pathological self-structure [1982, p. 913]). Kohut's conception of a narcissistic person can be imaged as a plant whose growth was stunted by too little water and sun at critical points; Kernberg's narcissist can be viewed as a plant that has mutated into a hybrid.

A consequence of their differing theories is that some approaches to narcissism stress the need to give the plant plenty of water and sun so that it will finally thrive, and others propose that it must be pruned of its aberrant parts so that it can become what it should have been. Those more responsive to Kohut's formulation (e.g., 1971, 1977) recommend benign acceptance of idealization or devaluation and unwavering empathy for the patient's experience. Kernberg (e.g., 1975, 1976) advocates the tactful but insistent confrontation of grandiosity, whether owned or projected, and the systematic interpretation of defenses against envy and greed. Self psychologically oriented therapists try to remain inside the patient's subjective experience, whereas analysts influenced by ego psychology and object relations theory oscillate between internal and external positions (see Gardner, 1991).

Most analysts I know have patients for whom Kohut's formulations, both etiological and therapeutic, seem to fit and others for whom Kernberg's seem apt. Kernberg has suggested that Kohut's approach might be considered a subtype of supportive therapy, and hence appropriate for narcissistic patients in the borderline-to-psychotic range (even though Kohut's clinical work, unlike Kernberg's, was mostly with high-functioning patients). This idea is implicitly endorsed by many of my colleagues, who say they find Kohut's recommendations applicable to their more disturbed and depressed–depleted narcissistic clients. Because the jury is still out on the dispute, and because readers can consult the original sources for recommendations about overall approach, I offer some general suggestions on the treatment of narcissism that exist outside this controversy.

I have already mentioned patience. Implicit in that attitude is an acceptance of human imperfections that make therapeutic progress a tedious and taxing business. The matter-of-fact assumption that we are all imperfect and resistant to change contrasts sharply with what the narcissistic person has internalized. Such an attitude is humane and realistic rather than critical and omnipotent. Some therapeutic mileage is already inherent in such a position. Although humility is important to all clinical work, it is particularly critical when one works with narcis-

sistic patients that therapists embody a nonjudgmental, realistic attitude toward their own frailties.

One of Kohut's greatest contributions to practice (Kohut, 1984) was his attention to the consequences of the therapist's acknowledgment of errors, especially of lapses in empathy. According to the ego psychologists who preceded him (e.g., Greenson, 1967), a therapist's mistake need not impel any activity other than private reflection; the patient is simply encouraged, as always, to associate to what happened and to report any reactions. Even Carl Rogers (1951), who had advocated a style almost identical to Kohut's later recommendations (Stolorow, 1976), seems not to have assumed, as Kohut did, that well-meaning therapists would inevitably inflict narcissistic injuries on clients. Thus, client-centered therapy did not address whether to acknowledge such errors—though I read Rogers's principle of authenticity as implying that they should. Self psychologists have called our attention to how devastated a narcissistic person can be by a professional's failure of empathy, and how the only way to repair such an injury is by expressing regret. An apology both confirms the client's perception of mistreatment (thereby validating his or her real feelings rather than furthering the insincere compliance with which narcissistic people are used to operating) and sets an example of maintaining self-esteem while admitting to shortcomings.

It is important not to become excessively self-critical when acknowledging one's inevitable errors. If the patient perceives that the therapist is in an agony of remorse, the message that may be received is that mistakes should be rare and require stern self-censure—a delusion from which the narcissistic person is already suffering. It is better to take one's cue from Winnicott, who is reputed to have fielded a query about his rules for interpretation with the comment: "I make interpretations for two purposes. One, to show the patient that I am awake. Two, to show the patient that I can be wrong." Similarly, Arthur Robbins (personal communication, April 1991), a psychoanalyst with expertise in art therapy and other expressive modes of treatment, describes his theory of technique as "Fuck-up therapy: I fuck up, and the patient corrects me." Contemporary relational writing (e.g., Kieffer, 2007), drawing on research with infants (Beebe & Lachmann, 1994), emphasizes the centrality to all therapy of what Kohut (1984) deemed the inevitable "rupture and repair" process; I think this process is especially central to the treatment of people with characterological narcissism.

Attempts to help a narcissistic patient also require a constant mindfulness of the person's latent self-state, however overwhelming the manifest one is. Because even the most arrogant, entitled narcissist is subject to excruciating shame in the face of what feels like criticism, therapists must take pains to frame interventions sensitively. True mutuality with

narcissistic clients is tenuous because they cannot tolerate circumstances in which their fragile self-esteem is diminished. Their early reputation for being impossible to treat derived partly from analysts' experience with their abruptly terminating therapies of even several years' duration when their feelings were hurt.

I have mentioned the power of shame in the experience of the narcissistic person, and the value of the therapist's discriminating between shame and guilt. People with fragile self-esteem may go to great lengths to avoid acknowledging their role in anything negative. Unlike people who easily feel guilty and who handle their transgressions with efforts at reparation, narcissistically motivated people run from their mistakes and hide from those who would find them out. They may induce in therapists either a disposition to confront them unempathically about their own contributions to their difficulties or a tendency to join them in bemoaning the bad deal they have gotten from others. Neither position is therapeutic, although the second is temporarily palliative to a person who otherwise may suffer chagrin bordering on mortification.

Because of their devastation when their imperfections are visible, narcissistic individuals tend to use obfuscating language that implicitly disowns personal responsibility ("Mistakes were made"). The therapist faces the daunting task of expanding the narcissistic patient's awareness of, and honesty about, the nature of his or her behavior without stimulating so much shame that the person either leaves treatment or keeps secrets. One way to do this in the context of a client's complaints and criticisms about others is to ask, "Did you make your needs explicit?" The rationale for this query is that narcissistic people have deep shame about asking for anything; they believe that to admit a need exposes a deficiency in the self. They consequently get into situations where they are miserable because another person does not effortlessly divine their needs and offer what they want without their suffering what they see as the humiliation of asking. They often try to persuade the analyst that their problem is that the people they live with are insensitive. A question about articulating needs may gently expose a narcissistic patient's belief that it is shameful to need someone and may create opportunities to learn something different about human interdependency.

I noted earlier the difference between selfobject and object transferences. An implication of this difference is that therapists treating narcissistic clients cannot fruitfully investigate their transference reactions as they would those of other people. Questions about who we are to the patient tend to fall flat; interpretations along the lines of "Maybe you're experiencing me as like your mother right now" may be received as pointless distractions. Therapists need to know that despite the countertransference feeling that one means nothing to the patient, a narcis-

sistic person often actually needs the therapist more than do people without significant self-esteem deficits. It can be stunning to therapists inexperienced with narcissistic patients to learn that the same person who renders them insignificant and impotent during therapy sessions is quoting them admiringly outside the consulting room. Even the arrogant, boastful, seemingly impervious patient betrays a deep dependency on the therapist by his or her vulnerability to feeling crushed when the therapist is insensitive. In working with narcissistic people, practitioners have to become accustomed to absorbing a great deal that they would address with other types of patients.

DIFFERENTIAL DIAGNOSIS

Injuries to self-esteem may lead anyone to behave temporarily like a narcissistic character. Moreover, all types of personality structure have a narcissistic function: They preserve self-esteem via certain defenses. But to qualify as characterologically narcissistic, one must have longstanding, automatic, and situation-independent patterns of subjectivity and behavior. Narcissistic personality organization seems currently overdiagnosed, perhaps especially by psychodynamic clinicians. The concept is often misapplied to people having situation-specific reactions and to psychopathic, depressive, obsessive compulsive, and hysterical personalities.

Narcissistic Personality versus Narcissistic Reactions

I have already suggested one caveat in diagnosing characterological narcissism: Even more than with other psychological conditions to which all human beings are vulnerable, narcissistic concerns are ubiquitous and can easily be situationally incited. Kohut and Wolf (1978) referred to individuals who (like the Chinese graduate student mentioned in the Introduction to this part) confront circumstances that challenge their prior sense of identity and undermine their self-esteem as suffering from a "secondary narcissistic disturbance," not a narcissistic character disorder. It is an important distinction. Any non-narcissistic person can sound arrogant or devaluing, or empty and idealizing, under conditions that strain his or her identity and confidence.

Medical school and psychotherapy training programs are famous for taking successful, autonomous adults and making them feel like incompetent children. Compensatory behaviors like bragging, opinionated proclamations, hypercritical commentary, or idealization of a mentor are common under such circumstances. Phenomena like these are

sometimes referred to in the psychoanalytic literature as comprising a "narcissistic defense" (e.g., Kernberg, 1984). That one is suffering with narcissistic issues does not make one a narcissistic personality. Where situational factors dominate a narcissistic presentation, the interviewer should rely on historical data and the feel of the transference to infer the personality structure underneath the narcissistic injury.

Narcissistic versus Psychopathic Personality

In the last section of the previous chapter, I mentioned the importance of discriminating between a predominantly psychopathic personality structure and one that is essentially narcissistic. Kohutian efforts at empathic relatedness, at least as they are conventionally put into practice, would be ineffective with psychopathic people because they do not emotionally understand compassionate attitudes; they scorn a sympathetic demeanor as the mark of weakness. The approach advocated by Kernberg (e.g., 1984) centering on the confrontation of the grandiose self, would be more respectfully assimilated by a psychopathically organized person, and is consistent with the recommendations of therapists such as Greenwald (1974), Bursten (e.g., 1973a, 1973b), Groth (e.g., 1979), and Meloy (e.g., 2001), who have specialized in working with psychopathic clients.

Narcissistic versus Depressive Personality

The more depressed kind of narcissistic person can easily be misunderstood as having a depressive personality. The essential difference between the two groups is, to condense a great deal of clinical theory and observation into a simple image, that narcissistically depressed people are subjectively empty, whereas depressive people with introjective psychologies (Blatt, 2004) (those who used to be described as suffering depression of the more "melancholic" or guilty type) are subjectively full—of critical and angry internalizations. The narcissistic depressive feels devoid of a substantial self; the melancholic depressive feels the self is real but irreducibly bad. I comment on these differences and their divergent therapeutic implications more in Chapter 11.

Narcissistic versus Obsessive–Compulsive Personality

It is easy to misconstrue a narcissistic person as obsessive and/or compulsive on the basis of the attention to detail that may be part of the narcissistic quest for perfection. In the early days of psychoanalytic practice, fundamentally narcissistic people were often considered obsessive or compulsive because their presenting symptoms fell into one or both

of those categories. They were then treated according to assumptions about the etiology of obsessive–compulsive character that emphasized struggles for control and guilt over anger and fantasied aggression.

Narcissistic patients, who were empty more than angry, did not make much progress in that kind of therapy; they would feel misunderstood and criticized when the therapist seemed to harp on issues that were not central to their subjectivity. Although many people have both narcissistic and more classically obsessive concerns, those whose personalities were predominantly narcissistic tended to get little help from analytic therapy before the 1970s, when theories of the etiology and treatment of pathological narcissism radically extended our capacity to help people with disorders of the self. I know of a number of people treated analytically before that time who still bear grudges against their therapist and against psychoanalysis in general. In popular accounts of psychotherapy experiences one can find what seem to be examples of the effects of this misdiagnosis. I give more details on this distinction and the implications of this diagnostic error in Chapter 13.

Narcissistic versus Hysterical Personality

While the narcissistic versus obsessive–compulsive personality differential is called for somewhat more frequently with men than with women, the need to distinguish between narcissism and hysteria comes up much more commonly with female patients. Because hysterically organized people use narcissistic defenses, they are readily misinterpreted as narcissistic characters. Heterosexual women whose hysterical presentation includes considerable exhibitionistic behavior and a pattern of relating to men in which idealization is quickly followed by devaluation may appear to be basically narcissistic, but their concerns about self are gender specific and fueled by anxiety more than shame. Outside certain highly conflicted areas, they are warm, loving, and far from empty (see Kernberg, 1984).

The import of this differential lies in the contrasting therapeutic requirements for the two groups: Hysterical patients thrive with an attention to object transferences, whereas narcissistic ones require an appreciation of selfobject phenomena. In Chapter 14 I go into more detail on this topic.

SUMMARY

This chapter has described the depleted subjective world of the person with a narcissistically organized character and the compensatory

behaviors with which such a person tries to maintain a reliable and valued sense of self. I have emphasized the affects of shame and envy, the defenses of idealization and devaluation, and relational patterns of using and being used to equilibrate one's self-esteem and to repair damage to it. I discussed the narcissistic person's propensity for selfobject transferences and noted countertransference reactions in which a sense of unrelatedness prevails. I mentioned some implications for technique that derive from an appreciation of these special aspects of the narcissistic condition, although I acknowledged current controversies in the psychoanalytic understanding of narcissism that make effective approaches with this population a matter of some dispute. Finally, I distinguished narcissistic character organization from narcissistic reactions, from psychopathy, from introjective depressive personality, from obsessive and compulsive character structure, and from hysterical psychology.

SUGGESTIONS FOR FURTHER READING

There has been a voluminous psychoanalytic literature on narcissism since the 1970s, when Kohut published *The Analysis of the Self* (1971) and Kernberg offered an alternative conception in *Borderline Conditions and Pathological Narcissism* (1975). Both these books contain so much jargon that they are almost impossible for someone new to psychoanalysis to read. More manageable alternatives include Alice Miller's *Prisoners of Childhood* (1975) (known in another edition as *The Drama of the Gifted Child*), Bach's *Narcissistic States and the Therapeutic Process* (1985), and Morrison's *Shame: The Underside of Narcissism* (1989). Morrison also edited a collection, available in paperback, titled *Essential Papers on Narcissism* (1986), which contains major psychoanalytic essays on the topic, most of which are excellent. For a scholarly analysis of the cultural trends behind the "empty self" that is central to narcissistic personality, see Philip Cushman's *Constructing the Self, Constructing America* (1995).

Newer works on narcissism tend to be based on the description in DSM-IV, and thus strike me as more superficial, trait based, and one-dimensional than these analytic writings. But the oversimplification and popularization of a concept can have its advantages: There are now many helpful popular books for individuals coping with narcissistic parents, lovers, colleagues, employers, and other difficult people.

9

Schizoid Personalities

The person whose character is essentially schizoid is subject to widespread misunderstanding, based on the common misconception that schizoid dynamics are always suggestive of grave primitivity. Because the incontrovertibly psychotic diagnosis of schizophrenia fits people at the disturbed end of the schizoid continuum, and because the behavior of schizoid people can be unconventional, eccentric, or even bizarre, nonschizoid others tend to pathologize those with schizoid dynamics—whether or not they are competent and autonomous, with significant areas of ego strength. In fact, schizoid people run the gamut from the hospitalized catatonic patient to the creative genius.

As with the other typological categories, a person may be schizoid at any level, from psychologically incapacitated to saner than average. Because the defense that defines the schizoid character is a primitive one (withdrawal into fantasy), it may be that healthy schizoid people are rarer than sicker ones, but I do not know of any research findings or disciplined clinical observations that support this assumption empirically. There is long-standing evidence (E. Bleuler, 1911; M. Bleuler, 1977; Nannarello, 1953; Peralta, Cuesta, & de Leon, 1991) and some recent suggestions from neuroscience and genetics (Weinberger, 2004) that the most frequent premorbid personality type in those who become schizophrenic is schizoid. But the converse idea, that all schizoid people are at risk of a psychotic break, has no empirical basis.

One reason schizoid people may be pathologized is that they are comparatively rare. People in majorities tend to assume that their own psychology is normative and to equate difference with inferiority (as

happened with people of minority sexual orientation for many years). The psychoanalytic concept of the schizoid person has a lot in common with the Jungian concept of the introvert, specifically the kind of individual who would test as an introverted, intuitive, feeling, judging type (INFJ) on the Jungian-derived Myers Briggs inventory. INFJs constitute only about 1% of the overall population in the areas where personality distribution has been studied, and are understood as having strengths as "mystics" or "confidants."

Vocations like philosophical inquiry, spiritual discipline, theoretical science, and the creative arts attract people with this kind of character. At the high-functioning end of the schizoid spectrum we might find people like Ludwig Wittgenstein, Martha Graham, and other admirably original and somewhat eccentric individuals. Albert Einstein (1931) wrote about himself:

> My passionate sense of social justice and social responsibility has always contrasted oddly with my pronounced lack of need for direct contact with other human beings and human communities. I am truly a "lone traveler" and have never belonged to my country, my home, my friends, or even my immediate family, with my whole heart; in the face of all these ties, I have never lost a sense of distance and a need for solitude.... (p. 9)

In 1980, with the publication of DSM-III, conditions that most analysts would regard as different possibilities on the schizoid spectrum, or as minor variants on a general schizoid theme, appeared as discrete categories in the DSM. Complicated theoretical issues influenced this decision (see Lion, 1986), one reflecting differences of current opinion that echo old controversies about the nature of certain schizoid states (Akhtar, 1992; E. Bleuler, 1911; Gottesman, 1991; Jaspers, 1963; Kraepelin, 1919; Kretschmer, 1925; Schneider, 1959). Many analytic practitioners continue to regard the diagnoses of schizoid, schizotypal, and avoidant personality disorders as nonpsychotic versions of schizoid character, and the diagnoses of schizophrenia, schizophreniform disorder, and schizoaffective disorder as psychotic levels of schizoid functioning.

I am often asked whether I see schizoid people as on the autistic spectrum, and I am not sure how to answer. Our taxonomic categories remain arbitrary and overlapping, and acting as if there are discrete present-versus-absent differences between labels is not usually wise clinically, when one is trying to get a sense of a patient's individual uniqueness. Perhaps schizoid psychology, especially in its high-functioning versions, can be reasonably viewed as at the healthy end of the autistic spectrum. Certainly on the basis of their observable behavior, some

schizoid individuals seem as unrelated, odd, and detached as those with diagnosed autism or Asperger syndrome.

But people who are diagnosably autistic often report an internal inability to imagine what others are thinking and feeling and being motivated by, whereas schizoid people, despite their withdrawal, are more likely to be preternaturally attuned to the subjective experience of others. I have heard Asperger-diagnosed parents say that they had to be taught that their children need to be hugged. Even if he had trouble getting himself to hug his child, a schizoid father would have no difficulty understanding the child's need. Schizoid people are more likely to describe themselves as overwhelmed by affect than as lacking it. So in these areas there seems to me a significant difference in the territory under consideration.

DRIVE, AFFECT, AND TEMPERAMENT IN SCHIZOID PSYCHOLOGY

Clinical experience suggests that temperamentally, the person who becomes schizoid is hyperreactive and easily overstimulated. Schizoid people often describe themselves as innately sensitive, and their relatives frequently mention their having been the kind of baby who shrinks from too much light or noise or motion (cf. Bergman & Escalona, 1949, on babies with unusual sensitivities). It is as if the nerve endings of schizoid individuals are closer to the surface than those of the rest of us. Doidge (2001) depicts them as "hyperpermeable" to external impingements. Although most infants cuddle, cling, and mold themselves to the body of a warm caregiver, some newborns stiffen or pull back as if the adult has intruded on their comfort and safety (Brazelton, 1982; Kagan, 1994). One suspects that such babies are constitutionally prone to schizoid personality structure, especially if there is a "poor fit" (Escalona, 1968) between themselves and their main caregivers.

In the area of drive as classically understood, the schizoid person seems to struggle with oral-level issues. Specifically, he or she is preoccupied with avoiding the dangers of being engulfed, absorbed, distorted, taken over, eaten up. A talented schizoid therapist in a supervision group I belonged to once described to the group members his vivid fantasy that the physical circle of participants constituted a huge mouth or a giant letter C. He imagined that if he exposed his vulnerability by talking candidly about his feelings toward one of his patients, the group would close around him, making the C into an O, and that he would suffocate and expire inside it.

While fantasies like those of my colleague invite the interpretation that they constitute projections and transformations of the fantasizer's

own hunger (Fairbairn, 1941; Guntrip, 1961; Seinfeld, 1991), the schizoid person often does not experience appetitive drives as coming from within the self. Rather, the outer world feels full of consuming, distorting threats against security and individuality. Fairbairn's understanding of schizoid states as "love made hungry" addresses not the day-to-day subjective experience of the schizoid person but the dynamics underlying the opposite and manifest tendencies: to withdraw, to seek satisfactions in fantasy, to reject the corporeal world. As Kretschmer noted in 1925, schizoid people are even apt to be physically thin, so removed are they from emotional contact with their own greed.

Similarly, schizoid people do not impress one as being highly aggressive, despite the violent content of some of their fantasies. Their families and friends often regard them as unusually gentle, placid people. A friend of mine, whose general brilliance and schizoid indifference to convention I have long admired, was described lovingly at his wedding by an older sister as having always been a "soft person." This softness exists in fascinating contradiction to his affinity for horror movies, true-crime books, and visions of apocalyptic world destruction. The projection of drive can be easily assumed, but this man's conscious experience—and the impression he makes on others—is of a sweet, low-keyed, lovable eccentric. Most analytic thinkers who have worked with people like my friend have inferred that schizoid clients bury both their hunger and their aggression under a heavy blanket of defense.

Affectively, one of the most striking aspects of many high-functioning individuals with schizoid dynamics is their *lack* of common defenses. They tend to be in touch with many emotional reactions at a level of genuineness that awes and even intimidates their acquaintances. It is common for the schizoid person to wonder how everybody else can be lying to themselves so effortlessly when the harsh facts of life are so patent. Part of the alienation from which schizoid people suffer derives from their experiences of not having their own emotional, intuitive, and sensory capacities validated—because others simply do not see what they do. The ability of a schizoid person to perceive what others disown or ignore is so natural and effortless that he or she may lack empathy for the less lucid, less ambivalent, less emotionally harrowing world of nonschizoid peers.

Schizoid people do not seem to struggle quite the way narcissistic people do with shame or introjectively depressive people do with guilt. They tend to take themselves and the world pretty much as is without the internal impetus to make things different or to shrink from judgment. Yet they may suffer considerable anxiety about basic safety. When they feel overwhelmed, they hide—either literally with a hermit's reclusiveness or by retreat into their imagination (Kasanin & Rosen, 1933; Nannarello, 1953). The schizoid person is above all else an outsider, an onlooker, an observer of the human condition. One of my schizoid

friends told me his tombstone should read, "Here lies _____. He read and thought about life to the hilt."

The "split" implied in the etymology of the word "schizoid" exists in two areas: between the self and the outside world, and between the experienced self and desire (see Laing, 1965). When analytic commentators refer to split experience in schizoid people, they refer to a sense of estrangement from part of the self or from life that is essentially "dissociative" (another word used frequently by analysts personally and professionally acquainted with schizoid psychology, such as D. W. Winnicott). The defense mechanism of splitting, in which a person alternately expresses one ego state and then another opposite one, or divides the world defensively into all-good and all-bad aspects, is a different use of the word.

DEFENSIVE AND ADAPTIVE PROCESSES IN SCHIZOID PSYCHOLOGY

As I noted previously, the pathognomonic defense in schizoid personality organization is withdrawal into an internal world of imagination. In addition, schizoid people may use projection and introjection, idealization, devaluation, and to a lesser extent, the other defenses that have their origins in a time before self and other were fully differentiated psychologically. Among the more "mature" defenses, intellectualization seems to be the preference of most schizoid people. They rarely rely on mechanisms that blot out affective and sensory information, such as denial and repression; similarly, the defensive operations that organize experience along good-and-bad lines, such as compartmentalization, moralization, undoing, reaction formation, and turning against the self, are not prominent in their repertoires. Under stress, schizoid individuals may withdraw from their own affect as well as from external stimulation, appearing blunted, flat, or inappropriate, often despite showing evidence of heightened attunement to affective messages coming from others.

The most adaptive and exciting capacity of the schizoid person is creativity. Most truly original artists have a strong schizoid streak—almost by definition, given that one has to stand apart from convention to influence it in a new way. Healthier schizoid people turn their assets into works of art, scientific discoveries, theoretical innovations, or spiritual pathfinding, while more disturbed individuals in this category live in a private hell where their potential contributions are preempted by their terror and estrangement. The sublimation of autistic withdrawal into creative activity is a primary goal of therapy with schizoid patients.

RELATIONAL PATTERNS IN SCHIZOID PSYCHOLOGY

The primary relational conflict of schizoid people concerns closeness and distance, love and fear. A deep ambivalence about attachment pervades their subjective life. They crave closeness yet feel the constant threat of engulfment by others; they seek distance to reassure themselves of their safety and separateness yet may complain of alienation and loneliness (Eigen, 1973; Karon & VandenBos, 1981; Masterson & Klein, 1995; Modell, 1996; Seinfeld, 1991). Guntrip (1952), who depicted the "classic dilemma" of the schizoid individual as "that he can neither be in a relationship with another person nor out of it, without in various ways risking the loss of both his object and himself," refers to this dilemma as the "in and out programme" (p. 36).

Schopenhauer's famous parable about porcupines on a cold night (see Luepnitz, 2002) captures the dilemma of schizoid people: When they move close for warmth, they prick one another; when they move away from the pain, they get cold. This conflict can be enacted in the form of intense but brief connection followed by long periods of retreat. A. Robbins (1988) summarizes the dynamic as the message, "Come close for I am alone, but stay away for I fear intrusion" (p. 398). Sexually, some schizoid people are remarkably apathetic, often despite being functional and orgasmic. The closer the other, the greater the worry that sex means enmeshment. Many a heterosexual woman has fallen in love with a passionate musician, only to learn that her lover reserves his sensual intensity for his instrument. Similarly, some schizoid people crave unattainable sexual objects, while feeling vague indifference toward available ones. The partners of schizoid people sometimes complain of a mechanical or detached quality in their lovemaking.

Object relations theories of the genesis of schizoid dynamics have been, in my own view, burdened by efforts to locate the origins of schizoid states in a particular phase of development. The adequacy of the fixation–regression hypothesis in accounting for type of character structure is, as I suggested previously, problematic, yet its appeal is understandable: It normalizes puzzling phenomena by considering them simple residues of ordinary infantile life. Melanie Klein (1946) thus traced schizoid mechanisms to a universal paranoid–schizoid position of early infancy, before the child has fully taken in the separateness of others. Other early object relations analysts followed suit in developing explanatory paradigms in which schizoid dynamics were equated with regression to neonatal experience (Fairbairn, 1941; Guntrip, 1971). For a long time, theorists tended to accept the developmental bias of the fixation–regression model, yet they differed about which early phase is the fixation point. For example, in the Kleinian tradition, Giovac-

chini (1979) regarded schizoid disorders as essentially "prementational," whereas Horner (1979) assigned their origins to a later age when the child emerges from symbiosis.

The concept of schizoid personality overlaps considerably with the paradigm of avoidant attachment, one of the insecure attachment styles (Wallin, 2007). Babies labeled "avoidant" or "dismissive" by attachment researchers react to Ainsworth's Strange Situation with what looks like indifference to whether or not their mother is present. Although they may seem perfectly comfortable, their heart rates during separation have been found to be elevated, and their cortisol (stress hormone) levels rise (Spangler & Grossmann, 1993; Sroufe & Waters, 1977). Ainsworth and colleagues (1978) reported that the mothers of these children were rejecting of their normal dependency. Grossmann and Grossmann (1991) later noted that they were particularly unresponsive to sadness in their babies. Main and Weston (1982) described mothers of avoidant infants as brusque, emotionally unexpressive, and averse to physical contact with their children.

These findings are interesting to consider in the context of clinical speculations about the interpersonal etiologies of schizoid personality. A parent who is dismissive or contemptuous of a child's neediness could certainly foster a defensive self-sufficiency in that child (Doidge, 2001; Fairbairn, 1940). Some people with a history of early isolation and neglect may be understood as having learned to make a virtue out of a necessity by avoiding closeness and relying on their inner world for stimulation. Harry Stack Sullivan and Arthur Robbins, two analysts whose own schizoid trends prompted them to interpret the schizoid experience to the larger mental health community, both suffered significant early deprivation of companionship (Mullahy, 1970; A. Robbins, 1988).

A seemingly opposite type of relatedness that may encourage a child's withdrawal is an impinging, overinvested, overinvolved kind of parenting (*Winnicott, 1965*). The schizoid man with the smothering mother is a staple of popular literature and can also be found in scholarly work. A type of family background commonly reported to clinicians by schizoid male patients is a seductive or boundary-transgressing mother and an impatient, critical father. Although DSM-IV gives no information on gender distribution for schizoid, schizotypal, and avoidant diagnoses, it is my impression that therapists see more males than females with schizoid personalities. This would accord with the psychoanalytic observation that because most primary caregivers are female, and because girls identify with female caregivers whereas boys tend to disidentify from them eventually (Chodorow, 1978, 1989; Dinnerstein, 1976), women are more prone to disorders characterized by too much attachment (e.g.,

depression, masochism, dependent personality disorders) and men to those characterized by too little (e.g., psychopathy, sadism, schizoid conditions).

The content, not just the degree, of parental involvement may also contribute to the development of a pattern of schizoid aloofness and withdrawal. Numerous observers of the families of people who developed a schizophrenic psychosis have stressed the role of contradictory and confusing communications in psychotic breakdowns (Bateson et al., 1956; Laing, 1965; Lidz & Fleck, 1965; Searles, 1959; Singer & Wynne, 1965a, 1965b). It is possible that such patterns foster schizoid dynamics in general. A child raised with double-binding, pseudomutual, emotionally dishonest messages could easily come to depend on withdrawal to protect the self from intolerable levels of confusion and anger. He or she would also feel deeply hopeless, an attitude often noted in schizoid patients (e.g., Giovacchini, 1979).

It is typical of the literature on schizoid phenomena—an extensive literature because of the huge social cost of schizophrenia—that contrasting and mutually exclusive formulations can be found everywhere one looks (Sass, 1992). These inconsistencies uncannily mirror the dissociated self-states of the schizoid person. It is not impossible that both impingement and deprivation codetermine the schizoid pattern: If one is lonely and deprived, yet the only kind of parenting available is unempathic and intrusive, a conflict between yearning and avoiding, between closeness and distance, would be highly likely.

Elizabeth Howell (2005) notes that Fairbairn's conceptualization of schizoid experience can form a basis for also understanding dissociative disorders, borderline phenomena, and narcissism (p. 3), all of which have elements of falseness, split experience, difficulty with affect tolerance, and internalization of toxic others. Schizoid psychology in particular may emerge from a pattern of microdissociations in response to traumatic overstimulation by caregivers who are insensitive to the child's temperamental sensitivity and intensity. Masud Khan's (1963, 1974) studies of schizoid conditions inferred "cumulative trauma" from failures of realistic maternal protection inherent in the mother's intense overidentification with the baby. Some contemporary students of trauma and dissociation (e.g., R. Chefetz, personal communication, September 12, 2010) consider schizoid psychology to be understandable through the lens of dissociative processes (disordered affect regulation and somatic experience, chronic depersonalization and/or derealization, etc.) as the product of repetitive relational trauma. In a vivid communication of this process, a talented musician once told me, with characteristic schizoid access to imagery, that before his father died (when he was 9), the world was in color; afterward, it was in black and white.

THE SCHIZOID SELF

One of the most striking aspects of people with schizoid personalities is their disregard for conventional social expectations. In dramatic contrast to the narcissistic personality style, the schizoid person may be markedly indifferent to the effect he or she has on others and to evaluative responses coming from those in the outside world. Compliance and conformity go against the grain for schizoid people, whether or not they are in touch with a painful subjective loneliness. Even when they see some expediency in fitting in, they tend to feel awkward and even fraudulent making social chitchat or participating in communal forms, regarding them as essentially contrived and artificial. The schizoid self tries to stand at a safe distance from the rest of humanity.

Many observers have commented on the detached, ironic, and faintly contemptuous attitude of many schizoid people (E. Bleuler, 1911; M. Bleuler, 1977; Sullivan, 1973). This tendency toward an isolated superiority may have its origins in fending off the incursions of an overcontrolling or overintrusive Other about which I have just hypothesized. Even in the most seemingly disorganized schizophrenic patients, a kind of deliberate oppositionality has long been noted, as if the patient's only way of preserving a sense of self-integrity is in making a farce of every conventional expectation. Under the topic of "counter-etiquette," Sass (1992) comments on this phenomenon:

> Cross-cultural research has shown ... that schizophrenics generally seem to gravitate toward "the path of most resistance," tending to transgress whatever customs and rules happen to be held most sacred in a given society. Thus, in deeply religious Nigeria, they are especially likely to violate religious sanctions; in Japan, to assault family members. (p. 110)

One way of understanding these apparently deliberate preferences for eccentricity and defiance of custom is to assume that the schizoid person is assiduously warding off the condition of being defined—psychologically taken over and obliterated—by others.

Abandonment is thus a lesser evil than engulfment to schizoid people. Anticipating Blatt's (2008) comprehensive work on the polarities of self-definition and relationship, Michael Balint (1945), in a famous essay with the evocative title "Friendly Expanses—Horrid Empty Spaces," contrasted two antithetical characters: the philobat (lover of distance), who seeks the comforts of solitude when upset, and the "ocnophil" (lover of closeness), who gravitates toward others, seeking a shoulder to cry on. Schizoid people are the ultimate philobats. Perhaps predictably,

since human beings are often drawn to those with opposite and envied strengths, schizoid people tend to attract (and to be attracted to) warm, expressive, sociable people such as those with hysterical personalities. These proclivities set the stage for certain familiar and even comic problems in which the nonschizoid partner tries to resolve interpersonal tension by continually moving closer, whereas the schizoid person, fearing engulfment, keeps moving farther away.

I do not want to give the impression that schizoid individuals are cold or uncaring. They may care very much about other people yet still need to maintain a protected personal space. Some gravitate to careers in psychotherapy, where they put their exquisite sensitivity to use safely in the service of others. Allen Wheelis (1956), who may have experienced himself as schizoid, wrote an eloquent essay on the attractions and hazards of a psychoanalytic career, stressing how people with a core conflict over closeness and distance may be drawn to the profession of psychoanalysis. As an analyst, one gets to know others more intimately than anyone else has ever known them, but one's own exposure is within predictable professional bounds.

For someone with schizoid dynamics, self-esteem is often maintained by individual creative activity. Issues of personal integrity and self-expression tend to dominate self-evaluative concerns. Where the psychopath pursues evidence of personal power, or the narcissist seeks admiring feedback to nourish self-regard, the schizoid person wants confirmation of his or her genuine originality, sensitivity, and uniqueness. This confirmation must be internally rather than externally bestowed, and because of their high standards for creative endeavors, schizoid people are often rigorously self-critical. They may take the pursuit of authenticity to such extreme lengths that their isolation and demoralization are virtually guaranteed.

Sass (1992) has compellingly described how schizoid conditions are emblematic of modernity. The alienation of contemporary people from a communal sensibility, reflected in the deconstructive perspectives of 20th-century art, literature, anthropology, philosophy, and criticism, has eerie similarities to schizoid and schizophrenic experience. Sass notes in particular the attitudes of alienation, hyperreflexivity (elaborate self-consciousness), detachment, and rationality gone virtually mad that characterize modern and postmodern modes of thought and art, contrasting them with "the world of the natural attitude, the world of practical activity, shared communal meanings, and real physical presences" (p. 354). His exposition also calls effectively into question numerous facile and oversimplified accounts of schizophrenia and the schizoid experience.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH SCHIZOID PATIENTS

Although one would assume intuitively from their predilection for withdrawal that schizoid people would shun encounters as intimate as psychotherapy and psychoanalysis, when treated with consideration and respect, they are often appreciative of and cooperative in the therapy process. The clinician's discipline in addressing the client's own agenda, and the safe distance created by the customary boundaries of treatment (time limitations, fee arrangements, ethical prohibitions against social or sexual relationships with clients), seem to decrease the schizoid person's fears about enmeshing involvements.

Schizoid clients approach therapy with the same combination of sensitivity, honesty, and fear of engulfment that typifies their other relationships. They may be seeking help because their isolation from the rest of the human community has become too painful, or because they have suffered a loss of one of the very few people they felt close to, or because they have circumscribed goals related to their isolation, such as a wish to get over an inhibition against dating or pursuing other specific social behaviors. Sometimes the psychological disadvantages of their personality type are not evident to them; they may want relief from a depression or an anxiety state or another symptom syndrome. At other times, they may arrive for treatment afraid—sometimes rightly—that they are on the brink of going mad.

It is not uncommon for a schizoid person to be tongue-tied and to feel empty, lost, and pained in the early phases of therapy. An anguished schizoid woman I treated (McWilliams, 2006a), who became mute for long periods in every session, finally telephoned to tell me, poignantly, "I want you to know that I want to talk to you, but it hurts too much." A therapist may have to endure long silences while the patient internalizes the safety of the setting. Eventually, however, unless a client is excruciatingly nonverbal or confusingly psychotic, most people with schizoid psychologies are a pleasure to work with. As one would expect, they are often highly perceptive of their internal reactions, and they are grateful to have a place where honest self-expression will not arouse alarm, disdain, or derision. I have been touched many times by the gratitude of schizoid individuals when they feel understood and treated with respect, not only when patients have expressed such appreciation, but when I get warm e-mails from self-diagnosed schizoid readers who spontaneously thank me for writing this chapter and another article (McWilliams, 2006b) that explores their psychology without pathologizing them.

The initial transference–countertransference challenge for the therapist working with a schizoid patient is to find a way into the person's

subjective world without arousing too much anxiety about intrusion. Because schizoid people may withdraw into detached and obscure styles of communication, it is easy to fall into a counterdetachment, in which one regards them as interesting specimens rather than as fellow creatures. Their original transference "tests," as per control–mastery theory, involve efforts to see whether the therapist is concerned enough for them to tolerate their confusing, off-putting messages while maintaining the determination to understand and help. Naturally, they fear that the therapist will, like other people in their lives, withdraw from them emotionally and consign them to the category of hopeless recluse or amusing crackpot.

The history of efforts to understand schizoid conditions is replete with examples of "experts" objectifying the lonely patient, being fascinated at schizoid phenomena but keeping a safe distance from the emotional pain they represent and regarding the schizoid person's verbalizations as meaningless, trivial, or too enigmatic to bother to decode. The current psychiatric enthusiasm for physiological explanations of schizoid states is a familiar version of this disposition not to take the schizoid person's subjectivity seriously. As Sass (1992) has argued, efforts to find biochemical and neurological contributions to schizoid and schizophrenic states do not obviate the continuing need to address the *meaning* of the schizoid experience to the patient. In *The Divided Self*, R. D. Laing (1965) reassesses a schizophrenic woman interviewed by Emil Kraepelin. The patient's words, which had been incomprehensible to Kraepelin, gain meaning when regarded from Laing's empathic perspective. Karon and VandenBos (1981) present case after case of helpable patients who might easily be dismissed as "management" projects by clinicians who are untrained or unwilling to try to understand them.

People who are characterologically schizoid and in no danger of a psychotic break—the majority of schizoid people—provoke much less incomprehension and defensive detachment in their therapists than do hospitalized schizophrenics, the subject of most of the serious analytic writing on pathological withdrawal. But the same therapeutic requirements apply, in less extreme degree. The patient needs to be treated as if his or her internal experience, even if outlandish to others, has potentially discernable meaning and can constitute the basis for a nonthreatening intimacy with another person. The therapist must keep in mind that the aloofness of the schizoid client is an addressable defense, not an insurmountable barrier to connection. If the clinician can avoid acting on countertransference temptations either to prod the patient into premature disclosure, or to objectify and distance him or her, a solid working alliance should evolve.

Once a therapeutic relationship is in place, certain other emotional complexities may ensue. In my experience, the subjective fragility of the schizoid person is mirrored in the therapist's frequent sense of weakness or helplessness. Images and fantasies of a destructive, devouring external world may absorb both parties to the therapy process. Counterimages of omnipotence and shared superiority may also be present ("We two form a universe"). Fond perceptions of the patient as a unique, exquisite, misunderstood genius or underappreciated sage may dominate the therapist's inner responses, perhaps in parallel to the attitude of an overinvolved parent who imagined greatness for this special child.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF SCHIZOID PERSONALITY

The therapist who works with a schizoid patient must be open to a degree of authenticity and a level of awareness of emotion and imagery that would be possible only after years of work with patients of other character types. While I have known many practitioners who do well with many kinds of clients without having undergone a thoroughgoing personal analysis, I doubt that unless they are schizoid themselves, they can respond effectively to schizoid patients without having had extensive therapeutic exposure to their own inner depths.

Because many therapists have somewhat depressive psychologies, and their fears of abandonment are thus stronger than their fears of engulfment, they naturally try to move close to people they wish to help. Empathy with the schizoid patient's need for emotional space may consequently be hard to come by. A supervisor of mine once commented about my earnest and overly impinging efforts to reach a schizoid patient, "This man needs bicarbonate of soda, and you keep trying to feed him pumpkin pie." Emmanuel Hammer (1968) commented on the effectiveness of simply moving one's chair farther from the patient, thus giving nonverbal reassurance that the therapist will not intrude, hurry, take over, or smother.

In the early phases of therapy, most interpretation should be avoided on the basis of the patient's fears of being treated intrusively. Also, schizoid patients probably know more about their inner life than the therapist can at this point. Comments and casual reactions may be gratefully accepted, but efforts to push the client beyond what he or she is expressing will disconcert or antagonize the schizoid person, increasing tendencies toward withdrawal. Susan Deri (1968) emphasized the importance of phrasing one's remarks in the words or images just used by the patient

in order to reinforce the person's sense of reality and internal solidity. Hammer (1990) further cautioned against probing, quizzing, or treating the schizoid patient in a way that makes him or her feel like a "case."

Normalizing is an important part of effective therapy with schizoid people. In Chapter 4 I discussed the general technique of "interpreting up" with reference to people at the psychotic end of the psychotic–borderline–neurotic axis; it may also be useful for schizoid patients at any level of psychological health because of their difficulty believing that their hyperacute reactions will be understood and appreciated. Even if they are demonstrably high functioning, most schizoid people worry that they are fundamentally aberrant, incomprehensible to others. They want to be fully known by the people they care about, but they fear that if they are completely open about their inner life, they will be exposed as freaks.

Even those schizoid people who are confident of the superiority of their perceptions are not indifferent to the effect they may have in alienating others. By behaving in a way that conveys that the schizoid person's inner world is comprehensible, the therapist helps the client to take in the experience of being accepted without being asked to submit to the agenda of another person. Eventually, schizoid patients accrue enough self-esteem that even when other people fail to understand, they can appreciate that the difficulty may lie in the limitations of others rather than in the grotesqueness of their own sensibilities. The therapist's reframing of imaginal richness as talent rather than pathology may be deeply relieving to schizoid people, who may have had their emotional reactions disconfirmed or minimized all their lives by less sensitive commentators.

One way to give a schizoid patient confirmation without being experienced as either engulfing or minimizing is to use artistic and literary sources of imagery to communicate understanding of the patient's issues. A. Robbins (1988) describes the early part of his own psychoanalysis as follows:

> When there were many lengthy silences in which I had little sense of what to say or how to communicate my feelings regarding my life history, fortunately my analyst did not desert me. Sometimes he would offer me "bedtime stories" [Robbins had never been read to as a child] in the form of citing plays, literature, and movies that had some relevance to the diffuse threads and images I presented to him in treatment. My curiosity was aroused by the references, and I made a point of reading the material. The likes of Ibsen, Dostoyevsky, and Kafka became important sources of rich symbolic material that seemed to mirror and clarify my inner experiences. Literature, and later art, seemed to give symbolic form to what I was trying

> to express. Most importantly, this material provided a significant means of sharing emotionally with my analyst. (p. 394)

A. Robbins and his colleagues (1980; A. Robbins, 1989) have made rich contributions to the creative arts therapies and have elaborated on the aesthetic dimension of psychoanalytic work with clients, aspects of therapy that hold particular promise for those who are schizoid.

