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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 Congressman 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 suffer 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 identification:

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 children (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 empathically 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 banishing 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 irritability, 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 imbalance 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 counteractive 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 clients 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 longstanding 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 *juissance* 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; narcissistically 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 depressive 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 constitutional 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 (Dorpat, 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 inevitable 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 orientations. 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 presumption 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 intuition 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 de-personalized 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*.

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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 comparably 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 behavior 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 theoretical 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 reinforced 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. Sometimes, 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 comments 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 observation 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.