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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 ("initiative 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 psychological 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 noteworthy 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.