Perhaps the most common obstacle to therapeutic progress with schizoid patients—once the therapy relationship is soundly in place and the work of understanding is proceeding—is the tendency for both therapist and patient to form a kind of emotional cocoon, in which they feel they understand each other comfortably and look forward to therapy sessions as a respite from a demanding world. Schizoid people have a tendency, with which an empathic therapist may unwittingly collude, to try to make the therapy relationship a substitute for, rather than an enhancer of, their lives outside the consulting room. Considerable time may go by before the therapist notices that although the patient develops rich insights in nearly every session, he or she has not gone to a social function, asked anybody out, improved a sexual relationship, or embarked on a creative project.

The generalization to the outside world of the schizoid client's attainment of a safe intimacy with the therapist can be a challenge. The therapist confronts the dilemma of having been hired to foster better social and intimate functioning yet realizing that any reminders to the patient that he or she is not pursuing that goal may be received as intrusive, controlling, and unempathic with the need for space. This tension is addressable, and the naming of it may deepen the schizoid person's appreciation of how powerful is the conflict between desire for closeness and fear of it. As with most aspects of therapy, timing is everything.

A. Robbins (1988) has emphasized the importance of the therapist's willingness to be seen as a "real person," not just a transference object. This recommendation has particular relevance for the schizoid person, who has an abundance of "as if" relationships and needs the sense of the therapist's active participation as a human being: supporting risks in the direction of relationships, being playful or humorous in ways that were absent in the schizoid person's history, and responding with attitudes that counteract the patient's tendencies to hide or "pass" or go through the motions of connecting emotionally with others. Authenticity is important with every client, but for those with schizoid personalities, it is critical at a cellular level. With these sensitive people who have radar for falseness, one finds that the client's transference reactions are not only not obscured by a more responsive therapeutic style, they may even become more accessible.

DIFFERENTIAL DIAGNOSIS

Schizoid psychology is usually easy to recognize, given the relative indifference of schizoid people to making a conventional impression on the interviewer. The central diagnostic challenge is assessing the strength of the client's ego: schizoid people may be misunderstood as both more and less troubled than they are, depending on what they share with the interviewer. Less portentously, some obsessive and compulsive people, especially in the borderline-to-psychotic range, are easily misconstrued as more schizoid than they are.

Degree of Pathology

It is critical, first of all, to evaluate how disturbed a person in the schizoid range is. It is probably experience with the importance of this dimension that led the contributors to DSM-IV to give several alternative schizoid diagnoses, something they did not do for several other personality disorders that also exist with a wide range of severity. Obviously, it is critical to consider possible psychotic processes in an intake interview; questions about hallucinations and delusions, attention to the presence or absence of disordered thinking, evaluation of the patient's capacity to distinguish ideas from actions, and, in puzzling instances, psychological testing are warranted with people who present with a schizoid style. Medication and/or hospitalization may be indicated when the results of such inquiries suggest psychosis.

Misunderstanding a schizophrenic person as a nonpsychotic schizoid personality can be a costly blunder. It is an equally unfortunate mistake, however, to assume that a patient is at risk of decompensation simply because he or she has a schizoid character. Schizoid people are often seen as sicker than they are, and for a therapist to make this error compounds the insults these clients have absorbed throughout a life in which their individuality may have always been equated with lunacy. (Actually, even with a psychotic patient, the therapist's stance that the client is not "just" a schizophrenic but a person with significant strengths, who can reasonably expect to be helped, is the most effective reducer of psychotic-level anxiety.)

Admiration for the schizoid person's originality and integrity is a therapeutic attitude that is easy to adopt once one has accepted the fact that schizoid processes are not necessarily ominous. Some healthy schizoid individuals who have come to therapy about a problem not inextricably tied up with their personality will not want their eccentricities to be addressed. This is their right. Therapeutic knowledge of how to make a schizoid person comfortable and self-

revealing can still facilitate work on the issues that the patient does wish to confront.

Schizoid versus Obsessive and Compulsive Personalities

Schizoid people often isolate themselves and spend a great deal of time thinking, even ruminating, about the major issues in their fantasy life. They can also, because of their conflict about closeness, appear wooden and affectless, and may respond to questions with intellectualization. Some have quirks of behavior that are or appear to be compulsive, or they use compulsive defenses to arrange their lives by an idiosyncratic set of rituals that protects them from disturbing intrusions. Consequently, they can be misunderstood as having an obsessive or obsessive–compulsive personality structure. Many people combine schizoid and obsessive or compulsive qualities, but insofar as the two kinds of personality organization can be discussed as "pure" types, there are some important differences.

Obsessive individuals, in marked contrast to schizoid people, are usually sociable and, in equally marked contrast to the schizoid person's march to a unique drummer, may be highly concerned with respectability, appropriateness, the approval of their peers, and their reputation in the community. Obsessive people are also apt to be moralistic, observing carefully the mores of their reference group, whereas schizoid people have a kind of organic integrity and are not particularly invested in mulling over conventional questions of right and wrong. People with obsessive–compulsive personalities deny or isolate feelings, whereas schizoid individuals identify them internally and pull back from relationships that invite their expression.

SUMMARY

I have emphasized how people with schizoid personalities preserve a sense of safety by avoiding intimacy with others from whom they fear engulfment and by escaping to internal fantasy preoccupations. When conflicted about closeness versus distance, schizoid people will opt for the latter, despite its loneliness, because closeness is associated with unbearable overstimulation and with having the self taken over in noxious ways. Possible constitutional sources of schizoid tendencies include hypersensitivity and hyperpermeability of the self. In addition to the use of autistic-like withdrawal into fantasy, the schizoid person employs other "primitive" defenses but also shows enviable capacities for authenticity and creativity.

I discussed the impact of these tendencies on relations with others, with attention to the patterns of family interaction that may have fostered the schizoid person's approach–avoidance conflict, namely the coexistence of deprivation and intrusion. I framed relevant transference and countertransference issues as including difficulties in the therapist's initial admission into the client's world, a tendency for the therapist to share the client's feelings of either helpless vulnerability or grandiose superiority, and temptations to be complicit with the patient's reluctance to move toward others. I recommended maximal self-awareness in the therapist, as well as patience, authenticity, normalization, and a willingness to show one's "real" personality. Finally, I emphasized the importance of assessing accurately a person's location on the schizoid continuum, and I differentiated the schizoid character from obsessive and compulsive personalities.

SUGGESTIONS FOR FURTHER READING

Much commentary on schizoid conditions is buried in writing on schizophrenia. An eloquent and absorbing exception is Guntrip's *Schizoid Phenomena, Object Relations and the Self* (1969). Seinfeld's *The Empty Core* (1991) is also an excellent representative of object-relational thinking about schizoid psychology. More recently, Ralph Klein's chapters about the "self-in-exile" in a book he coedited on disorders of the self (Masterson & Klein, 1995) are very helpful to the clinician. Arnold Modell's *The Private Self* (1996) is an important contribution. For more of my own thinking on this topic, readers can consult my essay on the mute schizoid woman I mentioned earlier (McWilliams, 2006a) or a recent article in the journal *Psychoanalytic Review* (McWilliams, 2006b).

The American Psychological Association intends to put out two videos in August 2011, to be marketed as *Three Approaches to Psychotherapy: The Next Generation* (Beck, Greenberg, & McWilliams, in press-a, in press-b) modeled after the famous "Gloria" tapes (Shostrum, 1965), in which a woman with that pseudonym was filmed in single-session interaction with Carl Rogers, Fritz Perls, and Albert Ellis, respectively. This time, the therapists will be Judith Beck, Leslie Greenberg, and me, and there will be one DVD of our work with a male patient and one with a female patient. Readers who would like to see me doing short-term, analytically oriented work with a patient I saw as having a basically schizoid personality structure (at the healthy end of the spectrum) can watch the DVD of my interview (and those of Beck and Greenberg) with a man named Kevin (Beck, Greenberg, & McWilliams, in press-b).

10

Paranoid Personalities

Most of us have a clear mental image of a paranoid person and recognize the type when it is portrayed fictionally. Peter Sellers's brilliant performance in the classic movie *Doctor Strangelove*, for example, captures the suspiciousness, humorlessness, and grandiosity that strike familiar chords in any of us who have paranoid acquaintances, or who recognize the comic elaboration of the paranoid streak we can all find in ourselves. Identifying less flagrant paranoid presentations requires a more disciplined sensibility. The essence of paranoid personality organization is the habit of dealing with one's felt negative qualities by disavowing and projecting them; the disowned attributes then feel like external threats. The projective process may or may not be accompanied by a consciously megalomanic sense of self.

The diagnosis of paranoid personality structure implies to many people a serious disturbance in mental health, yet as with other dynamics that infuse personality, this type of organization exists on a continuum of severity from psychotic to normal (Freud, 1911; Meissner, 1978; D. Shapiro, 1965). As with the personality types in the preceding chapters, the defense that defines paranoia may derive from a time before the child had clarity about internal versus external events, where self and object were thus confused. Paranoia intrinsically involves experiencing what is inside as if it were outside the self. It may be that "healthier" paranoid people are rarer than "sicker" ones, but someone can have a paranoid character at any level of ego strength, identity integration, reality testing, and object relations.

The trait-based descriptions of paranoid personality disorder in *DSM-IV* are from a clinician's perspective rather superficial, but the manual is accurate in noting that our knowledge of this personality type may be limited. A paranoid person has to be in fairly deep trouble before he or she seeks (or is brought for) psychological help. In contrast to depressive, hysterical, or masochistic people, for example, higher-functioning paranoid individuals tend to avoid psychotherapy unless they are in severe emotional pain or are causing significant upset to others. Because they are not disposed to trust strangers, paranoid people are also unlikely to volunteer to be research subjects.

People with normal-level paranoid characters often seek out political roles, where their disposition to oppose themselves to forces they see as evil or threatening can find ready expression. Reporters and satirists have often portrayed Dick Cheney as paranoid, but even if they hate his politics, they have seldom questioned his capacity to cope efficaciously in the world. At the other end of the continuum, some serial murderers who killed their victims out of the conviction that the victims were trying to murder them exemplify the destructiveness of projection gone mad; that is, paranoia operating without the moderating effects of more mature ego processes and without a solid grounding in reality. Several recent notorious murders seem to have had a paranoid basis.

I want to emphasize again as I did in Chapter 5 that attributions of paranoia should not be made on the basis of an interviewer's belief that a person seeking help is wrong about the danger he or she is in. Some people who look paranoid are actually being stalked or persecuted—by members of a cult they have left, for example, or by a rejected lover or a disaffected relative. (Some people who are diagnosably paranoid are also realistically imperiled; in fact, the off-putting qualities of many paranoid people make them natural magnets for mistreatment.) Some people who are not characterologically paranoid become temporarily so in paranoiagenic situations that are humiliating and entrapping. When interviewing for diagnostic purposes, one should not reject out of hand the possibility that the interviewee is legitimately frightened, or that those who are urging him or her to seek therapy have a personal stake in making the client look crazy.

Contrastingly, some individuals who are in fact paranoid do not appear to be. Nonparanoid associates in their social group—and the interviewer for that matter—may share their beliefs about the dangers of certain people, forces, or institutions (terrorists, capitalists, religious authorities, pornographers, the media, the government, patriarchy, racists—whatever is seen as the obstacle to the triumph of good) and may therefore fail to discern that there is something internally generated and driven about their preoccupations (Cameron, 1959). If Congress-

man Allard Lowenstein had fathomed the paranoid character of Dennis Sweeney, one of his protégés in the student movements of the 1960s and the man who later assassinated him in the grip of a delusion, he might have known better than to behave in a way that was interpretable as sexually seductive, and he might still be alive (see D. Harris, 1982). But Lowenstein and Sweeney had similar beliefs about what social evils required confrontation, and where Lowenstein's were not primarily projections, Sweeney's were.

There are also people whose perceptions turn out to be prescient, who are nevertheless paranoid. Howard Hughes had a consuming terror of the consequences of atomic testing in Nevada at a time when few others were concerned with nuclear contamination of the environment. Years later, as the toll exacted by radiation became clearer, he looked a lot less crazy. But the eventual vindications of his point of view do not make his psychology less paranoid; the events of his later life speak for the extent to which his own projections were the source of his suffering (Maheu & Hack, 1992). My aim in bringing up all these possibilities is to stress the importance of making informed, reflective diagnostic judgments instead of automatic, a priori assumptions—especially with clients whose grim, suspicious qualities may make them hard to warm up to.

DRIVE, AFFECT, AND TEMPERAMENT IN PARANOIA

Because they see the sources of their suffering as outside themselves, paranoid people in the more disturbed range are likely to be more dangerous to others than to themselves. They are much less suicidal than equally disturbed depressives, although they have been known to kill themselves to preempt someone else's expected destruction of them. The angry, threatening qualities of many paranoid people have prompted speculations that one contributant to a paranoid psychology is a high degree of innate aggression or irritability. It stands to reason that high levels of aggressive energy would be hard for a young child to manage and integrate into a positively valued sense of self, and that the negative responses of caregivers to an obstreperous, demanding infant or toddler would reinforce the child's sense that outsiders are persecutory. There has not been much recent research relating paranoia to temperament; in 1978 Meissner marshalled empirical evidence connecting it with an "active" symptomatic style in infancy (irregularity, nonadaptability, intensity of reaction, and negative mood) and with a thin stimulus barrier and consequent hyperexcitability.

Affectively, paranoid people struggle not only with anger, resentment, vindictiveness, and other visibly hostile feelings, they also suf-

fer overwhelmingly from fear. Silvan Tomkins (e.g., 1963) regarded the paranoid stance as a combination of fear and shame. The downward-left eye movements common in paranoid people (the "shifty" quality that even nonprofessionals notice) are physically a compromise between the horizontal-left direction specific to the affect of pure fear and the straight-down direction of uncontaminated shame (S. Tomkins, personal communication, 1972). Even the most grandiose paranoid person lives with the terror of harm from others and monitors each human interaction with extreme vigilance.

Analysts have long referred to the kind of fear suffered by paranoid clients as "annihilation anxiety" (Hurvich, 2003); that is, the terror of falling apart, being destroyed, disappearing from the earth. Anyone who has experienced this level of dread knows how terrifying it is. The research of Jaak Panksepp (1998) into mammalian affect has identified this kind of anxiety as part of the FEAR system that evolved evolutionarily to cope with the possibility of predation. Panksepp differentiates it from attachment/separation anxiety that belongs neurobiologically to the PANIC system and is mediated by serotonin. Paranoid anxiety tends not to be quelled by serotonin reuptake inhibitors, but is instead responsive to benzodiazepines, alcohol, and other "downer" drugs, which may be why paranoid patients often struggle with addiction to those chemical agents.

As for shame, that affect is as great a menace to paranoid people as to narcissistic ones, but paranoid people experience the danger differently. Narcissistic individuals, even arrogant ones, suffer conscious feelings of shame if they feel unmasked. Their energies go into efforts to impress others so that the devalued self will not be exposed. Paranoid people, contrastingly, may use denial and projection so powerfully that no sense of shame remains accessible within the self. The energies of the paranoid person are therefore spent on foiling the efforts of those who are seen as bent on shaming and humiliating them. People with narcissistic character structures are afraid of revealing their inadequacies; those with paranoid personalities are afraid of other people's malevolence. This focus on the assumed motives of others rather than on what is happening internally can be, as anyone experienced with paranoid patients can testify, a formidable obstacle to therapy.

Also like narcissistic people, paranoid individuals are vulnerable to envy. Unlike them, they handle it projectively. The degree of anger and intensity they have to manage may account for some of the difference. Resentment and jealousy, sometimes of delusional proportions, darken their lives. These attitudes may be directly projected (the conviction that "others are out to get me because of the things about me that they envy"); more often, they are ancillary to the denial and projection

of other affects and impulses, as when a paranoid husband, oblivious to his own normal fantasies of infidelity, becomes convinced his wife is dangerously attracted to other men. Frequently involved in this kind of jealousy is an unconscious yearning for closeness with a person of the same sex. Because such longings may be unconsciously confused with erotic homosexuality (Karon, 1989), which can frighten heterosexual males, the wishes are abhorred and denied. These desires for care from a man then resurface as the conviction that it is, for example, one's girlfriend rather than oneself who wants to be more intimate with a mutual male friend.

Finally, paranoid people are profoundly burdened with guilt, a feeling that may be unacknowledged and projected in the same way that shame is. Some reasons for their deep sense of badness will be suggested below, along with ways of trying to relieve it therapeutically. Their unbearable burden of unconscious guilt is another feature of their psychology that makes paranoid clients so hard to help: They live in terror that when the therapist *really* gets to know them, he or she will be shocked by all their sins and depravities, and will reject or punish them for their crimes. They are chronically warding off this humiliation, transforming any sense of culpability in the self into dangers that threaten from outside. They unconsciously expect to be found out, and they transform this fear into constant, exhausting efforts to discern the "real" evil intent behind anyone else's behavior toward them.

DEFENSIVE AND ADAPTIVE PROCESSES IN PARANOIA

Projection, and disavowal of what is projected, dominate the psychology of the paranoid person. Depending on the patient's ego strength and degree of stress, the paranoid process may be at a psychotic, borderline, or neurotic level. Let me first review those differences. In a frankly psychotic person, upsetting parts of the self are projected and fully believed to be "out there," no matter how crazy the projections may seem to others. The paranoid schizophrenic who believes that homosexual Bulgarian agents have poisoned his water is projecting his aggression, his wish for same-sex closeness, his ethnocentrism, and his fantasies of power. He does not find ways of making his beliefs fit with conventional notions of reality; he may be quite convinced that he is the only one in the world who sees the threat.

Because reality testing is not lost in people at a borderline level of personality organization, paranoid patients in the borderline range project in such a way that those on whom disowned attitudes are projected are subtly provoked to feel those attitudes. This is projective identifica-

tion: The person tries to get rid of certain feelings, yet retains empathy with them and needs to reassure the self that they are justified. The borderline paranoid person works to make what is projected "fit" the target. Thus the woman who disowns her hatred and envy announces to her therapist in an antagonistic manner that she can tell that the therapist is jealous of her accomplishments; comments made in a sympathetic spirit are reinterpreted by the client as evidence of envy-driven wishes to undermine and control, and soon the therapist, worn down by being steadily misunderstood, is hating the patient and envying her freedom to vent her spleen (Searles, 1959). This remarkable process torments therapists, who do not choose our profession expecting to have to endure such powerful negative feelings toward those we hope to help; it accounts for the general intolerance among many mental health professionals toward both borderline and paranoid patients.

In paranoid people at the neurotic level, internal issues are projected in a potentially ego-alien way. That is, the patient projects yet has some observing part of the self that eventually will be capable, in the context of a reliable relationship, of acknowledging the externalized contents of the mind as projection. People who, in an intake interview, describe themselves as paranoid are often in this category (though borderline and psychotic paranoid clients may sometimes talk this way also, in an effort to show that they know the jargon but without any real internal appreciation that their fears constitute projections). I knew one of my patients was getting better when he came in announcing that he was having fantasies that I was critical, even though he couldn't find any evidence of my critical attitude. Sensitive to the possible grain of truth in a projection, I said something like, "Well, let me think about whether there *is* some way in which I may have been critical," and he responded, "Can't you sometimes just let it be my crazy paranoia?!"

A talented and healthy but characterologically paranoid client of mine was subject to profound fears that I would sell him out in the service of my need to look good to others. If a professional in the community who knew both of us were to criticize him to me, he was sure that I would somehow convey agreement. (Meanwhile, when he felt hurt by me, he had no reluctance to complain about me in ways that made some of my colleagues quite critical of my treatment of him.) Even before he was able to understand this fear as the projection of his own—unnecessarily hated—needs for acceptance and admiration, plus the projection and acting out of his defensive criticism, he was willing to consider that he might be putting on me something that I did not deserve.

The need of the paranoid person to handle upsetting feelings projectively entails the use of an unusual degree of denial and its close relative, reaction formation. All of us project; indeed, the universal

disposition toward projection is the basis for transference, the process that makes analytic therapy possible. But paranoid people do it in the context of such a great need to disavow upsetting attitudes that it feels like a whole different process from projective operations in which denial is not so integral. Freud (1911) accounted for paranoia, at least of the psychotic variety, by the successive unconscious operations of reaction formation ("I don't love you; I hate you") and projection ("I don't hate you; you hate me"). Implicit in this formulation is the paranoid person's terror of experiencing normal loving feelings, presumably because prior attachment relationships were toxic. Freud thought same-sex longing was particularly implicated in paranoia, but my own experience suggests that any kind of longing feels unbearably dangerous to a paranoid person.

Freud's paradigm shows only one of several possible routes by which a paranoid person may emerge at a psychological place very far from the original, more humanly comprehensible attitudes that initiated the paranoid process (Salzman, 1960). Karon (1989) summarizes the ways in which a delusional paranoid person can handle wishes for same-sex closeness:

> If one considers the different ways in which one could contradict the feeling "I love him," one derives many typical delusions. "I do not love him, I love me (megalomania)." "I do not love him, I love her (erotomania)." "I do not love him, she loves him (delusional jealousy)." "I do not love him, he loves me (projecting the same-sex longing, producing a delusional homosexual threat)." "I do not love him, I hate him (reaction formation)." And, finally, most common, projecting the delusional hatred as "He hates me, hence, it is alright for me to hate him (and if I hate him, I do not love him)." (p. 176)

Again, a significant difficulty in working with paranoid people concerns how long and convoluted is the distance between their basic affects and their defensive handling of them.

RELATIONAL PATTERNS IN PARANOID PSYCHOLOGY

Clinical experience suggests that children who grow up paranoid have suffered severe insults to their sense of efficacy; they have repeatedly felt overpowered and humiliated (MacKinnon et al., 2006; Tomkins, 1963; Will, 1961). The father of Daniel Paul Schreber, from whose report of a paranoid psychosis Freud (1911) extracted a theory of paranoia, was reportedly a domineering patriarch who advocated, and insisted on his son's adopting, arduous physical regimes intended to toughen up chil-

dren (Niederland, 1959). Then Schreber suffered humiliation by authorities he had trusted and by the legal system of his era (Lothane, 1992).

Criticism, capricious punishment, adults who cannot be pleased, and utter mortification are common in the backgrounds of paranoid people. Those who rear children who become paranoid also frequently teach by example. A child may observe suspicious, condemnatory attitudes in parents, who emphasize—paradoxically, in view of their abusive qualities and the objectively kinder worlds of school and community—that family members are the only people one can trust. Paranoid people in the borderline and psychotic ranges may come from homes where criticism and ridicule dominated familial relationships, or where one child, the future sufferer of paranoia, was the scapegoat—the target of the family members' hated and projected attributes, especially those in the general category of "weakness." In my experience, those in the neurotic-to-healthy range tend to come from families in which warmth and stability were combined with teasing and sarcasm.

Another source of paranoid personality organization is unmanageable anxiety in a primary caregiver. A paranoid patient of mine came from a family in which the mother was so chronically nervous that she took a thermos of water with her everywhere she went (for her dry mouth) and described her body as having "turned into a cement block" from accumulated tension. Whenever her daughter would come to her with a problem, the mother would either deny it, because she could not bear any additional worries, or catastrophize about it, because she could not contain her anxiety. The mother was also confused about the line between fantasy and behavior and hence conveyed to her child that thoughts equaled deeds. The daughter got the message that her private feelings, whether loving or hateful, had a dangerous power.

For example, when once as an adult my patient told her mother that in reaction to her husband's arbitrariness she had challenged him, her mother first contended she was misreading him: He was a devoted husband, and she must be imagining anything objectionable coming from him. When my patient persisted with an account of the argument, her mother urged her to be careful, as he might beat her up or abandon her if provoked (she herself had been battered and then divorced by her husband). And when my patient went on to vent anger at how he had acted, she was begged to think about something else so that her negative thoughts would not make things worse. An adolescent prototype for this interaction was her telling her mother of her father's effort to molest her. The mother managed both to insist that it had not happened and to blame it on her daughter's sexuality.

This well-meaning but very disturbed mother, who had had no comfort as a youngster, was incapable of comforting. In her daughter's

formative years, her anxiety-soaked advice and dire predictions compounded the girl's fears. My client thus grew up being able to console herself only by drastic transformations of her feelings. When I began working with her, she had already seen several therapists who had been defeated by her bottomless need and relentless hostility. All of them had seen her as paranoid in either the psychotic or low-level borderline range. Her capacity to report transactions like the preceding to me, and to comprehend how destructive similar ones had been all her life, came only after many years of therapy.

One can detect in the preceding example of distorted maternal responsiveness several different seeds of paranoia. First, both reality and the patient's normal emotional reactions to it were disconfirmed, instilling fear and shame rather than a sense of being understood. Second, denial and projection were modeled. Third, primitive omnipotent fantasies were reinforced, laying the foundation for a diffuse and overwhelming guilt. Finally, the interaction created additional anger while resolving none of the original distress, thus magnifying the patient's confusion about basic feelings and perceptions. In situations like this, in which a person has been implicitly insulted (in this case, seen as unappreciative, incapable of managing feelings, dangerous), he or she must at some level feel even more aggravated than originally. But such a reaction may be judged as either incomprehensible or evil because the insulting party was only trying to help.

Such mind-muddling transactions get replicated repeatedly in the adult relationships of paranoid people. Their internalized objects keep undermining both the paranoid person and those to whom he or she relates. If a child's primary source of knowledge is a caregiver who is deeply confused and primitively defended, who—in desperate attempts to feel safe or important—uses words not to express honest feeling but to manipulate, the child's subsequent human relations cannot be unaffected. The struggle of the paranoid person to understand what is "really" going on (D. Shapiro, 1965) is comprehensible in this light, as is the bewilderment, helplessness, and estrangement that beset people dealing with paranoid friends, acquaintances, and relatives.

The mother's anxiety was not the only influence on this woman's psychology, of course. If she had had any significant caregiver capable of relating in a confirmatory way, her personality would probably not have developed in a paranoid direction. But her father, prior to abandoning his family when she was an older teenager, was frighteningly critical, explosive, and disrespectful of boundaries. The tendency of paranoid people to lash out rather than endure the anxiety of passively awaiting inevitable mistreatment ("I'll hit you before you hit me") is another well-known and unfortunate cost of this kind of parenting (Nydes, 1963).

The presence of a frightening parent and the absence of people who can help the child process the resulting feelings (except by making them worse) is, according to many therapists who have successfully mitigated the condition, a common breeding ground for paranoia (MacKinnon et al., 2006).

Because of their orientation toward issues of power and their tendency to act out, paranoid people have some qualities in common with psychopathic ones. But a critical difference lies in their capacity to love. Even though they may be terrified by their own dependent needs and wracked with suspicion about the motives and intentions of those they care about, paranoid individuals are capable of deep attachment and protracted loyalty. However persecutory or inappropriate their childhood caregivers were, paranoid clients apparently had enough availability and consistency in their early lives to be able to attach, albeit anxiously or ambivalently. Their capacity to love is what makes therapy possible in spite of all their hyperreactivity, antagonisms, and terrors.

THE PARANOID SELF

The main polarity in the self-representations of paranoid people is an impotent, humiliated, and despised image of the self versus an omnipotent, vindicated, triumphant one. A tension between these two images suffuses their subjective world. Cruelly, neither position affords any solace: A terror of abuse and contempt goes with the weak side of the polarity, whereas the strong side brings with it the inevitable side effect of psychological power, a crushing guilt.

The weak side of this polarity is evident in the degree of fear with which paranoid people chronically live. They never feel fully safe and spend inordinate energy scanning the environment for dangers. The grandiose side is evident in their "ideas of reference": Everything that happens has something to do with them personally. This is most obvious in psychotic levels of paranoia, instances in which a patient believes, say, that he or she is the personal target of an international spy ring or is receiving covert messages during TV commercials about the incipient end of the world. But I have also heard high-achieving, reality-oriented clients ruminate about whether the fact that someone sat in their usual chair revealed a plot to harass and humiliate them. Incidentally, such clients often do not come across as paranoid in the intake interview, and it can be startling to hear, after several sessions, the emergence of the organizing conviction that everything that happens to them reflects the significance to other people of their personal existence.

The megalomania of paranoid people, whether unconscious or overt, burdens them with unbearable guilt. If I am omnipotent, then all kinds of terrible things are my fault. The intimate connection between guilt and paranoia can be intuitively comprehended by any of us who have felt culpable and then worried about being exposed and punished. I notice that when one of my students is late turning in a paper, he or she avoids me whenever possible, as if the only thing on my mind is that transgression and my planned retribution. A woman I was treating who was having an extramarital affair reported with amusement that while she was on a drive with her lover, holding hands in the car, she noticed a police vehicle ahead and pulled her hand away.

When an unbearable attitude is denied and projected, the consequences can be grave. A connection between paranoia and disavowed homosexual preoccupations has been noted for some time by clinicians (e.g., Searles, 1961) and was confirmed by some empirical studies (e.g., Aronson, 1964) several decades ago. More recently, Adams, Wright, and Lohr (1996) did a series of experiments that showed that the more a man was aroused by homosexual imagery, the more homophobic he tested. Paranoid people, even the minority of them who have acted on homoerotic feelings, may regard the idea of same-sex attraction as upsetting to a degree that is scarcely imaginable to the nonparanoid. To gay and lesbian people, who find it hard to see why their sexual orientation is perceived as so threatening, the homophobia of some paranoid groups is truly menacing.

As the brief triumph of Nazism demonstrates (and Nazism targeted gay people, mentally disabled people, and the Roma, as well as the Jews), when paranoid trends are shared by a whole culture or subculture, the most horrific possibilities arise. Students of the rise of Nazism (e.g., Gay, 1968; Rhodes, 1980; F. Stern, 1961) locate its psychological origins in the same kinds of events that clinicians have found in the childhoods of paranoid individuals. The crushing humiliation of Germany in World War I and the subsequent punitive measures that created runaway inflation, starvation, and panic, with little responsiveness from the international community, laid the groundwork for the appeal of a paranoid leader and the organized paranoia that is Nazism (for a description of the role of paranoia in recent American politics, see Welch, 2008).

At the core of the self-experience of paranoid people is a profound emotional isolation and need for what Sullivan (1953) called "consensual validation" from a "chum" or what Benjamin (1988) later called "recognition." The main way in which paranoid people try to enhance their self-esteem is through exerting effective power against authorities and other people of importance. Experiences of vindication and triumph give them a relieving (although fleeting) sense of both safety and moral

rectitude. The dreaded litigiousness of paranoid individuals derives from this need to challenge and defeat the persecutory parent. Some people with paranoid personalities provide devoted service to victims of oppression and mistreatment, because their disposition to battle unjust authorities and vindicate underdogs keeps them on the barricades far longer than other well-meaning social activists whose psychodynamics do not similarly protect them against burnout.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH PARANOID PATIENTS

Transference in most paranoid patients is swift, intense, and often negative. Occasionally, the therapist is the recipient of projected savior images, but more commonly he or she is seen as potentially disconfirming and humiliating. Paranoid clients approach a psychological evaluation with the expectation that the interviewer is out to feel superior by exposing their badness, or is pursuing some similar agenda that has nothing to do with their well-being. They tend to strike clinicians as grim, humorless, and poised to criticize. They may fix their eyes relentlessly on the therapist in what has been called the "paranoid stare."

Not surprisingly, interviewers respond with a sense of vulnerability and general defensiveness. Countertransference is usually either anxious or hostile; in the less common instance of being regarded as a savior, it may be benevolently grandiose. In any case, the therapist is usually aware of strong reactions, in contrast to the often subtler countertransferences that arise with narcissistic and schizoid patients. Because of the combination of denial and projection that constitute paranoia, causing the repudiated parts of the self to be extruded, therapists of paranoid patients often find themselves consciously feeling the aspect of an emotional reaction that the client has exiled from consciousness. For example, the patient may be full of hostility, whereas the therapist feels the fear against which the hostility is a defense. Or the patient may feel vulnerable and helpless, while the therapist feels sadistic and powerful.

Because of the weight of these internal reactions in the therapist, and the extent to which they betray to a sensitive person the degree of suffering that a paranoid client is trying to manage, there is a countertransference tendency in most therapists to try to "set the patient straight" about the unrealistic nature of whatever danger the patient believes he or she is in. Most of us who have practiced for any length of time have had at least one client who seemed to be crying out for reassurance and yet, upon receiving it, became convinced that we were part of the conspiracy to divert him or her from a terrible threat. The therapist's powerlessness

to give much immediate help to a person who is so unhappy and suspicious is probably the earliest and most intimidating barrier to establishing the kind of relationship that can eventually offer relief.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF PARANOID PERSONALITY

The first challenge a therapist faces with a paranoid patient is creating a solid working alliance. Although establishing such a relationship is necessary (and sometimes challenging) for the successful treatment of any client, it is particularly important in work with paranoid people because of their difficulty trusting. A beginning student of mine, asked about his plan for working with a very paranoid woman, commented, "First I'll get her to trust me. Then I'll work on assertiveness skills." Wrong. When a paranoid person truly trusts the therapist, many years may have passed, and the treatment has been a huge success. But the student was right in one sense: There has to be some initial embrace by the client of the possibility that the therapist is well intentioned and competent. This takes not only considerable forbearance from the therapist, it takes some capacity for comfort talking about the negative transference and conveying that the degree of hatred and suspicion aimed at the clinician is to be expected. The therapist's unflustered acceptance of intense hostility fosters the patient's sense of safety from retribution, mitigates fear that hatred destroys, and exemplifies how aspects of the self that the patient has regarded as evil are simply ordinary human qualities.

This section will be longer than in other chapters because effective work with paranoid clients differs substantially from "standard" psychoanalytic practice. Although it has in common the goals of understanding at the deepest level, bringing into consciousness the unknown aspects of the self, and promoting the most thoroughgoing possible acceptance of one's full humanity, it accomplishes these ends differently. For example, interpretation "from surface to depth" is usually impossible with paranoid clients because so many radical transformations of their original feelings have preceded their manifest preoccupations. A man who longs for support from someone of his gender, who has unconsciously misread that yearning as sexual desire, denied that, projected it on to someone else, displaced it, and become overwhelmed with fears that his wife is having an affair with his friend will not have his real concerns addressed if the therapist simply encourages him to associate freely to the idea of his wife's infidelity.

"Analyzing resistance before content" can be similarly ill fated. Commenting on actions or statements made by a paranoid client only

makes that client feel judged or scrutinized like a laboratory guinea pig (Hammer, 1990). Analysis of the defenses of denial and projection elicits only more Byzantine uses of the same defenses. The conventional aspects of psychoanalytic technique—such as exploring rather than answering questions, bringing up aspects of a patient's behavior that may be expressing an unconscious or withheld feeling, calling attention to slips, and so forth—were designed to increase patients' access to internal material and to support their courage to talk more openly about it (Greenson, 1967). With paranoid people, such practices boomerang. If the standard ways of helping clients to open up elicit only further elaborations of a paranoid sensibility, how can one help?

First, one can call on a sense of humor. Many of my teachers advised against joking with paranoid patients lest they feel teased and ridiculed. This caution is warranted, but it does not rule out the therapist's modeling an attitude of self-mockery, amusement at the world's irrationalities, and other nonbelittling forms of wit. Humor is indispensable in therapy—perhaps especially with paranoid clients—because jokes are a time-honored way to discharge aggression safely. Nothing relieves both patient and therapist more than glimpses of light behind the gloomy stormcloud that surrounds a paranoid person. The best way to set the stage for mutual enjoyment of humor is to laugh at one's own foibles, pretensions, and mistakes. Paranoid people miss nothing; no defect in the therapist is safe from their scrutiny. A friend of mine claims to have perfected the "nose yawn," a priceless asset to the conduct of psychotherapy, but I would bet my couch that even he could not fool a good paranoid.

The woman whose history I described earlier in this chapter has never failed to notice my yawning, no matter how immobile my face. I reacted to her initial confrontations about this with apologetic admissions that she had found me out again, and with whining self-pity about not being able to get away with anything in her presence. This kind of reaction, rather than the heavy, humorless exploration of what her fantasy was when she thought I was yawning, has deepened our work together. Naturally, one stands ready to apologize if one's wit is mistaken for ridicule, but the idea that work with hypersensitive patients must be conducted in an atmosphere of oppressive seriousness seems to me unnecessarily fussy and somewhat patronizing. Especially after a reliable alliance has been established, something that may take months or years, judicious teasing, in an effort to make omnipotent fantasies ego alien, can be helpful to a paranoid person. Jule Nydes (1963), who had a gift for working with difficult clients, cites the following interventions:

> One patient ... was convinced that his plane would crash while en route to a well earned vacation in Europe. He was startled and relieved when I

> remarked, "Do you think God is so merciless that He would sacrifice the lives of a hundred other people simply to get at you?"
>
> Another such example is that of a young woman ... who developed strong paranoid fears shortly before her forthcoming marriage which she unconsciously experienced as an outstanding triumph. This was at the time the "mad bomber" was planting his lethal weapons in subway cars. She was certain that she would be destroyed by a bomb, and so she avoided the subway. "Aren't you afraid of the 'mad bomber'?" she asked me. And then before I could reply she sneered, "Of course not. You ride only in taxicabs." I assured her that I rode the subways and that I was unafraid for the very good reason that I knew the "mad bomber" was out to get her, not me. (p. 71)

Hammer (1990), who stresses the importance of indirect, face-saving ways of sharing insights with paranoid patients, recommends the following joke as a way to interpret the drawbacks of projection:

> A man goes toward his neighbor's house to borrow a lawnmower, thinking how nice his friend is to extend him such favors. As he walks along, however, doubts concerning the loan begin to gnaw at him. Maybe the neighbor would rather not lend it. By the time he arrives, the doubts have given way to rage, and as the friend appears at the door the man shouts, "You know what you can do with your damn lawnmower; shove it!" (p. 142)

Humor, especially willingness to laugh at oneself, is probably therapeutic in that to the patient it represents being "real," rather than playing a role and pursuing a secret game plan. The histories of paranoid people may be so bereft of basic authenticity that the therapist's direct emotional honesty comes as a revelation about how people can relate to each other. With some reservations cited below, having to do with maintaining clear boundaries, I recommend being quite forthcoming with paranoid clients. This means responding to their questions honestly rather than withholding answers and investigating the thoughts behind the inquiry; it is my experience that when the manifest content of a paranoid person's concern is respectfully addressed, he or she becomes more rather than less willing to look at the latent concerns represented in it.

Second, one can "go under" or "sidestep" or "do an end run around" (depending on one's favored metaphor) the complex paranoid defense and into the affects against which it has been erected. In the case of the man consumed with ruminations about his wife's possible infidelity, one could be helpful by commenting on how lonely and unsupported he seems to feel. It is startling to see how fast a paranoid rant can disappear if the therapist simply lets it run its course, avoiding all temptations to deconstruct a convoluted defensive process, and then engages empathi-

cally with the disowned, projected feelings from which the angry preoccupation originally sprang.

Often the best clue to the feeling being defended against is one's countertransference; paranoid people are usefully imagined as actually projecting their unacknowledged attitudes physically into the therapist. Thus, when the patient is in an unrelenting, righteous, powerful rage, and the therapist feels resultingly threatened and helpless, it may be deeply affirming for the client to be told, "I know that what you're in touch with is how angry you are, but I sense that in addition to that anger, you're coping with profound feelings of fear and helplessness." Even if one is wrong, the client hears that the therapist wants to understand what is creating such severe upset.

Third, one can frequently help patients suffering from an increase in paranoid reactions by identifying what has happened in their recent experience to upset them. Such triggers often involve separation (a child has started school, a friend has moved away, a parent has not answered a letter), failure, or—paradoxically—success (failures are humiliating; successes involve omnipotent guilt and fears of envious attack). One of my patients tends to go on long paranoid tirades, during which I can usually figure out what he is reacting to only after 20 or 30 minutes. If I assiduously avoid confronting his paranoid operations and instead comment on how he may be underestimating how bothered he is by something that he mentioned in passing, his paranoia tends to lift without any analysis of that process at all. Educating people to notice their states of arousal and to look for triggers often preempts the paranoid process altogether. And I have found that especially if one can tap into underlying grief and bear gentle witness to the client's pain, paranoia may evaporate.

One should usually avoid direct confrontation of the content of a paranoid idea. Paranoid people are acutely perceptive about emotion and attitude; where they get mixed up is on the level of interpretation of the meaning of these manifestations (Josephs & Josephs, 1986; Meissner, 1978; D. Shapiro, 1965; Sullivan, 1953). When one challenges their interpretations, they tend to believe that one is telling them they are crazy for having seen what they saw, rather than suggesting that they have misconstrued its implications. Hence, although it is tempting to offer alternative interpretations, if one does this too readily, the patient feels dismissed, disparaged, and robbed of the astute perceptions that stimulated the paranoid interpretation.

When a paranoid client is brave enough to ask outright whether the clinician agrees with his or her understanding of something, the therapist can offer other interpretive possibilities with suitable tentativeness ("I can see why you thought the man intended to cut you off, but another

possibility is that he'd had a fight with his boss and would have been driving like a maniac no matter who was on the road"). Note that the therapist in this example has not substituted a more benevolent motive for the paranoid person's self-referential one ("perhaps he was swerving to avoid hitting an animal") because if paranoid people think one is trying to pretty up intentions that they know are debased, they will get more anxious. Note also that the comment is made in the tone of a throwaway line, so that the patient can either take it or leave it. With paranoid patients one should avoid asking them to explicitly accept or reject the therapist's ideas. From their perspective, acceptance may equal a humiliating submission, and rejection may invite retribution.

Fourth, one can make repeated distinctions between thoughts and actions, holding up the most heinous fantasies as examples of the remarkable, admirable, creative perversity of human nature. The therapist's capacity to feel pleasure in hostility, greed, lust, and similar less-than-stellar tendencies without acting them out helps the patient to reduce fears of an out-of-control, evil core. Lloyd Silverman (1984) stressed the general value of going beyond interpretation of feelings and fantasies to the recommendation that one *enjoy* them, a particularly important dimension of work with paranoid people. Sometimes without this aspect of treatment, patients get the idea that the purpose of therapy is to get them to expose such feelings and be humiliated, or to help them purge themselves of them, rather than to embrace them together as part of the human condition.

When my older daughter was about 3, a nursery school teacher promulgated the idea that virtue involves "thinking good thoughts and doing good deeds." This troubled her. She was relieved when I commented that I disagreed with her teacher and felt that thinking bad thoughts is a lot of fun, especially when one can do good deeds in spite of those thoughts. For months afterward, especially when she was trying not to abuse her infant sister, she would get a mischievous expression on her face and announce, "I'm doing good deeds and thinking very bad thoughts!" Although she was a much quicker study than a person with a lifetime of confusion about fantasy and reality, what I was trying to teach her is the same message that is healing to paranoid clients.

Fifth, one must be hyperattentive to boundaries. Whereas one might sometimes lend a book or spontaneously admire a new hairstyle with another kind of patient, such behaviors are rife with complication when enacted with a paranoid person. Paranoid clients are perpetually worried that the therapist will step out of role and use them for some end unrelated to their psychological needs. Even those who develop intensely idealizing transferences and insist that they want a "real" friendship with

the therapist—perhaps especially these clients—may react with terror if one acts in a way that seems uncharacteristically self-extending.

