CHAPTER 2

THE THEORETICAL BASIS OF DYNAMIC PSYCHIATRY

Nothing is as practical as a good theory.

Kurt Lewin

Like a sailor without a sextant, a psychiatrist who sets out to navigate the dark waters of the unconscious without a theory will soon be lost at sea. Psychoanalytic theory is the foundation of dynamic psychiatry. It brings order to the seemingly chaotic inner world of the patient. It allows the psychiatrist to supplement and transcend the descriptive level of cataloging symptoms and applying diagnostic labels. It provides a means of entering and understanding the cavernous interior of the mind. Theory not only guides clinicians toward diagnostic understanding, it also informs the choice of treatment for each patient. Theoretical understanding helps the dynamic psychiatrist decide what to say, when to say it, how to say it, and what is better left unsaid.

Contemporary dynamic psychiatry subsumes at least four broad psychoanalytic theoretical frameworks: 1) ego psychology, derived from the classic psychoanalytic theory of Freud; 2) object relations theory, derived from the work of Melanie Klein and members of the “British School,” such as Fair-
bairn and Winnicott and also including American relational/intersubjectivist theories; 3) self psychology, originated by Heinz Kohut and elaborated by many subsequent contributors; and 4) attachment theory.

Although volumes have been written on each of these schools of thought, here we merely examine the salient features of the four theoretical frameworks. In subsequent chapters the theories are “fleshed out” to illustrate their application to clinical situations.

**Ego Psychology**

Freud’s early years as a psychoanalytic investigator were heavily influenced by his topographic model (described in Chapter 1). Hysterical symptoms were seen as the result of repressed memories of events or ideas. Freud hypothesized that psychotherapeutic intervention could lift repression, leading to the recall of memories. In turn, a detailed verbal description of the remembered pathogenic idea or event, accompanied by intense affect, would lead to the symptom’s disappearance. For example, a young man’s paralyzed arm might be the result of a repressed wish to hit his father. According to this model, the young man might regain the use of his arm by retrieving the wish from his unconscious, verbalizing it, and expressing the anger toward his father. This cathartic method, also known as *abreaction*, makes conscious the unconscious pathogenic memory.

However, the topographic model soon began to fail Freud. He repeatedly encountered resistances in his patients to his therapeutic maneuvers. Some memories could not be brought back into consciousness. The defense mechanisms responsible for this resistance were themselves unconscious and therefore inaccessible. These observations led Freud to conclude that the ego has both conscious and unconscious components.

With the publication of “The Ego and the Id,” Freud (1923/1961) introduced his tripartite structural theory of ego, id, and superego. In the structural model, which superseded the topographic model, the *ego* was viewed as distinct from the instinctual drives. The conscious aspect of the ego was the executive organ of the psyche, responsible for decision making and integration of perceptual data. The unconscious aspect of the ego contained defense mechanisms, such as repression, that were necessary to counteract the powerful instinctual drives harbored in the id—specifically, sexuality (libido) and aggression.

The *id* is a completely unconscious intrapsychic agency that is only interested in discharging tension. The id is controlled both by the unconscious aspects of the ego and by the third agency of the structural model—the superego. For the most part, the *superego* is unconscious, but aspects of it are
certainly conscious. This agency incorporates the moral conscience and the ego ideal. The former prescribes (i.e., dictates what one should not do based on the internalization of parental and societal values), whereas the latter prescribes (i.e., dictates what one ought to do or be). The superego tends to be more sensitive to the strivings of the id and is therefore more immersed in the unconscious than is the ego (Figure 2–1).

Ego psychology conceptualizes the intrapsychic world as one of interagency conflict. The superego, the ego, and the id battle among themselves as sexuality and aggression strive for expression and discharge. Conflict between the agencies produces anxiety. This signal anxiety (Freud 1926/1959) alerts the ego that a defense mechanism is required. The mechanism of neurotic symptom formation may be understood in this manner. Conflict produces anxiety, which results in defense, which leads to a compromise between the id and the ego. A symptom, then, is a compromise formation that both defends against the wish arising from the id and gratifies the wish in disguised form.

For example, an accountant with obsessive-compulsive personality disorder was always concerned that his boss might be angry with him. He secretly resented his boss, and his anxiety about his boss’s anger was a projection of his own wish to explode at his boss and tell him what he thought of him. As an unconscious defense, he was obsequious and ingratiating toward his boss to make sure that he could not possibly be accused of being angry with him. The boss found this behavior irritating, and as a result there was an ever-present tension between the two of them. In other words, the accountant’s obsequious style defended against the eruption of his own
anger, but it also contained an attenuated expression of his aggressive wishes because of the reaction it produced in his boss.

Such compromise formations are a normal mental process (Brenner 1982). Neurotic symptoms represent only the pathological variety. Character traits themselves can be compromise formations and may represent adaptive and creative solutions to intrapsychic conflict.

Defense Mechanisms

Freud acknowledged the existence of other defense mechanisms, but he devoted most of his attention to repression. Freud's daughter Anna, in her landmark work *The Ego and the Mechanisms of Defense* (Freud 1936/1966), expanded his work by describing in detail nine individual defense mechanisms: regression, reaction formation, undoing, introjection, identification, projection, turning against the self, reversal, and sublimation. Even more important, she acknowledged the implications that this increased scrutiny of the defensive operation of the ego had for treatment. No longer could the psychoanalyst simply attend to the uncovering of unacceptable wishes from the id. Equal attention would need to be paid to the vicissitudes of defensive efforts put forth by the ego, which would manifest themselves as resistances in treatment.

In shifting the emphasis of psychoanalysis from drives to ego defenses, Anna Freud anticipated the movement of psychoanalysis and dynamic psychiatry away from neurotic symptom formation and toward character pathology. We now partially define many forms of personality disorder according to their typical defensive operations. Thus, the dynamic psychiatrist must be thoroughly familiar with a broad range of defense mechanisms because of their usefulness in understanding both neurotic problems and personality disorders.

All defenses have in common the protection of the ego against instinctual demands from the id (Freud 1926/1959). None of us is without defense mechanisms, and which defenses we use reveals a lot about us. They are often classified according to a hierarchy from the most immature or pathological to the most mature or healthy (Vaillant 1977), and a profile of one's defense mechanisms is a good barometer of psychological health. The most common defense mechanisms are listed according to this hierarchy in Table 2–1.

Although this hierarchy is in common usage in both clinical practice and research, it may imply a rigidity that is misleading. Terms such as “primitive” can have a pejorative connotation. It is more accurate to say that we are all prone to use a variety of defenses, some in the primitive category, when under stress or in large groups. Conversely, some psychiatric patients with serious disorders can use some of the more mature defenses in specific circumstances.
TABLE 2–1.  A hierarchy of defense mechanisms

<table>
<thead>
<tr>
<th>Defense mechanism</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primitive defenses</strong></td>
<td></td>
</tr>
<tr>
<td>Splitting</td>
<td>Compartmentalizing experiences of self and other such that integration is not possible. When the individual is confronted with the contradictions in behavior, thought, or affect, he or she regards the differences with bland denial or indifference. This defense prevents conflict stemming from the incompatibility of the two polarized aspects of self or other.</td>
</tr>
<tr>
<td>Projective identification</td>
<td>Both an intrapsychic defense mechanism and an interpersonal communication, this phenomenon involves behaving in such a way that subtle interpersonal pressure is placed on another person to take on characteristics of an aspect of the self or an internal object that is projected into that person. The person who is the target of the projection then begins to behave, think, and feel in keeping with what has been projected.</td>
</tr>
<tr>
<td>Projection</td>
<td>Perceiving and reacting to unacceptable inner impulses and their derivatives as though they were outside the self. Differs from projective identification in that the target of the projection is not changed.</td>
</tr>
<tr>
<td>Denial</td>
<td>Avoiding awareness of aspects of external reality that are difficult to face by disregarding sensory data.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Disrupting one's sense of continuity in the areas of identity, memory, consciousness, or perception as a way of retaining an illusion of psychological control in the face of helplessness and loss of control. Although similar to splitting, dissociation may in extreme cases involve alteration of memory of events because of the disconnection of the self from the event.</td>
</tr>
<tr>
<td>Idealization</td>
<td>Attributing perfect or near-perfect qualities to others as a way of avoiding anxiety or negative feelings, such as contempt, envy, or anger.</td>
</tr>
<tr>
<td>Acting out</td>
<td>Enacting an unconscious wish or fantasy impulsively as a way of avoiding painful affect.</td>
</tr>
<tr>
<td>Somatization</td>
<td>Converting emotional pain or other affect states into physical symptoms and focusing one's attention on somatic (rather than intrapsychic) concerns.</td>
</tr>
<tr>
<td>Regression</td>
<td>Returning to an earlier phase of development or functioning to avoid the conflicts and tensions associated with one's present level of development.</td>
</tr>
</tbody>
</table>
### TABLE 2–1. A hierarchy of defense mechanisms (continued)

<table>
<thead>
<tr>
<th>Defense mechanism</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoid fantasy</td>
<td>Retreating into one’s private internal world to avoid anxiety about interpersonal situations.</td>
</tr>
</tbody>
</table>

#### Higher-level neurotic defenses

**Introjection**
Internalizing aspects of a significant person as a way of dealing with the loss of that person. One may also introject a hostile or bad object as a way of giving one an illusion of control over the object. Introjection occurs in nondefensive forms as a normal part of development.