Consistency is critical to a paranoid person's sense of security; inconsistency stimulates fantasies that wishes have too much power. Exactly what the individual therapist's boundaries are (e.g., how missed sessions or phone calls to the therapist's home are handled) matters less than how reliably they are observed. It is much more therapeutic for a paranoid person to rage and grieve about the limits of the relationship than to worry that the therapist can actually be seduced or frightened out of his or her customary stance. While a surprising deviation that speaks for the therapist's caring can light a spark of hope for a depressive person, it may ignite a blaze of anxiety in a paranoid patient.

On this topic, I should mention the risk of pseudoerotic transference storms in paranoid clients. Same-sex therapists may have to be even more carefully professional than opposite-sex ones, on account of the vulnerability of many paranoid people to homosexual panic, but both may find themselves suddenly the target of an intense sexualized hunger or rage. The combination of extreme psychological deprivation and cognitive confusion (affection with sex, thoughts with action, inside with outside) often produces erotized misunderstandings and fears. The best the therapist can do is to restore the therapeutic frame, tolerate the outburst, normalize the feelings behind the eruption, and differentiate between those feelings and the behavioral limits that make psychotherapy possible.

Finally, it is critical that one convey both personal strength and unequivocal frankness to paranoid clients. Because they are so full of hostile and aggressive strivings, so confused about where thoughts leave off and actions begin, and so plagued with feelings of destructive omnipotence, their greatest worry in a therapy relationship is that their evil inner processes will injure or destroy the therapist. They need to know that the person treating them is stronger than their fantasies. Sometimes what matters more than what is said to a paranoid person is how confidently, forthrightly, and fearlessly the therapist delivers the message.

Most people who have written about the actual experience of treating paranoid people (as opposed to the much larger literature theorizing about the origins of paranoid processes) have stressed respect, integrity, tact, and patience (Arieti, 1961; Fromm-Reichmann, 1950; Hammer, 1990; Karon, 1989; MacKinnon et al., 2006; Searles, 1965). Some, especially those who have worked with psychotic clients, have recommended joining in the patient's view of reality, in order to create enough affirmation that the patient can start shedding the paranoid constructions that

therapist and client now seem to share (Lindner, 1955; Spotnitz, 1969). Most writers, however, feel one can convey respect for the client's view of the world without going that far.

Because of their excruciating sensitivity to insult and threat, it is not possible to treat paranoid patients without some debacles. Periodically, the therapist will be made into a monster (Reichbart, 2010), as the client makes what Sullivan (1953) called "malevolent transformations" and suddenly experiences the therapist as dangerous or corrupt. Sometimes the therapy work seems like an endless exercise in damage control. In the short run, one has to tolerate a protracted feeling of standing alone, since people with paranoid psychologies are not inclined to confirm, by verbal acknowledgment or visible appreciation, one's exertions in the service of understanding. But a devoted, reasonably humble, honest practitioner can make a radical difference over the years with a paranoid person, and will find beneath all the client's rage and indignation a deep well of warmth and gratitude.

DIFFERENTIAL DIAGNOSIS

The diagnosis of paranoid personality structure is usually easy to make, except, as noted previously, in instances in which a person is high functioning and trying to keep the extent of his or her paranoia hidden from the interviewer. As with schizoid clients, attention to the possibility of psychotic processes in a manifestly paranoid patient is warranted.

Paranoid versus Psychopathic Personality

In Chapter 7 I commented on the differential importance of guilt as a central dynamic in the respective psychologies of paranoid and antisocial people. I should also mention love. If a paranoid person feels that you and he or she share basic values, and that you can be counted upon in adversity, there is virtually no limit to the loyalty and generosity of which the person may be capable. Projective processes are common in antisocial people, but where psychopaths are fundamentally unempathic, paranoid people are deeply object related. The main threat to long-term attachment in paranoid people is not lack of feeling for others but rather experiences of betrayal; in fact, they are capable of cutting off a relationship of 30-years' duration when they feel wronged. Because they connect with others on the basis of similar moral sensibilities and hence feel that they and their love objects are united in an appreciation of what is good and right, any perceived moral failing by the person with whom they are identified feels like a flaw in the self that must be eradicated by banish-

ing the offending object. But a history of aborted relationships is not the same thing as an inability to love.

Paranoid versus Obsessive Personality

Obsessive people share with paranoid individuals a sensitivity to issues of justice and rules, a rigidity and denial around the "softer" emotions, a preoccupation with issues of control, a vulnerability to shame, and a penchant for righteous indignation. They also scrutinize details and may misunderstand the big picture because of their fixation on minutia. Further, obsessional people in the process of decompensating into psychosis may slide gradually from irrational obsessions into paranoid delusions. Many people have both paranoid and obsessional features.

People in these respective diagnostic categories differ, however, in the role of humiliation in their histories and sensitivities; the obsessive person is afraid of being controlled but lacks the paranoid person's fear of physical harm and emotional mortification. Obsessive patients are more likely to try to cooperate with the interviewer despite their oppositional qualities, and therapists working with them do not suffer the degree of anxiety that paranoid patients induce. Standard psychoanalytic technique is usually helpful to obsessive clients; rage reactions to conventional clarifications and interpretations in a patient one has believed to be obsessional may be the first sign that his or her paranoid qualities predominate.

Paranoid versus Dissociative Psychology

Many people with dissociative identity disorder have an alter personality that carries the paranoia for the personality system and may impress an interviewer as representative of the whole person. Because emotional mistreatment is implicated in the etiologies of both paranoia and dissociation, the coexistence in individual people of these processes is common. In Chapter 15 I discuss the diagnosis of dissociative disorders thoroughly enough that it will be clear how to discriminate an individual with a paranoid personality from a dissociative person with a paranoid alter personality or paranoid tendencies.

SUMMARY

I have described the manifest and latent qualities of people whose personalities are predominantly paranoid, stressing their reliance on projection. Possible etiological variables include innate aggressiveness or irri-

tability, and consequent susceptibilities to fear, shame, envy, and guilt. I considered the role of formative experiences of threat, humiliation, and projective processes in the family system, and anxiety-ridden, contradictory messages in the development of this type of personality organization, and I described the paranoid person's sense of self as alternately helplessly vulnerable and omnipotently destructive, with ancillary preoccupations resulting from a core fragility in identity and self-esteem. Finally, I discussed the intensity of transference and countertransference processes, especially those involving rage.

I recommended that therapists of paranoid patients demonstrate a good-humored acceptance of self and an amused appreciation of human foibles; work with affect and process rather than defense and content; identify specific precipitants of symptomatic upset, avoiding frontal assaults on paranoid interpretations of experience; distinguish between ideas and actions; preserve boundaries; and convey attitudes of personal power, authenticity, and respect. Finally, I differentiated people with predominantly paranoid psychologies from those with psychopathic, obsessive, and dissociative types of personality organization.

SUGGESTIONS FOR FURTHER READING

The most comprehensive book on paranoia may be Meissner's *The Paranoid Process* (1978). But D. Shapiro's (1965) chapter on the paranoid style is better written, shorter, and livelier. Much recent psychoanalytic writing on paranoia has addressed social justice issues or commented on political phenomena, as paranoia is central to the process by which groups achieve cohesion by exploiting fears of other groups. The journal *Psychoanalytic Review* recently devoted an interesting issue (2010, vol. 97[2]) to this topic, in which I have an essay.

11

Depressive and Manic Personalities

In this chapter I discuss people with character patterns shaped by depressive dynamics. I also address briefly the psychologies of those whose personalities are characterized by the denial of depression; that is, those who have been called manic, hypomanic, and cyclothymic. Whereas people in the latter diagnostic groups approach life with strategies antithetical to those used unconsciously by depressive people, the basic organizing themes, expectations, wishes, fears, conflicts, and unconscious explanatory constructs of depressive and manic people are similar. Many people experience alternating manic and depressive states of mind; those with psychotic-level conditions used to be described as having a "manic–depressive" illness, a term that implied delusion and suicidality. Yet many people who never become psychotic or suicidal undergo marked cycles of mania and dysthymia. Currently, they tend to be diagnosed as bipolar.

Individuals who are mainly depressive, those who are mainly manic, and those who swing from one pole to the other all exist at every point on the severity continuum. Although Kernberg (1975) considers hypomanic personality disorder to be a definitionally borderline condition because it reflects the primitive defense of denial, this observation applies only to instances when a person's character is problematic enough to be seen as a personality *disorder* rather than just a personality *type*. I have known people with core hypomanic dynamics whose denial exists alongside too integrated an identity and too keen a self-observing capacity to be considered borderline.

DEPRESSIVE PERSONALITIES

A serious impediment to our collective understanding of depressive psychology arose when the formulators of DSM-III elected to put all depressive and manic conditions under the heading of Mood Disorders (see Frances & Cooper, 1981; Kernberg, 1984). With this decision, they privileged the affective aspects of dysthymic states over the imaginal, cognitive, behavioral, and sensory components that are equally important in the phenomenology of depression. They also dispensed with the clinically and empirically long-established diagnosis of depressive personality disorder and diverted us from attending to the internal processes that characterize depressive people even when they are not in a clinically depressed state. I was recently told that every member of the work group who made this call had some connection with a drug company. I do not think they were corrupt people, but such involvements raise the question of unconscious influence on putatively "scientific" decisions. Pharmaceutical companies generally prefer to construe mental suffering in terms of discrete disorders rather than as longstanding personality patterns that are notoriously unresponsive to pharmacology.

A clinical depression is pretty unmistakable. Many of us have had the bad luck to have suffered the unremitting sadness, lack of energy, anhedonia (inability to enjoy ordinary pleasures), and vegetative disturbances (problems in eating, sleeping, and self-regulating) that characterize the disorder. Freud (1917a) was the first writer to compare and contrast depressive ("melancholic") conditions with normal mourning; he observed that the significant difference between the two states is that in ordinary grief, the external world is experienced as diminished in some important way (e.g., it has lost a valuable person), whereas in depression, what feels lost or damaged is a part of the self. Grief tends to come in waves; between the episodes of acute pain when one is reminded of a loss, one can function almost normally, whereas depression is relentless and deadening. The mourning process ends in slow recovery of mood, whereas depression can go on and on.

In some ways, then, depression is the opposite of mourning; people who grieve normally tend not to get depressed, even though they can be overwhelmingly sad during the period that follows bereavement or loss. The cognitive, affective, imaginal, and sensory processes that are so striking in a clinical depression operate in a subtle, chronic, organizing, self-perpetuating way in the psyches of those of us with depressive personalities (Laughlin, 1956, 1967). Given the intended audience of this book, the phrase "those of us" may be apposite, since it appears

that a substantial proportion of psychotherapists are characterologically depressive (Hyde, 2009). We empathize with sadness, we understand wounds to self-esteem, we seek closeness and resist loss, and we ascribe our therapeutic successes to our patients' efforts and our failures to our personal limitations.

Greenson (1967), commenting on the connection between a depressive sensibility and the qualities of successful therapists, went so far as to argue that analysts who have not suffered a serious depression may be handicapped in their work as healers. Greenson might reasonably have considered himself an exemplar of someone at the healthy end of the depressive continuum, along with more visibly anguished historical figures like Abraham Lincoln. At the highly disturbed end of the spectrum one finds the delusional and ruthlessly self-hating mental patients who, until the discovery of antidepressive medicines, could absorb years of a devoted therapist's efforts and still believe uncritically that the best way to save the world is to destroy the self.

Since writing the first edition of this book I have become more familiar with Sidney Blatt's work (Blatt, 2004, 2008; Blatt & Bers, 1993) on subtypes within the depressive spectrum. In brief, Blatt has studied the different internal experiences and different therapeutic needs of people who formulate their depressive state as "I'm not good enough, I'm flawed, I'm self-indulgent, I'm evil" (the "introjective" version) versus those whose subjective world feels like "I'm empty, I'm hungry, I'm lonely, I need a connection" (the "anaclitic" version, from the Greek word for "to lean on"). In the 1994 edition, this chapter assumed a more introjective version of depressive psychology; I think I implicitly construed the more anaclitic version as a dependent personality style or disorder. In this rewriting I have tried to accommodate both subtypes, especially in the section on therapy.

When he examined those polarities beyond the depressive realm, Blatt (2008) renamed them as "self-definition" and "self-in-relationship" inclinations. We all have both self-definitional and relational needs, and one aspect of overall mental health is surely having some balance between the two. But just as people with narcissistic personalities, despite both devaluing others and craving their attention, tilt toward either the more arrogant (self-definition) or depleted (self-in-relationship) pole, depressive people tend to lean more one way than the other. Members of the Personality Task Force for the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006) discovered that where there is longstanding clinical lore about personality subtypes, those subtypes map nicely onto Blatt's polarity. His differentiation will come up again in later chapters.

DRIVE, AFFECT, AND TEMPERAMENT IN DEPRESSION

That one can inherit a vulnerability to depression has long been suggested by studies of family histories, twins, and adoptees (Rice et al., 1987; Wender et al., 1986). Depression clearly runs in families, although no one can yet confidently evaluate the extent to which the transmission of depressive tendencies is genetically determined versus the extent to which depressed parents behave in ways that set up their children for dysthymic reactions. Research with other mammals has identified patterns of reaction to early maternal loss or rejection that look identical to depression in humans (Panksepp, 2001). That a prototype for loss and its accompanying affect, cognition, and bodily experience could be set down in one's youngest days, could then permanently affect one's brain function, and could then be reenacted with one's children because of how one's brain got structured suggests that what may look simply genetic may be more complex.

Freud (1917a) speculated, and Abraham (1924) subsequently elaborated, that an important precursor to depressive states is the experience of premature loss. In line with the classical theory that people who are either overindulged or deprived become fixated at the infantile stage when this happened, depressive individuals were initially understood as having been weaned too soon or too abruptly, or as having suffered some other early frustration that overwhelmed their capacities to adapt (see Fenichel, 1945). The "oral" qualities of people with depressive characters influenced this construction; it was noted that depressive people were often overweight, that they usually liked eating, smoking, drinking, talking, kissing, and other oral gratifications, and that they tended to describe their emotional experience in analogies about food and hunger. The idea that depressive people are orally fixated has not completely disappeared, probably more because of the intuitive appeal of such a formulation than because of its theoretical status. When one of my supervisors commented that I see everybody as hungry, thus confronting my tendency to project my depressive issues on all my clients, I was able to start discriminating between those who needed to be emotionally fed and those who needed to be asked why they had not learned to cook.

An early psychodynamic way of describing a depressive process, and one that has been thoroughly popularized, illustrates the application of drive theory to specific clinical problems. Freud (1917a) noted that people in depressed states aim negative affect away from others and toward the self, hating themselves out of all proportion to their actual shortcomings. At a time when psychological motivation was translated

into libido and aggression, this phenomenon was described as "sadism (aggression) against the self" or as "anger turned inward." Because of its clinical promise, this formulation was embraced eagerly by Freud's colleagues, who began trying to help their patients to identify things that had angered them so that the pathological process could be reversed. It fell to later theorists to explain why a person would have learned to turn angry reactions against the self and what functions would be served by maintaining such a pattern.

The aggression-inward model is consistent with observations that depressive people seldom feel spontaneous or unconflicted anger on their own behalf. Instead, especially if their version of depressive personality is more introjective, they feel guilt. Not the denied, defensively reinterpreted guilt of the paranoid person, but a partly conscious, ego-syntonic, pervasive sense of culpability. Author William Goldman once quipped to an interviewer, "When I'm accused of a crime I didn't commit, I wonder why I have forgotten it." Depressive people are agonizingly aware of every sin they have committed, every kindness they have neglected to extend, every selfish inclination that has crossed their minds.

Sadness, the dominant feeling in anaclitic depressives, is the other major affect of people with a depressive psychology. Evil and injustice distress them but rarely produce in them the indignant anger of the paranoid, the moralization of the obsessive, the undoing of the compulsive, or the anxiety of the hysterical person. The sorrow of someone who is clinically depressed is so palpable and arresting that in the public mind—and evidently now in the professional mind as well—the terms "sadness" and "depression" have become virtually synonymous (Horowitz & Wakefield, 2007). Since many people who are free of dysthymic symptoms have depressive personalities, and since grief and depression are in at least one respect mutually exclusive conditions, this equation is misleading; yet even a psychologically robust, high-spirited person with a depressive character will convey to a perceptive listener the hint of an inner melancholy.

Monica McGoldrick's (2005) brilliant depiction of the Irish, a group famous for having a song in the heart and a tear in the eye, captures the ambience of a whole ethnic subculture with a depressive soul. Unless they are so disturbed that they cannot function normally, most depressive people are easy to like and admire. Because they aim hatred and criticism inward rather than outward, they are usually generous, sensitive, and compassionate to a fault. Because they give others the benefit of any doubt, and strive to preserve relationships at any cost, they are natural appreciators of therapy. In a later section I discuss how to prevent these appealing qualities from working to their detriment.

DEFENSIVE AND ADAPTIVE PROCESSES IN DEPRESSION

The most powerful and organizing defense used by introjectively depressive people is, not surprisingly, introjection. Clinically, it is the most important operation to understand in order to reduce their suffering and modify their depressive tendencies. As psychoanalytic clinical theory developed, simpler energic concepts (aggression-in vs. aggression-out) yielded to reflections on the internalization processes that Freud had begun to describe in "Mourning and Melancholia" (1917a) and that Abraham (1911) had noted as the depressive person's "identification with the lost love object." As analysts began emphasizing the importance of incorporative processes in depression (Bibring, 1953; Blatt, 1974; Jacobson, 1971; Klein, 1940; Rado, 1928), they added immeasurably to our therapeutic power in the face of depressive misery.

In working with introjectively depressive patients, one can practically hear the internalized object speaking. When a client says something like, "It must be because I'm selfish," a therapist can ask, "Who's saying that?" and be told, "My mother" (or father, or grandparent, or older sibling, or whoever is the introjected critic). Often the therapist feels as if he or she is talking to a ghost, and as if therapy, to be effective, will have to include an exorcism. As this example shows, the kind of introjection that characterizes depressive people is the unconscious internalization of the more hateful qualities of an old love object. That person's positive attributes are generally remembered fondly, whereas negative ones are felt as part of the self (Klein, 1940).

As I noted in Chapter 2, the internalized object does not have to be a person who in reality was hostile, critical, or negligent (though this is often the case, and it encumbers therapy with extra challenges) for the patient to have experienced the object that way and internalized such images. A young boy who feels deserted by a father who deeply loves him—perhaps he suddenly had to work two jobs to make ends meet or was deployed to a war zone or was hospitalized for a serious illness—will feel hostility over his abandonment but will also yearn for him and feel self-rebuke for not having appreciated him sufficiently when he was around. Children project their reactions onto love objects who desert them, imagining that they left feeling angry or hurt. Then such images of a malevolent or injured abandoner, because they are too painful to bear and because they interfere with hopes for a loving reunion, are driven out of awareness and felt as a bad part of the self.

A child may thus emerge from experiences of traumatic or premature loss with an idealization of the lost object and a relegation of all negative affect into his or her sense of self. These well-known depressive dynamics create a pervasive feeling that one is bad, has driven away

a needed and benevolent person, and must work very hard to prevent one's badness from provoking future desertions. The reader can see that this formulation is not inconsistent with the older anger-inward model; in fact, it accounts for why someone could get into the habit of handling hostile feelings in precisely this way. If one emerges from painful separations believing that it is one's badness that drove the beloved objects away, one may try very hard to feel nothing but positive affects toward those who are loved. The resistance of depressive people toward acknowledging ordinary and natural hostility and criticism is comprehensible in this context, as is the upsetting and much-remarked phenomenon of the person who stays with an inconsiderate or abusive partner, believing that if only he or she were somehow good enough, the partner's mistreatment would stop.

Turning against the self (A. Freud, 1936; Laughlin, 1967), a related defense mechanism in introjectively depressive people, is a less archaic outcome of these dynamics. Introjection as a concept covers the more total experience of feeling incomplete without the object and taking that object into one's sense of self in order to feel whole, even if that means taking into one's self-representation the sense of badness that comes from painful experiences with the object. Turning against the self gains a reduction in anxiety, especially separation anxiety (if one believes it is one's anger and criticism that ensure abandonment, one feels safer directing it against the self), and also maintains a sense of power (if the badness inheres in me, I can change this disturbing situation).

Children are existentially dependent. If those on whom they must depend are unreliable or badly intentioned, they have a choice between accepting that reality or denying it. If they accept it, they may generalize that life is empty, meaningless, and uninfluenceable, and they are left with a chronic sense of incompleteness, emptiness, longing, futility, and existential despair. This is the anaclitic version of depressive suffering. If instead they deny that those they must depend upon are untrustworthy (because they cannot bear living in fear), they may decide that the source of their unhappiness lies within themselves, thereby preserving hope that self-improvement can alter their circumstances. If only they can become good enough, can rise above the selfish, destructive person they know themselves to be, life will get better (Fairbairn, 1943). This is the introjective dyanmic. Clinical experience attests resoundingly to the human propensity to prefer the most irrational guilt to an admission of impotence. The introjective depressive person feels bad but powerful in that badness, whereas the anaclitically depressed person feels victimized, powerless, and passive.

Idealization is the other defense important to note in depressive patients. Because their self-esteem has been damaged by the effects of

their experiences (either by feeling chronically empty or feeling secretly bad), the admiration with which they view others is correspondingly increased. Self-perpetuating cycles of holding others in excessively high regard, then feeling diminished in comparison, then seeking idealized objects to compensate for the diminution, feeling inferior to those objects, and so on, are typical for depressive people. This idealization differs from that of narcissistic people in that it constellates around moral concerns rather than status and power.

RELATIONAL PATTERNS IN DEPRESSIVE PSYCHOLOGY

The above section on ego processes suggests some important themes in the object relations of depressive patients. First, there is the role of early and/or repeated loss. The striking affective correspondences between depression and mourning have prompted theorists at least as far back as Freud to look for the origins of dysthymic dynamics in painful, premature experiences of separation from a love object. And such experiences are usually easy to find in the histories of depressive clients. Early loss is not always concrete, observable, and empirically verifiable (e.g., death of a parent); it may be more internal and psychological, as in the case of a child who yields to pressure to renounce dependent behaviors before he or she is emotionally ready to do so.

Erna Furman's (1982) deceptively modest essay "Mothers Have to Be There to Be Left" explores this second kind of loss. In a respectful but trenchant critique of classical ideas about the mother's responsibility to wean infants when they are ready to accept the loss of a need-gratifying object, Furman stressed that unless they are hurried, children wean themselves. The striving for independence is as primary and powerful as the wish to depend; separation is naturally sought by youngsters who are confident of the availability of the parent if they need to regress and "refuel" (Mahler, 1972a, 1972b). Furman's recasting of the separation process in terms of the child's natural movement forward challenges a persistent Western notion (reflected in older psychoanalytic thinking and in many popular books on child rearing) that parents must titrate frustrations because left to themselves, youngsters will prefer regressive satisfactions.

According to Furman (1982), it is ordinarily the mother, not the baby, who feels keenly the loss of a gratifying instinctual satisfaction at weaning—and by analogy at other times of separation. Along with her pleasure and pride in her child's growing autonomy, she suffers some pangs of grief. Normal children appreciate these pangs; they expect their parents to shed a tear on the first day of school, at the first prom, at

graduation. The separation–individuation process eventuates in depressive dynamics, Furman believed, only when the mother's pain about her child's growth is so great that she either clings and induces guilt ("I'll be so lonely without you") or pushes the child away defensively ("Why can't you play by yourself?!"). Children in the former situation are left feeling that normal wishes to be aggressive and independent are hurtful; in the latter, they learn to hate their natural dependent needs. Either way, an important part of the self is experienced as bad.

Not just early loss but conditions that make it difficult for the child to understand realistically what happened, and to grieve normally, may engender depressive tendencies. One such condition is developmental. Two-year-olds are simply too young to fathom fully that people die, and why they die, and are incapable of appreciating complex interpersonal motives such as "Daddy loves you, but he is moving out because he and Mommy don't get along." The world of the 2-year-old is still magical and categorical. At the height of conceiving things in gross categories of good and bad, the toddler whose parent disappears may generate assumptions about badness that are impossible to counteract, even with reasonable educative comments. A major loss in the separation–individuation phase virtually guarantees some depressive dynamics.

Other circumstances include family members' neglect of their children's needs when they are beset by difficulties and their ignorance of the degree to which children require explanations that counteract their self-referential and moralistic interpretations. Judith Wallerstein's long-term research on the outcome of divorce (Wallerstein & Blakeslee, 1989; Wallerstein & Lewis, 2004) has demonstrated that along with lack of abandonment by the noncustodial parent, the best predictor of a nondepressive adaptation to parental divorce is the child's having been given an age-appropriate, accurate explanation of what went wrong in the marriage.

Another circumstance that encourages depressive tendencies is a family atmosphere in which mourning is discouraged. When parents and other caregivers model the denial of grief, or insist (e.g., after an acrimonious divorce) that the child join in a family myth that everyone is better off without the lost object, or need the child to reassure them that he or she is not in pain, mourning can go underground and eventually take the form of the belief that there is something wrong in the self. Sometimes children feel intense, unspoken pressures from an emotionally overburdened parent to protect the adult from further grief, as if acknowledging sorrow were equivalent to falling apart. The child naturally concludes that grief is dangerous and that needs for comfort are destructive.

Sometimes in a family system the prevailing morality is that mourning and other forms of self-care and self-comfort are "selfish" or "self-

indulgent," or "just feeling sorry for yourself," as if such activities were prima facie contemptible. Guilt induction of this sort, and associated admonishments to a stricken child to stop whining and get over it, instill both a need to hide any vulnerable aspects of the self and, out of identification with the critical parent, an eventual hatred of those aspects of oneself. Many of my depressive patients were called names whenever they could not control their natural regressive reactions to family difficulties; as adults, they abused themselves psychologically in parallel ways whenever they were upset.

The combination of emotional or actual abandonment with parental criticism is particularly likely to create depressive dynamics. A patient of mine lost her mother to cancer when she was 11 and was left with a father who repeatedly complained that her unhappiness was aggravating his ulcer and hastening his death. Another client was called a sniveling baby by her mother when she cried because, at age 4, she was being shipped away to overnight camp for several weeks. A depressive man I worked with whose mother was severely depressed and unavailable emotionally during his early years was told that he was selfish and insensitive for wanting her time, and that he should be grateful she was not sending him to an orphanage. In such instances it is easy to see that angry reactions to emotional abuse by the parent would have felt too dangerous to the child, who already feared rejection.

Some depressive patients I have worked with appear to have been the most emotionally astute person in their family of origin. Their reactivity to upsetting situations that other family members handled by denial got them branded "hypersensitive" or "overreactive," labels they continued to carry internally and to connect with their general sense of inferiority. Alice Miller (1975) described how families can unwittingly exploit the emotional talent of a particular child, with the result that he or she eventually feels valued only for serving a particular family function. If the child is also scorned and pathologized for the possession of emotional gifts, depressive dynamics will be even stronger than if he or she is simply used as a kind of family therapist.

Finally, a powerful causative factor in depressive dynamics is significant depression in a parent, especially in a child's earliest years. A seriously depressed mother with no one to help out will give a baby only the most custodial kind of care, no matter how sincerely she wishes to help it start life on the best possible footing. The more we learn about infants, the more we know about how critical their earliest experience is in establishing their basic attitudes and expectations (Beebe et al., 2010; Cassidy & Shaver, 2010; M. Lewis & Haviland-Jones, 2004; D. N. Stern, 2000). Children are deeply bothered by a parent's depression; they feel guilty for making normal demands, and they come to believe that their

needs drain and exhaust others. In general, the earlier their dependence on someone who is deeply depressed, the greater is their emotional privation.

Numerous different pathways can thus lead to a depressive accommodation. Both loving and hateful families can breed depressive dynamics out of infinitely varied combinations of loss and insufficient psychological processing of that loss. In a society where adults fail to make enough time to listen sensitively to the concerns of children, where people move their residence routinely, where family breakups are common, and where painful emotions can be ignored because drugs will counteract them, it is not surprising that our rates of youthful depression and suicide have skyrocketed, that counterdepressive compulsions like prescription drug abuse, obesity, and gambling are on the rise, that we are seeing an explosion of popular movements in which the "lost child" or the "child within" is rediscovered, and that self-help groups that reduce feelings of isolation and fault are widely sought. Human beings seem not to have been designed to handle as much instability in their relationships as contemporary life provides.

THE DEPRESSIVE SELF

People with introjective depressive psychologies believe that at bottom they are bad. They lament their greed, their selfishness, their competition, their vanity, their pride, their anger, their envy, their lust. They consider all these normal aspects of experience to be perverse and dangerous. They worry that they are inherently destructive. These anxieties can take a more or less oral tone ("I'm afraid my hunger will destroy others"), or an anal-level one ("My defiance and sadism are dangerous"), or a more oedipal dimension ("My wishes to compete for and win love are evil").

Depressive people have made sense out of their experiences of unmourned losses by the belief that it was something in them that drove the object away. The fact that they felt rejected has been converted into the unconscious conviction that they deserved rejection, that their faults provoked it, and that future rejection is inevitable if anyone comes to know them intimately. They try very hard to be "good," but they fear being exposed as sinful and discarded as unworthy. One of my patients became convinced at one point that I would refuse to see her again after hearing about her childhood death wishes toward a younger sibling. She, like many sophisticated psychotherapy clients today, knew at the conscious level that such wishes are an expectable part of the psychology of the displaced child, yet in her deeper experience she was still awaiting condemnation.

The guilt of the introjectively depressive person is at times unfathomable. Some guilt is simply part of the human condition, and is appropriate to our complex and not entirely benign natures, but depressive guilt has a certain magnificent conceit. In someone with a psychotic depression it can emerge as the conviction that some disaster was caused by one's sinfulness—police departments are accustomed to delusional depressives calling up to claim responsibility for highly publicized crimes they could not possibly have committed—but even in expansive, high-functioning adults with a depressive character structure similar ideas will emerge in psychotherapy. "Bad things happen to me because I deserve them" may be a consistent underlying theme. Introjective depressive clients may even have a paradoxical kind of self-esteem based on the grandiose idea that "No one is as bad as I am."

Because of their readiness to believe the worst about themselves, they can be very thin-skinned. Criticism may devastate them; in any message that includes mention of their shortcomings they tend to hear only that part of the communication. When criticism is intended constructively, as in an evaluation at work, they may feel so exposed and wounded that they miss or minimize any complimentary facets of the report. When they are subject to genuinely mean-spirited attacks, they are incapable of seeing beyond any grains of truth in the content to the fact that no one deserves to be treated abusively, no matter how legitimate are the persecutor's complaints.

Introjectively depressive people often handle their unconscious dynamics by helping others, by philanthropic activity, or by contributions to social progress that have the effect of counteracting their guilt. It is one of the great ironies of life that it is the most realistically benevolent people who seem most vulnerable to feelings of moral inferiority. Many individuals with depressive personalities are able to maintain a stable sense of self-esteem and avoid depressive episodes by doing good. In researching characterological altruism (McWilliams, 1984), I found that the only times my charitable subjects had experienced depression were when circumstances had made it temporarily impossible for them to carry on their humanitarian activities.

Psychotherapists, as previously noted, often have significant introjective dynamics. They seek opportunities to help others so that their unconscious anxieties about their destructiveness will be kept at bay. Since it is hard to help people psychologically, at least as fast as we would all wish, and since we cannot avoid inflicting temporary pain on patients in the service of their growth or when we simply make a mistake, feelings of exaggerated responsibility and disproportionate self-criticism are common in beginning therapists. Supervisors can confirm how often such dynamics get in the way of their trainees' learning of

their craft. One of my depressive patients, a therapist, responded to any setback with a client, especially if it provoked negative feelings in her, with a search for her own role in the problem—to such a degree that she ignored opportunities to learn about the ordinary vicissitudes of working with that particular kind of patient. The fact that therapy is a two-person process, where intersubjectivity is a given, was converted by her into a quest for self-purification and a terror that she was somehow basically unsuited to helping people.

Parenthetically, I think training to be a therapist tends to create depression even if one lacks powerful introjective and anaclitic dynamics. In the program where I teach, I have noticed that most students go through a depressive period some time around their second year. Graduate training can be a breeding ground for dysthymic reactions, since one has the worst of both adult and child roles (one is expected to be responsible, autonomous, and original, but one has no power; one is dependent on one's "elders" in the field, yet with no accompanying protection and comfort). Training in therapy additionally confronts people with the fact that learning an art is very different from mastering a content area. Students who come to our program as stars in their prior roles find the transition to self-exposure and critical feedback on their work to be emotionally jarring.

So far I have talked mostly about the introjectively depressive self. Anaclitically depressive individuals experience themselves not so much as actively bad; they see themselves as chronically inadequate and longing, but destined to a life of disappointment. They are more likely to suffer shame (because no one wants them) than to react with guilt that they get love they feel they do not deserve. They may view their yearning for closeness without self-hatred but still see it as futile. They may try to talk the therapist into sharing their view that "life sucks and then you die," because anything better than that is not in their future, and they would feel unbearable envy if they were to imagine other possibilities. One of my patients told me she couldn't stand my tendency to frame issues as problems to be solved; the closest she had come in her history to feeling connected with friends and relatives was via a "misery loves company" bemoaning of how fate had treated them. Any effort to change what was fated threatened the sweetness of their mutual lamentation.

Women seem more at risk of depressive solutions to emotional problems than men. In the 1970s and 1980s, feminist theorists (e.g., Chodorow, 1978, 1989; Gilligan, 1982; J. B. Miller, 1984; Surrey, 1985) accounted for this phenomenon by reference to the fact that in most families, the primary caregiver is female. Male children consequently attain a sense of gender identity from being different from the mother, and females derive it from identification with her. An outcome of this imbal-

ance in early parenting is that men use introjection less, as their masculinity is confirmed by separation rather than by fusion, and women use it more, because their sense of femaleness comes from connection. When feeling internally empty, men may be more likely to use denial and to behave counterdependently than to experience themselves anaclitically as needy and longing.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH DEPRESSIVE PATIENTS

Depressive clients are often easy to love. They attach quickly, ascribe benevolence to the therapist's aims even when fearing criticism, are moved by empathic responsiveness, work hard to be "good" in the patient role, and appreciate bits of insight as if they were morsels of life-sustaining food. They tend to idealize the clinician (as morally good, in contrast to their subjective badness, or as filling their internal emptiness), but not in the emotionally unconnected way typical of more narcissistically structured patients. Depressive people are highly respectful of the therapist's status as a separate, real, and caring human being, and they try hard not to be burdensome.

At the same time, introjectively depressive people project on to the therapist their internal critics, voices that have variously been conceptualized in the psychoanalytic literature as a harsh, sadistic, or primitive superego (Abraham, 1924; Freud, 1917a; Klein, 1940; Rado, 1928; Schneider, 1950). It can be startling to see a patient writhe in miserable anticipation of disapproval when confessing some minor crime of thought. Depressive clients are subject to the chronic belief that the therapist's concern and respect would vanish if he or she *really* knew them. This belief can persist over months and years, even in the face of their having volunteered every negative thing they can think of about themselves, and having encountered only steadfast acceptance.

Anaclitically depressive individuals are more likely to feel initially comfortable in treatment. Blatt (2004) found that their pleasure in having a therapist's warm, noncritical attention had immediate positive effects, including reduction of their depressive symptoms. This makes intuitive sense: If my internal experience of depression is that I am desperate for a warm attachment, and I get one from a therapist, I may feel better immediately. Anaclitically depressive people are more likely to develop a benign idealization and to assume that a therapist is taking care of them. Difficulties in the transference and countertransference tend not to arise until the therapist begins confronting the client about making real-world changes.

As introjectively depressive patients progress in therapy, they project their hostile attitudes less and experience them more directly as anger and criticism toward the therapist. At this point in treatment, their negativity may take the form of comments that they do not really expect to be helped and that nothing the therapist is doing is making a difference. It is important to tolerate this phase without taking their criticisms too personally, and to console oneself that in the process, they are getting out from under all the self-directed complaining that was previously keeping them unhappy. As anaclitically oriented clients progress, they tend to get critical, too, because they have to confront the painful fact that even though they now have a warm connection, there are things they have to work on. I have noticed that the more their complaints are welcomed, the more likely they are afterward to take positions on their own behalf outside the treatment room.

State-of-the-art psychopharmacology now enables us to work with depressive people at all levels of disturbance and to analyze depressive dynamics even in psychotic clients. Before the discovery of the antidepressive properties of lithium and other chemicals, many patients with borderline and psychotic structure were so firmly convinced of their badness, so sure of the therapist's inevitable hatred of them, or so despairing of real devotion, that they could not tolerate the pain of attachment. Sometimes they would commit suicide after years of treatment because they could not bear to start feeling hope and thereby risk another devastating disappointment.

Healthier introjective clients tend to be easy to work with because their convictions about their basic flaws are mostly unconscious and are ego alien when brought into awareness. People who are more troubled may need medication to reduce the intensity of their depressive feelings and convictions. The ruthless, implacable states of self-loathing by which borderline and psychotic depressive people can be possessed are infrequent in medicated patients. It is as if their depressive dynamics have been made chemically ego dystonic. The shadows of self-hatred that remain after they are established on an appropriate medication can then be addressed as one would analyze pathological introjects with neurotic-level depressive people.

Healthier anaclitic clients are also easy to work with, though their underlying passivity can be irritating. At borderline and psychotic levels, they can be very difficult because their sense that the therapist should simply fix things for them can be deeply ego syntonic, and the experience of being medicated reinforces their sense that help has to come from outside because their internal resources are completely inadequate.

Countertransference with depressive individuals runs the gamut from benign affection to omnipotent rescue fantasies, depending upon

the severity of the depressive issues. Such reactions constitute a complementary countertransference (Racker, 1968); the therapeutic fantasy is that one can be God, or the "Good Mother," or the sensitive, accepting parent that the client never had. These longings can be understood as a response to the patient's unconscious belief that the cure for depressive dynamics is unconditional love and total understanding. (There is a lot of truth in this idea, but as I will spell out shortly, it is also dangerously incomplete.)

There is also a concordant countertransference familiar to therapists of depressive patients: One can feel incompetent, blundering, damaging, "not good enough" (the introjective elements) or hopeless, incompetent, demoralized, and futile (the anaclitic elements). Depressive attitudes are contagious. I first became aware of this when I was working in a mental health center and (naively) scheduled four severely depressed people in a row. By the time I came shambling to the office coffee pot after the fourth session, the clinic secretaries were offering me chicken soup and a shoulder to cry on. One can easily conclude during work with depressive people that one is simply an inadequate therapist. These feelings can be mitigated if one is fortunate enough to have plentiful sources of emotional gratification in one's personal life (see Fromm-Reichmann, 1950; McWilliams, 2004). They also tend to diminish over one's professional lifetime as it becomes incontrovertible that one has succeeded in helping even relentlessly depressive patients.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF DEPRESSIVE PERSONALITY

The most important condition of therapy with a depressed or depressively organized person is an atmosphere of acceptance, respect, and compassionate efforts to understand. Most writings about therapy—whether they express a general humanistic stance, a psychodynamic orientation, or a cognitive-behavioral preference—emphasize a style of relatedness that is particularly adapted to the treatment of depressive clients. Although a basic tenet of this book is that this generic attitude is insufficient to the task of therapy for some diagnostic groups (e.g., psychopathic and paranoid), I want to stress how critical it is to helping depressive people. Because they have radar for the slightest verification of their fears of criticism and/or rejection, a therapist working with depressive patients must take special pains to be nonjudgmental and emotionally constant.

With introjectively depressive clients, addressing undercurrent presumptions about inevitable rejection, including understanding counter-

active efforts to be "good" in order to forestall it, constitutes much of the work. Blatt and Zuroff (2005) discovered, in an analysis of data collected for an ambitious National Institute of Mental Health (NIMH) study of major depression, that improvement in the introjective patients was centrally related to the therapist's addressing the patient's presumed internal beliefs about badness and its role in any losses they had had. Whether the clinician came at the topic from a cognitive perspective (as in Beck's [e.g., 1995] focus on "irrational cognitions") or from a psychodynamic one (as in the control–mastery emphasis on "pathogenic beliefs"), the critical issue was to expose and challenge the person's implicit thoughts.

For higher-functioning introjective patients, the famous analytic couch is useful because it brings such themes quickly into focus. A woman I treated (who had no overt depressive symptoms but whose character was depressively organized) was an expert at reading my expressions. When we worked face to face, she so rapidly disconfirmed expectations that I was critical and rejecting that she was not even aware she had had such apprehensions. Neither was I; she was so skilled at this monitoring that my usual mindfulness of someone's searching gaze was not aroused. When her decision to use the couch deprived her of eye contact, she was amazed to find herself suddenly hesitant to talk about certain topics because of the conviction that I would not approve of her. When the couch is not an option, there are ways of sitting and talking that minimize opportunities for visual search so that clients can get in touch with how chronic and automatic is their vigilance.

In the case of anaclitic patients, Blatt and Zuroff (2005) found that they got better quite quickly in therapy almost no matter what they talked about with their therapists. Not surprisingly, given that their experience of depression centered on the need to attach, as soon as they felt safely connected with a caring person, their symptoms diminished. The bad news with this group was that when the relatively brief therapy covered by the NIMH study ended, they became symptomatic again. This finding suggests that therapy with anaclitically depressed clients may have to be long term or at least open ended in order to avoid recreating a situation in which they make an attachment and then lose it prematurely under circumstances beyond their control. It takes time to internalize the therapist's presence as a reliable positive inner voice.

Since short therapies are often presented by insurance companies or clinics as the treatment of choice, patients whose only option is brief treatment may conclude that they are sicker than they thought. The assumption that "this obviously works for other patients but not for a bottomless pit like me" will undermine self-esteem even if the therapy temporarily improves the person's mood. In working with depressive cli-

ents under conditions that force termination, it is especially important to predict preemptively the patient's expectable interpretation of the meaning of the loss. Treatments that are arbitrarily limited to a certain number of sessions may provide welcome comfort during a painful episode of clinical depression, but the time-limited experience may be ultimately assimilated unconsciously by the depressive person as another relationship that was traumatically cut short—further evidence that the patient is a failure in maintaining attachments.

Effective therapy with either anaclitic or introjective depressive patients in the borderline and psychotic ranges may require a particularly long period of building a safe alliance with a real, visible, emotionally responsive person. Their presumptions of their unlovability and terrors of rejection are so profound and ego syntonic that without the freedom to scrutinize the therapist's face and invalidate their worst fears, they are apt to be too anxious to talk freely. The therapist may have to log a great deal of time demonstrating acceptance before even the conscious expectations of rejection in a depressive client can become open to scrutiny and eventual invalidation.

It is critical with depressive patients of both types to explore and interpret their reactions to separation, even to the separation of brief silence from the therapist. (Long silences should be avoided; they arouse the feelings of being uninteresting, valueless, adrift, hopeless.) Depressive people are deeply sensitive to abandonment and are unhappy being alone. More important, they may experience loss—usually unconsciously, but especially those introjectively depressive people with psychotic tendencies, sometimes consciously—as evidence of their badness or inadequacy. "You must be going away because you're disgusted with me," or "You're leaving to escape my insatiable hunger," or "You're taking off to punish me for my sinfulness" are all variants on the depressive theme of basic unlovability. Hence it is critical not only to be attuned to how bothersome ordinary losses are to a depressive patient—this will come up naturally in anticipation of the therapist's vacations or when the therapist cancels a session—but also to how the client interprets them.

While basic nonjudgmental acceptance is a necessary condition of therapy with a depressive person, it is not a sufficient one, especially with introjective individuals. I have noted in beginning therapists treating depressive clients a tendency to avoid taking vacations or imposing cancellations that are not rescheduled out of a wish to spare the patient unnecessary pain. Most of us in the field probably started out being neurotically flexible and generous in an effort to protect our depressive patients from suffering. But what depressive people really need is not uninterrupted care. What they need is the experience that the therapist

returns after a separation. They need to know that their anger at being abandoned did not destroy the relationship and that their hunger did not permanently alienate the therapist. One cannot learn these lessons without enduring a loss in the first place.

On being encouraged to get in touch with negative feelings, depressive patients may protest that they cannot take the risk of noticing hostility toward the therapist: "How can I get angry at someone I need so much?" It is important not to join in this elliptical thinking. (Unfortunately, because their dynamics are similar to those of the patient, therapists with depressive sensibilities may regard such remarks as making perfect sense.) One can point out that the question contains the unexamined assumption that anger drives people apart. It may come as a revelation to depressive individuals that the freedom to admit negative feelings increases intimacy, unlike being false or out of touch. Anger interferes with normal dependency only if the person one is depending upon has pathological reactions to it—a circumstance that defines the childhood experience of many depressive clients but not the possibilities for adult relationships.

Therapists often find that their efforts to improve their depressive patients' self-esteem are either ignored or received paradoxically. Supportive comments to a person immersed in self-loathing may provoke increased depression, via the internal transformation: "Anyone who *really* knew me could not possibly say such positive things. I must have duped this therapist into thinking I am okay. I'm bad for misleading such a nice person. And I can't trust support from this direction because this therapist is easily fooled." Hammer (1990) is fond of quoting Groucho Marx here, who used to insist that he would not be interested in joining any club that would have him for a member.

If support backfires, as it almost always will, especially with introjective clients, what can one do to improve the self-esteem of a depressive person? The ego psychologists had a useful prescription: Don't support the ego; attack the superego. If a man is berating himself for the crime of envying a friend's success, and the therapist responds that envy is a normal emotion, and that especially since the patient did not act it out, he might congratulate himself rather than running himself down, the patient may respond with silent skepticism. But if the therapist says, "So what's so terrible about that?" or teases him for trying to be purer than God, or tells him good-naturedly to "Join the human race!" the patient may be able to take the message in. When interpretations are put in a critical tone, they are more easily tolerated by depressive people ("If she's criticizing me, there must be some truth in what she says, since I know I'm bad in some way"), even when what is being criticized is a critical introject.

Another aspect of sensitive treatment of depressive patients is the therapist's willingness to appreciate, as achievements, behaviors that would signify resistance in other clients. For example, many therapy patients express their negative reactions to treatment by canceling sessions or failing to bring a check. Depressive people work so hard to be good that they are usually exemplary in the patient role—so much so that their compliant behavior may be legitimately considered part of their pathology. One can make small dents in a depressive mentality by interpreting a client's cancellation or temporary nonpayment as a triumph over the fear that the therapist will retaliate at the slightest sign of opposition. One is tempted with excessively cooperative patients just to relax and appreciate one's luck, but if a depressive person never behaves in adversarial or selfish ways in treatment, the therapist should bring that pattern up as worthy of investigation.

Overall, therapists of characterologically depressive patients must accept and even welcome the client's removing their halo. It is nice to be idealized, but it is not in the patient's best interest. Therapists in the earliest days of the psychoanalytic movement knew that it signified progress when a depressed patient became critical or angry or disappointed with the clinician; while they understood this more or less hydraulically (angry energy turned outward instead of inward), contemporary analysts appreciate it from the standpoint of self-valuation. Depressive patients need eventually to leave the "one-down" position and to see the therapist as an ordinary, flawed human being. Retaining idealization inherently retains an inferior self-image.

Finally, where circumstances permit, it is more important with depressive patients than with others to leave decisions about termination up to them. It is also advisable to leave an open door for further treatment and to analyze ahead of time any inhibitions the client may have about asking for help in the future (one often hears that coming back for a psychological "tune-up" would be admitting defeat, or that the therapist might be disappointed with a less than complete "cure"). Since the causes of a depressive sensibility so frequently include irreversible separations—which forced the growing child to cut all ties and suppress all regressive longings, instead of feeling secure in the availability of an understanding parent—the termination phase with depressive patients must be handled with special care and flexibility.

DIFFERENTIAL DIAGNOSIS

The two dispositions most commonly confused with depressive psychology are narcissism (the depleted version) and masochism. It is my

impression that misdiagnoses are more often made in the direction of construing as depressive someone who is more basically either narcissistic or masochistic than in the direction of misunderstanding an essentially depressive person as either of the others. The tendency of therapists to misread a narcissistic or masochistic patient as depressive seems to me attributable to two factors. First, depressively inclined therapists may project their own dynamics onto people whose core internal story is different. Second, people with either narcissistic or masochistic personality structure frequently have symptoms of clinical depression, especially dysthymic mood. Either misreading can have unfortunate clinical consequences.

Depressive versus Narcissistic Personality

In Chapter 8 I described people with depressed–depleted forms of narcissistic personality. There is some overlap between people with this psychology and people with the anaclitic version of depressed dynamics. As there are no clean boundaries in personality differences, many of us have both tendencies. The more narcissistic person is subjectively less hungry, however, less valuing of relationship, and defends more against shame than the anaclitically depressive person, who may also express feelings of emptiness, meaninglessness, and existential despair. The subjective *sense* of emptiness of the anaclitic depressive is not the same thing as the therapist's inference of an *actual* emptiness at the core of the self in narcissistic clients. Narcissistically depressed people tend to have self-object transferences, whereas those with depressive character have object transferences. Countertransference with the former tends to be vague, irritated, affectively shallow; with the latter it is much clearer, warmer, and more powerful, usually involving rescue fantasies.

Explicitly sympathetic, encouraging reactions can be comforting to a narcissistically organized person, but to whatever extent a depressive person has introjective dynamics, they may be demoralizing. Because self-attack is not central to the narcissistic dynamism, attacking the presumed superego—even in gentle ways such as commenting on possible self-reproach—will not likely help a person whose basic structure is narcissistic. Interpretations that redefine affective experience in the direction of anger rather than more passive emotional responses will similarly fizzle with narcissistic patients because anger is not a core affect state for them. Such interpretive efforts may, however, relieve and even energize introjective clients, whose responsiveness can make the old anger-in-versus-anger-out formulations look uncannily apt.

Interpretive reconstructions that emphasize critical parents and injurious separations will generally fall on deaf ears with narcissistic clients,

no matter how depressed they are, because rejection and trauma are not the main internal narrative in narcissistic dynamics. But they may be gratefully received by depressive patients as an alternative to their long-standing habit of attributing all their pain to their personal shortcomings. With a narcissistic person, attempts to work "in the transference" may be shrugged off, belittled, or absorbed into an overall idealization, but a depressive patient will appreciate the traditional approach and make good use of it.

The difference between introjectively depressive and narcissistically depressed individuals, even though their observable symptoms may be the same, comes down to the metaphorical understanding of narcissistic clients as pathologically empty and depressive ones as pathologically filled with hostile introjects. Therapy must be tailored to these contrasting subjective worlds.

Depressive versus Masochistic Personality

Depressive and self-defeating (masochistic) patterns are closely connected, since both orientations may be adaptations to unconscious guilt. They coexist so frequently, in fact, that Kernberg (e.g., 1984), in acknowledgment of Laughlin's (1967) seminal observations, considers the "depressive–masochistic personality" to be one of three common neurotic-level kinds of character organization. In spite of their frequent coexistence and synergism, I prefer to differentiate carefully between depressive and masochistic psychologies. An organizing principle of this text has been to attend to those differences among people that have an established conceptual status in the psychoanalytic tradition and that have significant implications for psychotherapy technique. In Chapter 12 I explore the differences between predominantly depressive and predominantly masochistic personalities and elaborate on the implications of those differences for treatment.

HYPOMANIC (CYCLOTHYMIC) PERSONALITIES

Mania is the flip side of depression. People with hypomanic personalities have a fundamentally depressive organization, counteracted by the defense of denial. Because most people with manic tendencies suffer from episodes in which their denial fails and their depression surfaces, the term "cyclothymic" has sometimes been used to describe their psychology. In the second edition of the DSM (DSM-II; American Psychiatric Association, 1968), both depressive and cyclothymic personality disorders were accepted diagnoses.

Hypomania is not a state that simply contrasts with depression; point for point, it is a mirror image of it. The hypomanic individual is elated, energetic, self-promoting, witty, and grandiose. Akhtar (1992) describes the individual with hypomanic personality disorder as follows:

> The individual with hypomanic personality is overtly cheerful, highly social, given to idealization of others, work-addicted, flirtatious, and articulate, while covertly guilty about aggression toward others, incapable of being alone, defective in empathy, unable to love, corruptible, and lacking a systematic approach in his cognitive style. (p. 193)

Many individuals with characterological hypomania, however, have more mild versions than the personality *disorder* Akhtar is describing, and are able to love and to behave with integrity.

People in a manic state or with a manic personality are famous for grand schemes, racing thoughts, and extended freedom from ordinary physical requirements, such as food and sleep. They seem constantly "up"—until exhaustion eventually sets in. Because the person experiencing mania literally cannot slow down, drugs like alcohol, barbiturates, and opiates that depress the central nervous system may be highly attractive. Many comics and humorists appear to have hypomanic personalities; their relentless wit can sometimes be quite wearing. Sometimes the dysthymic side of a very funny person is more visible, as with Mark Twain, Ambrose Bierce, Lenny Bruce, or Robin Williams, all of whom suffered serious depressive episodes.

DRIVE, AFFECT, AND TEMPERAMENT IN MANIA

People with hypomanic psychologies are notable for high energy, excitement, mobility, distractibility, and sociability. They are often great entertainers, storytellers, punsters, mimics—treasures to their friends, who nevertheless sometimes complain that because they turn all serious remarks into occasions for humor, they are hard to get close to emotionally. When negative affect appears in people with manic and hypomanic psychologies, it tends to manifest itself not as sorrow and disappointment, but as anger, sometimes in the form of episodes of sudden, uncontrolled rage.

Like their counterparts in the depressive realm, they have struck psychoanalytic observers as organized along oral lines (Fenichel, 1945): They may talk nonstop, drink recklessly, bite their nails, chew gum, smoke, gnaw on the insides of their mouth. Especially at the disturbed end of the manic continuum, many are overweight. Their perpetual

motion suggests considerable anxiety, despite their often markedly elevated mood. The delight they display and, by contagion, bestow, has a somewhat fragile, undependable quality; their acquaintances often harbor worries about their stability. Whereas exhilaration is a familiar condition for hypomanic individuals, a calm serenity or a Lacanian *jouissance* may be completely outside their experience (Akiskal, 1984).

DEFENSIVE AND ADAPTIVE PROCESSES IN MANIA

The core defenses of manic and hypomanic people are denial and acting out. Denial is conspicuous in their tendency to ignore (or to transform into humor) events that would distress or alarm others. Acting out often takes the form of flight: They run from situations that might threaten them with loss. They may escape painful affects by sexualization, intoxication, provocation, and even acts that appear psychopathic, such as theft; hence, some analysts have questioned the stability of the reality principle in manic clients (Katan, 1953). Manic people also devalue, a process isomorphic with the depressive tendency to idealize, especially when they contemplate making loving attachments that they fear will disappoint.

For a manic person, anything that distracts is preferable to emotional suffering. Those with severe personality disorders and those in a temporarily psychotic state may also use the defense of omnipotent control; they may feel invulnerable, immortal, convinced of the assured success of some grandiose scheme. Acts of impulsive exhibitionism, rape (usually of a spouse or intimate), and authoritarian control are not unknown during a manic psychotic break.

RELATIONAL PATTERNS IN MANIC PSYCHOLOGY

In the histories of hypomanic people, perhaps even more strikingly than in those of depressive individuals, one finds a pattern of repeated traumatic separations with no opportunity for the child to process them emotionally. Deaths of important people who went unmourned, divorces and separations that no one addressed, and family relocations for which there was no preparation litter their childhoods. One hypomanic man I worked with had moved 26 times during his first 10 years; more than once he arrived home after school to find the moving van in the driveway.

Criticism and abuse, emotional and sometimes physical, are also common in the backgrounds of manic and hypomanic individuals. I

have already discussed this combination of traumatic separation and emotional neglect and mistreatment as it applies to depressive outcomes; it may be that in the histories of manic people the losses were more extreme, or that attention to their emotional significance by the child's caregivers was even scarcer than it is in the backgrounds of depressive people. Otherwise it is hard to explain the need for a defense as extreme as denial.

THE MANIC SELF

One of my hypomanic patients described herself as a spinning top. She was keenly aware of her need to keep moving lest she feel something painful. People with a hypomanic pattern are frightened of attachment, because to care about someone means that losing that person will be devastating. The manic continuum from psychotic to neurotic structure loads more heavily in the borderline and psychotic areas because of the primitivity of the processes involved; a consequence of this is that many hypomanic and cyclothymic people are at risk of the subjective experience of self-disintegration that self psychologists refer to as fragmentation. It is as if they fear that if they do not keep moving, they will fall apart. Often they come to therapy right after a depressive experience of profound self-fragmentation, when their manic defenses failed.

Self-esteem in hypomanic people may be maintained, somewhat tenuously, by a combination of success at avoiding pain and elation at captivating others. Some individuals with manic defenses are masterful at attaching other people to themselves emotionally without reciprocating an investment of comparable depth. Because they are often brilliant and witty, their friends and colleagues—especially those holding the common but fallacious belief that intelligence and severe psychopathology are mutually exclusive—can be nonplussed to learn of their psychological vulnerabilities. Suicide attempts and flagrantly psychotic behavior can suddenly invade a manic fortress if some loss becomes too painful to deny.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH MANIC PATIENTS

Manic clients can be winsome, insightful, and fascinating. They also tend to be confusing and exhausting. Once while working with a hypomanic young woman, I became aware of the fantasy that my head was in a clothes dryer, the kind in the laundromat that whirl garments in full

view but too fast to track. Sometimes in an initial interview one is aware of a nagging feeling that with such a turbulent history, the patient should be showing more emotionality in recounting it. At other times one is aware of somehow not being able to put all the pieces together.

Perhaps the most dangerous countertransference tendency in therapists working with hypomanic people is underestimating the degree of suffering and potential disorganization that lies beneath their engaging presentation. What may appear to be a congenial observing ego and a reliable working alliance may be manic denial and defensive charm. More than one therapist has been shocked by the results of projective testing with an appealing hypomanic client; the Rorschach often picks up a level of psychopathology that no one on the intake team suspected.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF HYPOMANIC PERSONALITY

One's primary concern with a hypomanic patient must be the prevention of flight. Unless the therapist discusses this in an early session, interpreting the person's defensive need to escape from meaningful attachments (which will be evident from the history) and contracting with the client to remain for a certain period after feeling the impulse to bolt, there will be no therapy because there will be no patient. One can do this as follows:

> "I notice that every important relationship in your life has been disrupted abruptly, usually at your initiative. There's no reason why that won't also happen in this relationship—especially because in therapy so many painful things get stirred up. When life gets painful, your pattern is to flee. I want you to make a deal with me up front that no matter how reasonable it seems, if you suddenly decide to break off your therapy at any point, you'll come back for at least six more sessions [or any other number that seems reasonable or can be negotiated], so that we can understand in depth your decision to go and have a chance to process the ending in an emotionally appropriate way."

This may be the first time the patient has been confronted with the fact that there is an emotionally appropriate way to end relationships; that is, one has to deal with grief and other expectable feelings that surround endings. A constant focus on the denial of grief and negative emotions in general should inform the therapy work. Most analysts (e.g., Kernberg, 1975) have considered the prognosis for hypomanic patients to be guarded at best, even when the therapist takes every precaution to prevent flight, because of these clients' extreme difficulties tolerating

grief. Sometimes more manifestly "sick" manic patients are easier to help, because the degree of their psychological discomfort supports their motivation to stay in treatment.

With more disturbed manic patients, as with more seriously ill depressive ones, psychotropic medicine has been a godsend. Current psychiatric sophistication makes it possible to adjust type and dosage of medication to the specific needs of the patient; the days when lithium was the only effective drug for mania are long gone. I have found it important, however, to be sure that the prescribing physician takes a careful, individualized approach to each patient; clients with manic tendencies are as variable as anyone else and often have idiosyncratic physical sensitivities, addictions, and allergies. A dependable relationship with their physician as well as their psychotherapist, and a mutually supportive relationship between these practitioners, supports their recovery. Contrary to some conventional wisdom, psychotherapy is valuable and effective with manic patients; without it, they fail to work through their experiences of ungrieved loss and to learn how to love with less fear. They also stop taking their medicine.

Healthier hypomanic people tend to come to therapy later in life, when their energies and drives have lessened, and when they can see clearly in retrospect how fragmented and unsatisfying their histories are. They sometimes come for individual help after a long stint of work on an addiction in a 12-step program, when their self-destructiveness has lessened and they want to make sense of their life. Like narcissistic clients of the grandiose type, with whom they share some defensive patterns, older hypomanic people are sometimes easier to help than their younger counterparts (Kernberg, 1984). But they still need to contract against premature flight. The dearth of literature on the psychotherapeutic treatment of hypomanic personalities may reflect the fact that many therapists learn the hard way that they should have made such an agreement.

Some considerations applicable to the treatment of paranoid patients also apply to hypomanic ones. Frequently one must "go under" a defense; for example, aggressively confronting denial and naming what is denied rather than inviting the patient to explore this intrinsically rigid, inflexible defense. The therapist must be strong and devoted. He or she should interpret upward, educating the hypomanic person about normal negative affect and its lack of catastrophic effects.

Because of manic terrors of grief and self-fragmentation, therapy must move slowly. The clinician who demonstrates deliberateness offers a spinning client a different model of how to live in the world of feelings. Treatment should also be conducted in an especially forthright tone. In their efforts to avoid psychic pain, most hypomanic people have learned

to say whatever works. Emotional authenticity may be a struggle for them. The therapist must therefore inquire periodically whether they are telling the truth, as opposed to explaining away, entertaining, or temporizing. Like paranoid people, hypomanic clients need a therapist who is active and incisive, and who is notably lacking in cant, hypocrisy, and self-deception.

DIFFERENTIAL DIAGNOSIS

I noted the main obstacle to identification of hypomanic clients in the section on transference and countertransference: Therapists may misperceive these initially appealing people as having more mature defenses, more ego strength, and better identity integration than they do, a mistake that may alienate a sensitive hypomanic person after only one interview. Manically organized clients outside the psychotic range are most commonly diagnosed as hysterical, narcissistic, or compulsive, or as having attention-deficit disorder (ADD). Those with psychotic symptoms are most frequently misunderstood as schizophrenic.

Hypomanic versus Hysterical Personality

Because of their charm, their seeming capacity to engage warmly, and their apparent insightfulness, hypomanic clients, especially women, can be misunderstood as hysterical. This error risks losing the patient quickly, since the therapeutic style that helps people with hysterical organization may make the hypomanic person feel insufficiently "held" and only superficially understood. The unconscious conviction that anyone who seems to like them has been duped exists in manically structured people just as in introjectively depressive ones; it will issue in devaluation of and flight from the therapist unless addressed directly in ways that would be contraindicated with a hysterically structured patient. Evidence of abruptly ended relationships with people of both sexes, a history of traumatic and unmourned losses, and absence of the hysterical person's concern with gender and power are some of the areas that differentiate hypomanic from hysterical people.

Hypomanic versus Narcissistic Personality

Because grandiosity is a central feature of manic functioning, it is easy to misconstrue a hypomanic or cyclothymic person as the more grandiose kind of narcissistic patient—again, in remarkable parallel to confusions between depressive patients and the depressed–depleted type of narcissistic person. A good history should highlight the disparity; narcissisti-

cally structured people lack the turbulent, driven, catastrophically fragmented backgrounds of most hypomanic clients.

The intrapsychic difference is between inner emptiness in the narcissistic person and the presence of savagely negative introjects—managed by denial—in the hypomanic one. Although an arrogant narcissistic person can be difficult to treat, and resists attachment in many ways, the threat of immediate flight is less severe. Misconstruing a hypomanic individual as narcissistic can thus cost one a patient. The two groups have an affinity, however, in that both become more accessible therapeutically when older; moreover, analysts who understand grandiose narcissism in introjective terms (e.g., Kernberg, 1975) advocate a similar approach to each type of client.

Hypomanic versus Compulsive Personality

The driven qualities of the hypomanic person invite comparison with characterological compulsivity. Both compulsive and hypomanic people are ambitious and demanding, and on this basis, they have sometimes been compared (Akiskal, 1984; Cohen, Baker, Cohen, Fromm-Reichmann, & Weigart, 1954). Their similarities are mostly superficial, however. Akhtar (1992), contrasting the hypomanic person with the compulsive client (whom he construes, following Kernberg (1984), as being by definition at the neurotic level of personality organization), summarizes:

> Unlike the hypomanic, the compulsive individual is capable of deep object relations, mature love, concern, genuine guilt, mourning, and sadness.... The compulsive is capable of lasting intimacy but is modest and socially hesitant. The hypomanic, on the contrary, is pompous, loves company, and rapidly develops rapport with others only to lose interest in them soon afterward. The compulsive loves details, which the hypomanic casually disregards. The compulsive is tied down by morality and follows all rules, while the hypomanic, like the "perverse character" (Chasseguet-Smirgel, 1985), cuts corners, defies prohibitions, and mocks conventional authority. (pp. 196–197)

Thus, as is the case with the distinction between hypomania and hysteria, it is critical to notice the difference between the internal meaning and the manifest content of behavior.

Mania versus Schizophrenia

A person in a manic psychotic condition can look very much like a schizophrenic in an acute hebephrenic episode. This differential is important for medication purposes. Popular impressions aside, the fact

that someone is overtly psychotic does not equate to his or her being schizophrenic. To determine the nature of a person's disorganization, especially with younger patients having an initial psychotic break, it is important to take a good history (from the client's family if the client is too delusional to talk), to assess underlying flatness of affect and to evaluate the capacity to abstract. The conditions we sometimes call "schizoaffective" comprise psychotic-level reactions that have both manic–depressive and schizophrenic features and consequently require especially sensitive pharmacological treatment.

Mania versus Attention-Deficit Disorder

In recent years there has been a lot of attention to adult ADD and attention-deficit/hyperactivity disorder (ADHD). I assume that this trend reflects the fact that contemporary life presents us with countless competing stimuli, reinforcing any tendencies we have toward distractedness, and that this diagnostic tendency has arisen because we now have so many medications that reduce distractibility. The characterologically manic person is highly distractible and can be easily assumed to be suffering from ADD. But internal themes of loss, longing, and self-hatred, countered by the defense of denial, can discriminate a personality tendency from the symptomatic difficulties of people with adult ADD. Of course, it is possible to have a hypomanic personality and also have an attention-deficit problem; physicians medicating in this situation should be particularly careful not to prescribe a drug with known risks of triggering a manic state.

SUMMARY

In this chapter I have discussed patients who are organized characterologically along depressive lines, whatever their experience with the disorders of mood that we define as clinical depression. I followed Blatt (2004, 2008) in differentiating between the anaclitic or longing version of depressive personality and the introjective or self-attacking version. In terms of drive, emotion, and temperament, I emphasized orality, unconscious guilt, and exaggerated sorrow or joy, depending on whether the patient is depressively or manically inclined. I covered the ego processes of introjection, turning against the self, and idealization in predominantly depressive structure, and denial, acting out, and devaluation in predominantly manic organization. I framed object relations in terms of traumatic loss, inadequate mourning, and parental depression, criticism, abuse, and misunderstanding. I characterized introjective depres-

sive images of self as irredeemably bad and anaclitic images as insatiably hungry. In the sections on transference and countertransference, I noted the appealing qualities of depressive and manic people, and the associated rescue wishes and potential demoralization of the therapist who cannot rescue fast enough.

As for treatment style, in addition to a sustained empathic attitude, I recommended the vigorous interpretation of explanatory constructs, persistent exploration of reactions to separation, attacks on the superego, and in manic patients, flight-prevention contracts and a persistent demand for honest self-expression. Diagnostically, I distinguished depressive clients from narcissistically and masochistically oriented patients; I differentiated hypomanic and manic clients from hysterical, narcissistic, compulsive, and schizophrenic people and from those with ADD and ADHD.

SUGGESTIONS FOR FURTHER READING

Laughlin's (1967) chapter on the depressive personality is excellent, though hard to find these days. Gaylin's (1983) anthology on depression contains a fine summary of psychoanalytic thinking on depression. The only recent essay I know of on the hypomanic personality is in Akhtar's *Broken Structures* (1992). Again, Fenichel (1945) is worth reading on both depressive and manic conditions for those who are not put off by his somewhat arcane terminology. Although they do not describe so much the personality attributes as the clinical phenomenon of major depression or bipolar illness, I think the best window into the subjective experience of the person with depressive and/or manic psychology can be found in memoirs. Those of William Styron, Kay Redfield Jamison, and Andrew Sullivan are particularly compelling.

At the end of Chapter 9, I mentioned two DVDs that the American Psychological Association plans to release in 2011 and suggested watching the session I had had with a man whose psychology I saw as schizoid (Beck, Greenberg, & McWilliams, in press-b). The woman who volunteered to be the patient in the other demonstration video (Beck, Greenberg, & McWilliams, in press-a) seemed to me to have some hypomanic dynamics. Chi Chi was sensitive and funny and talented, and she related with immediate warmth. She and I had unexpectedly bonded before the filming, when I had a meltdown about my professionally done makeup (I looked in the mirror and saw Cruella de Ville).

Chi Chi complained of a pattern of dropping or sabotaging things, including relationships, whenever she got emotionally invested. The daughter of a diplomat, she had been uprooted again and again during

her childhood, and her critical mother had tolerated no grief or yearning for lost connection. When I asked why she had volunteered to be filmed, she told me she had been the patient in several *Master Clinician* videos, that she liked being on stage. I wondered if her fear to attach deeply had left her trying to address her underlying depressive tendencies by getting therapy in bits and pieces, unconsciously replicating the dislocations of her history. During the second session with her, I speculated about her fear of intimate connection and, despite her expressed discomfort with exploratory therapies, tried to talk her into considering long-term work with a carefully chosen therapist. She seemed dubious, and in a follow-up interview she said that she had not felt safe with me—perhaps because I was trying to demonstrate a psychoanalytic idea rather than staying in her comfort zone. So I feel some pain about this DVD, but readers who would like to view me trying to be of help to a client with hypomanic defenses may find it illuminating.

12

Masochistic (Self-Defeating) Personalities

People who seem to be their own worst enemies pose fascinating questions for students of human nature. When someone's history is filled with decisions and actions antithetical to that person's well-being, we find it hard to grasp. Freud saw self-defeating behavior as the most vexing problem addressed by his theory, since he had founded it (in conformance with the biological theory of his day) on the premise that organisms try to maximize pleasure and minimize pain. He emphasized how in normal development, infantile choices are determined by the pleasure principle, later modified by the reality principle (see Chapter 2). Because some choices seem at face value to observe neither the pleasure nor the reality principle, Freud did a lot of stretching and revising of his own metapsychology to account for self-defeating or "masochistic" behavior patterns (Freud, 1905, 1915a, 1916, 1919, 1920, 1923, 1924).

Early analytic theory needed to account for the erotic practices of those who, like the Austrian writer Leopold von Sacher-Masoch, sought orgasm via torment and humiliation. Sexual excitement in suffering pain had already been named after Sacher-Masoch, just as pleasure in inflicting it (sadism) had been named after the Marquis de Sade (Krafft-Ebing, 1900). To Freud, who emphasized the ultimate sexual origins of most behavior, it followed naturally to apply the term "masochism" to ostensibly nonsexual patterns of self-created pain (see LaPlanche & Pontalis, 1973; Panken, 1973).

To distinguish a general pattern of suffering in the service of some ultimate goal from the narrow sexual meaning of masochism, Freud (1924) coined the phrase "moral masochism." By 1933 the concept was accepted widely enough that Wilhelm Reich included the "masochistic character" in his compilation of personality types, stressing patterns of suffering, complaining, self-damaging and self-depreciating attitudes, and an inferred unconscious wish to torture others with one's pain. Moral masochism and masochistic personality dynamics have intrigued analysts for a long time (Asch, 1985; Berliner, 1958; Grossman, 1986; Kernberg, 1988; Laughlin, 1967; Menaker, 1953; Reik, 1941; Schafer, 1984) and have interested the larger community as well; for example, Millon (1995) describes an "aggrieved" self-defeating personality style, and the American Psychiatric Association (1994) considered including "self-defeating personality disorder" in DSM-IV.

The concept remains vital: In a 1990 paper that attained iconic status within contemporary relational psychoanalysis, Emmanuel Ghent argued that masochism is a perversion of the natural wish to surrender, a challenge to the Western assumption that surrender is synonymous with defeat. Comparably, a Jungian perspective on masochism frames it as the "shadow side" of our archetypal need to venerate and worship (Gordon, 1987). Gabriel and Beratis (1997) have related masochistic patterns to early trauma.

Like other phenomena covered in this book, masochistic behavior is not necessarily pathological, even though it is, in the narrowest sense, self-abnegating. Sometimes morality dictates that we suffer for the sake of something worthier than our short-term individual comfort (see C. Brenner, 1959; de Monchy, 1950; Kernberg, 1988). This is the spirit in which Helena Deutsch (1944) observed that motherhood is inherently masochistic; mammals put the welfare of their young ahead of their personal survival. This may be "self-defeating" for an individual animal but not for the offspring and the species. Even more praiseworthy instances of masochism occur when people risk their lives, health, and safety in the service of a greater social good, like the survival of their culture or values. Some people—Mahatma Gandhi and Mother Teresa come to mind—who may have had masochistic trends in their personalities, have demonstrated heroic, even saintly devotion to causes greater than their individual selves.

The term "masochistic" is sometimes used to refer to nonmoralized patterns of self-destructiveness, as with people who are accident prone, or with those who mutilate or otherwise harm themselves deliberately but without suicidal intent. Implied in this use of the word is that there is some method behind the self-destructive person's apparent madness, that some objective is being pursued that makes physical suffering pale,

in the mind of the self-injurer, when evaluated next to the emotional relief being sought through these improbable means. Self-cutters, for example, will typically explain that the sight of their own blood makes them feel alive and real, and that the anguish of feeling nonexistent or alienated from sensation is profoundly worse than any temporary physical discomfort. Masochism thus exists in varying degrees and tones. Self-destructiveness can characterize anyone from the psychotic self-mutilator to the workaholic. Moral masochists range from the Christian martyrs of legend to the Jewish mothers of lore.

Everyone behaves masochistically under certain circumstances (see Baumeister, 1989; Salzman, 1960), often to good effect. Children learn on their own that one way to get attention from caregivers is to get themselves in trouble. A colleague of mine described his initiation into the dynamics of normal masochism when his 7-year-old daughter, angry at him for not having spent any time with her, announced her intention to go upstairs and break all her toys. A modus operandi of moral triumph through self-imposed suffering may become so habitual in a person that he or she may be legitimately seen as having a masochistic character. Richard Nixon, for instance, has been regarded as a moral masochist by many observers (see Wills, 1970) on the basis of his aggrieved, self-righteous tone, his predilection to present himself as suffering nobly, and his questionable judgment in situations in which his welfare was at stake (e.g., his failure to destroy the Watergate tapes that eventually destroyed his presidency).

I want to stress that the term "masochism" as used by psychoanalysts does not connote a love of pain and suffering. The person who behaves masochistically endures pain and suffering in the hope, conscious or unconscious, of some greater good. When an analytic observer comments that a battered wife is behaving masochistically in staying with an abusive man, the commentator is not accusing her of liking to be beaten up. The implication is rather that her actions betray a belief that tolerating abuse either accomplishes some goal that justifies her suffering (such as keeping her family together), or averts some even more painful eventuality (such as complete abandonment), or both. The remark also suggests that her calculation is not working, that her staying with an abuser is objectively more destructive or dangerous than her leaving would be, yet she continues to behave as if her ultimate well-being were contingent on her enduring mistreatment. I emphasize this because in discussions about whether the DSM should include a self-defeating personality disorder, it became apparent that many people regard the attribution of masochism or self-destructiveness as equivalent to accusing someone of enjoying pain—of "blaming the victim" as if he or she consciously provoked abuse for the sake of some perverse form of enjoyment.

When anyone's character is problematic enough to be considered a personality disorder, there is by definition something masochistic about it. If one's core ways of thinking, feeling, relating, coping, and defending are repeatedly maladaptive, one's personality patterns have become self-defeating. People whose masochism is in the *foreground* of their repetitive patterns, rather than being a by-product of other dynamics, are the ones analysts may consider masochistic personalities. As with depressively organized people, their dynamics range from more anaclitic (self-in-relation) to more introjective (self-definition) (Blatt, 2008). Masochistic people with intense anaclitic needs are sometimes called relational masochists; that is, their self-defeating actions result from efforts to keep an attachment at any cost. The term "moral masochist" is more commonly applied to more introjectively organized people who have organized their self-esteem around their capacity to tolerate pain and sacrifice. In the latter category I would put the exhausted intensive-care nurse to whom I suggested working fewer than 80 hours a week. "Well, maybe *some* professionals have low standards," she announced, looking intently at me, "but I'm not one of them."

Masochistic and depressive character patterns overlap considerably, especially at the neurotic-to-healthy level; most people with one have aspects of the other. Kernberg (1984, 1988) regards the depressive–masochistic personality as one of the most common types of neurotic character. I am emphasizing the differences between the two psychologies because, especially at the borderline and psychotic levels, they require significantly contrasting therapeutic styles. Much damage can be done when, with the best intentions, a therapist misunderstands a predominantly masochistic person as basically depressive, and vice versa. I recently found that Richard Friedman (1991), coming from a different disciplinary tradition from mine, has made similar observations, distinguishing depression that is "integrally associated with characterological masochism" from depression that is not, and arguing that "masochistic depressed patients constitute one important, presently hidden, subgroup among those who are chronically depressed. They are particularly likely to be found among chronically depressed patients whose treatment response is suboptimal" (p. 11).

DRIVE, AFFECT, AND TEMPERAMENT IN MASOCHISM

In interesting contrast with depressive conditions, self-defeating patterns have not been subject to extensive empirical research, possibly because the concept of masochism has not been widely embraced beyond the psychoanalytic community. Consequently, little is known about consti-

tutional contributions to masochistic personality organization. Except for Krafft-Ebing's (1900) conclusion that sexual masochism is genetic and some speculations about the role of oral aggression (e.g., L. Stone, 1979), few hypotheses have been made about innate temperament. Clinical experience suggests that the person who becomes characterologically masochistic may be (as may also be true of those who develop a depressive character) more constitutionally sociable or object-seeking than, say, the withdrawing infant who inclines toward a schizoid style.

The question of constitutional vulnerability to masochism is thus still open. A topic that has claimed more professional attention concerns gender. Many scholarly observers (e.g., Galenson, 1988) have the impression that childhood trauma and maltreatment have different effects on children of different sexes: abused girls tend to develop a masochistic pattern, whereas abused boys are more likely to identify with the aggressor and to develop in a more sadistic direction. Like all generalizations, this one has many exceptions—masochistic men and sadistic women are not rare. But perhaps the greater physical strength of adult males, and the anticipation of that advantage by little boys, disposes them to master trauma by proactive means and leaves their sisters with a disposition toward stoicism, self-sacrifice, and moral victory through physical defeat—time-honored weapons of the weak. Differential secretions of hormones such as testosterone, dopamine, and oxytocin may also play a role in such sex differences.

The affective world of the masochistic person is similar to that of the depressive, with a critical addendum. Conscious sadness and deep unconscious guilt feelings are common, but in addition, most masochistic people can easily feel anger, resentment, and even indignation on their own behalf. In such states, self-defeating people have more in common with those disposed to paranoia than with their depressive counterparts. In other words, many masochistic people see themselves as suffering, but unfairly; as victimized or just ill-starred, cursed through no fault of their own (as in "bad karma"). Unlike those with simply depressive themes, who are at some level resigned to their unhappy fate because it is all they think they deserve, masochistic people may rail against it like Shakespeare's lover who troubled deaf Heaven with his bootless cries.

DEFENSIVE AND ADAPTIVE PROCESSES IN MASOCHISM

Like depressive people, masochistic ones may employ the defenses of introjection, turning against the self, and idealization. In addition, they rely heavily on acting out (by definition, since the essence of masochism lies in self-defeating actions). Moral masochists also use moralization

(again, definitionally) to cope with their inner experiences. For reasons that I will cover shortly, people with self-defeating personalities are more active in general than depressive individuals, and their behavior reflects their need to do something with their depressive feelings that counteracts states of demoralization, passivity, and isolation.

The hallmark of masochistic personality is defensive acting out in ways that risk harm. Most unconsciously driven, self-defeating actions include the element of an effort to master an expected painful situation (R. M. Loewenstein, 1955). If one is convinced that, for example, all authority figures will sooner or later capriciously punish those who depend on them, and if one is in a chronic state of anxiety waiting for this to happen, then provoking the expected punishment will relieve the anxiety and provide reassurance about one's power: At least the time and place of one's suffering is self-chosen. Therapists with a control–mastery orientation (e.g., Silberschatz, 2005) refer to this behavior as "passive-into-active transformation."

Freud (1920) was initially impressed with the power of what he called the repetition compulsion in instances of this type. Life is unfair: Those who suffer most in childhood usually suffer most as adults, and in scenarios that uncannily mirror their childhood circumstances. To add insult to injury, the adult situations seem to observers to be of the sufferer's own making, though that is hardly the conscious experience of that person. As Sampson, Weiss, and their colleagues have pointed out (e.g., Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986), repetitive patterns characterize everyone's behavior; if one is lucky enough to have had a safe and affirming childhood, one's repetitive patterns are fairly invisible, since they fit comfortably with realistic opportunities in life and tend to reproduce emotionally positive situations. When one has had a frightening, negligent, or abusive background, the need to recreate those circumstances in order to try to master them psychologically can be both visible and tragic.

A self-cutting patient I treated for many years eventually located the sources of her masochism in early abuse by her mother, including once when this deeply disturbed woman had, in a blind rage, cut my patient with a knife. As memories came back, and as she grieved over her prior helplessness and began discriminating between present and past realities, her self-mutilation gradually ceased. But not before she had scarred her skin irreversibly and had created traumatic scenes for other people. Because she was at the psychotic level of personality organization, the work was slow and precarious, though ultimately successful.

A much healthier woman I worked with used to announce her latest financial extravagances to her frugal husband whenever their relationship began to feel warm and comfortable. This would reliably send him

into a fury. We figured out together that this provocative habit revealed the enduring power of a conclusion she had drawn as a child that whenever things are calm, a storm is about to break. When her marriage was going well, she would begin unconsciously to worry that like her explosive father, her husband was about to destroy their happiness with an outburst. She was thus behaving in a way that she viscerally knew would bring it on, in order to get it over with and restore a pleasurable connection. Unfortunately, from her husband's standpoint she was not reinstating pleasure, she was causing pain.

Reik (1941) explored several dimensions of masochistic acting out, including (1) provocation (as in the preceding vignette), (2) appeasement ("I'm already suffering, so please withhold any further punishment"), (3) exhibitionism ("Pay attention: I'm in pain"), and (4) deflection of guilt ("See what you made me do!"). Most of us use minor masochistic defenses frequently for one or more of these reasons. Therapists in training who approach supervision in a flood of self-criticism are often using a masochistic strategy to hedge their bets: If my supervisor thinks I made a major error with my client, I've already shown that I'm aware of it and have been punished enough; if not, I get reassured and exonerated.

Self-defeating behavior in relational masochism can be understood as a defense against separation anxiety (Bach, 1999). It has a way of engaging others and involving them in the masochistic process. Once in a therapy group I belonged to, a member kept bringing the group's criticism down upon himself in a relentlessly predictable way, of which he seemed naively unaware. When confronted with the evidence that his whining, self-abasing stance evoked exasperation and attack from others, he became uncharacteristically subdued and admitted, "I'd rather be hit than not touched at all." I say more about this dynamic in the object relations section.

With those whose masochism is more introjective, moralization can be an exasperating defense. Often they are much more interested in winning a moral victory than in solving a practical problem. It took me weeks of work to get one self-defeating patient to consider writing a letter to the Internal Revenue Service (IRS) that would get her the large refund to which she was legally entitled. She spent her therapy hours trying to convince me that the IRS had handled her tax return ineptly—which was emphatically true but completely beside the point if the point was to get her money back. She much preferred my sympathetic indignation to my attempts to help her get recompensed. Left to herself, she would have gone on collecting and bemoaning injustices rather than eliminating one.

Part of the dynamic here seems to be a special way of handling the introjective depressive conviction that one is bad. The need to get

listeners to validate that it is others who are guilty can be great enough to overwhelm the practical objectives to which most people give priority. One reason that children with a stepparent—even a kind and well-meaning one—tend to behave masochistically (acting resentful or defiant, and inciting punitive responses) may pertain to unconscious guilt. Youngsters who have lost a parent tend to worry that their badness drove that parent away. Preferring a sense of guilty power to helpless impotence, they try to convince themselves and others that it is the substitute parent who is bad, thus deflecting attention from their own felt wrongdoing. They may provoke until the stepparent's behavior supports their conviction.

These dynamics may explain why it is often hard to influence a stepfamily system in a purely behavioral way. The agenda of an angry and guilt-driven party may have much more to do with continuing to suffer (so that someone else is seen as culpable) than with improving the family atmosphere. This phenomenon is of course not exclusive to children or to reconstituted families. Any elementary school teacher has a reservoir of anecdotes about biological parents who presented themselves as long-suffering martyrs to their child's misbehavior yet could not implement any suggestions for improving it. One gets the feeling that their need to be confirmed in a perception of the child as bad, and in their own role as enduring stolidly, outranks other considerations.

Another frequent defense is denial. Masochistically organized people frequently demonstrate by their words and behavior that they are suffering, or that someone is abusing them, yet they may deny that they are feeling any particular discomfort and protest the good intentions of the perpetrator. "I'm sure she means well and has my best interests at heart," one of my clients once remarked about an employer who obviously disliked him and had humiliated him in front of all his colleagues. "How did you feel about her treatment of you?" I asked. "Oh, I figured she was trying to teach me something important," he responded, "so I thanked her for her efforts."

RELATIONAL PATTERNS IN MASOCHISTIC PSYCHOLOGY

Emmanuel Hammer was fond of saying that a masochistic person is a depressive who still has hope. What he meant is that in the etiology of masochistic as opposed to depressive conditions, the deprivation or traumatic loss that led to a depressive reaction was not so devastating that the child simply gave up on the idea of being loved (see Berliner, 1958; Bernstein, 1983; Lax, 1977; Salzman, 1962; Spitz, 1953). Many parents who are barely functional can nevertheless be jarred into action

if their child is hurt or endangered. Their children learn that although they generally feel abandoned and therefore worthless, if they are suffering enough, they may get some care (Thompson, 1959). To a child, any parental attention can feel safer than neglect, a reality that Wurmser captured in a book titled *Torment Me but Don't Abandon Me* (2007).