**Identification**
Internalizing the qualities of another person by becoming like the person. Whereas introjection leads to an internalized representation experienced as an “other,” identification is experienced as part of the self. This, too, can serve nondefensive functions in normal development.

**Displacement**
Shifting feelings associated with one idea or object to another that resembles the original in some way.

**Intellectualization**
Using excessive and abstract ideation to avoid difficult feelings.

**Isolation of affect**
Separating an idea from its associated affect state to avoid emotional turmoil.

**Rationalization**
Justification of unacceptable attitudes, beliefs, or behaviors to make them tolerable to oneself.

**Sexualization**
Endowing an object or behavior with sexual significance to turn a negative experience into an exciting and stimulating one or to ward off anxieties associated with the object.

**Reaction formation**
Transforming an unacceptable wish or impulse into its opposite.

**Repression**
Expelling unacceptable ideas or impulses or blocking them from entering consciousness. This defense differs from denial in that the latter is associated with external sensory data, whereas repression is associated with inner states.

**Undoing**
Attempting to negate sexual, aggressive, or shameful implications from a previous comment or behavior by elaborating, clarifying, or doing the opposite.
TABLE 2–1. A hierarchy of defense mechanisms (continued)

<table>
<thead>
<tr>
<th>Defense mechanism</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mature defenses</td>
<td></td>
</tr>
<tr>
<td>Humor</td>
<td>Finding comic and/or ironic elements in difficult situations to reduce unpleasant affect and personal discomfort. This mechanism also allows some distance and objectivity from events so that an individual can reflect on what is happening.</td>
</tr>
<tr>
<td>Suppression</td>
<td>Consciously deciding not to attend to a particular feeling, state, or impulse. This defense differs from repression and denial in that it is conscious rather than unconscious.</td>
</tr>
<tr>
<td>Asceticism</td>
<td>Attempting to eliminate pleasurable aspects of experience because of internal conflicts produced by that pleasure. This mechanism can be in the service of transcendent or spiritual goals, as in celibacy.</td>
</tr>
<tr>
<td>Altruism</td>
<td>Committing oneself to the needs of others over and above one’s own needs. Altruistic behavior can be used in the service of narcissistic problems but can also be the source of great achievements and constructive contributions to society.</td>
</tr>
<tr>
<td>Anticipation</td>
<td>Delaying of immediate gratification by planning and thinking about future achievements and accomplishments.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Transforming socially objectionable or internally unacceptable aims into socially acceptable ones.</td>
</tr>
</tbody>
</table>

Adaptive Aspects of the Ego

The ego’s importance to the psyche is not limited to its defensive operations. Heinz Hartmann established himself as one of the foremost contributors to contemporary ego psychology by focusing on the nondefensive aspects of the ego. He turned the ego away from the id and refocused it on the outside world. Hartmann (1939/1958) insisted that there was a “conflict-free sphere of the ego” that develops independently of id forces and conflicts. Given an “average expectable environment,” certain autonomous ego functions present at birth are allowed to flourish without being impeded by conflict. These include thinking, learning, perception, motor control, and language, to name a few. Hartmann’s adaptive point of view, then, is an outgrowth of his concept of the existence of an autonomous, conflict-free area of the ego. Through neutralization of sexual and aggressive energies, Hartmann be-
lieved, even certain defenses could lose their connection with the instinctual forces of the id and become secondarily autonomous or adaptive.

David Rapaport (1951) and Edith Jacobson (1964) picked up where Hartmann left off and further refined his seminal contributions to ego psychology. Bellak et al. (1973) systematized ego functions into scales used both for research and for clinical evaluation. The most important of these ego functions include reality testing, impulse control, thought processes, judgment, synthetic–integrative functioning, mastery–competence, and primary and secondary autonomy (after Hartmann).

Object Relations Theory

The view of ego psychology is that drives (i.e., sexuality and aggression) are primary, whereas object relations are secondary. (It is a well-established, although perhaps unfortunate, tradition in psychoanalytic writing to use the term object to mean person. Despite the somewhat pejorative connotations of object, I will retain the usage here for the sake of consistency and clarity.) In other words, the infant’s most compelling agenda is tension discharge under the pressure of drives. Object relations theory, on the other hand, holds that drives emerge in the context of a relationship (e.g., the infant–mother dyad) and therefore can never be divorced from one another. Some object relations theorists (Fairbairn 1952) would even suggest that the drives are primarily geared to object seeking rather than tension reduction.

Stated in its simplest terms, object relations theory encompasses the transformation of interpersonal relationships into internalized representations of relationships. As children develop, they do not simply internalize an object or person; rather, they internalize an entire relationship (Fairbairn 1940/1952, 1944/1952). A prototype of loving, positive experience is formed during periods when the infant is nursing (Freud 1905/1953). This prototype includes a positive experience of the self (the nursing infant), a positive experience of the object (the attentive, caretaking mother), and a positive affective experience (pleasure, satiation). When hunger returns and the infant’s mother is not immediately available, a prototype of negative experience occurs, including a negative experience of the self (the frustrated, demanding infant), an inattentive, frustrating object (the unavailable mother), and a negative affective experience of anger and perhaps terror. Ultimately, these two experiences are internalized as two opposing sets of object relationships consisting of a self representation, an object representation, and an affect linking the two (Ogden 1983).

The internalization of the infant’s mother, usually referred to as introjection (Schafer 1968), begins with the physical sensations associated with the
presence of the mother during nursing but does not become meaningful until a boundary between inner and outer has developed. Around the sixteenth month of life, isolated images of the mother gradually coalesce into an enduring mental representation (Sandler and Rosenblatt 1962). At the same time an enduring self representation forms, first as a body representation and later as a compilation of sensations and experiences perceived as belonging to the infant.

The object that has been introjected does not necessarily correlate with the real external object. For example, a mother who is unavailable to feed her infant on demand may simply be occupied with an older sibling, but she is experienced and introjected by the infant as hostile, rejecting, and unavailable. Object relations theory acknowledges that there is not a one-to-one correlation between the real object and the internalized object representation.

Object relations theory also views conflict differently than it is viewed by ego psychology. Unconscious conflict is not merely the struggle between an impulse and a defense; it is also a clash between opposing pairs of internal object relations units (Kernberg 1983; Ogden 1983; Rinsley 1977). In other words, at any one time different constellations of self representations, object representations, and affects vie with one another for center stage in the intrapsychic theater of internal object relations.

Internalization of object relations always involves a splitting of the ego into unconscious suborganizations (Ogden 1983). These fall into two groups:

1. self-suborganizations of ego, i.e., aspects of the ego in which the person more fully experiences his ideas and feelings as his own, and
2. object suborganizations of ego through which meanings are generated in a mode based upon an identification of an aspect of the ego with the object. This identification with the object is so thorough that one's original sense of self is almost entirely lost. (Ogden 1983, p. 227)

This model clearly shows the influence of Freud's notion of the superego, which is commonly experienced as though it is a “foreign body” (i.e., an object-suborganization of the ego that monitors what a self-suborganization of the ego is doing). Ogden's model also provides a pathway back from the intrapsychic to the interpersonal. In this framework, transference can be viewed as taking one of two forms—either the role of the self-subdivision of the ego or that of the object-subdivision of the ego may be externalized onto the treater, a process that is discussed in detail later in this chapter.

A Historical Perspective

Melanie Klein is usually seen as the founder of the object relations movement. She emigrated from Budapest, and later from Berlin, to England in
1926, where her theory of early infantile development became highly controversial. She was influenced by Freud but also broke new ground in her focus on internal objects. Through psychoanalytic work with children, she evolved a theory that relied heavily on unconscious intrapsychic fantasy and that compressed the developmental timetable of classical theory into the first year of life. The Oedipus complex, for example, was viewed by Klein as coinciding approximately with weaning in the latter half of the first year.

In the first few months of life, according to Klein, the infant experiences a primal terror of annihilation connected with Freud's death instinct. As a way of defending against this terror, the ego undergoes splitting, in which all “badness” or aggression deriving from the death instinct is disavowed and projected onto the mother. The infant then lives in fear of the mother's persecution—which may be concretized as a fear that the mother will get inside the infant and destroy any goodness (deriving from libido) that has also been split off and is protected inside the infant. This latter fear is the primary anxiety of what Klein (1946/1975) termed the paranoid-schizoid position. This early mode of organizing experience gains its name from the prominent defense mechanisms of splitting of the ego (“schizoid”) and projection (“paranoid”). Indeed, projection and introjection are crucial to understanding the paranoid-schizoid position. These mechanisms are used to separate “good” and “bad” as much as possible (Segal 1964). After persecuting, or bad, objects have been projected onto the mother to separate them from good, or idealized, objects, they may be reintrojected (i.e., taken back inside) to gain control and mastery over them. Concomitantly, the good objects may be projected to keep them safe from the “bad,” which is now inside.

These oscillating cycles of projection and introjection continue until the infant begins to realize that the “bad” mother and the “good” mother are not in fact different but are the same person. As children integrate the two part-objects into one whole object, they become disturbed that their sadistic, destructive fantasies toward the mother may have destroyed her. This newfound concern for the mother as a whole object is termed depressive anxiety by Klein and heralds the arrival of the depressive position. This mode of experience involves concern that one may harm others, in contrast to the paranoid-schizoid position, in which the concern is that one will be harmed by others. Guilt becomes a prominent part of the affective life of the infant, who attempts to resolve it through reparation. This process may involve acts toward the mother that are designed to repair the “damage” inflicted on her in actuality or in fantasy. Klein recast the Oedipus complex as an effort to resolve depressive anxieties and guilt through reparation.

Klein's formulations have been criticized for relying exclusively on fantasy and thereby minimizing the influence of real persons in the environment, for overemphasizing the death instinct—a concept that is largely
discounted by contemporary psychoanalytic theorists—and for attributing sophisticated adult forms of cognition to infants in their first year of life. Nevertheless, her brilliant development of the paranoid-schizoid and depressive positions is of extraordinary clinical value, especially if we view these positions as two lifelong modes of generating experience that create a dialectical interplay in the mind rather than viewing them as developmental phases that are passed through or outgrown (Ogden 1986). This conceptualization of lifelong modes of experience decreases the significance of Klein’s developmental timetable.

For Klein, the drives were really complex psychological phenomena intimately tied to specific object relations. Rather than originating in the body, drives were seen as merely using the body as a vehicle for expression (Greenberg and Mitchell 1983). Similarly, the drives were not viewed as simply seeking tension reduction but as being directed toward specific objects for specific reasons. During the 1940s, this perspective and others held by Klein led to acrimonious debate in the British Psychoanalytic Society. Anna Freud was Klein’s principal nemesis, and when a schism finally ruptured the society, one segment, known as the B Group, followed Anna Freud’s leadership, whereas the A Group remained loyal to Klein. A third segment, the Middle Group, refused to take sides. The Middle Group, to some degree influenced by Klein’s thinking, created the theory of object relations as we know it today (Kohon 1986). The individuals associated with this third segment did not officially designate themselves a group until 1962, when they became known as the “Independents.” Among the key figures in the Independents, sometimes referred to as the “British School” of object relations (Sutherland 1980), were D.W. Winnicott, Michael Balint, W.R.D. Fairbairn, Margaret Little, and Harry Guntrip. This group dominated the British society in terms of numbers after the Controversial Discussions of 1943 and 1944 (see King and Steiner 1992), even though there was no central figurehead who had published a coherent theory (Tuckett 1996). Although there were in fact significant differences in the writings of these thinkers, their work shared common themes. All were concerned about early development prior to the Oedipus complex, and all focused on the vicissitudes of internal object relations rather than on drive theory. Moreover, like Klein and unlike the B Group, they tended to treat sicker patients with psychoanalytic methods, perhaps thereby obtaining a more intimate glimpse of primitive mental states.

The Independents served to counterbalance Klein’s overemphasis on fantasy by stressing the influence of the infant’s early environment. Winnicott (1965), for example, coined the term good-enough mother to characterize the minimum environmental requirements needed by the infant in order to proceed with normal development. Balint (1979) described the feeling in many patients that something was missing, which he termed the basic fault. He
viewed this lack as caused by the mother’s failure to respond to the child’s basic needs. Fairbairn (1963), perhaps the most divorced from drive theory, saw the etiology of his schizoid patients’ difficulties not in drive frustration but in their mothers’ failure to provide experiences that reassured them they were truly loved for themselves. He believed that the instincts or drives were not pleasure seeking but rather object seeking. Moreover, Fairbairn was instrumental in introducing the idea of early trauma as a major pathogenic factor that tended to “freeze” the patient at a developmental juncture before the age of 3 years (Fonagy and Target 2003).

These thinkers were all impressed with the fact that a theory of deficit, as well as a theory of conflict, was necessary for a complete psychoanalytic understanding of the human being. Analysts have another task in addition to the analysis of conflict. They also serve as a new object to be internalized by their patients so as to bolster deficient intrapsychic structures. This point is critical for a clinical theory of object relations—the patient’s internal object relations are not etched in granite; they are open to modification through new experiences.

Another key concept emerging from the British School is that an infant has an inborn tendency to grow toward self-realization (Summers 1999). Winnicott, in particular, felt that there was a true self whose growth could be facilitated or impeded by the responses of the mother and other figures in the environment. Bollas (1989) expanded on this view by arguing that the primary motivator within the child is the need to become himself or herself, which is facilitated by the mother’s capacity to let the child express his or her true self in interaction with her. The mother who cannot serve in this facilitating capacity may contribute to the child’s development of a false self in the service of accommodating the mother’s needs and wishes.

Self and Ego

Whereas ego psychologists tend to minimize the significance of the self in their pursuit of a thorough understanding of the ego, the object relations theorists, because of their focus on the self as it relates to objects, have sought to clarify further the place of the self in the psychic apparatus. As discussed in Chapter 1, the self is an aspect of the “person” that is elusive. It comprises various components, including both subject and object, an aggregate of personal memories, unconscious distressing and disavowed aspects, context-related dimensions that emerge at different times, and culture-based phenomena. Much of the controversy in psychoanalytic writing has revolved around its status as an intrapsychic representation versus an agent that initiates thought, feeling, and action (Guntrip 1968, 1971; Kernberg 1982; Meissner 1986; Schafer 1976; Sutherland 1983).
There is room for both the self-as-representation and the self-as-agency. In fact, the self may be viewed as embedded in the ego and may be defined as the end product of the integration of the many self representations (Kernberg 1982). This integrated end product, however, should not be regarded as a continuous, unvarying entity (Bollas 1987; Mitchell 1991; Ogden 1989; Schafer 1989). Although we often wish to maintain an illusion of a continuous self, the reality is that we all are composed of multiple discontinuous selves that are constantly being shaped and defined by real and fantasized relationships with others. Schafer (1989) understood this phenomenon as a set of narrative selves or story lines that we develop to provide an emotionally coherent account of our lives. Mitchell (1991) observed that a paradox of psychoanalytic work is that as patients learn to tolerate these multiple facets of themselves, they begin to experience themselves as more durable and more coherent.

Defense Mechanisms

Because of the historical association between object relations theory and seriously disturbed patients, considerable emphasis is placed on primitive defenses characteristic of personality disorders and psychoses: splitting, projective identification, introjection, and denial.

Splitting

Splitting is an unconscious process that actively separates contradictory feelings, self representations, or object representations from one another. Although Freud (1927/1961, 1940/1964) made scattered references to splitting, it was Klein (1946/1975) who exalted it to the position of the cornerstone of emotional survival during the first few months of life. Splitting allows the infant to separate good from bad, pleasure from displeasure, and love from hate so as to preserve positively colored experiences, affects, self representations, and object representations in safely isolated mental compartments, free from contamination by negative counterparts. Splitting may be viewed as a basic biological mode of ordering experience by which the endangering is separated from the endangered; it is secondarily elaborated into a psychological defense (Ogden 1986). It is also a fundamental cause of ego weakness (Kernberg 1967, 1975). The integration of libidinal and aggressive drive derivatives associated with “good” and “bad” introjects serves to neutralize aggression. Splitting prevents this neutralization and thus deprives the ego of an essential source of energy for growth.