One woman I assessed had an extraordinary history of injury, illness, and misfortune. She had also had a psychotically depressed mother. When I asked for her earliest memory, she cited an incident from age 3 when she had knocked over an iron, burned herself, and received a rare infusion of maternal solace. Usually the history of a masochistic person sounds like the history of a depressive one, with unmourned losses, critical or guilt-inducing caregivers, role reversals where the child feels responsible for the parents, instances of trauma and abuse, and depressive models (Durpat, 1982). Yet if one listens carefully, one also hears a theme of people having been responsive when the client was in deep enough trouble. Whereas depressive people feel that there is no one there for them, masochistic ones may feel that if only they can demonstrate sufficiently their need for sympathy or care, they may not have to endure complete emotional abandonment.

Esther Menaker (e.g., 1953) was one of the first analysts to describe how the origins of masochism lie in unresolved dependency issues and fears of being alone. "Please don't leave me; I'll hurt myself in your absence" is the essence of many masochistic communications, as it was in the example of my colleague's daughter who threatened to destroy all of her toys. In a fascinating research project on the psychologies of severely and repeatedly battered women, the ones who drive women's shelter personnel to tear their hair out because they keep returning to partners who barely stop short of killing them, Ann Rasmussen (1988) learned that these gravely endangered people fear abandonment much more than they fear pain or even death. She notes:

> When separated from their batterers, most of the subjects fell into an abyss of such acute despair that they succumbed to Major Depressions and could barely function.... Many described being incapable of feeding themselves, getting out of bed, and interacting with others. As one subject put it, "when we were apart I didn't know how to get up in the morning ... my body forgot how to eat, each bite was like a rock in my stomach." The depths to which they sank when alone were unrivaled by any states of distress they experienced when with their abusive mates. (p. 220)

It is not uncommon to learn from masochistic patients that the only time a parent was emotionally invested in them was when they were being punished. An association of attachment and pain is inevi-

table under these circumstances. Teasing, that peculiar combination of affection and cruelty, can also breed masochism (Brenman, 1952). Especially when punishment has been excessive, abusive, or sadistic, the child learns that suffering is the price of relationship. And children crave relationship even more than physical safety. Victims of childhood abuse usually internalize their parents' rationalization for the mistreatment, because it feels better to be beaten than to be neglected. Another subject in Rasmussen's (1988) study confided: "I have had the feeling I wished I was little again. I wish I was still up under my mother's care. I wish I could be whipped now, because whipping is a way of making people listen and to know in the future. If I had a mother to whip me more, I could keep myself in line" (p. 223).

One other aspect of the history of many people whose personalities become masochistically structured is that they have been powerfully rewarded for enduring tribulation gallantly. When she was 15, a woman I know lost her mother to cancer of the colon. The mother lived at home in the months she was dying, wasting away in an increasingly comatose and incontinent state. Her daughter took over the role of nurse, changing the dressings on her colostomy, washing the bloody sheets daily, and turning her mother's body to prevent bedsores. The mother's mother, deeply touched by such devotion, expounded fulsomely on how brave and unselfish her granddaughter was, how God must be smiling on her, how uncomplainingly she gave up normal adolescent pursuits to care for her dying mother. All this was true, but the long-term effect of her having received so much reinforcement for self-sacrifice, and so little encouragement to take some time off to meet her own needs, set her up for a lifetime of masochism: She handled every subsequent developmental challenge by trying to demonstrate her generosity and forbearance. Others reacted to her as tiresomely self-righteous, and they chafed at her repeated efforts to mother them.

In their everyday relationships, self-defeating people tend to attach to friends of the misery-loves-company variety, and if they are of the moral masochistic variety of sufferer, they gravitate toward those who will validate their sense of injustice. They also tend—battered partners being only the most extreme example—to recreate relationships in which they are treated with insensitivity or even sadism. Some sadomasochistic attachments seem to be a result of the self-defeating person's having chosen a mate with a preexisting tendency to abuse; in other instances it appears that the person enduring mistreatment has connected with an adequately kind partner and managed to bring out the worst in him or her.

Nydes (1963) argued (cf. Bak, 1946) that people with masochistic personalities have certain commonalities with paranoid people, and that some individuals swing cyclically from masochistic to paranoid orienta-

tions. The source of this affinity is their common orientation to threat. Both paranoid and self-defeating people feel in constant danger of attacks on their self-esteem, security, and physical well-being. The paranoid solution in the face of this anxiety is something like "I'll attack you before you attack me," whereas the masochistic response is "I'll attack myself first so you don't have to do it." Both masochistic and paranoid people are unconsciously preoccupied with the relationship between power and love. The paranoid person sacrifices love for the sake of a sense of power; the masochistic one does the reverse. Especially at the borderline level of personality organization, these different solutions may present as alternating self-states, leaving a therapist confused as to whether to understand the patient as a frightened victim or a menacing antagonist.

Masochistic dynamics may permeate the sexual life of someone with a self-defeating personality (Kernberg, 1988), but many characterologically masochistic people are not sexual masochists (in fact, whereas their masturbation fantasies may contain masochistic elements in order to magnify excitement, they are often turned off sexually by any note of aggression in their partner). Conversely, many people whose particular sexual history gave them a masochistic erotic pattern are not self-defeating personalities. One unfortunate legacy of early drive theory, which connected sexuality so intimately with personality structure at the conceptual level, has been a glib assumption that sexual dynamics and personality dynamics are always isomorphic. Often, they are. But, perhaps luckily, people are frequently more complex.

THE MASOCHISTIC SELF

The self-representation of the masochistic person is also comparable, up to a point, with that of the depressive: unworthy, guilty, rejectable, deserving of punishment. In addition, there may be a pervasive and sometimes conscious sense of being needy and incomplete rather than simply bereft, and a belief that one is doomed to be misunderstood, unappreciated, and mistreated. People with a moral-masochistic personality structure often impress others as grandiose and scornful, exalted in their suffering and scornful of those lesser mortals who could not endure equivalent tribulation with so much grace. Although this attitude makes moral masochists look as if they are enjoying their suffering, a better formulation would be that they have found a compensatory basis in it for supporting their self-esteem (Cooper, 1988; Kohut, 1977; Schafer, 1984; Stolorow, 1975).

Sometimes when masochistic clients are recounting instances of mistreatment by others, one sees traces of a sly smile on their otherwise

aggrieved features. It is easy to infer that they are feeling some sadistic pleasure in defaming their tormenters so soundly. This may be another source of the common assumption that self-defeating people enjoy their misery. It is more accurate to say that they derive some secondary gain from their attachment-through-suffering solutions to their interpersonal dilemmas. For those who tilt toward moral masochism, they may be fighting back by not fighting back, exposing their abusers as morally inferior for showing their aggression, and savoring the moral victory that this stratagem achieves.

Those who lean more relationally may be smiling because their masochistic behavior is expected to elicit more connection with the person to whom they are relating. Psychiatrists are painfully familiar with the returning patient who comes in looking disappointed, but with a tiny smile at the corner of the mouth, while announcing, "That medication didn't work either, it seems." Most therapists are familiar with clients who complain piteously about mistreatment by a boss, relative, friend, or mate, yet when encouraged to do something to remedy their situation, look disappointed, change the subject, and switch their grievances to another arena. When self-esteem is enhanced, and/or a relationship is felt to be reinforced, by bearing misfortune courageously, and when these goals are seen as less achievable if one acts on one's own behalf ("selfishly"), it is difficult to reframe an unpleasant situation as requiring corrective measures.

Unlike most depressively organized people, who tend to retreat into loneliness, masochistic individuals may handle their felt badness by projecting it onto others and then behaving in a way that elicits evidence that the badness is outside rather than inside. This is another way in which self-defeating patterns and paranoid defenses are similar. Masochistic people usually have less primitive terror than paranoid ones, however, and do not require as many defensive transformations of affect in order to eject their unwanted aspects. And unlike paranoids, who may be reclusive, they need other people close at hand to be the repositories of their disowned sadistic inclinations. A paranoid person can resolve anxiety by attributing projected malevolence to vague forces or distant persecutors, but a masochistic one attaches it to someone nearby, whose observable behavior demonstrates the rightness of the projector's belief in the moral turpitude of the object.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH MASOCHISTIC PATIENTS

Masochistic clients tend to reenact with a therapist the drama of the child who needs care but can only get it if he or she is demonstrably suffering.

The therapist may be seen as a parent who must be persuaded to save and comfort the patient, who is too weak, threatened, and unprotected to handle life's challenges without help. If the client has gotten into some truly disturbing, dangerous situations, and seems clueless as to how to get extricated, it is not uncommon for a therapist to feel that before treatment can begin, the person's safety must be secured. In less extreme examples of masochistic presentations, there is still some communication of helplessness in the face of life's insults, along with evidence that the only way the client knows how to cope with difficulty is by trying to be tolerant, stoic, or even cheerful in the face of misfortune.

Masochistic clients often try to persuade the therapist that they need to be, and deserve to be, rescued. Coexisting with these aims is the fear that the therapist is an uncaring, distracted, selfish, critical, or abusive authority who will expose the client's worthlessness, blame the victim for being victimized, and abandon the relationship. The rescue agendas and fears of maltreatment may be either conscious or unconscious, ego syntonic or ego alien, respectively, depending on the client's level of organization. In addition, self-defeating people live in a state of dread, almost always unconscious, that an observer will discern their shortcomings and reject them for their sins. To combat such fears, they try to make obvious both their helplessness and their efforts to be good.

There are two common countertransferences to masochistic dynamics: countermasochism and sadism. Usually both are present. The most frequent pattern of practitioner response, especially for newer therapists, is first to be excessively (and masochistically) generous, trying to persuade the patient that one appreciates his or her suffering and that one can be trusted not to attack. Then, when that approach only seems to make the patient more helpless and wretched, the therapist notices ego-alien feelings of irritation, followed by fantasies of sadistic retaliation toward the client for being so intractably resistant to help.

Because therapists often have depressive psychologies, and because it is easy—especially early in treatment—to misunderstand a predominantly masochistic person as a basically depressive one, clinicians often seek to do for the patient what would be helpful to themselves if they were in the patient role. They emphasize in their interpretations and their conduct that they are available, that they appreciate the extent of the person's unhappiness, and that they will take extra pains to be of help. Therapists have been known to reduce the fee, schedule extra sessions, take phone calls around the clock, and make other special accommodations in the hope of increasing a therapeutic alliance with a patient who is stuck in a dismal morass. Such actions, which might facilitate work with a depressive person, are counterproductive with a masochistic one in that they invite regression. The patient learns that self-defeating

practices pay off: The more pronounced the suffering, the more giving the response. The therapist learns that the harder he or she tries, the worse things get—a perfect mirror of the masochistic person's experience of the world.

I have observed in myself and my students that we all learn the hard way how to work with masochistic clients, how to avoid acting out masochistically and suffering upsetting sadistic reactions to people for whom we would rather feel sympathy. Most therapists recall vividly the client with whom they learned to set limits on masochistic regression rather than to reinforce it. In my own case, I am embarrassed to report that in the flush of a rescue fantasy toward one of my first deeply disturbed patients, a paranoid–masochistic young man in the psychotic range, I was so eager to prove I was a good object that, on hearing his sad story about how there was no way for him to get to work anymore, I lent him my car. Not surprisingly, he drove it into a tree.

In addition to the common inclination to support rather than confront masochistic reactions, therapists usually find it hard to admit to sadistic urges. Because feelings that go unacknowledged are likely to be acted out, this inhibition can be dangerous. The sensitivity of consumers of mental health services to the possibility of therapists' blaming the victim is probably not accidental; it may derive from the sense of many former patients that they were subjected to unconscious sadism from therapists when they were in a vulnerable role. If one has extended oneself to the point of resentment with a client who only becomes more dysphoric and whiny, it gets easy to rationalize either a punitive interpretation or a rejection ("Perhaps this person needs a different therapist").

Masochistic clients can be infuriating. There is nothing more toxic to a therapist's self-esteem than a client who radiates the message, "Just try to help me—I'll only get worse." This negative therapeutic reaction (Freud, 1937) has long been related to unconscious masochism, but understanding that intellectually and going through it emotionally are two different things. It is hard to maintain an attitude of benign support in the face of someone's stubbornly self-abasing behavior (see Frank et al., 1952, on the "help-rejecting complainer"). Even in writing this chapter I am aware of slipping into a mildly affronted tone as I try to describe the masochistic process; some analysts (e.g., Bergler, 1949) writing about self-defeating patients have sounded outright contemptuous. The ubiquity of such feelings highlights the need for careful self-monitoring. Masochistic and sadistic countertransference reactions need not burden treatment unduly, though a therapist who denies feeling them will almost certainly run into trouble.

Finally, because masochistic patients tend to view their self-destructive behaviors with emotional denial of their implications, therapists are left

holding the anxiety that would normally accompany the danger of self-harm. I have often noticed, as I try to explore the possible consequences of a masochistic person's behavior, that as I am getting more anxious about what the client is risking, he or she is getting more casual, matter-of-fact, and minimizing. "Were you worried that you might contract HIV?" may elicit a vague "I don't think that's going to happen" or "That was just one time" or "Maybe a little, but that's not what I want to talk about right now."

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF MASOCHISTIC PERSONALITY

Freud and many of his early followers wrote about masochistic dynamics, describing their origins and functions, their unconscious objectives, and their hidden meanings, but without comment on particular treatment implications. Esther Menaker (1942) was the first to observe that many aspects of classical treatment, such as the patient's lying supine and the analyst's interpreting in an authoritative manner, can be experienced by masochistic clients as replicating humiliating interactions of dominance and submission. She recommended technical modifications such as face-to-face treatment, emphasis on the real relationship as well as on the transference, and avoidance of all traces of omnipotence in the analyst's tone. Without the elimination of all potentially sadomasochistic features of the therapy situation, Menaker felt that patients would be at risk of feeling only a repetition of subservience, compliance, and the sacrifice of autonomy for closeness.

This argument still holds, though perhaps more in the spirit than the letter of Menaker's (1942) recommendations. Her remarks about the couch have become somewhat moot, since in current psychoanalytic practice, only high-functioning patients would be encouraged to lie down and free associate (and presumably the neurotic-level masochistic person would have a strong enough observing ego to appreciate that relaxing on a couch does not equate to accepting a humiliating defeat). But her stress on the centrality of the real relationship stands. Because the masochistic person urgently needs an exemplar of healthy self-assertion, the quality of the therapist as a human being, expressed in the way he or she structures the therapeutic collaboration, is critical to the prognosis of a self-defeating patient. The therapist's unwillingness to be exploited or to extend generosity to the point of inevitable resentment may open up whole new vistas to someone who was brought up to sacrifice all self-regarding concerns for the sake of others. Hence, the first "rule" for treating self-defeating clients is not to model masochism.

Years ago, one of my supervisors, knowing I had a commitment to serving people of limited means, told me that it was fine to let most patients run up a bill if they suffered financial reverses, but stressed that I should never be lenient in this way with a masochistic client. As I seem to be constitutionally incapable of taking good advice until I make the mistake that illuminates its wisdom, I disregarded his warning in the case of a diligent, earnest, and appealing man who convincingly described a money crisis that seemed outside his control. I offered to "carry" him until he got back on his feet financially. He proceeded to get more and more incompetent with money, I got more and more aggrieved, and eventually we had to rectify my mistake with a headache of a plan for repayment. I have not made this error since, but I notice that my students typically learn this piece of wisdom through bitter experience, just as I did. It would not be so upsetting if the therapist were the only one to pay the price of misguided generosity, but as the harm to the patient becomes obvious, one's confidence as a healer can suffer as much as one's pocketbook.

It is thus no service to self-defeating clients to demonstrate "therapeutic" self-sacrifice. It makes them feel guilty and undeserving of improvement. They can scarcely learn how to exert their prerogatives if the therapist exemplifies self-effacement. Rather than trying to give a masochistic person a break with the fee, one should charge an amount that is adequate recompense for the skill needed to work with a challenging dynamic, and then receive payment in the spirit of feeling entitled to it. Nydes (1963) would intentionally show masochistic patients his pleasure in being paid, fondling their bills happily or pocketing their checks with obvious relish.

The resistance of most therapists to showing appropriate amounts of self-concern and self-protectiveness, despite the clear need of masochistic patients to have a model of reasonable self-care, probably comes not only from possible internal inhibitions about self-interest—always a good bet with therapists—but also from accurate forebodings that self-defeating patients will react to their limits with anger and criticism. In other words, they will be punished for selfishness, in the same way many masochistic people were punished by their early objects. This is true. It is also to be hoped for. Self-destructive people do not need to learn that they are tolerated when they smile bravely; they need to find out that they are accepted even when they are losing their temper.

Moreover, they need to understand that anger is natural when one does not get what one wants and can be simply understood as such by others. It does not have to be fortified with self-righteous moralism and exhibitions of suffering. Masochistic people may believe they are entitled to feel hostility only when they have been clearly wronged, a presump-

tion that costs them countless hours of unnecessary psychological exertion. When they feel some normal disappointment, anger, or frustration, they may either deny or moralize in order not to feel shamefully selfish. When therapists act self-concerned, and treat their masochistic patients' reactive outrage as natural and interesting, some of these patients' most cherished and damaging internal categories get reshuffled.

For this reason, experienced therapists may advise "No rachmones" (no expressions of sympathy) with masochistic patients (Hammer, 1990; Nydes, 1963). This does not mean that one blames them for their difficulties, or returns sadism for their masochism, but it does mean that instead of communications that translate into "You poor thing!" one tactfully asks, "How did you get yourself into that situation?" The emphasis should always be on the client's capacity to improve things. These ego-building, noninfantilizing responses tend to irritate self-defeating people, who may believe that the only way to elicit warmth is to demonstrate helplessness. Such interventions provide opportunities for the therapist to welcome the expression of normal anger, to show acceptance of the client's negative feelings, and to feel relief in an increase in authenticity.

Similarly, one should not rescue. One of my most disturbed masochistic patients, whose symptoms ranged from bulimia to multiple addictions to anxieties of psychotic proportions, used to go into a paralysis of panic whenever she feared that an expression of her anger had alienated me. On one such occasion, she became so frantic that she persuaded the staff of the local mental health center to hospitalize her and signed herself in for 72 hours. Within half a day, having calmed down and now wanting no part of an in-patient experience, she got a psychiatrist to agree that if she obtained my permission, she could be discharged early. "You knew you were signing yourself in for 3 days when you did this," I responded, "so I would expect you to keep your commitment." She was livid. But years later, she confided that that had been the turning point in her therapy, because I had treated her like a grown-up, a person capable of living with the consequences of her actions.

In the same vein, one should not buy into guilt and self-doubt. One can feel powerful pressure from masochistic clients to embrace their self-indicting psychology. Guilt-provoking messages are often strongest around separations. A person whose self-destructiveness escalates just when the therapist is about to take a vacation (a common scenario) is unconsciously insisting that the therapist is not allowed to enjoy something without agonizing over how it is hurting the patient. Behaviors that translate into "Look what you made me suffer!" or "Look what you made me do!", are best handled by empathic reflection of the client's pain, combined with a cheerful unwillingness to let it rain on one's parade.

Setting an example that one takes care of oneself without feeling guilt about the neurotic reactions of others may elicit moralistic horror from masochistic people, but it may inspire them to experiment with being a bit more self-respectful. I originally learned this while working with a group of young mothers whose shared masochism was formidable (McWilliams & Stein, 1987). My co-leader was the target of oppressive nonverbal broadcasts that her upcoming vacation was wounding the group members. These messages were delivered with disingenuous maternal reassurances that she should not feel too bad about forsaking them. In response, she announced that she did not feel the slightest bit guilty, that she was looking forward to having a good time and not having to think about the group at all. The women became incensed but were animated and honest again, as if pulled out of a quagmire of deadness, hypocrisy, and passive aggression.

It is often helpful to resist the anxiety one feels about a masochistic patient in a dangerous situation, and to address the upsetting material in a casual, dispassionate tone. My friend Kit Riley taught me that when one is trying to help a woman who keeps going back to a dangerous abuser, expressing anxiety only allows the patient to feel magically "rid" of worry—now it is in the therapist, not her. Instead, it can be valuable to say, in a serious but matter-of-fact tone:

> "I get that he doesn't want to kill you, and that he's contrite after he attacks you, and that that shows his love, and that you love him and want to go back. Fine. But of course we have to take seriously the possibility that without intending to, he'll get into a state in which he *does* kill you. So we should address this danger. Do you have a will? Have you talked to your kids about who would take care of them if you were murdered? Do you have life insurance? If your partner is the beneficiary, you might want to change that.... "

When the therapist refuses to take on anxiety and simply talks reality, such a client tends to feel in herself the anxiety she has failed to put into her therapist and to have to face the implications of her masochistic behavior.

Timing, of course, is critical. If one comes on too strong too fast, before a reliable working alliance is in place, the patient will feel criticized and blamed. The art of conveying a sympathetic appreciation that the suffering of masochistic people is truly beyond their conscious control (despite its appearing to be self-chosen) and at the same time adopting a confrontational stance, one that respects their ability to make their volition conscious and change their circumstances, cannot be taught in a textbook. But any reasonably caring practitioner develops an intu-

ition about how and when to confront. If one's efforts wound the client beyond a therapeutic level of discomfort, one should apologize (E. S. Wolf, 1988), but without excessive self-recrimination.

In addition to behaving in ways that counteract the pathological expectations of masochistic patients, the therapist should actively interpret evidence for irrational but prized unconscious beliefs such as "If I suffer enough, I'll get love," or "The best way to deal with my enemies is to demonstrate that they are abusers," or "The only reason something good happened to me was that I was sufficiently self-punitive." It is common for self-defeating people to have magical beliefs that connect assertiveness or confidence with punishment, and self-abasement with eventual triumph. One finds in most religious practices and folk traditions a connection between suffering and reward, and masochistic people often support their pathology uncritically with these ideas. Such beliefs may console us, softening our outrage about suffering that may be both capricious and unambiguously destructive. However, when these ideas get in the way of taking action that might be effective, they do more harm than good.

Among the contributions of control–mastery theory to psychoanalytic understanding is its emphasis on pathogenic beliefs and on the client's repeated efforts to test them. In addition to passing these tests by such means as refusing to act masochistically in the role of therapist, the clinician must help the client become aware of what the tests are, and what they reveal about the person's underlying ideas about the nature of life, human beings, the pursuit of happiness, and so on. This part of treatment, though not as emotionally challenging as controlling one's countertransferences, is the hardest to effect. Omnipotent fantasies behind masochistic behaviors die hard. One can always find evidence in random events that one's successes have been punished and one's sufferings rewarded.

The therapist's persistance in exposing irrational beliefs often makes the difference between a "transference cure"—the temporary reduction of masochistic behaviors based on idealization of and identification with the therapist's self-respecting attitude—and a deeper and lasting movement away from self-abnegation.

DIFFERENTIAL DIAGNOSIS

As I noted earlier, there is a masochistic component in all the personality configurations discussed in this book—at least when they approach a pathological level of defensive rigidity or developmental arrest sufficient to establish them as character *disorders* rather than simply character.

But the masochistic function of any type of pattern is not identical to masochism as an organizing personality theme. The types of individual psychology most easily confused with the kind of characterological masochism covered here are depressive and dissociative psychologies.

Masochistic versus Depressive Personality

Many people have a combination of depressive and masochistic dynamics, and are reasonably regarded as depressive–masochistic characters. In my experience, however, in most individuals the balance between these elements tilts in one direction or the other. Because the optimal therapeutic style for each differs, it is important to discriminate between these two depressively toned psychologies. The predominantly depressive person needs above all else to learn that the therapist will not judge, reject, or abandon, and will, unlike the internalized objects that maintain depression, be particularly available when the client is suffering. The more masochistic person needs to find out that self-assertion, not helpless suffering, can elicit warmth and acceptance, and that the therapist, unlike the parent who could be brought to reluctant attention if a disaster was in progress, is not particularly interested in the details of the patient's current misery.

If one treats a depressive person as masochistic, one may provoke increased depression and even suicide, as the client will feel both blamed and abandoned. If one treats a masochistic person as depressive, one may reinforce self-destructiveness. At the most concrete level, most experienced clinicians have found that when antidepressant medication is given to someone with a masochistic personality, even if that person has diagnosable Axis I depression, the medicine does very little other than to feed the patient's pathogenic belief that to feel better, one needs authorities and their magic. When seeing a person with both depressive and masochistic tendencies, the therapist must keep assessing whether a more depressive or more masochistic dynamic is currently active, so that the tone of one's interventions is appropriate to the primary defensive process in the patient.

Masochistic versus Dissociative Psychology

Over the past several decades there has been an explosion in our knowledge about dissociation. Acts that we used to understand exclusively according to theories of masochism have been reinterpreted in more specific ways for patients with a history of traumatic abuse and neglect (Gabriel & Beratis, 1997; Howell, 1996). Many people are subject to dissociated states in which they repeat, symbolically or concretely, prior

harm to themselves. The most dramatic exemplar of a vulnerability to dissociated self-injury is the client who switches self-states by self-hypnotic means and then engages in a reenactment of early tortures. Investigation may reveal the existence of an alter personality, identified with the original tormentor, for whom the main personality is amnesic.

The general dynamic in such cases is indeed masochistic, but if the therapist misses the fact that the self-injury was carried out in a dissociated state by a part of the person not always in consciousness, interpretations will be futile. Chapter 15 addresses treatment for dissociative people; for now, readers should note that especially in more bizarre cases of self-harm, the patient should be asked matter-of-factly if he or she remembers doing it. If the client does recall inflicting the injuries, one can inquire about the degree to which he or she felt depersonalized or disembodied. Until such a patient has access to the state of mind in which a self-destructive act was committed, interventions aimed at reducing dissociation take priority over interpretations of masochism.

SUMMARY

I have given a brief history of the concept of masochism and related self-defeating patterns, distinguishing them from lay conceptions of masochism as joy in pain. I differentiated moral from relational masochism and mentioned gender predispositions (to masochism in women and sadism in men) while stressing that masochistic personality organization is common in people of both sexes. I construed masochism as involving the main depressive affects plus anger and resentment, and noted that masochistic ego processes include the depressive defenses plus acting out, moralization, and denial. I argued that masochistic relationships may parallel early experiences with objects who attended to the growing child negligently or abusively, yet with occasional warmth when he or she was suffering. The masochistic self is similar to that of the depressive self, with the addition that self-esteem is regulated through enduring mistreatment bravely.

I characterized transferences of self-defeating patients as reflecting wishes to be valued and rescued, and I discussed countertransferences of masochism and sadism. In terms of treatment style, I recommended attention to the real relationship (specifically the therapist's modeling of healthy self-regard), respect for the patient's capability and responsibility for problem solving, and persistence in exposing, challenging, and modifying pathogenic beliefs. Finally, I distinguished masochism from depressive and dissociative psychologies.

SUGGESTIONS FOR FURTHER READING

Reik's (1941) study of moral masochism, though dated, is still worth reading and is not so mired in difficult metapsychology that a beginner would be put off. Stolorow's (1975) essay examines masochism from a self psychology perspective. Cooper's (1988) article on the narcissistic–masochistic character is a classic. Jack and Kerry Kelly Novick (e.g., 1991) have examined the concept developmentally in readable ways. An edited volume on masochism by Glick and Meyers (1988) includes several good essays, most of which concern characterological patterns; *Essential Papers on Masochism* (Hanley, 1995) is also a nice compilation. The books I cited in this chapter by Leon Wurmser (2007) and Sheldon Bach (1999) are both excellent. Finally, I strongly recommend the relational classic by Emmanuel Ghent (1990) for a subtle and wide-ranging exploration of how different the valuable experience of surrender is from masochistic submission.

I did a DVD in the *Master Clinicians* series for the American Psychological Association (McWilliams, 2007) that involved an interview with a patient I saw as having a predominantly masochistic personality. This is available at *www.apa.org/videos*.

13

Obsessive and Compulsive Personalities

People with personalities organized around thinking and doing abound in Western societies. The idealization of reason and the faith in progress through human action that were hallmarks of Enlightenment thinking still permeate our collective psychology. Western civilizations, in conspicuous contrast to some Asian and Third World societies, esteem scientific rationality and "can-do" pragmatism above most other attributes. Many individuals thus place the highest value on their logical faculties and their abilities to solve practical problems. Pursuing pleasure and attaining pride by thinking and doing are so normative in our society that we scarcely think about the complex implications of their being such esteemed and privileged activities.

Where both thinking and doing propel someone psychologically, in marked disproportion to feeling, sensing, intuiting, listening, playing, daydreaming, enjoying the creative arts, and other modes that are less rationally driven or instrumental, we may infer an obsessive–compulsive personality structure. Many highly productive and admirable people are in this category. An attorney who loves to construct and deliver legal arguments operates psychologically by reason and action; an environmental activist who derives self-esteem from political involvement may be similarly impelled. Among people so rigidly organized that they meet the DSM criteria for obsessive–compulsive personality disorder, many combine roughly equal amounts of thinking and doing, often in an obviously defensive way. The "workaholic" and the "Type A personality" are popularly acknowledged variations on the obsessive–compulsive theme.

There are also people who are strongly invested in thinking yet who are relatively indifferent to doing, and vice versa. Professors of philosophy sometimes have obsessional but not compulsive character structure; they get pleasure and self-esteem from mentation, and feel no press to implement their ideas. People drawn to carpentry or accounting frequently have compulsive but not obsessive styles; their gratifications come from accomplishing specific and detailed tasks, often with little cognitive elaboration. Some people with no tendencies toward compulsive rituals come to therapists to get rid of intrusive thoughts, and some come with the converse complaint. Because we are so accustomed, after a century of Freudian thinking about the connections between obsessive and compulsive symptoms, to putting the two phenomena together, it is easy to miss the fact that they are conceptually and sometimes clinically separate.

I have followed convention in putting obsessive and compulsive personalities in the same chapter. Obsessive and compulsive trends often coexist in a person, and analytic explorations of their respective origins have revealed similar dynamics. Note, however, that this is a somewhat artificial coupling with respect to character. As *symptoms*, obsessions (persistent, unwanted thoughts) and compulsions (persistent, unwanted actions) can occur in anyone, not just in those who are characterologically obsessive and compulsive. And not all obsessive and compulsive individuals suffer recurrent intrusive thoughts or engage in irresistible actions. We refer to them as obsessive–compulsive because their coping style involves the same defenses that are implicated in obsessive and compulsive symptoms (Nagera, 1976). Complex biological processes are also implicated in obsessive–compulsive disorders, but like many other analysts (e.g., Chessick, 2001; Gabbard, 2001; Zuelzer & Mass, 1994) I feel we have become too reductive in neglecting the psychological side of such conditions simply because we now know more about their biology.

In obsessive–compulsive disorders (in older language, neuroses), the repetitive thoughts and irresistible actions are ego alien; they disturb the person who has them. In obsessive–compulsive character structure, they are ego syntonic (D. Shapiro, 2001). Obsessive–compulsive personality has been recognized for a long time as a common or "classic" neurotic-level organization. Salzman (1980) summarizes early observations about obsessive–compulsive psychology as follows:

> Obsessive character structures were described by Freud as orderly, stubborn, and parsimonious; others have described them as being obstinate, orderly, perfectionistic, punctual, meticulous, parsimonious, frugal, and inclined to intellectualism and hair-splitting discussion. Pierre Janet

> described such people as being rigid, inflexible, lacking in adaptability, overly conscientious, loving order and discipline, and persistent even in the face of undue obstacles. They are generally dependable and reliable and have high standards and ethical values. They are practical, precise, and scrupulous in their moral requirements. Under conditions of stress or extreme demands, these personality characteristics may congeal into symptomatic behavior that will then be ritualized. (p. 10)

He might have added that Wilhelm Reich (1933) depicted them as "living machines," on the basis of their rigid intellectuality (D. Shapiro, 1965). Woodrow Wilson or Hannah Arendt or Martin Buber could be considered representative of a high-functioning person in this diagnostic group, whereas Mark Chapman, whose obsession with John Lennon led to a compulsion to assassinate him, might be seen as at the psychotic end of the obsessive–compulsive continuum.

As was true for masochism as an overall concept, most behavior that we *tend* to see as *pathological* is by *definition compulsive*: The doer seems driven to act again and again in ways that prove futile or harmful. The schizoid person is compelled to avoid people, the paranoid to distrust, the psychopath to use, and so on. Only when *undoing* is prominent is an action compulsive in the narrower sense of an obsessive–compulsive dynamism or a compulsive personality organization.

DRIVE, AFFECT, AND TEMPERAMENT IN OBSESSION AND COMPULSION

Freud (1908) believed that people who develop obsessive–compulsive disorders were rectally hypersensitive in infancy, physiologically and constitutionally. Contemporary analysts question such an assumption, although they may agree with Freud (e.g., Rice, 2004) that there seems to be a genetic contributant to obsessionality. Still, most would probably say that "anal" issues color the unconscious worlds of people who obsess and act on compulsions. Freud's (1909, 1913, 1917b, 1918) emphasis on fixation at the anal phase of development (roughly 18 months to 3 years), particularly on aggressive urges as they become organized during that period, was novel, seminal, and far less outlandish than debunkers of psychoanalysis would have it.

First, Freud (1908, 1909, 1913) noted that many of the features that typically hang together in people with obsessive–compulsive personalities—cleanliness, stubbornness, concerns with punctuality, tendencies toward withholding—are the salient issues in a toilet-training scenario. Second,

he found anal imagery in the language, dreams, memories, and fantasies of obsessive–compulsive patients. I have found this, too: The earliest memory of one obsessive man I treated was of sitting on the toilet refusing to "produce." When I invited him to free associate, he described himself as "tightening up" and "keeping everything inside."

Third, Freud observed that the people he treated for obsessions and compulsions had been pushed toward bowel control prematurely or harshly or in the context of parental overinvolvement (Fenichel, 1945). (Since the rectal sphincter does not mature until around 18 months, authoritative advice to Western middle-class parents in the early 20th century to start toilet training in children's first year was most unfortunate. It promoted coercion in the name of parental diligence and transformed a benign process of mastery into a dominance–submission contest. If one considers the popularity in that era of subjecting young children to enemas, an intrinsically traumatic procedure usually rationalized in the name of "hygiene," one cannot fail to be impressed with the sadistic implications of the culturally sanctioned rush toward premature anal control.)

Connections between anality and obsessionality have been supported by empirical research (e.g., Fisher, 1970; Fisher & Greenberg, 1996; Noblin, Timmons, & Kael, 1966; Rosenwald, 1972; Tribich & Messer, 1974) as well as by clinical reports of obsessive–compulsive preoccupations with the anal issues of dirt, time, and money (MacKinnon, Michels, & Buckley, 2006). Classical formulations about obsessive and compulsive dynamics that center on early body experience are still alive and well (e.g., Benveniste, 2005; Cela, 1995; Shengold, 1988).

Freud reasoned that toilet training usually constitutes the first situation in which the child must renounce what is natural for what is socially acceptable. The responsible adult and the child who is being trained too early or too strictly or in an atmosphere of lurid parental overconcern enter a power struggle that the child is doomed to lose. The experience of being controlled, judged, and required to perform on schedule creates angry feelings and aggressive fantasies, often about defecation, that the child eventually feels as a bad, sadistic, dirty, shameful part of the self. The need to feel in control, punctual, clean, and reasonable, rather than out of control, erratic, messy, and caught up in emotions like anger and shame, becomes important to the maintenance of identity and self-esteem. The kind of harsh, all-or-nothing superego created by these kinds of experiences manifests itself in a rigid ethical sensibility that Ferenczi (1925) wryly called "sphincter morality."

The basic affective conflict in obsessive and compulsive people is rage (at being controlled) versus fear (of being condemned or punished).

But what especially strikes those of us who work with them is that affect is unformulated, muted, suppressed, unavailable, or rationalized and moralized (MacKinnon et al., 2006). Many contemporary writers construe the obsessive allergy to affect as a type of dissociation (e.g., Harris & Gold, 2001).

Obsessive and compulsive people use words to conceal feelings, not to express them. Most therapists can recall instances of asking such a client how he or she *felt* about something and getting back what he or she *thought*. An exception to the rule of concealed affect in this diagnostic group concerns rage: If it is seen as reasonable and justified, anger is acceptable to the obsessional person. Righteous indignation is thus tolerable, even admired; being annoyed because one did not get what one wanted is not. Therapists frequently feel the presence of normal reactive anger in an obsessive person, but the patient typically denies it—despite sometimes being able to acknowledge intellectually that some behavior (forgetting the check for the third time, or interrupting the therapist in midsentence, or pouting) could denote a passive–aggressive or hostile attitude.

Shame is the other exception to the general picture of affectlessness in obsessive–compulsive people. They have high expectations for themselves, project them onto the therapist, and then feel embarrassed to be seen falling short of their own standards for proper thoughts and deeds. Shame is generally conscious, at least in the form of mild feelings of chagrin, and if gently treated, can usually be named and investigated by the therapist without the protest and denial that may be evoked by efforts to explore other feelings.

DEFENSIVE AND ADAPTIVE PROCESSES IN OBSESSION AND COMPULSION

As the preceding paragraphs imply, the organizing defense of predominantly obsessive people is isolation of affect (Fenichel, 1928). In compulsive people, the main defensive process is undoing. Those who are obsessive and compulsive employ both isolation and undoing. Higher-functioning obsessional people do not usually use isolation in its most extreme forms; they instead prefer more mature versions of the separation of affect from cognition: rationalization, moralization, compartmentalization, and intellectualization. Finally, people in this clinical group rely heavily on reaction formation. Obsessional people at all developmental levels may also use displacement, especially of anger, in circumstances in which by diverting it from its original source to a "legitimate" target, they can own such a feeling without shame.

Cognitive Defenses against Drives, Affects, and Wishes

Obsessive–compulsive individuals idealize cognition and mentation. They tend to consign most feelings to a devalued realm associated with childishness, weakness, loss of control, disorganization, and dirt. (And sometimes femininity; men with obsessive and compulsive personalities may fear that expressing tender emotions regresses them to an early, disowned, premasculine identification with Mother.) They are thus at a great disadvantage in situations where emotions, physical sensations, and fantasy have a powerful and legitimate role. The widow who ruminates ceaselessly about the details of her husband's funeral, keeping a stiff upper lip and converting all mourning into frenetic busyness, not only fails to process her grief effectively but also deprives others of the consolations of offering comfort. Obsessional people in executive positions deny themselves adequate release and recreation, and hurt their employees by making drivenness the company rule.

People with obsessive characters are often effective in formal, public roles yet out of their depth in intimate, domestic ones. Although they are capable of loving attachments, they may not be able to express their tenderer selves without anxiety and shame; consequently, they may turn emotionally toned interactions into oppressively cognitive ones. In therapy and elsewhere, they may lapse into second-person locutions when describing emotions ("How did you feel when the earthquake hit?" "Well, you feel kind of powerless"). Not every human activity should be approached from the standpoint of rational analysis and problem solving. One man with whom I did an intake interview responded to my question about the quality of his sexual relationship with his wife with the somber assertion, "I get the job done."

Obsessional people in the borderline and psychotic ranges may use isolation so relentlessly that they look schizoid. The prevalent misconception of the schizoid person as unfeeling may be based on observations of regressed obsessional people who have become wooden and robotic, so deep is the gulf between their cognition and emotion. Because the distance between an extreme obsession and a delusion is slight, more disturbed obsessional people border on paranoia. I have been told that in the era before antipsychotic medication, a common way to differentiate between an extremely rigid, nonpsychotic obsessive–compulsive person and a barely defended paranoid schizophrenic was to put the patient into a protected room and emphasize that now he or she was safe. Thus invited to suspend obsessional defenses, a schizophrenic person would begin to talk about paranoid delusions, whereas an obsessive–compulsive one would set about cleaning the room.

Behavioral Defenses against Drives, Affects, and Wishes

Undoing is the defining defense mechanism for the kind of compulsivity that characterizes obsessive and compulsive symptoms and personality structure. Compulsive people undo by actions that have the unconscious meaning of atonement and/or magical protection. Compulsivity differs from impulsivity in that a particular action is repeated over and over in a stylized and sometimes escalating way. Compulsive actions also differ from "acting out," strictly speaking, in that they are not so centrally driven by the need to master unprocessed past experiences by recreating them.

Compulsive activity is familiar to all of us. Finishing the food on our plate when we are no longer hungry, cleaning the house when we should be studying for an exam, criticizing someone who offends us even though we know it will have no effect other than making an enemy, throwing "just one more" quarter into the slot machine. Whatever one's compulsive patterns, the disparity between what one feels impelled to do and what is reasonable to do can be glaring. Compulsive activities may be harmful or beneficial; what makes them compulsive is not their destructiveness but their drivenness. Florence Nightingale was probably compulsively helpful; Jon Stewart may be compulsively funny. People rarely come to treatment for their compulsivity if it works on their behalf, but they do come with related problems. Knowing that these clients are organized compulsively can aid us in helping them with whatever they are looking to do in therapy.

Compulsive actions often have the unconscious meaning of undoing a crime. Lady Macbeth's handwashing is a famous literary example of this dynamic, though in her case the crime had actually been committed. In most instances, the compulsive person's crimes exist mainly in fantasy. One of my patients, a married oncologist who knew very well that AIDS is not easily transmitted by mouth-to-mouth contact, felt helplessly compelled to get tested repeatedly for HIV antibodies after she had kissed a man with whom she was tempted to have an affair. Even some compulsions that are manifestly free of a sense of guilt can be found to have originated in guilt-inducing interactions; for example, most people who compulsively clean their plates were made to feel guilty as children about rejecting food when, somewhere in the world, people are starving.

Compulsive behavior also betrays unconscious fantasies of omnipotent control. This dynamic is related to preoccupations with one's presumed crimes in that a determination to control, like the need to undo, derives from beliefs that originated before thoughts and deeds were differentiated. If I think my fantasies and urges are dangerous, that they are equivalent to powerful actions, I will try to restrain them with a compa-

rably powerful counterforce. In prerational cognition (primary process thought), the self is the center of the world, and what happens to oneself is the result of one's own activity, not the chance twists of fate. The baseball player who performs a ritual before each game, the priest who gets anxious if he left something out of a prayer, the pregnant woman who keeps packing and repacking her suitcase for the hospital—all think at some level that they can control the uncontrollable if only they do the right thing.

Reaction Formation

Freud believed that the conscientiousness, fastidiousness, frugality, and diligence of obsessive–compulsive people were reaction formations against wishes to be irresponsible, messy, profligate, and rebellious, and that one could discern in the overresponsible style of such individuals a hint of the inclinations against which they struggled. The incessant rationality of the obsessional person, for example, can be seen as a reaction formation against a superstitious, magical kind of thinking that obsessional defenses do not fully succeed in obscuring. The man who stubbornly insists on driving even though he is exhausted betrays the conviction that averting an accident depends on his being in charge of the car, not on a combination of an alert driver and some good fortune. In insisting on so much control, he is out of control in every significant way.

In Chapter 6 I talked about reaction formation as a defense against tolerating ambivalence. In working with obsessive and compulsive people, one is struck by their fixation on both sides of conflicts between cooperation and rebellion, initiative and sloth, cleanliness and slovenliness, order and disorder, thrift and improvidence, and so forth. Every compulsively organized person seems to have at least one messy drawer. Paragons of virtue may have a paradoxical island of corruption: Paul Tillich, the eminent theologian, had an extensive pornography collection; Martin Luther King Jr. was a womanizer. People who are strongly preoccupied with being upright and responsible may be struggling against more powerful temptations toward self-indulgence than most of us face; if this is so, it should not surprise us when they are only partially able to counteract their darker impulses.

RELATIONAL PATTERNS IN OBSESSIVE AND COMPULSIVE PSYCHOLOGIES

One route by which individuals emerge with obsessive and compulsive psychologies involves parental figures who set high standards of behav-

ior and expect early conformity to them. Such caregivers tend to be strict and consistent in rewarding good behavior and punishing malfeasance. When they are basically loving, they produce emotionally advantaged children whose defenses lead them in directions that vindicate their parents' scrupulous devotion. The traditional American child-rearing style documented in McClelland's (1961) classic studies of achievement motivation tends to produce obsessive and compulsive people who expect a lot of themselves and have a good track record for realizing their goals.

When caregivers are unreasonably exacting, or prematurely demanding, or condemnatory not only of unacceptable behavior but also of accompanying feelings, thoughts, and fantasies, their children's obsessive and compulsive adaptations can be more problematic. One man I worked with had been raised in a stern midwestern Protestant family of deep religious conviction but shallow emotional capacity. His parents hoped he would become a minister and began working on him early to forgo temptation and banish all thoughts of sin. This message gave him no trouble—in fact, he found it easy to imagine assuming the morally elevated role into which they were so eager to cast him—until he reached puberty and found that sexual temptation is not nearly so abstract a danger as it had previously seemed. From then on, he overdosed with self-criticism, conducted incessant rationalistic ruminations about sexual morality, and launched heroic efforts to counteract erotic feelings that another boy would have simply learned to enjoy and master.

From an object relations perspective, what is notable about obsessive and compulsive people is the centrality of issues of *control* in their families of origin. Whereas Freud (1908) depicted the anal phase as engendering a prototypical battle of wills, people with an object relations perspective emphasize that the parent who was unduly controlling about toilet training was probably equally controlling about oral- and oedipal-phase issues (and subsequent ones, for that matter). The mother who laid down the law in the bathroom is likely to have fed her child on a schedule, demanded that naps be taken at particular times, inhibited spontaneous motor activity, prohibited masturbation, insisted on conventional sex-role behavior, punished loose talk, and so on. The father who was forbidding enough to provoke regressions from oedipal to anal concerns was probably also reserved toward his infant, stern with his toddler, and authoritarian with his school-age child.

Meares (2001), citing research about the frequency of contamination fears in obsessional people in disparate cultures (e.g., India, Japan, Egypt), relates them to separation anxiety that is created by parental overinvolvement and overprotection. Rooting his observations in theo-

retical and empirical literature about cognitive development, he argues that overprotective parents get in the way of a young child's taking the small risks that are necessary to develop a sense of the boundary of self, and accounts for the omnipotent, magical thinking found in obsessive and compulsive people in terms of the lack of this boundary.

There is a version of obsessive and compulsive personality that is more introjective, or self-definition oriented, and one that is more anaclitic, or self-in-relation oriented (Blatt, 2008). The Freudian obsessive–compulsive (Freud, 1913) was definitely the former. When I refer to "traditional" or "old-fashioned" obsessive and compulsive dynamics, I am referring to a guilt-dominated psychology, which was common in Freud's era and culture. It can be found in many contemporary cultures and subcultures but now seems rarer in mainstream North American communities. In those, about which I say more shortly, we tend to see obsessive behaviors that are more shame based, more focused on looking perfect to others rather than responding to one's morally perfectionistic internal gyroscope. In the first edition of this book, I followed Kernberg's (1984) formulation that the second type is a subset of narcissistic personalities, but another way of construing less guilt-prone obsessive–compulsive people is as having an anaclitic version of obsessional psychology.

In old-fashioned obsessive–compulsive-breeding families, control may be expressed in moralized, guilt-inducing terms, as in "I'm disappointed that you were not responsible enough to have fed your dog on time," or "I expect more cooperative behavior from a big girl like you," or "How would you like it if somebody treated *you* that way?" Moralization is actively modeled. Parents explain their own actions on the basis of what is right ("I don't enjoy punishing you, but it's for your own good"). Productive behavior is associated with virtue, as in the "salvation through work" theology of Calvinism. Self-control and deferral of gratification are idealized.

There are still many families that operate this way, but in Western industrialized cultures, pop-Freudian ideas about the inhibiting effects of too moralistic an upbringing, in combination with 20th-century dangers and cataclysms that suggest the wisdom of "getting it while you can" rather than postponing gratification, have changed child-rearing practices. We see fewer obsessive and compulsive people of the morally preoccupied type common in Freud's day. Many contemporary families that emphasize control foster obsessive and compulsive patterns through shaming rather than guilt induction. Messages like "What will people think of you if you're overweight?" or "The other kids won't want to play with you if you behave like that," or "You'll never get into an Ivy League college if you don't do better" have, according to many clinicians

and societal observers, become more common messages in the West than communications stressing the primacy of individual conscience and the moral implications of one's behavior.

It is important to appreciate this change if one is working with more contemporary obsessive and compulsive psychopathologies such as eating disorders (not that anorexia and bulimia nervosa were unknown at the turn of the century, but they were almost certainly less prevalent). Freudian accounts of compulsion are insufficient in accounting for anorectic and bulimic compulsivity; post-Freudian writers drawing on object relations theory and on research on attachment, addiction, and dissociation have provided more clinically useful formulations (e.g., Bromberg, 2001; Pearlman, 2005; Sands, 2003; Tibon & Rothschild, 2009; Yarock, 1993).

Another kind of family background has been associated with obsessive and compulsive personality and, as is typical in psychoanalytic observation, it is the polar opposite of the overcontrolling, moralistic ambiance. Some people feel so bereft of clear family standards, so unsupervised and casually ignored by the adults around them, that in order to push themselves to grow up they hold themselves to idealized criteria of behavior and feeling that they derive from the larger culture. These standards, since they are abstract and not modeled by people known personally to the child, tend to be harsh and unbuffered by a humane sense of proportion. One of my patients, for example, whose father was a melancholy alcoholic and whose mother was overburdened and distracted, grew up in a house where nothing ever got done. The roof leaked, the weeds proliferated, the dishes sat in the sink. He was deeply ashamed of his parents' ineptitude and developed an intense determination to be the opposite: organized, competent, in control. He became a successful tax advisor, but a driven workaholic who lived in fear that he would betray himself as a fraud who was somehow in essence as ineffectual as his father and mother.

Early psychoanalysts noted with great interest the phenomenon of obsessive–compulsive character in underparented children; it challenged Freud's (1913) model of superego formation, which postulates the presence of a strong and authoritative parent with whom the child identifies. Many analysts were finding that their patients with the harshest superegos had been the most laxly parented (cf. Beres, 1958). They concluded that having to model oneself after a parental image that one invents oneself, especially if one has an intense, aggressive temperament that is projected into that image, can create obsessive–compulsive dynamics. Later, Kohut (1971, 1977, 1984) and other self psychologists made similar observations from the standpoint of their emphasis on idealization.

THE OBSESSIVE–COMPULSIVE SELF

Introjectively oriented obsessive and compulsive people are deeply concerned with issues of control and moral rectitude. They tend to define the latter in terms of the former; that is, they equate righteous behavior with keeping aggressive, lustful, and needy parts of the self under strict rein. They are apt to be seriously religious, hard-working, self-critical, and dependable. Their self-esteem comes from meeting the demands of internalized parental figures who hold them to a high standard of behavior and sometimes thought. They worry a lot, especially in situations in which they have to make a choice, and they can be easily paralyzed when the act of choosing has portentous implications. Anaclitically oriented obsessive individuals worry a lot, too, though the focus of their concern is more external: The "perfect" decision is one that no witness can criticize.

This paralysis is one of the most unfortunate effects of the reluctance of obsessional people to make a choice. Early analysts christened this phenomenon the "doubting mania." In the effort to keep all their options open, so that they can maintain (fantasied) control over all possible outcomes, they end up having no options. An obsessive–compulsive woman I know, on becoming pregnant, lined up two different obstetricians who worked at two different medical centers with opposing philosophies about childbirth. All through her pregnancy she ruminated about which person and which facility was preferable. When she went into labor, not having resolved this question, it took her so long to decide whether her condition warranted going to the hospital, and which hospital it should be, that she was suddenly in the later stages of giving birth and had to go to the nearest clinic and be delivered by the resident on duty. All her painstaking obsessing was rendered futile when reality finally enforced its own resolution of her ambivalence.

Her experience exemplifies the tendency of obsessively structured people to postpone decision making until they can see what the "perfect" (i.e., guilt and uncertainty free) decision would be. It is common for them to come to therapy trying to resolve ambivalence over two boyfriends, two competing graduate programs, two contrasting job opportunities, and the like. The client's fear of making the "wrong" decision and tendency to cast the process of deciding in purely rationalistic terms—lists of pros and cons are typical—often seduce the therapist into offering an opinion about which choice would be preferable, at which point the patient immediately responds with counterarguments. The "Yes, but" stance of the obsessive person may be seen as, at least in part, an effort to avoid the guilt that inevitably accompanies action. Obsessive people often postpone and procrastinate until external circumstances like the

rejection by a lover or the passing of a deadline determine their direction. In standard neurotic fashion, then, their overzealousness to preserve their autonomy or sense of agency serves eventually to disable it.

Where the obsessive person postpones and procrastinates, the compulsive one speeds ahead. People with compulsive psychologies have a similar problem with guilt or shame and autonomy, but they solve it in the opposite direction: They jump into action before considering alternatives. For them, certain situations have "demand characteristics" requiring certain behaviors. These are not always foolish (like knocking on wood every time one makes an optimistic prediction) or self-destructive (jumping into bed every time a situation becomes sexually tinged); some people are compulsively helpful (McWilliams, 1984). Some drivers will risk their own safety and wreck their cars before hitting an animal, so automatic is their compulsion to preserve life.

The compulsive person's rush to action has the same relationship to autonomy as the obsessive person's avoidance of action. Instrumental thinking and expressive feeling are both circumvented lest the person notice that he or she is actually making a choice. Choice involves responsibility for one's actions, and responsibility involves tolerance of normal levels of both guilt and shame. Non-neurotic guilt is a natural reaction to exerting power, and a vulnerability to shame comes with the territory of taking deliberate action that can be seen by others. Both obsessive and compulsive people may be so saturated with irrational guilt and/or shame that they cannot absorb any more of these feelings.

As I mentioned earlier, obsessive people support their self-esteem by thinking; compulsive ones by doing. When circumstances make it hard for obsessive or compulsive individuals to feel good about themselves on the basis of what they are figuring out or accomplishing, respectively, they become depressed. Losing a job is a disaster for almost anybody, but it is catastrophic for compulsive individuals because work is often the primary source of their self-esteem. I do not know if we have any research on this yet, but I assume that people with the guilt-ridden version of obsessive and compulsive dynamics are subject to more introjective depressions, with an actively bad (uncontrolled, destructive) self-concept gaining ascendancy, and that shame-prone obsessive and compulsive clients suffer more anaclitic depressive reactions (see Chapter 11).

Obsessive and compulsive people fear their own hostile feelings and suffer inordinate self-criticism over both actual and purely mental aggression. Depending on the content of their family's messages, they may be equally nervous about giving in to lust, greed, vanity, sloth, or envy. Rather than accepting such attitudes and basing their self-respect or self-condemnation solely on how they behave, they typically regard even feeling such impulses as reprehensible. Like moral masochists, with

whom they share tendencies toward overconscientiousness and indignation, introjective obsessive patients may nurture a kind of private vanity about the stringency of their demands on themselves. They value self-control over most other virtues and emphasize attributes like discipline, order, reliability, loyalty, integrity, and perseverance. Their difficulties in suspending control diminish their capacities in areas like sexuality, play, humor, and spontaneity in general.

Finally, obsessive–compulsive people are noted for avoidance of affect-laden wholes in favor of separately considered minutia (D. Shapiro, 1965). People with obsessional psychologies hear all the words and none of the music. In an effort to bypass the overall import of any decision or perception, the appreciation of which might arouse guilt, they become fixed on specific details or implications ("What if ... ?"). On the Rorschach test, obsessional subjects avoid whole percept responses and expound on the possible interpretations of small particulars of the inkblots. They cannot (unconsciously, will not) see the forest for the proverbial trees.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH OBSESSIVE AND COMPULSIVE PATIENTS

Obsessive and compulsive people tend to be "good patients" (except toward the lower end of the severity continuum, where the rigidity of their isolation of affect or the driving immediacy of their compulsions interfere with therapeutic collaboration). They are serious, conscientious, honest, motivated, and hard-working. Nonetheless, they have a reputation for being difficult. It is typical for obsessional clients to experience the therapist as a devoted but demanding and judgmental parent, and to be consciously compliant and unconsciously oppositional. Despite all their dutiful cooperation, they convey an undertone of irritability and criticism. When a therapist comments on possible negative feelings, they are usually denied. As Freud (1908) originally noted, obsessional patients tend to be subtly or overtly argumentative, controlling, critical, and resentful about parting with money. They wait impatiently for the therapist to speak and then interrupt before a sentence is completed. And at a conscious level, they seem utterly innocent of their negativity.

Thirty-five years ago I treated a man for severe obsessions and compulsions. Today I might send him for concurrent exposure therapy and possibly medication; at the time, those treatments had not been developed. He was an engineering student from India, lost and homesick in an alien environment. In India, deference to authority is a powerfully rein-

forced norm, and in engineering, compulsivity is adaptive and rewarded. But even by the standards of these comparatively obsessive and compulsive reference groups his ruminations and rituals were excessive, and he wanted me to tell him definitively how to stop them. When I reframed the task as understanding the feelings behind his preoccupations, he was visibly dismayed. I suggested that he might be disappointed that my way of formulating his problem did not permit a quick, authoritative solution. "Oh, no!" he insisted; he was sure I knew best, and he had only positive reactions to me.

The following week he came in asking how "scientific" the discipline of psychotherapy is. "Is it like physics or chemistry, an exact science?" he wanted to know. No, I replied, it is not so exact and has many aspects of an art. "I see," he pondered, frowning. I then asked if it troubled him that there is not more scientific accuracy in my field. "Oh, no!" he insisted, absentmindedly straightening up the papers on the end of my desk. Did the disorder in my office bother him? "Oh, no!" In fact, he added, it is probably evidence that I have a creative mind. He spent our third session educating me about how different things are in India, and wondering abstractedly about how a psychiatrist from his country might work with him. Did he sometimes wish I knew more about his culture, or that he could see an Indian therapist? "Oh, no!" He is very satisfied with me.

His was, by clinic policy, an eight-session treatment. By our last meeting, I had succeeded, mostly by gentle teasing, in getting him to admit to being occasionally a little irritated with me and with therapy (not angry, not even aggravated, just slightly bothered, he carefully noted). I thought the treatment had been largely a failure, though I had not expected to accomplish much in eight meetings. But 2 years later he came back to tell me that he had thought a lot about feelings since he had seen me, particularly about his anger and sadness at being so far from his native country. As he had let in those emotions, his obsessions and compulsions had waned. In a manner typical of people in this clinical group, he had found a way to feel that he was in control of pursuing insights that came up in therapy, and this subjective autonomy was supporting his self-esteem.

Countertransference with obsessional clients often includes an annoyed impatience, with wishes to shake them, to get them to be open about ordinary feelings, to give them a verbal enema or insist that they "shit or get off the pot." Their combination of excessive conscious submission and powerful unconscious defiance can be maddening. Therapists who have no personal inclination to regard affect as evidence of weakness or lack of discipline are mystified by the obsessional person's shame about most emotions and resistance to admitting them. Some-

times, one can even feel one's rectal sphincter muscle tightening, in identification with the constricted emotional world of the patient (concordant), and in a physiological effort to contain one's retaliatory wish to "dump" on such an exasperating person (complementary).

The atmosphere of veiled criticism that an obsessive–compulsive person emits can be discouraging and undermining. In addition, clinicians easily feel bored or distanced by the client's unremitting intellectualization. With one obsessive–compulsive man I treated, I used to find myself having a vivid image that his head was alive and talking, but his body was a life-sized cardboard cutout like the ones amusement parks provide for customers to put their heads through to be photographed. Feelings of insignificance, boredom, and obliteration are relatively rare when one works with introjective obsessional clients, but they may vex the therapist of a more anaclitically obsessive person. Hearing endless ruminations about whether one should do the Atkins or the South Beach diet, buy a poodle or a beagle, go by taxi or by foot can be aggravating.

There is something very object related about the unconscious devaluation of the more guilt-ridden obsessive–compulsive patients, something touching about their efforts to be "good" in such childlike ways as cooperating and deferring. Doubts about whether anything is being accomplished in therapy are typical for the therapist as well as for the obsessive or compulsive client, especially before the person is brave enough to express such worries directly. But underneath all the obstinacy of the obsessional individual is a capacity to appreciate the therapist's patient, noncondemnatory attitude, and as a result, it is not hard to maintain an atmosphere of basic warmth.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF OBSESSIVE OR COMPULSIVE PERSONALITY

The first rule of practice with obsessive and compulsive people is ordinary kindness. They are used to being exasperating to others, for reasons they do not fully comprehend, and they are grateful for nonretaliatory responses to their irritating qualities. Appreciation for, and interpretation of, their vulnerability to shame is essential. Refusal to advise them, hurry them, and criticize them for the effects of their isolation, undoing, and reaction formation will foster more movement in therapy than more confronting measures. Countertransference-driven power struggles are common between therapists and obsessional clients; they produce temporary affective movement, but in the long run they only replicate early and detrimental object relations.

At the same time that one carefully avoids the therapeutic equivalent of becoming the demanding, controlling parent, one needs to keep relating warmly. The degree of therapist activity will depend on the client—some obsessional people will not let the clinician get a word in edgewise until the last moments of a session, while others become disorganized and frightened if one remains quiet. Refusing to control should be distinguished from attitudes that will be felt as emotional disengagement. Remaining silent with a person who feels a pressure in silence is self-defeating, as is silence with a patient who feels abandoned when he or she is not addressed. Asking the patient's direction on how much the therapist should speak, like other respectful inquiries about what is helpful, may resolve the therapist's problem while supporting the client's sense of agency, human equality, and realistic control.

An exception to the general rule of refusing to advise or control concerns people whose compulsions are outright dangerous. With self-destructive compulsivity, the therapist has two choices: either tolerate anxiety about what the patient is doing until the slow integration of the therapy work reduces the compulsion to act, or, at the outset, make therapy contingent on the client's stopping the compulsive behavior. An example of the former would be hearing about one driven sexual affair after another while nonjudgmentally analyzing the dynamics involved, until the patient becomes unable to rationalize the defensive use of sexuality. An advantage of this position is its implicit encouragement of honesty (if one sets behavioral conditions for therapy, the patient will be tempted to hide it if he or she cheats). When the person's self-destructiveness is not life threatening, I think this choice is usually preferable.

Examples of the latter would include requiring that an addict go through detox and rehab before starting psychotherapy, insisting that a dangerously anorexic client first gain a given number of pounds in a hospital-supervised regime, or making therapy of an alcohol abuser conditional on attendance at AA meetings. When undoing is automatic, the wishes, urges, and fantasied crimes being undone will not surface. Moreover, by accepting compulsively self-harming people into treatment unconditionally, the therapist may unwittingly contribute to their fantasies that therapy will operate magically, without their having at some point to exert self-control. This position is particularly advisable when the patient's compulsion involves substance abuse; doing therapy with someone whose mental processes are chemically altered is an exercise in futility.

Many compulsions are not responsive to treatment until the driven person encounters sharp negative consequences. Shoplifters and pedophiles tend to get serious about therapy only after they have been arrested;

addicts often have to "bottom out" before getting help; cigarette smokers rarely try to stop before they get scared about their health. As long as one is "getting away with" compulsivity, there is little incentive to change. The reader may wonder why anyone would want to go through psychotherapy once the compulsive behavior is under control. The answer is that people feel strongly the difference between being able to discipline a compulsion (by efforts of will or submission to authority) and not having one in the first place. Therapy with someone who has stopped behaving compulsively allows that person to master the issues that drove the compulsion, and to find internal serenity rather than a tenuous achievement of self-control. The alcoholic who feels no more need to drink is in a lot better shape than the one who, through constantly reinforced efforts of will, can manage to stay sober despite temptation (Levin, 1987). Individuals in recovery from compulsion are also helped by understanding why they were vulnerable to addictive behavior.

The second important feature of good work with people in this diagnostic group, especially the more obsessional ones, is the avoidance of intellectualization. Interpretations that address the cognitive level of understanding, before affective responses have been disinhibited, will be counterproductive. I suspect we have all known people in psychoanalytic therapy who can discuss their dynamics in the tone of an auto mechanic detailing what is wrong with someone's motor, and who appear not a bit better for all this knowledge. It was experience with obsessive–compulsive people that infused analytic clinical theory with warnings about the dangers of premature interpretation (e.g., Glover, 1955; Josephs, 1992; Strachey, 1934) and comments on the difference between intellectual and emotional insight (e.g., Kris, 1956; Richfield, 1954).

Because it can feel like a power struggle (to both parties) for the therapist to keep harping on the question "But how do you *feel*?" one way to bring a more affective dimension into the work is through imagery, symbolism, and artistic communication. Hammer (1990), in exploring how obsessional people use words more to fend off feeling than to express it, mentions the special value to this population of a more poetic style of speech, rich in analogy and metaphor. With extremely constricted patients, the combination of group therapy (where other clients tend to attack the isolative defense head-on) and individual treatment (where the therapist can help the person to process such experiences privately) is sometimes therapeutic (Yalom & Leszcz, 2005).

A third component of good treatment with obsessionally and compulsively structured people is the practitioner's willingness to help them express their anger and criticism about therapy and the therapist. Usually one cannot accomplish this right away, but one can pave the way for the patient's eventual acceptance of such feelings by preparatory com-

ments such as "It can be exasperating that the therapy process does not work as fast as we would both want it to. Don't be surprised if you find yourself having resentful thoughts about coming here or about me. If you were to notice you were feeling dissatisfied with our work, would anything get in the way of your telling me that?" A frequent response to these ground-laying comments is a protest that the client cannot imagine being actively dissatisfied and critical. The therapist's position that such a statement is very curious may begin the process of making ego alien the automatic process of isolation.

To be useful to obsessive and compulsive people, one needs not only to help them find and name their affects but also to encourage them to enjoy them. Psychoanalytic therapy involves more than making the unconscious conscious; it requires changing the patient's conviction that what has been made conscious is shameful. Behind this susceptibility to shame lie pathogenic beliefs about sinfulness that propel both obsessive and compulsive mechanisms. That one could enjoy a sadistic fantasy, not just own up to it, or derive comfort from grieving, not just admit grudgingly that one is sad, may be news to these clients. The sharing of the therapist's sense of humor may lighten the guilt and self-criticism that weigh so heavily on them.

"What good will it do to feel that?" is a frequent query of individuals with obsessive and compulsive psychologies. The answer is that harm is being done in *not* feeling it. Emotions make one feel alive, energized, and fully human, even if they express attitudes that the patient has come to see as "not very nice." Especially with compulsive patients, it is useful to comment on their difficulty tolerating just *being*, rather than doing. It is no accident that 12-step programs, in their efforts to arrest self-destructive compulsivity, discovered the Serenity Prayer. Occasionally, one can appeal to the practical nature of obsessive and compulsive people when they flee their feelings; for example, some scientifically minded patients find it helpful to know that crying rids the brain of certain chemicals associated with chronic mood disturbances. If these patients can rationalize expressiveness as being something other than pathetic self-indulgence, they may risk it sooner. But ultimately, the therapist's quiet dedication to emotional honesty, and the patient's growing experience that he or she will not be judged or controlled, will move the work forward.

Via medications such as the selective serotonin reuptake inhibitors (SSRIs), and CBT techniques such as exposure, many people with obsessive–compulsive *disorder* are now being helped more than psychoanalytic therapy alone could help them previously. In those who have obsessive–compulsive *personality*, with ego-syntonic ruminations and compulsions, those approaches seem to be less effective. This observa-

tion parallels what I said in Chapter 11 about characterologically depressive patients, who seem less responsive to the drugs that mitigate major depression or dysthymia than individuals who suffer a depression but whose personality structure is not depressive. Nonetheless, many analytic therapists (e.g., Lieb, 2001) working with clients with obsessive and compulsive personalities report increased effectiveness when they combine dynamic psychotherapy with both pharmacological and cognitive-behavioral interventions.

DIFFERENTIAL DIAGNOSIS

Ordinarily, obsessive and compulsive dynamics are easy to differentiate from other kinds of psychology. Isolation and undoing are usually pretty visible; compulsive organization is particularly conspicuous, since the person's drivenness to act cannot be easily masked. Still, some kinds of confusion occur. Obsessive structure is sometimes hard to distinguish from schizoid psychology, especially at the lower-functioning end of the developmental continuum, and from narcissistic personalities with obsessive defenses. Sometimes it can be hard to differentiate obsessive and compulsive dynamics from organic brain syndromes.

Obsessive versus Narcissistic Personality

In Chapter 8 I discussed narcissistic versus obsessional character structure, with an emphasis on the damage done when an essentially narcissistic person is misunderstood as obsessive or compulsive, when the therapist accordingly looks for unconscious anger, omnipotent fantasies, and guilt rather than subjective emptiness and fragile self-esteem. The damage is probably less serious when a mistake is made the other way, since all of us, whatever our character, can profit from therapies that focus on issues of self. Nevertheless, an old-fashioned, moralistic obsessive or compulsive person being treated by someone who construes him or her as narcissistic would be eventually distressed, demoralized, and even insulted by being seen as needy rather than conflicted.

Obsessive and compulsive people with introjective dynamics have a strong center of gravity psychologically; they are judgmental and self-critical. A therapist who communicates empathic acceptance of their subjective experience without evoking the deeper affects and beliefs that shape that experience is depriving such patients of any empathy worth its name. Sometimes interventions that a therapist conceives as mirroring are received by obsessive and compulsive clients as corrupting, in that

the patient views the therapist as implicitly condoning aspects of the self that the patient sees as indefensible. Under these circumstances patients begin to doubt the moral credentials of the therapist. Analysis of the rationalistic and moralistic defenses of obsessive and compulsive clients should precede efforts to convey acceptance of the troublesome feelings these defenses have been erected to conceal.

Obsessive versus Schizoid Personality

In the symbiotic–psychotic range, some people who look schizoid may be in fact regressed obsessional patients. Although a schizoid person withdraws from the outer world, he or she tends to be conscious of intense inner feelings and vivid fantasies. In contrast, a withdrawn obsessional person uses isolation so completely that he or she may be subjectively "blank" or wooden in appearance. Knowledge of the premorbid functioning of someone for whom this differential applies will provide clues about whether to communicate to the patient that it is safe to express his or her intense inner experience, or to convey that it must be terrible to feel so cold and dead inside.

Obsessive–Compulsive versus Organic Conditions

This book does not cover psychopathology of organic origin, but I should note the frequency with which inexperienced interviewers—whether or not they have had medical training—misconstrue behavior related to brain damage as obsessive–compulsive. The perseverative thinking and repetitive actions typical of organic brain syndromes (Goldstein, 1959) can mimic "functional" obsessiveness and compulsivity, but dynamically informed questioning will reveal that isolation of affect and undoing are not involved. A good history, with inquiries about possible fetal alcohol syndrome or maternal addiction during pregnancy, complications at birth, illnesses with high fever (meningitis, encephalitis), head injury, and so forth may suggest an organic diagnosis, which may be confirmed by neurological examination.

Not all brain damage involves loss of intelligence. The practitioner should not assume that because a person is bright and competent, he or she could not suffer from organically based difficulties. This is a critical differential, since therapy to uncover unconscious dynamics in order to reduce a client's obsessive–compulsive inflexibility may be radically different from treatment that emphasizes, to the organically damaged person and to his or her family, the value of maintaining order and predictability for the sake of the client's emotional security and comfort.

SUMMARY

I have discussed in this chapter people who preferentially think and/or act, in order to pursue emotional safety, reduce anxiety, maintain self-esteem, and resolve internal conflicts. I reviewed classical conceptions of obsessive–compulsive character structure, with emphasis on Freud's (1908, 1909, 1913, 1931) formulations about the centrality of anal-phase issues in its development and related struggles over unconscious guilt and fantasies of omnipotence. I differentiated that version of the phenomenon from more anaclitic manifestations of obsessive–compulsive psychology. I noted that defensive processes in obsessive and compulsive people (isolation and undoing, respectively, and reaction formation in both) suppress or distract from most affects, wishes, and drives, but unconscious guilt (over hostility) and conscious susceptibility to shame (over falling short of standards) are easily inferred. Family histories of people in this group are notable for either overcontrol or lack of control; current relationships tend to be formal, moralized, and somewhat juiceless, despite the basic capacity for attachment that obsessive–compulsive people demonstrate.

I also addressed obsessive–compulsive perfectionism, ambivalence, and avoidance of guilt by either procrastination or impulsivity and noted that transference and countertransference issues center around noticing and absorbing the patient's unconscious negativity. Therapeutic inferences include being unhurried, avoiding power struggles, discouraging intellectualization, inviting anger and criticism, and modeling the enjoyment of devalued feelings and fantasies. I differentiated obsessive and compulsive personalities from schizoid patients, from narcissistically structured people with perfectionistic and compulsive defenses, and from those with organic brain syndromes.

SUGGESTIONS FOR FURTHER READING

Probably the most readable book on this topic is Salzman (1980). D. Shapiro's (1965) naturalistic study of the obsessive–compulsive personality style remains a classic; and his 1984 and 1999 books followed it up with interesting chapters on obsessive and compulsive rigidity.

Shengold's *Halo in the Sky* (1988) offers a brilliant exploration of anality as a concept and metaphor. The second issue of the journal *Psychoanalytic Inquiry* in 2001 (Bristol & Pasternack, 2001) contains many relevant essays, some of which I have cited in this chapter, mostly about obsessive–compulsive disorder but touching on obsessive–compulsive personality and the evaluation of psychoanalytic ideas about it in the context of recent research on neuroscience.

14

Hysterical (Histrionic) Personalities

Psychoanalysis began with the effort to understand hysterical conditions and has returned to that problem regularly since the 1880s, when Freud first tackled it. Inspired by the work of the French psychiatrists Charcot, Janet, and Bernheim, who were investigating hysterical afflictions via hypnosis, Freud first began asking the kinds of questions that gave psychoanalytic theory its shape: How can someone know and not know at the same time? What accounts for forgetting important experiences? Does the body express what the mind cannot fathom? What would explain such sensational symptoms as full epileptic-like seizures in a person without epilepsy? Or blindness in someone optically normal? Or paralysis when nothing is wrong with the nerves?

At the time, hysterically ill women were being thrown out of physicians' offices as malingerers. Whatever Freud's mistakes about female psychology or sexual trauma, it is to his credit that he took these women seriously and paid them the respect of trying to understand their particular suffering. By doing so, he believed he would begin comprehending processes that operate in the emotionally healthy as well as in the emotionally disabled. Although this chapter is not about the dramatic disturbances that were in Freud's day subsumed under the rubric of hysterical neurosis (conversion, amnesia, inexplicable attacks of anxiety, and other disparate phenomena), I review some psychoanalytic history relevant to those conditions in the service of eventually focusing on the personality structure that often accompanies them.

Hysterical (or, as per later editions of the DSM, histrionic) character is common in people without frequent or striking hysterical symptoms. As with obsessive–compulsive individuals who lack obsessions and compulsions but who operate on the same principles that produce them, there are many of us who have never had hysterical outbreaks but whose subjective experience is colored by the dynamics that create them. Although this type of personality is seen more in women, hysterically organized men are not uncommon. In fact, Freud (e.g., 1897) regarded himself—with good reason—as somewhat hysterical. One of his earliest publications (1886) was on hysteria in a man. Analytically oriented therapists are accustomed to thinking of individuals with hysterical personalities as in the neurotic range, since their defenses have been considered more mature, but many people have hysterical psychologies organized at the borderline and psychotic levels.

Elizabeth Zetzel (1968) noted some time ago (in an article that begins with the nursery rhyme that observes "When she was good she was very, very good, but when she was bad she was horrid") the great distance between healthier and more deeply impaired individuals in this group. Confusingly, post-1980 DSMs have reconceptualized histrionic personality disorder toward the pathological end of the hysterical continuum, indistinguishable from "Zetzel type 3 and 4" personalities and Kernberg's (1975, 1984) "infantile personality." Kernberg and others have used the term "hysterical" for higher-functioning patients and "hysteroid" or "histrionic" or "pseudohysterical infantile" to refer to those in the borderline and psychotic ranges.

In the language of more recent research on personality and personality disorder, people with hysterical tendencies who are securely attached may be seen as having a histrionic style (but not disorder) or hysterical personality. Researchers studying psychopathology and attachment (e.g., Ouimette, Klein, Anderson, Riso, & Lizardi, 1994) have noted an anxious–resistant attachment style in histrionic people who meet DSM criteria for histrionic personality disorder. Hysterically oriented people with histories of significant early trauma, for whom the infantile object of safety was also the source of fear, show a disorganized attachment style characterized by subjective helplessness and compulsive caregiving rather than hostility and aggression (Lyons-Ruth, 2001).

The phenomenon of hysterical psychosis, which may overlap with the extreme version of the disorganized, posttraumatic attachment style, has been known since antiquity (Veith, 1965, 1977), noted across cultures (Linton, 1956), and supported by earlier research (Hirsch & Hollender, 1969; Hollender & Hirsch, 1964; Langness, 1967; Richman & White, 1970). Its absence from the DSM has arguably impoverished our approach to assessment and contributed to the overdiagnosis of schizo-

phrenia when a trauma-related, hysteroid process should have been considered.

People with hysterical personalities have high anxiety, high intensity, and high reactivity, especially interpersonally. They are warm, energetic, and intuitive "people people," attracted to situations of personal drama and risk. They may be so addicted to excitement that they go from crisis to crisis. Because of their anxiety level and the conflicts they suffer, their own emotionality may look superficial, artificial, and exaggerated to others, and their feelings may shift rapidly ("hysterical lability of affect"). The great actress Sarah Bernhardt (Gottlieb, 2010) seems to have had many hysterical features, as did the fictional Scarlett O'Hara. People with hysterical characters may like high-visibility professions, such as acting, performing, preaching, teaching, and politics.

DRIVE, AFFECT, AND TEMPERAMENT IN HYSTERIA

Many have suggested that hysterically organized people are by temperament intense, hypersensitive, and sociophilic. The kind of baby who kicks and screams when frustrated but shrieks with glee when entertained may well have the constitutional template for hysteria. Freud (e.g., 1931) suggested that powerful appetites may be characteristic of people who become hysterical, that they crave oral supplies, love, attention, and erotic closeness. Blatt and Levy (2003) have reviewed extensive empirical data attesting to their tilt in the anaclitic direction. They seek stimulation but get overwhelmed by too much of it, and they have trouble processing distressing experiences. They may have the sensitivity of the schizoid person, to whom they often have an affinity (McWilliams, 2006), but they move toward people rather than away from them.

Others have speculated (e.g., D. W. Allen, 1977) that people with hysterical tendencies are more dependent constitutionally on right-hemisphere brain functioning (Galin, 1974; Wasserman & Stefanatos, 2000), in contrast to obsessively inclined individuals, who may be left-brain dominant. Before fMRI studies, one basis for this speculation was the careful work of D. Shapiro (1965) on the hysterical cognitive style. Hysterically organized people differ strikingly from more obsessional ones in the quality of their mental operations; specifically, they are impressionistic, global, and imaginal. Some highly intelligent people with hysterical personality organization are remarkably creative; their integration of affective and sensory apperception with more linear, logical approaches to understanding produces a rich integration of intellectual and artistic sensibility.

Developmentally, Freud (1925b, 1932) and many later analysts (e.g., Halleck, 1967; Hollender, 1971; Marmor, 1953) suggested a dual fixation in hysteria, at oral and oedipal issues. An oversimplified account of this formulation follows: A sensitive and hungry little girl needs particularly responsive maternal care in infancy. She becomes disappointed with her mother, who fails to make her feel adequately safe, sated, and prized. As she approaches the oedipal phase, she achieves separation from the mother by devaluing her. She turns her intense love toward Father, a most exciting object, especially because her unmet oral needs combine with later genital concerns to magnify oedipal dynamics. But how can she make a normal resolution of the oedipal conflict by identifying with and competing with her mother? She still needs her, and she has also devalued her.

This dilemma traps her at the oedipal level. As a result of her fixation, she continues to see males as strong and exciting, and females, herself included, as weak and insignificant. Because she regards power as inherently a male attribute, she looks up to men, but she also—unconsciously, for the most part—hates and envies them. She tries to increase her sense of adequacy and self-esteem by attaching to males, yet she also subtly punishes them for their assumed superiority. She uses her sexuality, the one kind of power she feels her gender affords, along with idealization and "feminine wiles"—the strategies of the subjectively weak—in order to access male strength. Because she uses sex defensively rather than expressively, and because she fears men and their abuses of power, she does not fully enjoy sexual intimacy with them and may suffer physical equivalents of fear and rejection, such as sexual pain or anesthesia, lack of full responsiveness, or failure of orgasm.

Freud's stress on penis envy as a universal female problem arose from his work with hysterically structured women. When he discovered that his patients symbolized male power in their dreams, fantasies, and symptoms with phallic images, he speculated that during their early years these women had learned to equate powerlessness—their own and that of their mothers—with penislessness. In a patriarchal and increasingly complex urban culture where traditional feminine virtues carried little prestige, such a conclusion was probably easy for many young girls to draw. Freud (1932) stated:

> The castration complex of girls is ... started by the sight of the genitals of the other sex. They at once notice the difference *and, it must be admitted, its significance too.* They feel seriously wronged, often declare that they want to "have something like it too," and fall victim to "envy for the penis," which will leave ineradicable traces on their development and the formation of their character. (p. 125; emphasis added)

This quotation suggests that despite his reputation in some intellectual quarters, Freud appreciated the negative consequences of patriarchy. In his life he encouraged women toward professional achievement and intellectual equality. He also hoped that by interpreting their penis envy he would foster his patients' realization that men are not *in fact* superior—that a belief to that effect betrays an infantile fantasy that can be examined and discarded. Blame for the fact that ideas about penis envy were used by some mid-century American therapists in the service of trying to keep women safely in an "appropriate" domestic sphere cannot justly be laid at Freud's door. (See Young-Bruehl, 1990, for a thoughtful commentary on Freud's complex views about women.)

In the affective realm, hysterical individuals are notable for their high level of anxiety and their vulnerability to both shame and guilt. Often conceptualized as having "shallow affect," they actually struggle with intense affect that terrifies them, against which they erect distinctive defenses. I say more about this in the context of the histrionic person's sense of self.

DEFENSIVE AND ADAPTIVE PROCESSES IN HYSTERIA

People with hysterical personalities use repression, sexualization, and regression. They act out in counterphobic ways, usually related to preoccupations with the fantasied power and danger of the opposite sex. They also use dissociative defenses, about which I say more in the next chapter.

Freud regarded repression as the cardinal mental process in hysteria. Amnesia was a phenomenon of such fascination for him that it led to a whole theory about the structure of the mind and about how we can "forget" things that at some inaccessible level we also "know." Freud's first constructions of repression as an active force rather than an accidental lapse derived from his work with people who under hypnosis recalled and relived childhood traumas, often incestuous ones, and then lost their hysterical symptoms. In his earliest therapeutic attempts, first with hypnosis and then with nonhypnotic suggestion, he put all his energies into undoing repression, inviting his patients to relax and exhorting them to let their minds be open to recollection. He observed that when traumatic memories returned with their original emotional power, a process he labeled "abreaction," hysterical disabilities would disappear.

Repressed memory and its associated affects became central objects of early psychoanalytic study, and lifting repression came to be seen as a key therapeutic task. Before long, however, Freud became convinced that some of the "memories" recovered by hysterical patients were actu-

ally fantasies, and his interest shifted from amnesia for trauma to the repression of wishes, fears, infantile theories, and painful affects. He saw Victorian myths about the asexual nature of females as particularly inimical to psychological health, and he felt that women raised to repress their erotic strivings were at risk of hysteria because so compelling a biological force could only be deflected, not quelled. He began to see some maladies as *conversions* of impulse into bodily symptoms. A woman who, for instance, had been reared to regard sexual self-stimulation as depraved might lose feeling and movement in the hand with which she would be tempted to masturbate. This phenomenon, known as "glove paralysis" or "glove anesthesia" because only the hand was affected (which cannot be of neurological origin because nerve damage that paralyzes the hand would also paralyze the arm), was not uncommon in Freud's time, and it begged for an explanation.

It was symptoms like glove paralysis that inspired Freud to conceive of hysterical ailments as achieving a *primary gain* in resolving a conflict between a wish (e.g., to masturbate) and a prohibition (against masturbating), and also *secondary gains* in the form of concern from others. The secondary gains compensated the afflicted person for the loss of sexual satisfaction by the resulting nonerotic attention to the person's body and its disability. With the development of the structural theory, this dynamic was seen as a conflict between the id and the superego. Freud felt that such a solution is highly unstable, since sexual energy is blocked up rather than expressed or sublimated, and he was inclined to interpret any outbreaks of sexualized interest as "the return of the repressed." Repression can be a useful defense, but it is a brittle and unreliable one when directed against normal impulses that will continue to exert a pressure for discharge. Freud's original formulation about the high degree of anxiety for which hysterical people are noted was that they were converting dammed-up sexual energy into diffuse nervousness (see Chapter 2).

I am dwelling on this formulation about hysterical symptoms because a comparable process can be inferred at a characterological level. People who repress erotic strivings and conflicts that seem dangerous or unacceptable tend to feel both sexually frustrated and vaguely anxious. Their normal wishes for closeness and love may become amplified, as if energized by unsatisfied sexual longing. They may be highly seductive (the return of the repressed) but unaware of the implied sexual invitation in their behavior. In fact, they are often shocked when their actions are construed as initiating a sexual connection. Moreover, if they proceed with such an encounter (as they sometimes do, both to placate the frightening sexualizing object and to assuage their guilt over the effects of their behavior), they generally do not enjoy it erotically.

In addition to these interacting processes of repression and sexualization, people with hysterical personalities may use regression. When insecure, fearful of rejection, or faced with a challenge that stimulates unconscious fear, they may become helpless and childlike in an attempt to fend off trouble by disarming potential rejecters and abusers. Like anyone in a state of high anxiety (cf. the "Stockholm syndrome" or the "Patty Hearst phenomenon," terms for situations in which captive people become trusting toward their abductors or persecutors), people with hysterical tendencies may be quite suggestible. In the high-functioning range they can be charming when operating regressively; in the borderline and psychotic ranges histrionic clients may become physically ill, clingily dependent, whiny and demanding, or addicted to crisis. The regressive aspect of hysterical dynamics was once so common in some female subcultures that playing dumb, giggling girlishly, and gushing over big, strong men were seen as normal. The 19th-century equivalent was the swoon.