In Kernberg’s view, splitting is characterized by certain clinical manifestations: 1) alternating expression of contradictory behaviors and attitudes,
which the patient regards with lack of concern and bland denial; 2) the compartmentalization of everyone in the environment into “all good” and “all bad” camps, which is often referred to as idealization and devaluation; and 3) the coexistence of contradictory self representations that alternate with one another. Although Kernberg viewed splitting as the key defensive operation in patients with borderline personality disorder, splitting may be observed in all patients at times (Rangell 1982), and it does not clearly differentiate borderline patients from those with other personality disorders (Allen et al. 1988). Kernberg distinguished between neurotic and borderline characters partly on the basis of the latter’s preference for splitting over repression, but empirical research suggests that these two defenses operate independently and may coexist in the same individual (Perry and Cooper 1986).

**Projective Identification**

A second defense mechanism, projective identification, is an unconscious three-step process by which aspects of oneself are disavowed and attributed to someone else (see Figures 2–2, 2–3, and 2–4). The three steps (Ogden 1979) are as follows:

1. The patient projects a self or an object representation onto the treater.
2. The treater unconsciously identifies with what is projected and begins to feel or behave like the projected self or object representation in response to interpersonal pressure exerted by the patient (this aspect of the phenomenon is sometimes referred to as projective counteridentification [Grinberg 1979]).
3. The projected material is “psychologically processed” and modified by the treater, who returns it to the patient through reintrojection. The modification of the projected material, in turn, modifies the corresponding self or object representation and the pattern of interpersonal relatedness.

These three steps are presented in an artificially linear manner for the sake of clarity. However, Ogden (1992) stressed that these aspects are not truly linear but rather should be conceptualized as creating a dialectic in which the patient and analyst enter into a relationship in which they are simultaneously separate but also “at one” with each other. A unique subjectivity is created through the dialectic of an interpenetration of subjectivities. Nevertheless, transference and countertransference can be correlated with steps 1 and 2, respectively. In this regard, projective identification has an interpersonal dimension in addition to its role as an intrapsychic defense mechanism. Splitting and projective identification are highly interrelated mechanisms that work together to keep “good” and “bad” separated (Grot-

FIGURE 2–3. Projective identification—step 2. Treater unconsciously begins to feel and/or behave like the projected bad object in response to interpersonal pressure exerted by the patient (projective counteridentification).

stein 1981). The interpersonal element inherent in Ogden’s definition of projective identification derives from Bion’s (1962) conceptualization of the therapist as a container for the projections of the patient, much as the mother contains the projections of her infant.

Contemporary Kleinian analysts in London view projective identification somewhat differently. They are more inclined to conceptualize the de-
fense as involving not the projection of a part of the patient but rather a fantasy of an object relationship (Feldman 1997). In this regard, the transformation of the target of the projection is not absolutely necessary. Nevertheless, a growing consensus is emerging from the Kleinians that the analyst or therapist is always influenced to some degree by what the patient is projecting and that some degree of responsiveness to “nudges” by the patient to act in accord with the patient’s projections may help the analyst become consciously aware of what is being projected (Joseph 1989; Spillius 1992).

As noted in Chapter 1, countertransference is a joint creation involving contributions from both patient and clinician (Gabbard 1995). The patient evokes certain responses in the therapist, but it is the therapist’s own conflicts and internal self- and object representations that determine the final shape of the countertransference response. In other words, the process requires a “hook” in the recipient of the projection to make it stick. Some projections constitute a better fit with the recipient than do others (Gabbard 1995).

To confine the concept of projective identification to a defense mechanism is unduly limiting. Because of the interpersonal component, it may also be regarded as 1) a means of communication, in which patients coerce the treater into experiencing a set of feelings similar to their own; 2) a mode of object relatedness; and 3) a pathway for psychological change, in the sense that the reintrojection of the projected contents after they have been modified by the treater results in a modification of the patient. Although this model of projective identification emphasizes what takes place in a clinical
setting, projective identification regularly occurs in nontherapeutic situations as well. In these nonclinical settings, the projections may be returned in completely distorted forms, or “crammed back down the patient’s throat,” instead of being modified or contained.

**Introjection**

The third defense, introjection, is an unconscious process by which an external object is symbolically taken in and assimilated as part of oneself. This mechanism may exist as a part of projective identification, where what is taken in was originally projected, or it may exist independently as the converse of projection. Classically, Freud (1917/1963) formulated depression as a result of the introjection of an ambivalently viewed object. Anger focused on this introject within the depressed patient resulted in self-deprecation and other symptoms of depression. In contemporary object relations parlance, introjection is distinguished from identification as one of the two principal modes of internalization. If a parent, for example, is introjected, then the parent is internalized as part of the object subdivision of the ego and is experienced as an internal presence that does not substantially alter the self representation. On the other hand, in identification, the parent is internalized as part of the self-subdivision of the ego and materially modifies the self representation (Sandler 1990).

**Denial**

The fourth defense mechanism, denial, is a direct disavowal of traumatic sensory data. Whereas repression is generally used as a defense against internal wishes or impulses, denial is ordinarily a defense against the external world of reality when that reality is overwhelmingly disturbing. Although associated primarily with psychoses and severe personality disorders, this mechanism may also be used by healthy people, especially in the face of catastrophic events.

**American Relational Theory**

The British School of object relations has greatly influenced American relational theory. This “two person” theory and its close cousins—intersubjectivity, constructivism, and interpersonal theory—have in common a view that the therapist’s perceptions of the patient are inevitably colored by the therapist’s subjectivity (Aron 1996; Gill 1994; Greenberg 1991; Hoffman 1992, 1998; Levine 1994; Mitchell 1993, 1997; Natterson 1991; Renik 1993, 1998; Stolorow et al. 1987). An essential feature of this view is that there are
two persons in the room mutually influencing each other at all times. Hence the therapist cannot transcend his or her own subjectivity when formulating the patient’s problems. Moreover, the actual behavior of the therapist will have a substantial impact on the patient’s transference. Some would argue that this intersubjective perspective transcends any particular school and is relevant to all psychotherapy situations (Aron 1996; Dunn 1995; Gabbard 1997; Levine 1996).

Over the past decade, the differences between American relational theory and the British School of object relations have become increasingly insignificant. As Harris (2011) notes, “What historically were major differences appear now as more subtle distinctions” (p. 702). Hence, geographic origins of a theory become relatively unimportant because there is considerable overlap between the British tradition and the American writers of today. Countertransference and two-person psychology are certainly at the heart of the relational movement. Acknowledgment of uncertainty and the need for improvisation in one’s technique are also of critical importance to a relational/intersubjective point of view (Ringstrom 2007). The notion of the self is also prominent in writers from the interpersonal and relational tradition. Bromberg (2006) emphasizes that shame-based self states are intolerable and may be split off or dissociated in such a way that false continuities and incoherences may be a prominent feature of the psychotherapeutic work. Finally, the acknowledgment of uncertainty in the process places considerable emphasis on the need for negotiation between therapist and patient around meaning and the optimal approach to the therapy itself (Bass 2007; Pizer 2004). The analyst’s or therapist’s view is not privileged over the subjective perspective of the patient as it often was in the history of classical psychoanalysis.

Self Psychology

Kohut

Whereas object relations theory emphasizes the internalized relationships between representations of self and object, self psychology stresses how external relationships help maintain self-esteem and self-cohesion. Derived from the seminal writings of Heinz Kohut (1971, 1977, 1984), this theoretical approach views the patient as being in desperate need of certain responses from other persons to maintain a sense of well-being.

Self psychology evolved from Kohut’s study of narcissistically disturbed outpatients he was treating in psychoanalysis. He noted that they seemed different from the classic neurotic patients who presented for treatment with hysterical or obsessive-compulsive symptoms. Instead, they complained of
nondescript feelings of depression or dissatisfaction in relationships (Kohut 1971). They were also characterized by a vulnerable self-esteem that was highly sensitive to slights from friends, family, lovers, colleagues, and others. Kohut observed that the structural model of ego psychology did not seem adequate to explain the pathogenesis and cure of these patients’ problems.

Kohut noted that these patients formed two kinds of transferences: the mirror transference and the idealizing transference. In the mirror transference the patient looks to the analyst for a confirming, validating response that Kohut linked to the “gleam in the mother’s eye” in response to phase-appropriate displays of exhibitionism on the part of her small child—what Kohut called the grandiose-exhibitionistic self. These approving responses, according to Kohut, are essential for normal development in that they provide the child with a sense of self-worth. When a mother fails to empathize with her child’s need for such a mirroring response, the child has great difficulty in maintaining a sense of wholeness and self-regard. In response to this failure of empathy, the child’s sense of self fragments, and the child desperately attempts to be perfect and to “perform” for the parent to gain the hungered-for approbation. This form of “showing off” is another manifestation of the grandiose-exhibitionistic self (Baker and Baker 1987). The same phenomena constitute the mirror transference in adults who seek treatment. The adult patient who “performs” for his or her therapist in a desperate attempt to gain approval and admiration may be developing a mirror transference.

The idealizing transference, as implied in the name, refers to a situation in which the patient perceives the therapist as an all-powerful parent whose presence soothes and heals. The wish to bask in the reflected glory of the idealized therapist is a manifestation of this transference. Just as the child may be traumatized by the empathic failures of a mother who does not provide mirroring responses to her child’s grandiose-exhibitionistic self, so can that same child be traumatized by a mother who does not empathize with the child’s need to idealize her or who does not provide a model worthy of idealization.

In either case, the adult patient who has such early disturbances of parenting and who presents these kinds of transference dispositions is struggling with a defective or deficient self—one that is developmentally frozen at a point at which it is highly prone to fragmentation. Kohut’s view was that the structural model of conflict associated with ego psychology is not sufficient to explain these narcissistic needs for mirroring and idealization. Moreover, he noted a moralizing, pejorative tone in the attitudes of analysts who approached narcissism from a classical point of view. He believed that much harm was done by following Freud’s (1914/1963) model, which proposed a transition from a state of primary narcissism to object love as part of the normal maturational process. The offshoot of Freud’s thinking was that
one should “outgrow” narcissistic strivings and be more concerned about the needs of others.

Kohut thought that this point of view was hypocritical. He asserted that narcissistic needs persist throughout life and that they parallel development in the realm of object love. He postulated a double-axis theory (see Figure 2–5) that allowed for ongoing development in both narcissistic and object love realms (Ornstein 1974). As infants mature, they attempt to capture the lost perfection of the early maternal–infant bond by resorting to one of two strategies—the grandiose self, where the perfection is captured within, and the idealized parent imago, where it is assigned to the parent. These two poles constitute the bipolar self. In his last book (posthumously published), Kohut (1984) expanded this conceptualization to a triplexual self by adding a third pole of selfobject needs, the twinship or alter ego. This aspect of the self appears in the transference as a need to be just like the therapist. It has its developmental origins in a wish for merger that is gradually transformed into imitative behavior. For example, a young boy might play at lawn mowing while his father cuts the grass. This third pole of the self has limited clinical usefulness compared with the other two and is often excluded from discussions of selfobject transferences. If failures of empathy were typical of the parental responses to these strategies, a developmental arrest occurs. With adequate parenting, on the other hand, the grandiose self is transformed into healthy ambitions, and the idealized parent imago becomes internalized as ideals and values (Kohut 1971). Hence, therapists could empathize with the narcissistic needs of their patients as developmentally normal rather than regarding them with contempt for being self-centered and immature. Whereas classical ego psychological theory conceptualizes the patient as having infantile wishes that need to be renounced, Kohut regarded patients as having needs that must be understood and partially met in the treatment (Eagle 1990). Kohut’s first book proposed this theoretical formulation as applicable primarily to narcissistic character pathology. By the time his last book appeared, he had greatly expanded the scope of self psychology:

Self psychology is now attempting to demonstrate...that all forms of psychopathology are based either on defects in the structure of the self, on distortions of the self, or on weakness of the self. It is trying to show, furthermore, that all these flaws in the self are due to disturbances of self-selfobject relationships in childhood. (Kohut 1984, p. 53)

The term selfobject came to be a generic term to describe the role that other persons perform for the self in regard to mirroring, idealizing, and twinship needs. From the standpoint of the growth and development of the self, others are not regarded as separate persons but as objects to gratify these needs of the self. In a sense, then, selfobjects may be viewed more as func-
1. The classical line of development leading to object love

2. The narcissistic line of development

Primary Narcissism

- Primary Narcissism (when nuclei achieve cohesiveness)
  - assigns perfection to grandiose self (mirror transference)

Object Love

Secondary Narcissism (following rebuff from objects)

- assigns perfection to idealized parental imago (idealizing transference)

Fragmented Self-Nuclei

Primary Narcissism (when nuclei achieve cohesiveness)

tions (e.g., soothing, validating) than as people. The need for selfobjects is never outgrown, according to Kohut, but rather persists throughout life—we need selfobjects in our environment for emotional survival much as we need oxygen in the atmosphere for physical survival (Kohut 1984).

One implication of Kohut’s final theoretical statement is that psychological separation is a myth. Self psychology views the separation of the self from the selfobject as impossible. We all need affirming, empathic responses from others throughout life to maintain our self-esteem. Maturation and growth move away from a need for archaic selfobjects toward an ability to use more mature and appropriate selfobjects. In the clinical setting, the goal of treatment is to strengthen the weakened self so it can tolerate less than optimal selfobject experiences without a significant loss of self-cohesion (Wolf 1988).

Kohut always resisted a simple definition of the self, which he believed was such an overarching structure that it defied crisp definition. However, by the time of his death in 1981, his view of the self had clearly gone from that of a self representation to that of a “supraordinate self as the primary psychic constellation, the center of experience and initiative and the main motivating agency” (Curtis 1985, p. 343). Further implications include a pervasive deemphasis on the ego and the vicissitudes of drives and defenses, a greater focus on conscious subjective experience, and the conceptualization of aggression as secondary to failures of selfobjects (e.g., narcissistic rage) rather than as a primary or innate drive. Defenses and resistances in this framework, or “defense-resistances,” as Kohut (1984) came to refer to them, are viewed entirely differently: “My personal preference is to speak of the ‘defensiveness’ of patients—and to think of their defensive attitudes as adaptive and psychologically valuable—and not of their ‘resistances” (p. 114). Clearly, they are valuable and adaptive because they preserve the integrity of the self.

In contrast to the ego psychologists, Kohut viewed the Oedipus complex as of secondary importance. The oedipal conflicts involving sexuality and aggression are mere “breakdown products” of developmentally earlier failures in the self–selfobject matrix. If a mother adequately fulfills the selfobject needs of her child, the Oedipus complex can be weathered without the child’s becoming symptomatic. The fundamental anxiety, according to self psychology, is “disintegration anxiety,” which involves the fear that one’s self will fragment in response to inadequate selfobject responses, resulting in an experiencing of a nonhuman state of psychological death (Baker and Baker 1987). From the standpoint of self psychology, most forms of symptomatic behavior (e.g., drug abuse, sexual promiscuity, perversions, self-mutilation, binge eating, and purging) do not grow out of neurotic conflict related to castration anxiety. Rather, they reflect “an emergency attempt to maintain and/or
restore internal cohesion and harmony to a vulnerable, unhealthy self” (Baker and Baker 1987, p. 5). These fragmentations of the self occur along a continuum that ranges from mild worry or anxiety to severe panic over the perception that one is completely falling apart (Wolf 1988).

The emphasis of self psychology on the failures of parenting figures and the resulting deficiencies of the self resonate with the British object relations theories. Echoes of Winnicott’s good-enough mothering and Balint’s basic fault can be heard in the themes of self psychological writings. Although Kohut does not acknowledge the contributions of these theorists, their influence is unmistakable. However, the object relations theorists did not develop the notion of the self to the extent that Kohut did, perhaps because of their adherence to a model of maturation that retains the moralizing potential eschewed by Kohut (Bacal 1987). Kohut also has made a significant contribution in recognizing the significance of self-esteem in the pathogenesis of psychiatric disturbances. For example, personality disorders can be viewed as disorders of the self manifested by desperate attempts to preserve self-cohesion that often result in problematic relationships with others (Silverstein 2007). Similarly, the role of the therapist shifts more to a sustained empathic effort rather than interpretive understanding, with the goal of providing a selfobject experience that will be healing of the personality disorder through a form of corrective emotional experience with the therapist. In other words, the provision of empathy for a prolonged period of time would be the optimal form of therapeutic action rather than emphasizing insight about patterns and relationships with others.

Post-Kohut Contributions

After Kohut’s death, a new generation of self psychologists elaborated and expanded aspects of his theory. Wolf (1988) identified two other selfobject transferences. The adversarial selfobject transference is one in which the patient experiences the analyst as a benignly opposing individual who nevertheless maintains some degree of supportiveness. The analyst is also perceived as encouraging a measure of autonomy for the patient’s self by accepting the patient’s need to be adversarial. The second selfobject transference observed by Wolf is related to the mirror transference, but because of its relationship to an intrinsic motivation to achieve mastery, it is sufficiently different to warrant a unique title. Known as the efficacy selfobject transference, it involves a perception by the patient that the analyst is allowing the patient to effectively produce necessary selfobject behavior in the analyst.