Acting out in hysterical people is often counterphobic: They approach what they unconsciously fear. Behaving seductively when they dread sex is only one example; they may also exhibit themselves when they are unconsciously ashamed of their bodies, make themselves the center of attention when they are feeling inferior to others, throw themselves into acts of bravery and heroism when they are unconsciously frightened of aggression, and provoke authorities when they are intimidated by their power. The depiction of histrionic personality disorder in DSM-IV (American Psychiatric Association, 1994) emphasizes the acting-out aspects of hysterical character to the exclusion of other equally important features. While counterphobic enactments are clearly the most striking of the purely behavioral phenomena associated with hysteria—and they are certainly the ones that get people's attention—the *meaning* of these behaviors is also important to the diagnosis. The most pressing internal characteristic of the hysterical style is anxiety.

Because hysterically structured people have a surfeit of unconscious anxiety, guilt, and shame, and because they may be temperamentally intense and subject to overstimulation, they are easily overwhelmed. Experiences that are manageable for others may be traumatic to hysterical people. Consequently, they may use dissociative mechanisms to reduce the amount of affectively charged information that they must deal with all at once. Examples include the phenomenon that 19th-century French psychiatrists labeled la belle indifférence, a strange minimization of the gravity of a situation or symptom; fausse reconnaissance, the conviction of remembering something that did not happen; pseudologia fantastica, the tendency to tell patent untruths while seeming, at least during the telling, to believe them; fugue states; body memories

of traumatic events not recalled cognitively; dissociated behaviors such as binge eating or hysterical rages, and so forth. There is considerable overlap between hysterical and dissociative personality structures; many contemporary writers view histrionic psychology as a version of dissociative psychology.

One of my patients, a highly successful professional woman in her 60s who had devoted a large portion of her career to educating people about safe sex, found herself during a conference going to bed with a man to whom she was not particularly attracted ("He wanted it, and somehow that felt like the final word"). It did not occur to her to ask him to use a condom. She dissociated both her capacity to say *no* and her awareness of the negative consequences of unprotected sex. The sources of her dissociation included a seductive, narcissistic father and unremitting childhood messages to the effect that the needs of the other person always come first.

RELATIONAL PATTERNS IN HYSTERICAL PSYCHOLOGY

In the backgrounds of heterosexual people of a hysterical bent, one often finds events and attitudes that assigned *differential power* and value to the different sexes. Common hysterogenic situations include families in which a little girl is painfully aware that one or both parents greatly favor her brother(s), or where she senses she was supposed to have been a boy. (Sometimes she is accurate; sometimes she erroneously deduces this theory from data such as her being the third of three daughters.) Or a young girl may notice that her father and the male members of the family have much more power than her mother, herself, and her sisters.

When positive attention is given to this child, it involves superficial, external attributes, such as her appearance, or nonthreatening, infantile ones such as her *innocence* and *niceness*. When negative attention is given to her brothers, their putative inadequacies are equated with femininity ("You throw like a girl!" or "You're not acting like someone who wears the pants in the family"). As she gets older and matures physically, she notices that her father pulls away from her and seems uncomfortable with her developing sexuality. She feels deeply rejected on the basis of her gender, yet she senses that femininity has a strange power over men (Celani, 1976; Chodoff, 1978, 1982).

It has often been observed (e.g., Easser & Lesser, 1965; Herman, 1981; Slipp, 1977) that the fathers of histrionic women were both frightening and seductive. Men may easily underestimate how intimidating they are to their young female children; male bodies, faces, and voices are harsher than those of either little girls or mothers, and they take

some getting used to. A father who is angry seems particularly formidable, perhaps especially to a sensitive female child. If a man engages in tantrums, harsh criticism, erratic behavior, or sexual violation, he may be terrifying. A doting father who also intimidates his little girl creates a kind of approach–avoidance conflict; he is an exciting but feared object. If he seems to dominate his wife, as in a patriarchal family, the effect is magnified. His daughter will learn that people of her own gender are less valued, especially once the days of delectable girlhood are gone, and that people of her father's gender must be approached with calculation. Mueller and Aniskiewitz (1986) emphasize the combination of maternal inadequacy and paternal narcissism in the etiology of hysterical personality:

> Whether the mother is resigned to a weak, ineffectual role or is threatened by the child and reacts competitively, the basic issue remains one of not having achieved a mature mutuality.... Similarly, whether the father's adequacy conflicts are expressed through a brittle, pseudomasculine exterior or directly in warm, sexual, or collusive ways with the daughter, he ... reveals his own immaturity.... Despite variations in the manifest traits of the fathers, the common latent personality trends reflect a phallic–oedipal orientation. The fathers are self-centered and possessive, and view relationships as extensions of themselves. (pp. 15–17)

Thus, a frequent source of hysterical personality structure is the sense that one's sexual identity is problematic. Some little boys reared in matriarchies where their masculinity is denigrated (e.g., with scornful contrasts to hypothetical "real" men) develop in a hysterical direction, despite the advantages the larger culture has traditionally conferred on males. There is an identifiable subgroup of gay men who meet DSM-IV criteria for histrionic personality, about whom such family dynamics have been reported (e.g., Friedman, 1988). The greater frequency of hysteria in females seems to me to be explicable by two facts: (1) men have more power than women in the larger culture, and no child fails to notice this; and (2) men do less of the primary care for infants, and their relative absence makes them more exciting, idealizable, and "other" than women.

The outcome of an upbringing that magnifies simplistic gender stereotypes (men are powerful but narcissistic and dangerous; women are soft and warm but weak and helpless) is for a woman thus reared to seek security and self-esteem from attaching herself to males she sees as particularly powerful. She may use her sexuality to do this and then find she has no satisfactory sexual response to physical involvement with such a person. She may also, because his power scares her, seek to evoke the more tender side of a male partner and then unconsciously devalue

him for being less of a man (i.e., soft, feminine, weak). Some hysterically organized people, male as well as female, thus go through repetitive cycles of gender-specific overvaluation and devaluation, where power is sexualized but sexual satisfaction is curiously absent or ephemeral.

THE HYSTERICAL SELF

The hysterical sense of self is that of a small, fearful, defective child coping as well as can be expected in a world dominated by powerful and alien others. Although people with hysterical personalities may come across as controlling and manipulative, their subjective state of mind is quite the opposite. Manipulations carried out by individuals with hysterical structure are, in marked contrast to the maneuvering of psychopathic people, secondary to their quest for safety and acceptance. Their orchestration of others involves efforts to achieve an island of security in a frightening world, to stabilize self-esteem, to master frightening possibilities by initiating them, to express unconscious hostility, or some combination of these motives (Bollas, 1999). They do not seek pleasure from "getting over on" others.

For example, one of my patients, a graduate student in theater arts, a young woman who had grown up with a loving but capriciously explosive father, used to become infatuated with one after another man in authority and would knock herself out to be the favorite student of each. She would approach all her male teachers and coaches with subtle flattery and an attitude of awestruck discipleship, a demeanor she rationalized as going with the territory of being an acting student at the mercy of arbitrary men. Her seductiveness was hard for some of her mentors to ignore. When she began getting signals that they were attracted to her, she reacted with excitement (at feeling powerful and valued), exhilaration (at feeling attractive and desired), fear (of their translating their attraction into sexual demands), and guilt (for exerting her will over them and winning their forbidden erotic interest). Her manipulativeness was limited to men, and men in authority at that, and although powerfully driven, it was full of conflict.

Self-esteem in histrionic people is often dependent on their repetitively achieving the sense that they have as much status and power as the people they fear (those of the other gender or, in the case of hysterically structured gay individuals, those of their own gender who are seen as powerful). Attachment to an idealized object—especially being seen with one—may create a kind of "derived" self-esteem (Ferenczi, 1913): "This powerful person is part of me." The psychology of groupies who idealize artists or politicians has this feel. Sexual acting out may be

fueled by the unconscious fantasy that to be penetrated by a powerful man is somehow to capture his strength.

Another way hysterically structured people attain self-esteem is through rescue operations. Via reversal, they may care for their internal frightened child by helping children at risk. Or they may handle their fear of authorities counterphobically and set out to change or heal present-day substitutes for a frightening–exciting childhood object. The phenomenon of sweet, warm, loving females falling in love with predatory, destructive males in the hope of "saving" them is bewildering but familiar to many parents, teachers, and friends of hysterical young women.

In the dream imagery of hysterical men and women one often finds symbols that represent possession of a secret uterus or penis, respectively. Hysterically organized women tend to see any power they have in their natural aggressiveness as representing their "masculine" side rather than as integrated with their gender identity. The inability to feel power in womanhood gives them an insoluble and self-perpetuating problem. As one of my clients put it, "When I feel strong, I feel like a man, not a strong woman." This kind of thinking—that maleness equates with activity and femaleness with passivity, and that an assertive woman is thus exercising her "masculine" side, or a tender man his "femininity"—was rife throughout the late 19th century and assumed in numerous psychoanalytic theories (e.g., Jung's [1954] archetypes of the animus and anima). Contemporary psychoanalytic gender theory (e.g., Dyess & Dean, 2000) challenges this essentialistic, reductive thinking, but in the unconscious, such images may retain great psychic force.

The perception that one's erotic objects, as a class, have the power can lead to depressive reactions to aging in people with hysterical personality structure. Because heterosexual women with hysterical dynamics feel that the only potency in femaleness is sexual attractiveness, they may be overinvested in how they look and subject to a greater-than-average dread of aging. Gay men who struggle with unconscious hysterical beliefs that they are insignificant and weak when not desired by the powerful may suffer similarly. The tragicomic quality of the older hysterical woman was captured in the character of Blanche duBois in *A Streetcar Named Desire*. The pain of the aging gay man is striking in the character of Gustav von Ashenbach in Thomas Mann's *Death in Venice*. Any hysterically inclined client needs to be encouraged to develop other areas besides attractiveness in which self-esteem may be sought and realized.

The tendency toward vanity and seductiveness in histrionic people, although constituting a narcissistic defense in that these attitudes function to achieve and maintain self-esteem, differs from behaviorally similar processes in individuals whose basic personality is narcissistic.

Hysterically structured people are not internally empty and indifferent; they charm people not because they crave any attention that fills a void but because they fear intrusion, exploitation, and rejection. When these anxieties are not aroused, they are genuinely warm and caring. In healthier hysterical people, the loving aspects of the personality are conspicuously in conflict with the defensive and sometimes destructive ones. The aspiring actress I described previously was painfully and guiltily aware of her complex effect on the men she worked so hard to beguile, and despite being able to dissociate the feeling most of the time, she felt guilt toward their wives.

The attention-seeking behavior of histrionic people has the unconscious meaning of attaining reassurance that they are acceptable—in particular that their gendered body is appreciated, in contrast to their childhood experiences. Hysterically organized individuals tend to feel unconsciously castrated; by showing off their bodies they may be converting a passive sense of physical inferiority into an active feeling of power in physicality. Their exhibitionism is thus counterdepressive.

Similar considerations illuminate the "shallow affect" associated with hysteria. It is true that when histrionic people express feelings, there is often a dramatized, inauthentic, exaggerated quality to what they say. This does not mean that they do not "really" have the emotions to which they are giving voice. Their superficiality and apparent playacting derive from their having extreme anxiety over what will happen if they have the temerity to express themselves to someone they see as powerful. Having been infantilized and devalued, they do not anticipate respectful attention to their feelings. They magnify them to get past their anxiety and convince themselves and others of their right to self-expression; simultaneously, by conveying that they are not really serious, they preserve their option to retract or minimize what they are saying if it should turn out that this is another unsafe place to express oneself. Announcements such as "I was SOOOO furious!", accompanied by theatrically rolling eyes, invite others to see the emotion as not really there or as trivial. It is there, but it is drenched in conflict.

Bromberg (1996, p. 223) makes the quip, attributing an earlier version of it to R. D. Laing (1962, p. 34), that a hysteric "is someone who goes through life pretending to be who he really is." Behind the wit here, there is a deeply empathic sensibility, in which the dilemma of the hysterical person is framed as the "tragic inability to convince others of the authenticity of his or her own subjective experience" (p. 224). In a therapeutic atmosphere of scrupulous respect, the histrionic person will eventually feel sufficiently heard to become able to describe anger and other feelings in a credible, direct way, and to augment a reactive, impressionistic style with a proactive, analytic one.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH HYSTERICAL PATIENTS

Transference was originally discovered with clients whose complaints were in the hysterical realm, and it is no accident that it became so visible there. Freud's whole conception of hysteria revolved around the observation that what is not consciously remembered remains active in the unconscious realm, finding expression in symptoms, enactments, and reexperiences of early scenarios. The present is misunderstood as containing the perceived dangers and insults of the past, partly because the hysterical person is too anxious to let contradictory information in.

In addition to these factors, histrionic people are strongly object related and emotionally expressive. They are more likely than other individuals to talk about their reactions to people in general and to the therapist in particular. Given the dynamics described above, the reader can probably see how the combination of a heterosexual female hysterical patient and a male therapist would immediately evoke the client's central conflicts. Freud (1925a) was initially quite exasperated to find that while he was trying to put himself across to his histrionic patients as a benevolent physician, they insisted on seeing him as a provocative male presence, with whom they would suffer, struggle, and sometimes fall in love.

Because hysterical personality is a psychology in which gender-related issues may dominate the patient's way of seeing the world, the nature of the initial transferences may differ as a function of the sex of both client and therapist. With male practitioners, heterosexual female clients with hysterical dynamics may be excited, intimidated, and defensively seductive. With female therapists, they are often subtly hostile and competitive. With both, they may seem somewhat childlike. The transferences of male hysterical patients will vary depending on whether their internal cosmology assigns greater power to maternal or paternal figures. Most hysterical clients are cooperative and appreciative of the therapist's interest, but borderline and psychotic-level hysteroid people are difficult to treat because they act out so destructively and feel so menaced by the treatment relationship (Lazare, 1971).

Even high-functioning hysterical clients, however, can have transferences of such intensity that they feel almost psychotic. Hot transferences are unnerving to both therapist and client. They can be addressed effectively by tactful investigation and by scrupulous observance of professional boundaries. Therapists who are secure in their role will find such reactions, as Freud did, not an obstacle to treatment but rather the means through which it heals, as clients learn to tolerate their complexly determined desire in a safe environment. When histrionic patients

are too afraid to admit to such passionate responses in the presence of the therapist, they may act out with objects who are transparent substitutes. A supervisee of mine named James began seeing a hysterical young woman whose father had alternated between traumatic intrusiveness and rejection; she had sequential affairs with men named Jim, Jamie, and Jay within the first several months of her treatment.

Occasionally the transference of a person with hysterical dynamics becomes painfully intense before he or she has sufficient trust in the therapist to bear that intensity. Especially in the early months, histrionic clients may flee treatment, sometimes with rationalizations and sometimes with awareness that it is the strength of their attraction, or fear, or hatred—and the anxiety that it evokes—that is driving them away. Even though the frightening reactions may coexist with warm feelings, they can be too upsetting to tolerate. I have worked with several women who became so upset by the hostility and devaluation they found themselves feeling in my presence that they could not keep coming to me. Similarly, several of my male colleagues have been fired by histrionic clients who became too obsessed with winning their therapist's love to benefit from therapy. In these cases, especially if the transference is somewhat ego alien, a change of therapists to someone who seems less like the original overstimulating or devalued object may work out well.

Countertransference with hysterical clients may include both defensive distancing and infantilization. The therapeutic dyad in which these potentials are most problematic is that of the male therapist, especially if his personality is at all narcissistic, and the female client. It can be hard to attend respectfully to what feels like pseudoaffect in histrionic clients; the self-dramatizing quality of these anxious patients invites ridicule. Most hysterically organized people are highly sensitive to interpersonal cues, however, and an attitude of patronizing amusement will be very injurious to them, even if they manage to keep the therapist's disrespect out of their awareness.

Before it was politically incorrect to talk openly and ego-syntonically about one's misogyny, it was common to hear (male) psychiatric residents condoling with each other man-to-man about their exasperating histrionic patients. "I've got this wacko hysteric—she bursts into tears every time I frown. And today she comes in with a skirt that barely reaches her thighs!" Female professionals within range of such conversations would exchange pained expressions and give silent thanks—or prayers—that they were not in treatment with someone who could talk like this about a person he hoped to help. One still hears this kind of conversation about borderline patients, and given that the DSM depiction of BPD emphasizes hysteroid features, the power of this devaluing countertransference remains impressive. It is arguable, in fact, that even though

"hysteria" has disappeared as a disease entity, we have seen the return of the repressed in the contemporary concept of BPD (Bollas, 1999).

Related to this more condescending and hostile reaction is the temptation to treat the histrionic woman like a little girl. As a major weapon in the hysterical arsenal, regression is to be expected. Still, it is surprising how many clinicians accept the hysterical invitation to act out omnipotence. The appeal of playing "Big Daddy" to a helpless, grateful young thing is evidently quite strong. I have known otherwise disciplined practitioners who, when treating a hysterically organized woman, could not contain their impulse to give her reassurance, consolation, advice, or praise, despite the fact that the subtext in all these messages is that she is too weak to figure things out on her own, or to develop the capacity to give herself her own reassurance or comfort. Because regression in most histrionic people is defensive—that is, it protects them from fear and guilt that accompany adult responsibility—it should not be confused with genuine helplessness. Being afraid and being incompetent are not the same thing. The problem with being too indulgent and commiserative with a hysterical person, even if that stance lacks any hostile condescension, is that the client's diminished self-concept will be reinforced. An attitude of parental solicitude is as much of an insult as one of scorn for the patient's "manipulativeness."

Finally, I should mention countertransference temptations to respond to seductiveness in hysterical clients. As has been repeatedly demonstrated in studies of the sexual abuse of clients (see Celenza, 2007; Gabbard & Lester, 2002; Gutheil & Brodsky, 2008; Pope, Tabachnick, & Keith-Spiegel, 1987), this is a greater danger to male than to female therapists. Women treating hysterical patients, even highly seductive males, are protected by internalized social conventions that make the dyad of dependent male–authoritative female harder to erotize. Cultural acceptance of the phenomenon of the older or more powerful man's attraction to the younger or more needy woman, in contrast, which has psychodynamic roots in male fears of female engulfment that are assuaged by this paradigm, leaves men much more vulnerable to sexual temptation in their therapeutic role.

The implications of theory and the lessons of practice emphatically confirm that sexual acting out with patients has disastrous effects (Celenza, 2007; Gabbard & Lester, 2002; Gutheil & Brodsky, 2008; Pope, 1987; Smith, 1984). What hysterical clients need, as opposed to what they may feel they need when their core conflicts are activated in treatment, is the experience of having and giving voice to powerful desires that are not exploited by the object of those desires. Trying and failing to seduce someone is profoundly transformative to histrionic people, because—often for the first time in their lives—they learn that

someone they depend on will put their welfare above the opportunity to use them, and that the direct exertion of their autonomy is more effective than defensive, sexualized distortions of it.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF HYSTERICAL PERSONALITY

Standard psychoanalytic treatment was invented for people with hysterical personality structure, and it is still the treatment of choice with healthier clients in this group. By standard treatment, I mean that the therapist is relatively quiet and nondirective, addresses process more than content, deals with defenses rather than what is being defended against, and limits interpretation mostly to addressing resistances as they appear in the transference. As David Allen (1977) notes:

> Hysterical patients make contact immediately, and it is a reparative contact they seek.... For the beginning therapist, such patients give the clearest and most accessible evidence of transference.... The crux of the treatment of the hysterical personality is the transference. If we give wrong interpretations, we can correct them in the light of later information. If we miss opportunities to interpret, they will occur again and again. But if we mishandle the transference, the treatment is in trouble. Mishandling of the transference or failing to establish a therapeutic alliance is almost the only vital mistake, and it is exceedingly difficult to repair. (p. 291)

One must first develop rapport and spell out the responsibilities of both parties to the therapy contract—a swift and easy process with higher-functioning hysterical clients because of their basic relatedness. Then, by a nonintrusive but warm demeanor, along with a judicious avoidance of self-disclosure, the therapist allows the transference to flourish. Once the patient's issues surface in the treatment relationship, the therapist can tactfully address feelings, fantasies, frustrations, wishes, and fears as they appear directly in the consulting room. It is critical that the therapist allow the hysterical client to come to his or her own understandings. A rush to interpret will only intimidate someone with hysterical sensibilities, reminding the patient once again of the superior power and insight of others. Comments with any trace of the attitude "I know you better than you know yourself" may, in the imagery that often dominates the internal representational world of the hysterical person, feel castrating or penetrating to the client. Raising gentle questions, remarking casually when the patient seems stuck, and continually bringing him or her back to what is being felt, and how that is understood, comprise the main features of effective technique.

With neurotic-level hysterical people, the therapist may have the experience of sitting back and watching the patient make him- or herself well. It is important to rein in one's narcissistic needs to be valued for making a contribution; the best contribution one can make to a histrionic person is confidence in the client's capacity to figure things out and make responsible adult decisions. One should attend not only to the elicitation of feelings but to the integration of thinking and feeling. D. W. Allen (1977) observes:

> An essential part of craftsmanship in therapy is to communicate within the cognitive style of the patient with full respect for the patient's feelings and values. The hysterical thinking style is not inferior as far as it goes, but the hysterical style needs the complementary advantages of detailed, linear "left-hemisphere thinking" as well. In a sense, the hysteric does need to learn how to think and what to connect in thinking, just as the obsessive compulsive needs to learn how to feel and what to connect in feeling. (p. 324)

More disturbed hysterical clients require much more active and educative work. In the first interview, besides tolerating and naming their crippling anxiety, one should predict any temptations that may imperil the treatment. For example: "I know that right now you are determined to work these problems out in therapy. But we can see that in your life so far when your anxiety has gotten too high, you have escaped into an exciting love affair [or gotten sick, or gone into a rage and left—whatever is the pattern]. That is likely to happen here, too. Do you think you can stick with our work over the long haul?"

Lower-functioning hysterical clients should be told to expect powerful and negative reactions to the therapist and urged to come in and talk about them. In general, approaches that apply to borderline patients across the typological spectrum are useful with more disturbed hysterical people, with special attention to their transference reactions.

DIFFERENTIAL DIAGNOSIS

The main conditions with which hysterical personality organization can be confused, on the basis of its surface characteristics, are psychopathy and narcissism. In addition, some imprecision exists, as it did in Freud's day, between the diagnoses of hysterical and dissociative psychology. Finally, also as in the time of Freud and earlier, individuals with undiagnosed physiological conditions may be misunderstood as having a hysterical personality disorder.

Hysterical versus Psychopathic Personality

Many writers, over many decades (e.g., Chodoff, 1982; Cloninger & Guze, 1970; Kraepelin, 1915; Lilienfield, Van Valkenburg, Larntz & Akiskal, 1986; Meloy, 1988; Rosanoff, 1938; Vaillant, 1975), have noted connections between psychopathy and hysteria. Anecdotal evidence suggests that there is an affinity between the two psychologies; specifically, some histrionic women, especially in the borderline range, are attracted to psychopathic men. Meloy (1988) mentions the familiar phenomenon of the convicted murderer who gets inundated with letters from female sympathizers looking to come to his defense and/or to become his lover.

Qualities seen as hysterical in women are often construed as psychopathic in men. A study by Richard Warner (1978), in which a fictional case vignette was given to mental health professionals, found that identical descriptions of sensational, flirtatious, excitable behavior attributed to either a man or a woman yielded assessments of antisocial or hysterical personality, respectively, depending on the gender of the patient portrayed. Warner concluded that hysteria and psychopathy are essentially the same. And yet every experienced clinician has seen at least a few women who were unquestionably psychopathic rather than hysterical characterologically, even if they had some hysterical symptoms, and a few men who were clearly histrionic and not antisocial. If these categories were just gendered versions of the same psychology, that would not be so. (Also, Warner's vignettes featured behaviors that make differential diagnosis difficult.) A more reasonable view of his findings is that because of the greater frequency of psychopathy in men and of hysteria in women, most of his diagnosticians engaged in the research task with an explanatory "set" that was not sufficiently counteracted to change their expectancies.

Confusion of hysteria with psychopathy is likelier toward the more disturbed end of the hysterical continuum. In the borderline and psychotic ranges, many people have aspects of both psychologies. But a determination of which dynamic predominates is valuable to the formation of an alliance and to the ultimate success of therapy. Hysterical individuals are intensely anaclitic, conflicted, and frightened, and a therapeutic relationship with them depends on the clinician's appreciation of their fear. Psychopathic people equate fear with weakness, resonate to self-definition themes over anaclitic ones, and disdain therapists who mirror their trepidation. Hysterical and antisocial people both behave dramatically, but the defensive theatricality of the histrionic person is absent in psychopathy. Demonstrating one's power as a therapist will

engage a psychopathic person positively yet will intimidate or infantilize a hysterical client.

Hysterical versus Narcissistic Personality

As I have noted, hysterical people use narcissistic defenses. Both hysterical and narcissistic individuals have basic self-esteem defects, deep shame, and compensatory needs for attention and reassurance; both idealize and devalue. But the sources of these similarities differ. First, for the hysterical person, self-esteem problems are usually related to gender identification or to particular conflicts, while with narcissistic people they are diffuse. Second, people who are hysterically organized are basically warm and caring; their exploitive qualities arise only when their core dilemmas and fears are activated. Third, hysterical people idealize and devalue in specific, often gender-related ways; their idealization frequently has its origins in counterphobia ("This wonderful man would not hurt me"), and their devaluation has a reactive, aggressive quality. In contrast, narcissistic people habitually rank all others in terms of better and worse, without the press of powerful, object-directed affects. Kernberg (1982) has commented on how a hysterical and a narcissistic woman may both have unsatisfactory intimate relationships, but the former tends to pick bad objects whom she has counterphobically idealized, while the latter picks adequate objects whom she then devalues.

Implications of this differential for treatment are substantial, though too complex to cover except with the overall observation that basically hysterical people do well with traditional analytic treatment, whereas narcissistic ones need therapeutic efforts adapted to the primacy of their efforts to maintain self-cohesion and a positively valued self-concept.

Hysterical versus Dissociative Conditions

Hysterical and dissociative psychologies are closely related and are viewed by many contemporary scholars as variations on the same traumatic theme. Because it is more common for a dissociative person to be presumed to be hysterical than vice versa, I discuss the distinctions between these two conditions, and the metapsychological problems of classification related to dissociative dynamics, in the next chapter.

Hysterical versus Physiological Conditions

Although it is much less common now than in the heyday of American pop Freudianism to attribute any baffling physical symptom to uncon-

scious conflict, a final word should be said about not overlooking the possibility of physical origins of mysterious ailments. Symptoms of some systemic illnesses—multiple sclerosis, for example—are frequently assumed to be of hysterical origin, as are many "female complaints" that frustrate physicians. In England in the 1990s there was an outbreak of what was widely diagnosed as "gardener's hysteria" in members of a group of horticulturists who had visited the United States; eventually it was discovered that they had gathered examples of American fall foliage on the trip, including a lot of brilliantly red poison ivy. More consequentially, George Gershwin probably would have lived well beyond 38 if his therapist had not interpreted the symptoms of his brain tumor as psychogenic rather than organic.

Because histrionic people regress when they are anxious, and have off-putting, self-dramatizing ways of expressing their complaints, a physical illness in a person with hysterical tendencies is in jeopardy of not being thoroughly investigated. It is more than simply medically prudent to pursue the possibility of an organic problem in a histrionic person; it also sends a therapeutic message to a scared human being whose basic dignity has not always been respected.

SUMMARY

I have described hysterical personality in the context of evolving psychoanalytic conceptualizations that include aspects of drive (intense and affectionate basic temperament, with oral and oedipal struggles aggravated by gender-related disappointments), ego (impressionistic cognitive style; defenses of repression, sexualization, regression, acting out, dissociation), object relations (inadequate parenting that includes narcissistic and seductive messages, replicated in later relationships dominated by the repetition compulsion), and self (self-image as small, defective, and endangered, and self-esteem burdened by conflicts over sexualized expressions of power).

I described transference and countertransference experiences as including strong, competitive, and erotized reactions, depending on the sexual orientation and gender of client and therapist, as well as regressive trends that invite contempt or infantilization rather than respect. I addressed the value of working through erotic transferences and stressed the destructiveness of therapist sexualization. I recommended a treatment style characterized by the careful maintenance of professional boundaries, a warm and empathic attitude, and an economy of interpretation guided by traditional psychoanalytic technique. I contrasted hysterical character with psychopathic, narcissistic, and dissociative

personality, and offered a final caveat about investigating possible physiological causes of presumptively hysterical symptoms.

SUGGESTIONS FOR FURTHER READING

For a sympathetic understanding of hysterical personality, I am partial to Mardi Horowitz's (1991) edited volume and also to the work of Mueller and Aniskiewitz (1986), whose tone lacks the condescension so common in male therapists' writing on hysteria. D. Shapiro's (1965) essay on the hysterical cognitive style is thorough and still timely.

For readers interested in hysterical neurosis as the emblematic mental illness of the late 19th century (perhaps comparable to depression in our current era), Scull's (2009) mordant "biography" of hysteria is fascinating. Veith's (1965) history from ancient to modern times is illuminating and entertaining. For those who enjoy thoughtful and passionate feminist scholarship I recommend Juliet Mitchell's (2001) plea that we resume attending to hysteria (contra to those who have regarded it as a constructed and bygone cultural phenomenon) and *Storms in Her Head* by Muriel Dimen and Adrienne Harris (2001). Bromberg's chapter on "Hysteria, Dissociation, and Cure" in *Standing in the Spaces* (1996) is a gracefully written, incisive commentary on Freudian and post-Freudian formulations, that foregrounds the relational context of healing for people with hysterical issues.

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Dissociative Psychologies

When I first wrote this chapter in 1993, it was new to include attention to dissociative psychologies in a psychodynamically oriented book on personality. Since then, there has been an explosion of psychoanalytic attention to dissociative phenomena, especially among therapists identified with the relational movement (e.g., Boulanger, 2007; Bromberg, 1998, 2010; Davies & Frawley, 1994; Grand, 2000; Howell, 2005; D. B. Stern, 1997, 2009) and researchers in attachment (Liotti, 2004; Lyons-Ruth, Bronfman & Parsons, 1999) and cognitive and affective neuroscience (Panksepp, 1998; Schore, 2002; Teicher, Glod, Surrey, & Swett, 1993). Students of trauma and child development have generated new paradigms for understanding what was once called multiple personality and what recent editions of the DSM have labeled "dissociative identity disorder"—that is, dissociative reactions that are automatic, chronic, and repeated throughout the lifespan, the pattern that has struck me and some other writers as describable in terms of dissociative personality structure (cf. I. Brenner, 2001, 2004; Classen, Pain, Field, & Woods, 2006).

To update this chapter in the face of a flood of new data, I have collaborated closely with Richard Chefetz, who straddles the worlds of psychoanalysis and trauma studies, has extensive experience treating dissociative clients, and writes with particular poignancy about the topic, integrating attachment theory, affective and cognitive neuroscience, and relational psychoanalytic perspectives on multiple self-states with core work in traumatology (e.g., Chefetz, 2000a, 2000b, 2009, 2010a, 2010b). He is further along than I am in the paradigm shift that is in process; he rejects the concept of dissociative personality structure

or personality disorder (Chefetz, 2004) and views my way of organizing diagnostic data as dependent on a flawed ego psychology model that has too often gotten in the way of therapists' appreciating the dissociative process.

It may be true that organizing chronic and severe dissociative conditions under the rubric of traditional personality categories is not the best paradigm or metaphor for dissociative phenomena. I continue to feel, however, that dissociative identity disorder and other complex dissociative conditions should be represented in this book, given the crucial diagnostic importance of distinguishing the dissociative process from other patterns that may infuse character. In this chapter, I try to provide some fundamental knowledge to help readers with dissociative clients, while holding open the possibilities for different constructions of how to organize that information.

Until approximately the 1980s, multiple personality disorder and related psychologies based on severe dissociation were considered rare enough to preclude their incorporation into schemata of personality types and disorders. It has become clear, however, that many people engage dissociative processes quite actively as a first-line adaptation to deal with destabilizing situations such as emotional intensity. For many of them, their dissociative experience is ego syntonic and assumed to be normal. If dissociative identity disorder were not "a pathology of hiddenness" (Gutheil, in Kluft, 1985), in which the patient is often unaware of having dissociated self-states (alter personalities), and in which trust is so problematic that even those parts of the self that know about the dissociation are reluctant to divulge their secret, we might have known long ago how to begin identifying and helping dissociative clients.

In fact, some people did know long ago. A regrettable side effect of Freud's ultimate privileging of maturational issues over traumatic ones, and of repression over dissociation, is that it distracted us from some fine scholarship on dissociation that was available at the end of the 19th century. Pierre Janet (1890), for example, explained many hysterical symptoms by reference to dissociative processes, explicitly disputing Freud's favoring of repression as a primary explanatory principle (see van der Hart, Nijenhuis, & Steele, 2006, which builds upon Janet's work). In the United States, William James and Alfred Binet were both interested in dissociation. Morton Prince (1906) published his detailed case of a dissociative woman around the time that *The Interpretation of Dreams* (Freud, 1900) was attracting notice (unfortunately, the eventual impact of the latter virtually eclipsed that of the former—see Putnam, 1989; C. A. Ross, 1989b). In mid-20th-century theorizing, Sullivan's (1953) concept of "not-me" states as a normal variant of experience came closest to capturing the subjective experience of dissociation.

Therapists experienced with dissociative clients view multiplicity not as a bizarre aberration but as an understandable adaptation to a particular kind of history—specifically, as a chronic posttraumatic stress syndrome of childhood origin (D. Spiegel, 1984). Because of the extensively documented differences among the self-states of someone with dissociative identity disorder, the condition has been widely sensationalized. These differences (which may include subjective age, sexual identity and preference, systemic illnesses, allergies, eyeglass prescriptions, electroencephalogram [EEG] readings, handwriting, handedness, addictions, and language facility) are so impressive that lay people may consider multiple personality disorder the most exotic mental illness they have ever heard of. So do many therapists with little experience treating dissociation.

No other documented disorder has inspired comparable arguments about *whether it exists at all* independent of iatrogenesis. Dissociative phenomena can certainly strain credulity, but I find it no harder to accept that the mind has a method of segregating intolerable experience than I do to take seriously the fact that some people believe they are obese when they are in fact starving to death. George Atwood once remarked to me that the controversy over whether dissociative identity disorder "exists" eerily parallels the quandary of the dissociative patient ("Do I remember this, or am I making it up?" "Should I take my experience seriously, or dismiss it as attention seeking?").

We now know (Solms & Turnbull, 2002) that glucocorticoids secreted during traumatic experience can shut down the hippocampus, making it impossible for episodic memory (the memory of *being there*) to be laid down in the first place. Semantic memory (third-person facts about the event), somatic–procedural memory (body experiences of it), and emotional learning (the amygdala's storing of affect connected to triggers) remain operative, but the sense of "I was there and it happened to me" may never have been established in the brain and hence is not recoverable. Thus, because trauma damages memory, one frequently knows *that* a client has been traumatized, but not the details of *how* (J. H. Slavin, 2007). Along with many other therapists who have treated dissociative patients, I have found myself construing the controversy about "whether dissociative identity disorder exists" as a pervasive social countertransference to a condition that can be unbearable to imagine.

Considered in context, dissociation that results in "alter personalities" (Putnam, 1989) or experiences of "isolated subjectivity" (Chefetz, 2004) and the "elsewhere thought known" (Kluft, 2000) is not so incomprehensible. Researchers in cognitive psychology (e.g., Hilgard, 1986; LeDoux, 1996, 2002) have described simultaneous, coexisting trains of thought in both patient populations and "normals." Investigations

into dissociative states and hypnosis (people who dissociate are actually entering spontaneous hypnotic trances) have revealed some remarkable capacities of the human organism and have raised absorbing questions about consciousness, brain functioning, integrative and disintegrative mental processes, and latent potential. Still, clinicians know that each of their dissociative patients is in most respects an ordinary human being—a single person with the subjective experience of different selves—one whose suffering is only too real.

The first carefully documented case of multiple personality since M. Prince's (1906) "Miss Beauchamps" was Eve (of *The Three Faces of* ...), the pseudonym of Christine Costner Sizemore (Sizemore, 1989; Sizemore & Pittillo, 1977; Thigpen & Cleckley, 1957). Sizemore, a woman of impressive energy and achievement, is a good exemplar of a high-functioning dissociative person. It is notable that the first sufferer of characterological dissociation to "come out" to a therapist in this era was someone with considerable basic trust, ego strength, and object constancy. More disturbed individuals who are diagnosable with dissociative identity disorder, even when they suspect their multiplicity, are much too afraid of mistreatment to let a naive clinician in on their troubled inner life—especially early in therapy. A dissociative woman I treated for several years said that the deinstitutionalization of mental patients in the 1970s, which made it less likely that she would be locked up for life in some snake pit, contributed to her mustering the courage to admit to her hallucinatory experiences and "lost time."

Josef Breuer's famous patient "Anna O" (Bertha Pappenheim), a person who influenced psychoanalytic history in incalculable ways, is another example of a high-functioning multiple personality. Breuer and Freud (1883–1885) regarded her dissociated states as only one part of her hysterical illness, but most contemporary diagnosticians would consider her primarily dissociative. Consider the following description:

> Two entirely distinct states of consciousness were present which alternated very frequently and without warning and which became more and more differentiated in the course of her illness. In one of these states she recognized her surroundings; she was melancholy and anxious, but relatively normal. In the other state she hallucinated and was "naughty"—that is to say, she was abusive, used to throw the cushions at people.... [I]f something had been moved in the room or someone had entered or left it (during her other state of consciousness) she would complain of having "lost" some time and would remark upon the gap in her train of conscious thoughts.... At moments when her mind was quite clear she would complain ... of having two selves, a real one and an evil one which forced her to behave badly. (p. 24)

This remarkable woman went on, after an abortive treatment with Breuer, to be a devoted and highly effective social worker (Karpe, 1961).

In contrast to Christine Sizemore and Bertha Pappenheim, who were able to function well through large parts of their lives, are the ruthlessly self-destructive and "polyfragmented" patients who dissociate so automatically and chaotically that they experience themselves as having hundreds of "personalities," most of which consist of limited attributes that address some current issue. Truddi Chase (1987), whose many self-states the popular media touted during the resurgence of interest in dissociation, may be in this category, though it is arguable that if her therapist had been less invested in publicizing her dissociated condition, she might not look so splintered. Many dissociative people in the psychotic range may be in jails rather than mental hospitals; alter personalities who rape and kill, often in delusional states of mind, are possible outcomes of the traumatic abuse and neglect that create multiplicity (Lewis, Yaeger, Swica, Pincus, & Lewis, 1997).

Since the rediscovery of dissociation in the last three decades, there has been considerable mutual ambivalence between the psychoanalytic community and those who led the movement to gain and disseminate knowledge of dissociation. On the one hand, analysts appreciate the power of organized unconscious forces; consequently, the idea of traumatically created, out-of-consciousness alter personalities does not require from them a huge leap of imagination. And they tend to work with patients over months and years, during which the covert parts of a dissociative person may build up the courage to expose experiences that are unacknowledged in the self-state in which the client usually comes to therapy. Thus, analytic therapists are more likely than other professionals to have worked with people who have revealed their multiplicity, and many of them doubtless addressed such revelations respectfully, with a willingness to learn from the client about a condition that was not emphasized in their psychoanalytic training.

On the other hand, until recent developments in analytic theory, psychodynamic clinicians tended to accept the explanatory preferences of Freud, who eventually put less emphasis on trauma and molestation than on fantasy and its interaction with developmental challenges. Also, and curiously, Freud had little to say about multiple personality, a condition that was recognized in his day by several of the psychiatrists he revered (although he once made the off-hand comment, "Perhaps the secret of the cases of what is described as 'multiple personality' is that the different identifications seize hold of consciousness in turn" [1923, pp. 30–31]). His blind spots contributed to a tendency in some Freudians to regard reports of incest and molestation as fantasy. Intriguingly, Freud's original "seduction theory" ran aground on a problem that later

resurfaced in the form of the "false memory controversy" about reports of childhood sexual abuse: Trauma distorts perception, impairs memory, and creates a basis for later confusions of fact and fantasy (Dorahy, 2001). This is true for traumatized patients as well as for therapists with traumatic histories—people who have suffered trauma may be especially attracted to the profession of helping others or to the study of trauma—and so the possibilities for misunderstanding and confusion are vast.

In addition to habits of thought that derive from Freud, people trained in the psychodynamic tradition have sometimes misapplied developmental concepts to the switches in consciousness that signal the emergence of dissociated self-states. For example, they have been more inclined than other mental health professionals to interpret them not as alterations in consciousness but as nonamnesic regressive episodes or as evidence of defensive splitting. As a result, they have often failed to ask questions that would discriminate between the splitting off of what has once been integrated and the dissociation of what has always been held separately (D. B. Stern, 1997).

Some therapists who have distinguished themselves by their commitment to learning and teaching about trauma and dissociation have thus found it hard to forgive Freud and Freudians for minimizing both the prevalence and the destructiveness of the sexual abuse of children. Some also lament the influence of thinkers like Kernberg, on the grounds that they have conflated trauma-related dissociation with developmentally normative splitting and have thereby misdiagnosed many people with dissociative personalities as borderline or schizophrenic—a mistake that can cost such a patient years of misguided treatment. Specialists in dissociation (e.g., C. A. Ross, 1989a) rightly complain that legions of desperate people have been misunderstood and retraumatized for years by unnecessary medical procedures (e.g., major tranquilizers, electroshock). Critics of exponents of dissociation counter that when one is looking for them, one can find a multiple under every rock (cf. Brenneis, 1996; D. R. Ross, 1992). Fads in psychopathology are not unknown, especially in conditions in which suggestibility may play a large role.

I review all of this because it remains true that, even though dissociative identity disorder and other dissociative conditions have attained respectability by inclusion in the DSM, a certain polemicism infuses the work of both explicators and critics of dissociative concepts. This is to be expected in any field when there has been a paradigm shift (Kuhn, 1970; R. J. Loewenstein, 1988; Loewenstein & Ross, 1992). I urge readers, whatever your biases, to try to comprehend the phenomenon of dissociation with an "experience-near" sensibility; that is, from the standpoint of empathy with the internal experience of the person who feels and behaves like a composite of many different selves. My own understand-

ing of dissociation is still developing, and I suspect that much of what I say here will eventually be revised. It is less important to decide which experts to believe than to try to comprehend what patients experience.

DRIVE, AFFECT, AND TEMPERAMENT IN DISSOCIATIVE CONDITIONS

People who use dissociation as their primary defense mechanism are essentially virtuosos in self-hypnosis. Movement into an altered state of consciousness when one is distressed is not possible for everybody; you have to have the talent. Just as people differ in their basic levels of hypnotizability (Spiegel & Spiegel, 1978), they differ in their capacities for autohypnosis. To learn to dissociate automatically, one has to have the constitutional potential to go into trance; otherwise, trauma may be handled in other ways (e.g., repression, acting out, substance use).