Other analysts influenced by self psychology believe that information outside the empathic–introspective mode of perception must be integrated into the analyst’s knowledge base. Lichtenberg (1998; Lichtenberg and Had-
ley 1989) regards knowledge of “model scenes” prototypical of childhood and infant experiences as highly relevant to reconstructing and understanding the patient’s early experience. He argued that five discrete motivational systems must be taken into account to fully understand the forces at work in the patient. Each of these systems is based on innate needs and associated patterns of response. One system develops in response to the need for attachment and affiliation. The second system involves responses to the need for psychic regulation and physiological requirements. The third system evolves in response to the need for assertion and exploration. The fourth system is responsive to the need to react to aversive experiences through withdrawal and/or antagonism. The fifth system involves responses to the need for sensual enjoyment and, ultimately, sexual excitement. These systems are in dialectical tension with one another and undergo continuous hierarchical rearrangement. Each of the five systems can develop only in the presence of a reciprocal response from caregivers. Lichtenberg had reservations about Kohut’s theory because of its tendency to relegate sexual and nonsexual pleasure to a relatively peripheral position.

Bacal and Newman (1990) sought to integrate self psychology with object relations theory. They argued that self psychology can be understood as a variant of object relations theory and that Kohut failed to acknowledge the influence of the British School of object relations on his ideas. Bacal and Newman point out that the self in connection with its object, rather than in isolation, is the true basic unit of self psychology.

Other revisionists have questioned the mode of therapeutic action endorsed by Kohut, which involves optimal frustration of the patient’s needs in the context of empathic understanding. Although Kohut repeatedly emphasized that his technique was essentially interpretive, some observers (e.g., Siegel 1996) have stressed that his approach was quite different from the type of frustration proposed by Freud. In his last book, Kohut acknowledged the role of corrective emotional experience. Nevertheless, Bacal (1985) was critical of Kohut’s notion of optimal frustration and suggested that “optimal responsiveness” was just as important to the analytic process. Lindon (1994) had similar concerns and proposed the term optimal provision to address the problem of too much abstinence on the part of the analyst. However, he did not view this type of provision as curative. Rather, Lindon’s conception of provision involved creation of an atmosphere to facilitate exploration of the patient’s unconscious, not necessarily to repair developmental defects. He stipulated that provisions should be in the service of furthering analytic work rather than subversions of the analytic process.

Finally, the post-Kohut self psychologists recognize that a shift away from the lived subjective experience emphasized by Kohut is taking place within the field. In keeping with the work of Stern (2004) and the Boston
Change Process Study Group (2010), there is a greater interest in what is implicit as well as what is subjectively felt (Coburn 2006). In this regard there is greater awareness of the intersubjective aspects of development and the procedural implicit knowledge that is “in one’s bones” even if not consciously experienced.

Developmental Considerations

To some extent, all psychoanalytic theories are based on developmental thinking. Just as psychoanalytic theory has evolved from an emphasis on drives, defenses, and intrapsychic conflict between agencies into concerns with self, object, and relationships, so too has developmental research moved in that direction. The early theories of development associated with ego psychology focused on libidinal zones and were largely reconstructions of early development based on psychoanalytic work with adults. Erikson (1959), following the lead of Hartmann, made an effort to weave interagency conflict into the broader fabric of ego psychology. He focused on psychosocial issues from the environment, which allowed him to evolve an epigenetic developmental scheme characterized by a psychosocial crisis at each phase. For example, during the oral phase of development, the infant must struggle with basic trust versus basic mistrust. The crisis of the anal phase involves autonomy versus shame and doubt. During the phallic-oedipal phase, the child grapples with initiative versus guilt.

The oedipal phase of development begins around age 3 years and is associated with a more intense focus on the genitals as the source of pleasure. Accompanying this interest is an intensified longing to be the exclusive love object of the parent of the opposite sex. However, at the same time, the child’s dyadic or mother–child frame of reference changes to a triadic one, with the child becoming aware of a rival for the affections of the parent of the opposite sex.

In the case of the male child, the first love object is the mother, which does not require a shift of affection. He desires to sleep with her, caress her, and be the center of her world. Because the father interferes with these plans, the child develops murderous wishes toward his rival. These wishes result in guilt, fear of retaliation by the father, and a sense of anxiety about that impending retaliation. Freud repeatedly observed that the leading source of the male child’s anxiety during this phase of development is that the father’s retaliation will come in the form of castration. To avoid this punishment, the boy renounces his sexual strivings for his mother and identifies with his father. This identification with the aggressor carries with it the decision to look for a woman like the mother so that the boy can be like his father. As
part of this oedipal resolution, the retaliatory father is internalized around the end of the fifth or sixth year, forming the superego, which Freud viewed as heir to the Oedipus complex. Contemporary thinking about the oedipal phase of development has clarified that there is also a libidinal longing for the same-sex parent associated with a wish to rid of the opposite-sex parent. This view is often referred to as the negative Oedipus complex.

Freud had more difficulty explaining girls’ oedipal development. In a series of papers (Freud 1925/1961, 1931/1961, 1933/1964), he frankly acknowledged his bewilderment by female psychology, yet he struggled to chart female development. One way he dealt with this difficulty was to assume that females’ development was basically analogous to that of males. As Freud saw it, whereas in boys the Oedipus complex is resolved by the castration complex, in girls it is promulgated by an awareness of “castration.” In the preoedipal phases of development, in Freud’s view, the little girl feels essentially like a little boy until she discovers the existence of the penis. At that point, she begins to feel inferior and falls victim to penis envy. She tends to blame her mother for her inferiority, so she turns to her father as her love object, and the wish for a child from her father replaces her wish for a penis. Freud believed that one of three paths was available to the female child after discovery of her “genital inferiority”: 1) cessation of all sexuality (i.e., neurosis); 2) a defiant hypermasculinity; or 3) definitive femininity, which entailed renunciation of clitoral sexuality. In the normal oedipal resolution, loss of the mother’s love, rather than fear of castration by the father, was postulated as the key factor.

More contemporary psychoanalytic authors have raised serious questions about Freud’s formulation of female development. Stoller (1976) disagreed with Freud about the evolution of femininity as a product of sexual differentiation, penis envy, and unconscious conflict. He felt that femininity was an inborn potential and that a confluence of sex assignment at birth, parental attitudes, neurophysiological fetal brain organization, early interactions between the infant and the parents, and learning from the environment formed a complex nucleus around which a mature sense of femininity would ultimately become organized. He termed this first step primary femininity because it was not viewed as a product of conflict. Tyson (1996) stressed that mature femininity begins with primary femininity but that conflict resolution, as well as identifications made with both parents, will ultimately determine the final form.

Stoller shared the view of other authors, such as Lerner (1980) and Torek (1970), that penis envy is only one aspect of the development of female-ness, not the origin of it. Contemporary feminist psychoanalytic theory has stressed the adverse therapeutic implications of viewing penis envy as a “bedrock” phenomenon (Freud 1937/1964) that defies further analysis and understanding. One hazard of the “bedrock” view is that it may lead to a mis-
guided attempt on the part of therapists to help female patients accept a view of themselves as inferior forms of males. Frenkel (1996) stressed that female patients do not generally feel that their genitalia or genital arousal is inadequate, in contrast to Freud’s thinking, and that the clitoris, far from being viewed as an inferior organ, is a locus for the initiation of intense pleasure and occasional orgasm as early as ages 4–6 years. Vaginal awareness also is present at that age. Current thinking about the construction of gender emphasizes the influence of culture, object relations, and identifications with parents rather than narrowly tying it to anatomic differences (Benjamin 1990; Chodorow 1996).

Neuroscience research has also expanded our knowledge of male-female differences. The areas of the brain involved in facial discrimination are more developed in females than males from early in life (McClure 2000). In fact, neurological maturation of the brain in general proceeds at a faster rate in females versus males (Moore and Cocoas 2006). The connectivity between the right and left hemispheres is shown to be greater in females than in males (Friedman and Downey 2008). Hence, the earlier lateralization of the female brain may result in the superior capacity to sensitively read emotions on the faces of others. Although these neurobiological gender differences are significant, they in no way overshadow the extraordinary importance of the early rearing environment in the development of the female. The interactions with the parents and other key caregiving figures are central to the shaping of the individual—that is, biology and environment are mutually influential in gender formation (Silverman 2010).

The contemporary perspective about femininity within psychodynamic thinking is perhaps best characterized by a systematic questioning of received wisdom. Chodorow (2012) emphasizes that there are many femininities just as there are many masculinities, and the clinician must not approach a female patient by listening for the confirmation of specific theories. Rather, the optimal psychotherapeutic position is to recognize that there are a host of cultural, intrapsychic, and biological factors that lead to a unique individuality in each woman. Chodorow (2012) argues for an open-mindedness to discovery of the uniqueness that defines the individual:

> Although anyone’s gender always includes some recognition of the difference between feminine and masculine, a particular individual’s personal animation of gender may or may not be organized around the masculine-feminine difference. Even in those cases when it is, moreover, genital awareness or feelings of genital difference between the sexes may or may not form its center. (p. 147)

Development, whether involving gender identity or formation of the self, is lifelong. Development does not cease with the resolution of the Oe-
dipus complex. Defensive constellations change with each succeeding phase—latency, adolescence, young adulthood, and old age. In fact, Vaillant (1976) documented an orderly shift during adult life from immature defenses to more mature defenses such as altruism and sublimation, suggesting that personality is truly dynamic and malleable over the entire life cycle. Moreover, whereas analytic therapy was once thought to be less useful in elderly patients, now it is commonplace to use psychodynamic methods in patients in their 60s, 70s, and 80s.

Mahler

Since the 1970s, a much more empirically based developmental theory has emerged in psychoanalysis. The infant observation studies of Margaret Mahler and her colleagues (1975) were among the earliest such studies and are often viewed as providing a bridge between ego psychology and object relations theory. Through observation of normal and abnormal mother–infant pairs, Mahler and her group were able to identify three broad phases of the development of object relations.

In the first 2 months of life, an autistic phase occurs in which the infant appears self-absorbed and concerned with survival rather than relatedness. The period between 2 and 6 months, denoted as symbiosis, begins with the smile response of the infant and the visual ability to follow the mother's face. Although the infant is vaguely aware of the mother as a separate object, the infant's primary experience of the mother–infant dyad is one of a dual unity rather than of two separate people.

The third phase, separation-individuation, is characterized by four subphases. Between 6 and 10 months, in the first subphase of differentiation, the child becomes aware that the mother is a separate person. This awareness may lead to the child’s need for a transitional object (Winnicott 1953/1971), such as a blanket or pacifier, to help deal with the fact that the mother is not always available. Practicing is the next subphase, which occurs between 10 and 16 months. With the newfound locomotor skills of this age, toddlers love to explore the world on their own, although they frequently return to their mothers for “refueling.” The third subphase, rapprochement, is characterized by a sharper awareness of the separateness of the mother and occurs between 16 and 24 months of age. This awareness brings with it a heightened sense of vulnerability to separations from the mother.

The fourth and final phase, a subphase of separation-individuation, is marked by consolidation of individuality and the beginnings of object constancy. The achievement of this period, which roughly corresponds to the third year of life, is integration of split views of the mother into a unified whole object that can be internalized as an emotionally soothing inner pres-
ence that sustains the child during the mother’s absence. This achievement corresponds with Klein’s depressive position and sets the stage for the child to enter the oedipal phase.

Stern and Beyond

As noted earlier, however, Kohut’s perspective challenged Mahler’s emphasis on separation-individuation by suggesting that some form of selfobject response from others in the environment was essential throughout life. In addition, the infant observation research of Daniel Stern (1985, 1989) called into question the idea that infants emerge from the womb in a state of autistic self-absorption. Stern’s work demonstrated that the infant seems to be aware of the mother or caretaker from the first days of life. In keeping with Kohut’s ideas, Stern observed that affirming and validating responses from the mothering figure is crucial to the developing infant’s evolving sense of self. He further stressed that the infant develops a sense of self-with-other in response to the caretaker’s attunement. Stern differed with Klein in that he regarded fantasy as having only minimal significance. By contrast, he viewed the infant as primarily experiencing reality. He concluded that infants are adept observers of reality and that it is only as older toddlers that they begin to make significant use of fantasy and distortion in an effort to alter their perceptions.

Stern described five discrete senses of self. Rather than viewing these as phases that are superseded by subsequent and more mature developmental periods, he regarded them as different domains of self-experience (emergent or “body” self, core self, subjective self, verbal or categorical self, and narrative self), each of which remains for the entire life span and operates in concert with the other coexisting senses of self. From birth to 2 months of age, an emergent self appears that is predominantly a physiologically based body self. From 2 to 6 months, a core sense of self emerges that is linked with greater interpersonal relatedness. A sense of subjective self appears between 7 and 9 months and is a major event because it involves the matching of intrapsychic states between infant and mother. Between 15 and 18 months of age, coinciding with the ability to think symbolically and to communicate verbally, the verbal or categorical sense of self emerges. The narrative sense of self arrives between 3 and 5 years of age. Stern believed this historical view of self is encountered when patients tell their life stories in the analytic setting.

Throughout his writing, Stern (2004) emphasizes that human existence is a fundamentally social existence. We emerge from an “intersubjective matrix” that is the result of sensitive affective attunement from mothers and caretakers. Stern’s understanding of this interconnectedness is much like
Kohut's in that he thinks the responses of others to us are like oxygen in the environment. As he puts it, “We need the eyes of others to form and hold ourselves together” (Stern 2004, p. 107). He strongly believes that the desire for relating in an intersubjective way is just as strong of a motivational system as the biological drives.

The concept that development proceeds in a self–other format has been extensively validated in further developmental research (Beebe et al. 1997; Fogel 1992). In accord with Kohut's and Winnicott's theoretical views, what is emerging is a dyadic systems view of communication between mother and infant that results in the internalization of a self-in-relation-to-object. In other words, as Fairbairn stressed, it is not an object but an object relationship that is internalized in development. What is represented by the infant is an interactive process, complete with a patterned sequence of movements, the rules for regulating these movements, and the self-regulatory consequences to the infant (Beebe et al. 1997). In keeping with postmodernist views, developmental research is suggesting that all face-to-face interaction is jointly constructed or bidirectionally regulated (Fogel 1992).

Posner and Rothbart (2000) studied arousal regulation and found that the early parent–infant interaction is crucial to regulate tension in the infant. Meins et al. (2001) examined how mothers talk to their 6-month-old infants. They concluded that self-formation was facilitated by making comments to the child that reflect the child's mental state and treat the child like a person. Hence these developmental studies confirm the importance of parental empathy on the development of the child's self.

Research examining the neural substrate for empathy underscores the developmental importance of sensitive attunement by a caregiver or parent in the development of the child. Empathy requires the capacity to map another person's feelings onto one's own nervous system (Leslie et al. 2004). Mirror neurons, first discovered in monkeys, where they were detected to have the unusual property of firing during both action execution and the observation of the same action in others, may play a crucial role. These neurons in the premotor cortex respond when a primate observes certain hand movements performed by another primate or by a human, or when the animal performs the same movements. In other words, they encode object-oriented actions, whether they are performed or observed. This group of neurons in the ventral premotor cortex are activated during observation of an agent acting in a purposeful way upon objects. Fogassi and Gallese (2002) suggested that mirror neurons may be involved in goal detection and therefore in understanding what is happening inside another person's mind. Functional imaging studies suggest that a right-hemisphere mirroring system may be critical for processing emotions in others (Leslie et al. 2004). A growing consensus in the developmental literature is that early experiences of parental
or caregiver responses initially regulate affects and eventually lead to internal working models or representations of the relationship, which continue internal regulatory functions (Hofer 2004). The right orbitofrontal region is thought to be essential in the development of internalized representations of relationships that ultimately act as biological regulators (Schore 1997).

As noted in Chapter 1, development generally is the outgrowth of the combined influence of genetic predisposition and environmental influences. Many psychoanalytic developmental theories neglect genetic factors in their formulations, and a contemporary theory must supplement pure psychoanalytic theorizing with knowledge from empirical research on gene–environment interactions. For example, Reiss et al. (2000) emphasized that genetic characteristics of the child elicit certain parental responses that may in turn influence which genes are expressed and which are suppressed.

Attachment Theory

The fourth major theory relevant to dynamic psychiatry is one that is rooted in empirical research—attachment theory. Although John Bowlby's seminal works on the subject (Bowlby 1969, 1973, 1980) have been around for a long time, only recently has attachment theory enjoyed a wide psychoanalytic audience. Attachment is a biologically based bond between the child and the caregiver that is designed to ensure the safety and survival of the child. In contrast to object relations theory, attachment theory posits that the goal of the child is not to seek an object but rather to seek a physical state achieved by proximity to the mother/object (Fonagy 2001). As development proceeds, the physical goal is transformed into a more psychological one of gaining a feeling of closeness to the mother or caregiver. Secure attachment strongly influences the development of internal working models of relationships that are stored as mental schemas and lead to experiences regarding the expectations of the behavior of others toward the self.