Some have suggested that people who develop dissociative identity disorder are innately more resourceful and interpersonally sensitive than the norm. A child with a complex, rich inner life (imaginary friends, fantasy identities, internal dramas, and a penchant for imaginative play) may be more able to retreat to a secret inner world when terrorized or emotionally traumatized than a less gifted youngster. Clinical lore suggests that people who struggle with dissociation are as a group brighter and more creative than average. Such observations may be artifactual; those who come for help may not be typical of the whole dissociative spectrum. It was once thought that Eve and Sybil (Schreiber, 1973) were paradigmatic multiples, but their more hysteroid presentations are now seen as characteristic of only a small percentage of those who dissociate (Kluft, 1991).

To my knowledge, no drive constructs have been put forward to account for dissociative phenomena, probably because by the time the mental health community attended seriously to dissociation, the hegemony of psychoanalytic drive theory was over. With respect to affect, however, the picture is clear: Dissociative people have been overwhelmed with it and have gotten virtually no help processing it. Their affect is consequently in a state of chronic dysregulation (Chefetz, 2000a). Primordial terror, horror, and shame are foremost among the emotions that provoke dissociation in any traumatic situation; rage, excitement, and guilt may also be involved. The more numerous and conflicting the emotional states activated, the harder it is to assimilate an experience without dissociation.

Bodily states that may instigate trance include intolerable pain and confusing sexual arousal. While it is possible to develop a dissociative

identity in the absence of early sexual trauma and abuse by caregivers, empirical studies have established this relationship in the vast majority of cases in hospital settings severe enough to be diagnosed as dissociative identity disorder (Braun & Sacks, 1985; Putnam, 1989). More and more, neglect is emerging as equally pathogenic (Brunner, Parzer, Schuld, & Resch, 2000; Teicher et al., 2004); the child who is sexually used by a parent and otherwise ignored (by both the exploitive parent and other caregivers) suffers unbearably and must resort to dissociative solutions. Bullying and peer aggression (Teicher, Samson, Sheu, Polcari, & McGreenery, 2010), emotional abuse, and—probably most pathogenic of all—witnessing of domestic violence (Wolf, Gales, Shane, & Shane, 2000) are found in the histories of people with severe enough dissociation to meet DSM criteria for dissociative identity disorder.

DEFENSIVE AND ADAPTIVE PROCESSES IN DISSOCIATIVE CONDITIONS

Dissociative defenses that become relied on as a first-order strategy are like any others in that they begin as the best possible adaptation of an immature organism to a particular situation, then become automatic and hence maladaptive in later circumstances. Some adults with dissociative personalities have merely continued to use simple and sophisticated "below-the-radar" dissociative processes to regulate affect ever since the time of their original traumas; others, once the abusive practices ceased, have achieved for significant periods either a tenuous cooperation of alter personalities or the consistent domination of their subjective world by one self-state.

One common clinical presentation is the person whose observable dissociation stopped when he or she left the family in which it originated, only to surface again when a son or daughter reached the age at which the parent was first abused. (This identificatory connection is usually completely out of consciousness.) Another frequent trigger for dissociation in an adult whose autohypnotic tendencies have been dormant is an experience that unconsciously recalls childhood trauma. One woman in my practice suffered a household fall that injured her in the same places where she had been mutilated during childhood ritual abuse, and for the first time in years she suddenly became someone else. In taking a careful history, one often finds many minor instances of dissociation throughout the patient's adult life, but what usually brings the person to treatment is some dramatic and disabling dissociative reaction (losing significant amounts of time, being told of things one cannot remember, suffering interruption of the daily routines of living that have allowed

the person to avoid feeling through doing). It is phenomena like these that prompted Kluft (1987) to talk about "windows of diagnosability" in dissociative conditions (see R. J. Loewenstein, 1991).

Dissociation is an oddly invisible defense. When one self-state or system of alters is running things smoothly, no one outside the client can see the dissociative process. Many clinicians believe they have never treated someone with dissociative identity disorder—perhaps because they expect such a client to announce his or her multiplicity or to generate a dramatically alien alter personality. Sometimes this happens, but more commonly, indications of dissociation are subtle. Frequently, only one alter personality goes to therapy in a particular session. Even when a fairly identifiable alter emerges in treatment (e.g., a frightened child), an unenlightened therapist will tend to read the change in the patient in nondissociative terms (e.g., as a passing regressive phenomenon).

My first experience with a severely dissociative client—knowingly, that is—was at one remove. In the early 1970s, a close friend and colleague at Rutgers was conferring with me about treating a student who had exposed her multiplicity in the second year of her therapy with him. I found his account riveting. *Sybil* had just been published, and I remember thinking that this woman must be one of only a dozen or so extant multiples. Then he mentioned that she was in a course that I taught and, with her permission, told me her name. I was stunned. I would never have guessed that this young woman was dissociative; from the outside, the shifts that indicated "switching" looked like minor changes of mood. Since I knew from my friend how painfully she struggled with amnesia, it was an unforgettable lesson in how opaque the condition is to observers, even credulous ones. I began to wonder how many other hidden dissociative people there might be.

Accurate appraisal of the demographics of dissociation is hampered by its invisibility. I have sometimes consulted with spouses of people with dissociative psychologies, who, despite full awareness of their partner's diagnosis, have made comments like, "But yesterday, she said the opposite!" Cerebral knowledge that one was talking to a different alter yesterday pales against the data provided by one's senses: I was speaking to the same physical person on both days. If intimate partners of those with admitted, diagnosed dissociative identity disorder miss signs of dissociation, it is not hard to see how professionals can be even blinder, especially if they have been advised to view the topic skeptically. People who dissociate learn to "cover" for their lapses. They develop techniques of evasion and fabrication in childhood, as they find themselves repeatedly accused of "lying" about things they do not remember. Because they have suffered grievously at the hands of people who were supposed to protect them, they do not trust authori-

ties, and they do not come to treatment with the expectation that full disclosure is in their interest.

The estimation of how many of us rely heavily on a dissociative adaptation to living also depends on how the term is defined. In addition to "classic" multiple personality, there is the condition currently labeled dissociative disorder not otherwise specified (DDNOS), in which alter personalities exist but do not take executive control of the body or who do so but with no demonstrable amnesia. There are also other dissociative phenomena such as depersonalization—after depression and anxiety the third most commonly reported psychiatric symptom (Cattell & Cattell, 1974; Steinberg, 1991)—that can be frequent and longstanding enough to be considered characterological.

In 1988, Bennett Braun suggested a conceptualization that has come to be known by the acronym BASK (behavior, affect, sensation, knowledge). With it, he elevated the concept of dissociation to the status of a superordinate category rather than, as Freud had conceived it, a more peripheral defense. Braun's model subsumes many processes that often occur together but have not always been seen as related. One can dissociate behavior, as in a paralysis or a trance-driven self-mutilation; or affect, as in acting with la belle indifférence or remembering trauma without feeling; or sensation, as in conversion anesthesias and body memories of abuse; or knowledge, as in fugue states and amnesia. The BASK model views repression as a subsidiary of dissociation (dissociation of knowledge) and puts a number of phenomena that were previously regarded as hysterical into the dissociative domain. It also links to trauma many issues that have tended to be understood in terms of intrapsychic conflict. Some contemporary psychoanalysts (Bromberg, 1998; D. B. Stern, 1997) have similarly relocated defensive processes under the umbrella of dissociation. Therapists working with diagnosed dissociative patients have found such formulations useful; those working with others may find that it sensitizes them to the dissociative processes that occur in all of us.

RELATIONAL PATTERNS IN DISSOCIATIVE CONDITIONS

The outstanding feature of the childhood relationships of someone who becomes regularly dissociative is abuse, including but not limited to sexual abuse. The caregivers of people with dissociative identity disorder are frequently themselves dissociative, either directly, as a result of their own traumatic histories, or indirectly, via altered self-states created by alcohol and other drugs. Because the parents often have amnesia for what they do—whether it is psychogenic amnesia or substance abuse-

related blackouts—they both traumatize their children and fail to help them understand what has happened to them.

Severely dissociative clients show "Type D" attachment, the disorganized–disoriented type associated with infantile experience in which the object of safety is also the object of fear (Blizard, 2001; Fonagy, 2001; Liotti, 1999; Lyons-Ruth et al., 1999; Main & Hesse, 1990; Solomon & George, 1999). Disorganized attachment may increase susceptibility to traumatic experiences even when its source lies not in overt abuse but in a mother's emotional unavailability (Pasquini, Liotti, Mazzotti, Fassone, & Picardi, 2002). Avoidant attachment may also predict dissociation (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997). Traumatic experience early in life has devastating effects on psychic structure (Schore, 2002), distorting the development of the limbic system (Teicher et al., 1993), causing abnormalities in the corpus callosum (Teicher et al., 2004), and interfering with the development of the cerebellar vermis (Anderson, Teicher, Polcari, & Renshaw, 2002). Chronic hyperarousal floods the brain with glucocorticoids that damage the hippocampus (Solms & Turnbull, 2002). Severe trauma can override any constitutional, environmental, genetic, or psychological resilience factor (de Bellis, 2001).

Herman (1992) and Liotti (1999, 2004) have elaborated on the internal presence in traumatized people of perpetrator, victim, and rescuer images—the "drama triangle" originally noted by Karpman in 1968. Others have noted witness and bystander roles as well (Davies & Frawley, 1994; R. Prince, 2007). Therapists can expect to find themselves cast in such roles, and to face dramatic eruptions of traumatic themes. Sudden, intense experiences of danger, affective deluge, and emotional pressure to enact one of these positions tend to repeat in treatment the overwhelming and formative life experiences that created this psychology.

Many have wondered whether dissociative identity disorder is more common now than it was generations ago, or whether the current increase in diagnosing it derives entirely from our increased ability to identify it. It is not impossible that severe child abuse has been on the rise over the past decades and that a greater portion of humanity has resulting dissociative problems. Sociological factors that might contribute to more child abuse include the nature of modern warfare (in which whole civilizations rather than small groups of warriors are traumatized, and more people may reenact their horror with their children); destabilization of families; increases in addiction made possible by modern capacities for distribution (an intoxicated parent will do things that he or she would not even conceive of doing sober); increased violent imagery in the media (such that trance states are more often stimulated in a susceptible person); and the mobility, anonymity, and privacy of contemporary life

(I have no idea how my next-door neighbors treat their kids, and I have no personal influence on their behavior).

On the other hand, children have been traumatized since antiquity. When one treats a patient for dissociative problems, one frequently finds that that person's parent was also abused, as was the parent's parent, and so on. Coontz's (1992) indictment of nostalgia in sociological theorizing should give pause to anyone inclined to postulate easier times for children in prior generations. It seems likely, though, that more people in our era are talking about their childhood abuse and seeking help for its dissociative legacy. In the United States, this conversation was fueled by both the feminist movement and the reports of soldiers traumatized in Vietnam. Dissociation is not just a Western phenomenon, however; recent studies in Turkey (Sar, Akyuz, & Dogan, 2006; Sar, Dogan, Yargic, & Tutkun, 1999) found roughly the same proportion of dissociative patients there as Latz, Kramer, and Hughes (1995) found in a North Carolina hospital.

Kluft (1984) has offered a four-factor theory of the etiology of multiple personality disorder and severe dissociation. First, the individual is talented hypnotically. Second, he or she is severely traumatized. Third, the patient's dissociative responses are shaped by particular childhood influences; that is, dissociation is adaptive and to some extent rewarded by the family. Fourth, there is no comfort during and after traumatic episodes. I have already discussed aspects of Kluft's first three prerequisites; the last is equally critical, and it never fails to move therapists. No one seems ever to have held the dissociative child, or wiped away a tear, or explained an upsetting experience. Typically, emotional responses to trauma elicited more abuse ("Now I'll *really* give you something to cry about!"). There is often a kind of systemic family collusion to deny feeling, to forget pain, to act as if the horrors of the preceding night were all imaginary.

One fascinating aspect of dissociative identity disorder is how lovable many dissociative people are—at least many who seek treatment. Despite all the devastations to their basic emotional security and all the corruptions of parental care that one would expect to have destroyed the capacity to attach, clinicians almost universally report that dissociative patients evoke in them deep feelings of concern and tenderness. Although they often get involved with abusive people (via the repetition compulsion, as in masochism), they also attract some generous, understanding friends. In the histories of dissociative individuals, there is often one person after another—a childhood friend who stayed in touch for years, a nurse who felt this patient was different from the "other" schizophrenics on the ward, a beloved teacher, an indulgent cop—who saw something special in the dissociative person and tried to act as a force for good.

Readers may recall that I have sequenced these typological chapters according to the degree of object-relatedness I have attributed to the overall psychology under consideration. Even more than the hysterical person, the dissociative patient may be object seeking, hungry for relationship, and appreciative of care. I have not seen any explanation for this widely noted phenomenon in the literature on dissociation, but perhaps the unresolved nature of the dissociative person's attachment style leads him or her to keep trying to connect. Whatever the reasons, many people with multiple personality disorder tend to attach powerfully and with hope. With others, one feels the conflicted pull of "please help me but don't come near me," a communication that has often been considered paradigmatic of borderline psychology (Masterson, 1976), especially when it is accompanied, as it often is in dissociation, by high levels of suicidal and parasuicidal behavior.

THE DISSOCIATIVE SELF

The most striking feature of the self of a chronically traumatized person is, of course, that it is fractured into numerous split-off partial selves, each of which performs certain functions. Often, an infancy characterized by neglect and maltreatment prevented the self from integrating in the first place. The discrete self-states typically include one that traumatologists originally dubbed the "host personality" (the one most often in evidence, usually the seeker of treatment, who may present as anxious, dysthymic, and overwhelmed), infant and child components, internal persecutors, victims, protectors and helpers, and special-purpose alters (see Putnam, 1989). The host may know all, some, or none of the alters, and each alter may likewise know all, some, or none.

It can be hard for inexperienced or skeptical people to appreciate how discrete and "real" the dissociated selves can seem, both to the dissociative individual and to knowledgeable others. One evening I picked up my phone when my answering machine was beginning to record and found myself talking to a petulant child, an alter personality of a patient. She was calling to tell me about an early trauma whose existence I had suspected and to ask why the treatment-seeking part of the self needed to know about it. The next day when I told my client about the message, she asked to hear it. After listening together to my conversation with this dissociated aspect of herself, she was amused to note that she had not been feeling at all identified with the childish voice recounting her own history but was instead feeling sympathy with me, the voice of parental reason (she was a mother), trying to persuade a peevish little girl that I knew what was good for her.

Running through all the identities of a dissociative person, like the themes in a complex musical composition, are core beliefs engendered by childhood abuse. Colin Ross, discussing the "cognitive map" of multiple personality disorder, summarizes them as follows:

1. Different parts of the self are separate selves.
2. The victim is responsible for the abuse.
3. It is wrong to show anger (or frustration, defiance, a critical attitude ...).
4. The past is present.
5. The primary personality can't handle the memories.
6. I love my parents but *she* hates them.
7. The primary personality must be punished.
8. I can't trust myself or others. (1989b, p. 126)

Ross then dissects each of these convictions, exposing its component beliefs and inevitable extrapolations. For example:

2. *The victim is responsible for the abuse.*
2a. I must have been bad otherwise it wouldn't have happened.
2b. If I had been perfect, it wouldn't have happened.
2c. I deserve to be punished for being angry.
2d. If I were perfect, I would not get angry.
2e. I never feel angry—*she* is the angry one.
2f. She deserves to be punished for allowing the abuse to happen.
2g. She deserves to be punished for showing anger. (p. 127)

Recent literature by traumatologists contains extensive information on how to access alter personalities and how to reduce amnesic barriers so that they may eventually become integrated into one person with all the memories, feelings, and assets that were previously sequestered and inaccessible. The therapist must keep in mind is that "everyone" is the patient. Even the most unsavory persecutory personality is a valuable, potentially adaptive part of the person. When alters are not in evidence, one should assume they are listening and address their concerns by "talking through" the available personality (Putnam, 1989).

People who have not worked closely with dissociative patients can be unsettled by the idea of joining the patient in reifying alter personalities, but to do anything else seems to be ineffective (Kluft, 2006). Refusal to acknowledge personified self-states could cause much of the client's mental life to be kept out of the therapeutic relationship. If my experience is normative, it would also be false to one's natural empathic response to the patient's experience. Some clinicians talk about "parts," whereas others refer to "different ways of being you," a commonsense

use of language that holds the experience of being one while feeling like many (Chefetz, 2010a). Treatment may seem a bit like family therapy—with one person who has constructed an internal family system.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH DISSOCIATIVE PATIENTS

The most impressive feature of transference in dissociative clients is that there is so much of it. A person who has been severely mistreated lives in constant readiness to see the abuser in anyone on whom he or she comes to depend. Especially when child self-states are in ascendance, the present can feel so much like the past that hallucinatory convictions (e.g., the therapist is about to rape me, to torture me, to desert me) are not uncommon. These transferences, which may strike the therapist as psychotic but are better understood as traumatic transferences (Kluft, 1994; R. J. Loewenstein, 1993), do not indicate psychotic or schizophrenic disorders, though professionals untrained in dissociation have frequently made that inference. Rather, they are posttraumatic perceptions, sensations, and affects that were severed from awareness at the time of the original abuse and that remain unintegrated into the client's personal narrative. They can perhaps be best conceptualized as conditioned emotional responses to a class of stimuli associated with abuse.

A common sequence with people with undiagnosed dissociation is for the therapist to feel a vague, benign positive transference from the person in the self-state that seeks therapy, who is treated as the whole patient for several weeks, months, or years. Then there is a sudden crisis driven by the patient's emerging recollection of trauma and its activation of alter personalities, somatic memories, and/or reenactments of abuse. Such developments can be deeply disturbing and can invite counterphobic responses from the naive clinician, who may assume a schizophrenic break. The histories of dissociative patients are littered with referrals for unwarranted pharmacological treatment (including major tranquilizers, which may aggravate dissociation), invasive medical procedures, electroshock, and infantilizing "management" approaches. But for a therapist who can see what has really happened, this crisis can signal the beginning of a reparative collaboration.

Because transference inundates dissociative patients, the therapist needs to be somewhat more "real" than some analytic therapists customarily behave. Many clinicians find that they do this naturally—albeit with guilt if their training emphasized an invariant, "orthodox" technique. It is true that relatively healthy nondissociative people can be so grounded in reality that for their underlying projections to become evi-

dent, the therapist must be relatively reserved. In the classical psychoanalytic paradigm, transferences become analyzable because the client discovers a tendency to make attributions in the absence of evidence and then discovers that the sources of such assumptions are historical. In contrast, people struggling with dissociation, even those who are high functioning, tend to assume that current reality is only a distraction from a more ominous *real* reality: exploitation, abandonment, torment.

To explore a dissociative person's transference, the therapist must first establish that he or she is someone different from the expected abuser—someone respectful, devoted, modest, and scrupulously professional. The dissociative person's world is so infused with unexamined transferences that the active contradiction of them, especially early in treatment or in reorienting during or after a flashback ("I'm Nancy McWilliams, and we're here in my office in Flemington"), may be critical to eventually understanding the intense reactions that confuse past and present.

The most disturbing experiences for both therapists and clients addressing dissociation include erotic (erotized) (Blum, 1973; Wrye & Welles, 1994) and traumatic transferences (Chefetz, 1997). The patient may exert intense pressure to be treated as "special," including as a lover, which can interact with the therapist's narcissistic needs to be seen as generous, benevolent, and altruistic. The temptation to act out the role of rescuer or idealized object of desire, while not acknowledging to oneself coexisting feelings of hatred and resentment, can produce enactments that infantilize and harm the client and exacerbate dissociative responses. The suffering of traumatized individuals is so profound and undeserved, their responsiveness to simple consideration so touching, that one yearns to put them on one's lap (especially the child alters) or take them home. But however intensely they evoke this reaction, they are also petrified by any violation of normal boundaries; it smacks of incestuous exploitation.

Pathfinders in the rediscovery of multiplicity in the second half of the 20th century, who lacked the benefit of prior work by trauma therapists who could have helped them manage their countertransferences, had a tendency toward excessive nurturance: Cornelia Wilbur was very motherly toward Sybil, and David Caul seems to have been overinvolved with Billy Milligan (Keyes, 1982). Like their intrepid predecessors, many clinicians seeing their first dissociative client tend to overextend themselves. Traumatized patients are notoriously hard to contain; at the end of each session they may linger and chat, evidently seeking a few extra shreds of moral support in facing the horrors that therapy has unearthed. Even experienced practitioners report that sessions with such clients tend to creep past the scheduled end of sessions. Dissociative patients use

time boundaries to gauge when the assumed re-abuse, the abuse that is seen as an inevitable part of relating, will likely occur. Being warmer and more emotionally expressive than one usually is with clients, while at the same time being fastidiously observant of limits, gets easier with practice. And when one inevitably blunders, some alter will usually be happy to provide corrective instruction.

One rather amusing countertransference to dissociative people is dissociation. Like other psychologies, dissociation is catching. Not only is it easy to get into trance states while working with an autohypnotist, one also gets oddly forgetful. When I began to work with my first known multiple, I enrolled twice in the International Society for the Study of Multiple Personality and Dissociation (now the International Society for the Study of Trauma and Dissociation), having forgotten that I had already joined.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF A DISSOCIATIVE CONDITION

New therapists can be intimidated by the prospect of working with someone with severe or chronic dissociation, and many training programs consider such clients too daunting for a beginner. This is unfortunate. Dissociation is common, and severe dissociation and its challenges are faced by any therapist sooner or later, whether or not it is seen for what it is. Putnam (1989) says that there is nothing fancy, no special wizardry, required to help a dissociative client. In the first edition of this book, I echoed this assessment, but as my experience with this population has increased, I want to qualify his assertion. The emotional demands of working with patients with dissociative identity disorder and other complex posttraumatic conditions are great. Because inductions into traumatic enactments are a risk with this group, one needs both a deep level of self-knowledge, preferably from one's own therapy, and a lot of support from dissociation-savvy supervisors and colleagues.

In distilling the essence of effective therapy with this population, I could not do better than Kluft (1991), who has derived the following principles:

1. MPD [multiple personality disorder] is a condition that was created by broken boundaries. Therefore, a successful treatment will have a secure treatment frame and firm, consistent boundaries.
2. MPD is a condition of subjective dyscontrol and passively

endured assaults and changes. Therefore, there must be a focus on mastery and the patient's active participation....

3. MPD is a condition of involuntariness. Its sufferers did not elect to be traumatized and find their symptoms are often beyond their control. Therefore, the therapy must be based on a strong therapeutic alliance, and efforts to establish this must be undertaken throughout the process.
4. MPD is a condition of buried traumata and sequestered affect. Therefore, what has been hidden away must be uncovered, and what feeling has been buried must be abreacted.
5. MPD is a condition of perceived separateness and conflict among the alters. Therefore, the therapy must emphasize their collaboration, cooperation, empathy, and identification....
6. MPD is a condition of hypnotic alternate realities. Therefore, the therapist's communications must be clear and straight....
7. MPD is a condition related to the inconsistency of important others. Therefore, the therapist must be evenhanded to all the alters, avoiding "playing favorites" or dramatically altering his or her behavior toward the different personalities. The therapist's consistency across all of the alters is one of the most powerful assaults on the patient's dissociative defenses.
8. MPD is a condition of shattered security, self-esteem, and future orientation. Therefore, the therapy must make efforts to restore morale and inculcate realistic hope.
9. MPD is a condition stemming from overwhelming experiences. Therefore, the pacing of the therapy is essential. Most treatment failures occur when the pace of the therapy outstrips the patient's capacity to tolerate the material.... [I]f one cannot get into the difficult material one planned to address in the first third of the session, to work on it in the second, and process it and restabilize the patient in the third [one should not approach] the material, lest the patient leave the session in an overwhelmed state....
10. MPD is a condition that results from the irresponsibility of others. Therefore, the therapist must be very responsible, and hold the patient to a high standard of responsibility once the therapist is confident that the patient, across alters, actually grasps what reasonable responsibility entails.
11. MPD is a condition that often results because people who could have protected a child did nothing. The therapist can anticipate that technical neutrality will be interpreted as uncaring and rejecting and is best served by taking a warmer stance that allows for a latitude of affective expression.
12. MPD is a condition in which the patient has developed many cognitive errors. The therapy must address and correct them on an ongoing basis. (pp. 177–178)

It also helps to know a little hypnosis. Since dissociative people by definition go into trance states spontaneously, it is not possible to work with them without hypnosis—either they are doing it alone, or you and they are doing it cooperatively. A therapist who can help the patient learn how to get the hypnotic process under control and use it autonomously and therapeutically rather than traumatically and defensively is providing a critical service. Trance-inducing techniques are extremely easy to use with this population of hypnotic prodigies, and they are especially effective in building a sense of safety, containing surplus anxiety, and handling emergencies. Help in this area can be found from the American Society for Clinical Hypnosis at *www.asch.net* and the International Society of Hypnosis at *www.ish-web.org*.

I say this as someone who came to hypnosis kicking and screaming. My colleague Jeffrey Rutstein calls this the "If-it-wasn't-good-enough-for-Freud-it-isn't-good-enough-for-me!" reaction. My resistance to learning hypnotic techniques came from my misgivings about any intervention I regarded as authoritarian; I did not want to tell clients they were getting sleepy if that was actually my directive rather than their natural experience. This prejudice remitted when I learned to hypnotize in an egalitarian, collaborative way (having the patient direct me as to induction images and other particulars), and when I saw how much calmer it made my dissociative clients in managing the emotional maelstrom created by going in and out of traumatic memories. For therapists who have no background in it, a weekend workshop in hypnosis is enough to provide adequate skill for work with most dissociative clients. The training also helps one to appreciate the full range of dissociative phenomena. Similarly, eye movement desensitization and reprocessing (EMDR) has shown promise as an adjunctive treatment (Chemtob, Tolin, van der Kolk, & Pitman, 2004), although it can be disorganizing to people with complex dissociation.

Because of the power of the traumatic transferences, one must tolerate being used by the patient in ways that feel "distorting." This requires swallowing one's defensiveness and engaging in what Sandler (1976) called "role responsiveness" and Lichtenberg (2001) has called "wearing the attributions" of the client. Chefetz (personal communication, October 11, 2010) offers an example of this kind of response: "So, you're feeling like you're at risk of being hurt by me? Tell me about what you imagine might happen. What comes to mind as you consider this? Does that match any scenes from the past? Are there other ways of being you in the background, close by, who are really engaged in a lot of this thinking and feeling? Why do you think they are so present?"

Chu's (1998) description of the stages of treatment for complex dissociation is pertinent here. Chu divides therapy into three phases: (1) the

early work (which may last a long time), focusing on self-care, symptom control, acknowledgment of early trauma, support for normal functioning, expression of feelings, and constant negotiation of the therapeutic alliance; (2) the middle part of treatment, involving abreation and reconstruction at a pace tolerable to the patient; and (3) late-stage work, consisting of consolidation of gains and increasing skills needed to live one's life. Chefetz (personal communication, October 11, 2010) summarizes phase-oriented treatment of the dissociative disorders as stabilization, working through trauma, integration, and termination. The stabilization period, which may be long and should not be rushed, may require teaching techniques for self-soothing, self-care, grounding, and affect tolerance.

In practice, as is true of any therapy, the treatment phases often occur out of order. Some trauma work might intrude into the stabilization period; some may recur during integration and termination as old issues are reworked or come to light for the first time. In a 10-year follow-up study of patients diagnosed with dissociative identity disorder, Coons and Bowman (2001) found that following the general treatment guidelines of the International Society for the Study of Trauma and Dissociation (*www.isst-d.org/education/treatmentguidelines-index.htm*) brought improvements in both dissociative and nondissociative symptoms.

Working with dissociative clients requires some flexibility. Deviations from standard care may occur in the form of apparently innocent boundary crossings or in the therapist's occasional deliberate decision to "throw away the book" (cf. Hoffman, 1998). In either case, it is critical to negotiate the boundary in an open, thoughtful manner that attends to potential meanings (Gabbard & Lester, 2002). I have occasionally attended a client's wedding, accepted a gift, or walked around the block with a person whose anxiety was too high to stay in one place, and sometimes such boundary crossings have been taken in as healing. When one has traversed the normal boundaries of treatment, intentionally or not, it is especially important to process mutually what has happened and what it means to the client. Because dissociative people are even more concerned than others about boundary infractions, attention to their responses to departures from standard operating procedure is particularly vital.

Especially with dissociative patients, it is wise to remember the old psychoanalytic chestnut, "The slower you go, the faster you get there." When multiplicity was rediscovered in the 1980s, some clinics and researchers experimented with ways to cut down on treatment time with exposure and planned abreaction, but they found that these techniques tended to retraumatize complexly dissociative clients. We have no busi-

ness, especially in the name of mental health, hurting someone who has already had more than an ordinary share of injury. For readers who want more education in this area, I recommend the psychotherapy program for the dissociative disorders and chronic complex trauma in children, adolescents, and adults that Richard Chefetz and Elizabeth Bowman started in 2001. Information is available at *www.isst-d.org.*

DIFFERENTIAL DIAGNOSIS

Because so much of the misunderstanding and mistreatment of dissociative patients derives from diagnostic errors, this section is more thorough than in other chapters. The typical profile for someone with chronic and complex dissociation includes having been in the mental health system for years, with different serious diagnoses (e.g., bipolar, schizophrenic, schizoaffective, and major depression), none of which has been effectively treated with medication. Often the patient is also diagnosed with BPD. There may be periods when the person is off all medication and somehow functions well. Dissociative clients leave in their wake numerous failed medication regimens and multiple therapists, and yet no one has asked them about being abused or hurt or has questioned them about depersonalization, derealization, and amnesia. In 1988, Coons, Bowman, and Milstein found that an average of 7 years elapses between a dissociative client's initial search for treatment and an accurate diagnosis. This lag may be shrinking, but it is still true that one factor that should alert a diagnostician to a possible dissociative identity problem is the presence of several prior, serious, and/or mutually exclusive diagnostic labels in a person's treatment history.

Unless a client has a known history of trauma, most beginning therapists are not encouraged to look for dissociation. In my training in the 1970s I was never taught to "rule out" dissociative possibilities. I was told, for example, that a client who reports hearing voices is presumptively psychotic, organically or functionally, probably some variety of schizophrenic. I was not told to ask whether the voices seemed to be inside or outside the person's head. This quick-and-dirty way of discriminating posttraumatic hallucinatory states from psychotic decompensation was not even known in the 1970s, and despite research that has since then established its value (Kluft, 1991; C. A. Ross, 1989a), it is still taught only rarely. It is my impression that even now, most graduate programs teach students, at best, only how to recognize classic PTSD.

I cannot stress enough that most people with dissociative psychologies do not come to therapy announcing that their problem is dissociation. It must be inferred. Data suggesting the possibility of a dissocia-

tive process include a known history of trauma; a family background of severe alcoholism or drug abuse; a personal background of unexplained serious accidents; amnesia for the elementary school years; a pattern of self-destructive behavior for which the client can offer no rationale; complaints of lost time, blank spells, or time distortion; headaches (common during switching); referral to the self in the third person or the first-person plural; eye-rolling and trance-like behaviors; voices or noises in the head; and prior treatment failures.

Individuals born with anomalous genitals (for whatever reason: chromosomal, hormonal, prenatal injury) who have had early surgeries and invasive medical treatments intended to make them look unambiguously like one gender are at serious risk of dissociation. This is a particular risk if, as pediatric protocols dictated until just a few years ago (Lee et al., 2006), the affected child was lied to about his or her condition and the reason for the painful, traumatically exposing medical interventions. As 1 in every 2,000 births involves anomalous genital presentation ("intersex" condition, "disorder of sexual development," or "atypical genitals"), there is a substantial group of people who have been deeply traumatized for this reason—over 100,000 in the United States alone have been subjected to the older medical protocol (Blackless et al., 2000).

Depersonalization and derealization are regularly features of the dissociative disorders, but patients are unlikely to volunteer this information and must be asked about them in a manner that does not make them feel that their basic sanity is being impugned. One may have to ask questions in several different ways; for example, "Do you ever have an experience of somehow, in a not really understandable way, not quite being in your body? Do you ever find yourself feeling unreal in ways you can't describe? Do you have other experiences that are hard to describe in the words I've used?") Because people often think they are crazy if they suffer depersonalization or derealization, a wise clinician is alert to the sad reality that shame is often at the core of dissociative dynamics.

Dissociative problems range from mild depersonalization to polyfragmented multiple personality disorder. Many of us have occasional dissociative symptoms, and neither they nor the dissociative strategies that may pervade personality can be addressed by a therapist who is not open to seeing them. The Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1993) is the current gold standard for diagnosis, but it can take 2 to 3 hours to complete. Other inventories by C. A. Ross (1989b: Dissociative Disorder Interview Schedule), Briere (1992; Trauma Symptom Inventory: *www.johnbriere.com/tsi.htm*), and Dell (2006: Multidimentional Inventory of Dissociation) may be helpful.

Dissociative Conditions versus the Psychoses

Because dissociative patients in crisis or under stress show most of Schneider's (1959) "first-rank" symptoms (Hoenig, 1983; Kluft, 1987, 2000), they are easily construed as schizophrenic. If an interviewer regards dissociative switching as lability of mood, the client may be seen as schizoaffective or bipolar at the psychotic level. Hallucinations and delusions in dissociative people tend to be flashback phenomena rather than dominantly projective operations. Their relationships with therapists often have an intensity from the beginning, whereas schizophrenic clients have a flat, deadened quality and do not tend to draw the therapist into an intense attachment. Schizophrenic withdrawal from reality and relatedness tends to start in the teens and progress insidiously toward further isolation in adulthood. Individuals with dissociative identity disorder, in contrast, live compartmentalized lives, functioning well in some areas and poorly in others.

Bipolar and schizoaffective people have shifts of mood but no disorders of memory. In a manic state the person with bipolar illness is much more grandiose than the agitated dissociative person. Whereas rapid cycling in bipolar disorders is defined as four times yearly, a dissociative patient may switch consciousness many times in 1 day or even in 1 hour.

Complicating the diagnostic challenge is the fact that dissociative symptoms can coexist with schizophrenia and with the affective psychoses. To assess whether dissociation is a major part of a psychotic picture when voices are reported, one can ask to speak with "the part of you that is saying these things." If dissociation predominates, an alter may answer back. The first time one does this it feels ludicrous, but after that it seems a rather prosaic question. Beginners should remember that the worst that can happen is for the patient to stare blankly and ascribe the request to some weird professional rite of intake.

Dissociative versus Borderline Conditions

From the psychoanalytic developmental perspective I have represented here, the diagnoses of borderline and dissociative conditions are not mutually exclusive. Dissociation can pervade personality at any level of severity. Referring to DSM-III-R definitions of multiple personality disorder and borderline personality disorder, Kluft (1991) reported that "of treatment-adherent patients who appear to have both MPD and BPD, one-third rapidly ceased to show BPD features once they settled into treatment, one-third lost their apparent BPD as their MPD resolved, and one-third retained BPD features even after integration"

(p. 175). Presumably, once patients in this last group had stopped dissociating, their borderline status could be addressed in further treatment.

Even though some dissociative clients are legitimately regarded as in the borderline range, where separation–individuation issues prevail, it is common for high-functioning dissociative people to be misconstrued as borderline when their dissociation becomes problematic. Dissociation resembles splitting, and switches of self-state can be easily mistaken for non-amnesic outbreaks of hostility, dependency, shame, and other attitudes. Thus, one must be sensitive to the presence or absence of amnesia. Because traumatized people do not trust in the benevolence of authorities, they may offer critical information only if it is expressly and respectfully welcomed, and so phrasing matters. Saying "Last Monday you were furious at me and thought I was worthless, but today you're saying I'm wonderful" may evoke defensiveness in either a dissociative or a generically borderline person. But saying "I'm noticing that today you are clear that I am really on your side. Do you recall how you felt about me in last Monday's session?" may permit the dissociative client to admit to having forgotten the Monday session. The person with borderline dynamics is more likely to rationalize moving back and forth from love to hatred, idealization to devaluation.

Dissociative versus Hysterical Psychology

As I have mentioned, there is considerable overlap between hysterical and dissociative psychologies; many of us have both, and many contemporary traumatologists regard the terms as synonymous. Neurotic-level hysterical personality (Kernberg, 1984), however, as opposed to the more serious histrionic personality disorder of the DSM or the severe conversion symptoms, does not in my experience necessarily result from trauma and may have more to do with temperamental sensitivity than with maltreatment. In contrast, no one with diagnosable dissociative identity disorder, even those with long periods of good functioning, has escaped severe trauma. Anyone with pronounced hysterical symptoms should be questioned about dissociation.

The therapeutic ramifications of this differential revolve around the importance with hysterical people of interpreting their recurrent impulses, fantasies, and unconscious strivings, as opposed to an emphasis with dissociative clients on reconstructing a traumatic past. If one does the former with a basically dissociative client, one will reinforce denial, increase guilt, and fail to deal with the pain that a terrible history has created. If one does the latter with a histrionic client, one may prevent the flowering of the sense of agency that comes from acknowledging

internal dynamics and redirecting one's energies in directions that are genuinely satisfying.

Dissociative versus Psychopathic Conditions

As I noted in Chapter 7, many antisocial people have dissociative defenses or frank dissociative identity disorder (Lewis et al., 1997). Discriminating between a psychopathic person with a dissociative streak and a dissociative person with a psychopathic alter is maddeningly difficult—mostly because by the time this question is asked, so many legal consequences hinge on the answer. A person accused of a serious crime may have a huge stake in convincing a judge or jury of multiplicity; less commonly, a persecutory alter may be punishing another part of the self by getting it assessed as antisocial. It is prudent to assume psychopathy when someone has powerful reasons to malinger (see Thomas, 2001, on differentiating malingering from dissociation).

If we do become adept at reliably differentiating essentially dissociative from essentially psychopathic people, even when there is significant advantage to a person in presenting as one or the other, the consequences for the criminal justice system could be substantial. Because most dissociative people have a better prognosis than psychopathic individuals, there would be significant crime-preventive value in giving intensive therapy to perpetrators discovered to have dissociative identity disorder. Clinicians can resolve dissociation more expeditiously than they can modify antisocial patterns; under conditions of limited resources, people working in jails or with the probation system could concentrate on those clients most receptive to their help.

SUMMARY

In this chapter I have discussed the history of the concept of dissociation and the psychology of people with dissociative identities. In accounting for individual development of dissociation as a core process, I mentioned constitutional talent for self-hypnosis, often coexisting with high intelligence, creativity, and sociophilia. These factors may predispose a person to respond to trauma with a dissociative defense invisible to outsiders. I mentioned Braun's (1988) BASK model of dissociation as an alternative to Freudian concepts of defense. I described object relations of dissociative people in terms of disorganized or avoidant attachment caused by childhood relational trauma. I depicted the self of someone with a dissociative identity as not only fragmented but also as permeated by paralyzing fears, shame, and self-blaming cognitions. Still, I noted how

well many dissociative people function, in their highly compartmentalized way.

I emphasized the power of transference and countertransference reactions with dissociative patients, especially as they provoke rescue fantasies and overinvolvement in the therapist. Treatment implications of this diagnosis included a stress on nurturing a sense of basic safety; teaching techniques in self-soothing, self-care, grounding, and stabilization of emotional lability; fostering cooperation in the therapeutic relationship; and only after stabilization promoting recall and emotional comprehension of dissociated experiences. Overall, I recommended maintaining consistency toward all personalities, being "real" and warm while adhering strictly to professional boundaries, analyzing pathogenic beliefs, using adjunctive techniques such as hypnosis and EMDR, and respecting the client's need to take time to tolerate the therapeutic process. I differentiated dissociative dynamics from schizophrenic and bipolar psychoses, generically borderline conditions, and hysterical and psychopathic personality organizations.

SUGGESTIONS FOR FURTHER READING

Herman's classic *Trauma and Recovery* (1992) and Terr's (1992) study of traumatized children are foundational for understanding the phenomena involved in dissociation. Putnam's (1989) text remains the starting point for anyone dealing with dissociative adults, and his 1997 book extends his work into the treatment of children and adolescents. R. J. Loewenstein's (1991) overview on diagnosis of chronic, complex dissociation is especially valuable. Kluft and Fine (1993) have published a good edited book on treating dissociation. For readers integrating psychoanalytic ideas with research and clinical experience with dissociation, I recommend Kluft's (2000) article, Ira Brenner's (2001, 2004, and 2009) contributions, and Elizabeth Howell's (2005) relational tour de force. Also within the relational tradition, both Philip Bromberg (1998, 2010) and Donnell Stern (1997, 2009) write eloquently about addressing dissociation in the clinical process. As I write this, Richard Chefetz is planning to publish a book on working with dissociative patients that I expect to be particularly valuable to therapists.

Appendix

Suggested Diagnostic Interview Format

DEMOGRAPHIC DATA

Name, age, gender, ethnic and racial background, religious orientation, relationship status, parental status, level of education attained, employment status, previous experience with psychotherapy, source of referral, informants other than client.

CURRENT PROBLEMS AND THEIR ONSET

Chief complaints and the client's ideas about their origins; history of these problems; how they have been addressed so far, including medications; why therapy is being sought *now*.

PERSONAL HISTORY

Where born, reared, number of children in family and client's place among them; major moves. Parents and siblings: Get objective data (whether alive, cause and time of death if not; age, health, occupation) and subjective data (personality, nature of relationship with patient). Psychological problems in family (diagnosed psychopathology and other conditions; e.g., substance use disorder, violence, boundary violations).

Infancy and Toddlerhood

Whether patient was wanted; family conditions after birth; anything unusual in developmental milestones; any early problems (eating, bowel control, talking, locomoting, bedwetting, night terrors, sleepwalking, nailbiting, etc.); earliest memories; family stories or jokes about the client; the story of the client's name.

Latency

Separation problems, social problems, academic problems, behavioral problems, cruelty to animals; illnesses, losses, moves, or family stresses at this time; sexual, physical, or emotional abuse or witnessing of domestic violence.

Adolescence

Age of puberty, any physical problems with sexual maturation, family preparation for sexuality, first sexual experiences, sexual preference (masturbation fantasies if this is uncertain); school experience, academically and socially; patterns of self-destructiveness (eating disorders, drug use, questionable sexual judgment, excessive risk-taking, suicidal tendencies, antisocial patterns; social withdrawal); illnesses, losses, moves or family stresses at this time.

Adulthood

Work history; relationship history; adequacy of current intimate relationship; relationship to children; hobbies, talents, pleasures, areas of pride and satisfaction, aspirations (where does the person hope to be in 5 years, 10 years, etc.).

CURRENT PRESENTATION (MENTAL STATUS)

General appearance, affective state, mood, quality of speech, soundness of reality testing, estimated intelligence, adequacy of memory; assess reliability of information. Pursue further investigation into any of these areas that suggest problems; for example, if mood is depressed, assess suicide. If it feels difficult to get a linear history, assess for depersonalization, derealization, and other dissociative reactions.

Dreams: Are they remembered? Any recurrent? Example of a recent dream.

Substance use, prescribed or otherwise, including alcohol.

CONCLUDING TOPICS

Ask the patient if he or she can think of any important information that your questions have not touched on. Ask whether the patient is comfortable with you and whether he or she has anything to ask.

INFERENCES

Major recurring themes; attachment pattern; areas of developmental arrest and internal conflict; favored defenses; inferred unconscious fantasies, wishes, fears, beliefs; central identifications, counteridentifications, unmourned losses; self-cohesion and self-esteem.

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