Attachment strategies, which are largely independent of genetic influences, are adopted in infancy and remain relatively stable. Ainsworth et al. (1978) studied these strategies in a laboratory scenario known as the Strange Situation. This situation, involving a toddler's separation from the caregiver, tended to elicit one of four behavioral strategies. Secure infants simply sought proximity with the caregiver upon her return and then felt comforted and returned to play. Avoidant behavior was seen in infants who appeared less anxious during the separation and snubbed the caregiver on her return. These infants showed no preference for the mother or caregiver over a stranger. In a third category, termed anxious-ambivalent or resistant, infants showed great distress at separation and manifested angry, tense, and clinging
behavior when the caregiver returned. A fourth group, termed disorganized-
disoriented, had no coherent strategy whatsoever to deal with the experience of separation.

Multiple studies have demonstrated that the parents’ attachment status will predict not only whether a child will be securely attached but also the precise attachment category in the Strange Situation (Fonagy 2001). Nevertheless, it is also true that biological temperament, which is genetically based, may influence the child’s response to caregiving by an attachment figure (Allen 2013). Conversely, temperament can be subject to environmental influence and can change over time because of the quality of caretaking and attachment. As noted in Chapter 1, inborn temperaments that predispose one to the development of shyness or social anxiety may be positively influenced by the quality of the environmental caregiving.

There is some evidence that these attachment patterns have continuity into adulthood, and these categories of attachment style can be measured with sophisticated interviews (George et al. 1996). The four responses to the Strange Situation correspond respectively to adult categories of attachment as follows: 1) secure/autonomous individuals who value attachment relationships; 2) insecure/dismissing individuals who deny, denigrate, devalue, or idealize past and current attachments; 3) preoccupied individuals who are confused or overwhelmed by both past and current attachment relationships; and 4) unresolved or disorganized individuals who often have suffered neglect or trauma. A survey of all of the longitudinal studies testing the stability of attachment classification from childhood to adulthood suggests a range from minimal continuity to high stability (George and Solomon 2008). This research reflects many factors that may be associated with changes in security from infancy to adulthood. These include stressful life events, parental death, social support, family functioning, divorce, and serious illness in either parents or children. Hence, we must conclude that early attachment patterns are not necessarily etched in granite.

Attachment theory has made significant contributions to our understanding of what motivates human beings. Sexuality, aggression, and self-cohesion all are relevant to understanding adult patients who come for psychotherapy. However, Joseph Sandler (2003) recognized that the search for safety is also a primary motivating factor, and he derived this understanding in part from the findings of attachment theory and research. Moreover, in contrast to the Kleinian emphasis on intrapsychic fantasy, attachment theory places real neglect, abandonment, and other early traumas, as well as the mental processing of those traumas, at center stage in psychoanalytic theory. A large body of evidence suggests that disorganized attachment is a vulnerability factor for later psychiatric disturbance and that attachment security can serve as a protective factor against adult psychopathology (Fonagy and Target 2003).
Some research suggests that attachment security or the lack of it may predict certain types of personality disorder. Incoherent/disorganized attachment is uniquely associated with a history of childhood trauma and disrupted attachments. Hence, borderline personality disorder is linked to both preoccupied and incoherent/disorganized attachment (Westen et al. 2006).

The caregiver's capacity to observe the infant's intentional state and internal world appears to influence the development of secure attachment in the child. A key concept in attachment theory is mentalization, which refers to the capacity to understand that one's own and others' thinking is representational in nature and that one's own and others' behavior is motivated by internal states, such as thoughts and feelings (Fonagy 1998). Parents or caregivers who themselves have the capacity to mentalize tune in to the infant's subjective mental state, and the infant ultimately finds himself or herself in the caregiver's mind and internalizes the caregiver's representation to form a core psychological self. In this manner, the child's secure attachment to the caregiver engenders the child's capacity to mentalize. In other words, through the interaction with the caregiver, the child learns that behavior can best be understood by assuming that ideas and feelings determine a person's actions.

Mentalizing is often referred to as having a “theory of mind.” Much of what happens in a clinical interaction, especially psychotherapy, depends on the clinician's ability to understand the minds of others. True mentalization becomes possible between the ages of 4 and 6 years, and recent neuroimaging studies suggest the medial prefrontal cortex, the temporal poles, the cerebellum, and the posterior-superior temporal sulcus may all be involved as components of a mentalization network (Calarge et al. 2003; Frith and Frith 2003; Sebanz and Frith 2004).

Role of Theory in Clinical Practice

Faced with a bewildering array of psychoanalytic theories, one may choose to deny the value of theory altogether. Who needs it? Why not just begin de novo with each patient and stick to the clinical material? To advocate this approach is simply to advocate the formation of new theories. As Kernberg (1987) noted, “All observations of clinical phenomena depend upon theories, and when we think that we are forgetting about theory, it only means that we have a theory of which we are not aware” (pp. 181–182).

A more sensible solution is to become familiar with the phenomena described by all the major theories and to focus on each perspective as it is clinically appropriate with a given patient (Gabbard 2007). Psychoanalysis and psychodynamic psychiatry are tragically beset with needless polarities—is it oedipal or preoedipal, conflict or deficit, classical theory or self psychology,
tension reduction or object seeking? Such questions tend to be cast in terms of right or wrong. Yet is it possible that different models are valid in different clinical situations? Is it not possible for both oedipal and preoedipal, conflict and deficit, to be relevant in the understanding of an individual patient? Of course it is.

Some aspects of all the theoretical perspectives examined in this chapter will most likely prove useful in the treatment of patients. From a developmental perspective, certain aspects of early childhood experience are better explained by one theory than another, and with certain patients, the emphasis will be more in one direction than another, depending on the clinical data (Pine 1988). In most patients, however, we will find both deficit and conflict. As Eagle (1984) noted in his appraisal of the role of theory in psychoanalysis: “We are most conflicted in the areas in which we are deprived….It is precisely the person deprived of love who is most conflicted about giving and receiving love” (p. 130). In practice, clinicians find themselves serving both as selfobjects and as real, separate objects for their patients.

For some clinicians, however, shifting from one theoretical perspective to another, depending on the patient’s needs, is too cumbersome and unwieldy. Wallerstein (1988) pointed out that it is possible for clinicians to pay attention to the clinical phenomena described by each theoretical perspective without embracing the entire metapsychological model. For example, one can address self and object representations, mirror and idealizing transfers, and impulse-defense configurations as they appear in the clinical setting without having to resort to invoking the entire theoretical edifice on which such observations are based. Others advocate greater theoretical flexibility (Gabbard 1996, 2007; Pine 1990; Pulver 1992), suggesting that different patients and different types of psychopathology require different theoretical approaches.

Each of these approaches to the theoretical pluralism of modern dynamic psychiatry is workable for some clinicians. Regardless of which approach is found to be more suitable, all clinicians should be wary of rigidly imposing theory onto clinical material. The patient must be allowed to lead the clinician into whatever theoretical realm appears to be the best match for the clinical material. Another possibility, of course, is that the material leads to uncharted terrain where no theoretical model is particularly useful. Clinicians may have to improvise and stay close to the clinical material without benefit of a theoretical edifice on which to stand. Open-mindedness is of paramount importance in this regard.

Clinicians must always remember that theory is metaphor. Our theories attempt to capture what human psychology is like, but because they are metaphors, they must suffer the fate of all metaphors: at some point they break down (Gabbard 2007). The best we can do is to use theories as a tool in help-
ing us grasp what is going on inside the patient, knowing that a good deal of trial and error may be necessary. We also must be prepared for the possibility that we will be stumbling through a cave for a period of time without knowing the path that lies before us. Nevertheless, we may still be far better off than the traveler with a map of an altogether different cave.

References

Bass A: When the frame doesn't fit the picture. Psychoanal Dialogues 17:1–27, 2007


Gabbard GO: Love and Hate in the Analytic Setting. New York, Jason Aronson, 1996


George C, Kaplan N, Main M: The Adult Attachment Interview. Department of Psychology, University of California, Berkeley, 1996


Kernberg OF: Borderline Conditions and Pathological Narcissism. New York, Jason Aronson, 1975


Kohon G: The British School of Psychoanalysis: The Independent Tradition. New Haven, CT, Yale University Press, 1986


Lindon JA: Gratification and provision in psychoanalysis: should we get rid of the “rule of abstinence?” Psychoanalytic Dialogues 4:549–582, 1994


Ornstein PH: On narcissism: beyond the introduction, highlights of Heinz Kohut’s contributions to the psychoanalytic treatment of narcissistic personality disorders. Annual of Psychoanalysis 2:127–149, 1974
Pizer SA: Impasse recollected and tranquility: love, dissociation, and discipline in clinical dyads. Psychoanal Dialogues 14:289–311, 2004
Schafer R: A New Language for Psychoanalysis. New Haven, CT, Yale University Press, 1976


Wallerstein RS: One psychoanalysis or many? Int J Psychoanal 69:5–21, 1988


