described the major ideas that influence the practice of psychoanalytic and psychodynamic psychotherapy today. A significant trend in the development of theory has been how we understand the self and the individual's relationship with others. As I discuss in the next several chapters, the therapy relationship is highly prognostic of the outcome of treatment, and it is no surprise that psychoanalytic and psychodynamic theory have come to incorporate the salience of the relationship in its thinking. The next chapter describes some additional theories that have been important in shaping the psychoanalytic and psychodynamic thinking and practice. Knowing these basic principles is important later on when we examine how theory interfaces with research and practice.

Notes

1. This phrase is taken from the title of an excellent book by Fred Pine (1990), titled *Drive, Ego, Object, Self: A Synthesis for Clinical Work.*
2. Note that this example is based on heterosexual parents, which is the framework for which Freud described his theories. Less has been written about same-sex parents and the development of sexual and gender identity.
3. Many analysts and nonanalysts consider Charles Socarides's writings to be hostile toward gay and lesbian individuals. Some have even suggested that his work is an outlier in the burgeoning psychoanalytic and psychodynamic literature on sexual orientation and gender identity development.
4. Infant research has found that this perspective is not entirely accurate. Infants have considerable awareness of things going on around them, which can be documented even in utero. For example, it has been well established that infants recognize and prefer their mother's voice to other voices well before they are born (DeCasper, Lecanuet, Busnel, & Granier-Deferre, 1994; DeCasper & Spence, 1988).
5. Confusion arose from the use of the phrase, "das Ich," which sometimes seemed to suggest the ego whereas at other times seemed to imply the sense of "I" or "me."

Huprich (2008)

4

The Evolution of Theory II

Integration and Expansion

When Pine (1990) described the history of psychoanalytic theory as drive–ego–object–self, he nicely captured the major theoretical shifts within psychoanalytic and psychodynamic theory. Yet many others have made important contributions to the development of theory that have had notable implications for conceptualization and treatment. Many of these advances have been reformulations or expansions of important ideas that were contained within the original theories or an integration of a different domain of study into psychodynamic ideas (e.g., cognitive psychology). In some cases, there have been important attempts at integrating the major ideas into one expansive theory. This chapter provides a selective review of more recent attempts to enrich psychoanalytic and psychodynamic theory.

Integrating Theoretical Models: The Contribution of Otto Kernberg

It would be misleading to suggest that Otto Kernberg is the only theorist who has attempted to integrate ideas of various theorists into one unified theory. However, I mention some of the works of Kernberg here because he has arguably made the most highly recognized contributions in integrating important theoretical developments in drive theory, ego psychology, and object-relations theory (Kernberg, 1970, 1975, 1983, 1984). He also has had a substantial influence in explaining and elaborating upon personality development and the treatment of character pathology.

Kernberg's ideas are an integration of the theories of Edith Jacobson, Melanie Klein, Margaret Mahler, William Fairbairn, and Sigmund Freud. Like Jacobson (1964), Kernberg believes that the earliest experience of the infant is organized around that of pleasure and pain. These experiences occur mainly in the relationship with the primary caregiver, and out of these experiences drive and affect are embedded. While *instincts* are biologically organized and present at birth, *drives* are highly individualized, malleable, and formed out of the affective experience with the caregiver. They are unconscious motivational systems that are oriented toward another person. "The basic units of self- and object representations and the affects linking them bring together these characteristics of drives" (Kernberg, 2001, p. 610). In other words, drives can be considered to be embedded within an object-relations unit.

Development occurs in three distinct stages. In the first stage, the most critical task becomes the differentiation of self and other, which occurs through the evaluation of experiences with others as either pleasurable or painful. Positive affects is associated with libidinal drive, and negative affect is associated with the aggressive drive, much in the way Jacobson (1964) described. Because self and other representations are not fully integrated—the good mother and the bad mother are not recognized as the same person—there is a psychological splitting of these representations, much as Klein (1964) described. When the first stage does not occur successfully, splitting processes become impaired. Consequently, psychotic pathology can emerge, as the fusion of self and other leads to significant deficits in reality testing. In the second phase, splitting that occurs must be overcome. The good and bad representations of self and other must be brought together into a distinct sense of self, who has both good and bad qualities, and a sense of the other—usually the caregiver—as having good and bad qualities. When this process does not occur, borderline conditions can occur—conditions similar to those described by Klein (1964) and Mahler, Pine, and Bergman (1975). This also means that powerful internal objects can influence a person's relationship to others in significant ways, much as Fairbairn (1952) described. In the third phase, self and other representations are clearly intact. How impulses are experienced and controlled can lead to neurotic conditions, much as Freud described in many of his writings.

The idea that conflicts in a particular stage of development could influence and dictate the nature of the adult's personality was

introduced by Freud (1908, 1931) and further elaborated upon by his student Karl Abraham (1921/1953, 1924/1953). Oral and anal characters were early concepts in psychoanalytic theory, and further descriptions of other character types were offered by Reich (1933), Fenichel (1945), and Schneider (1958). In 1970, Kernberg proposed a classification system of character pathology that reflected a hierarchical organization of pathology in the ego and superego, pathology in object relations, and pathology in the development of libidinal and aggressive drives. His organization reflected the ongoing expansion of analytic theory at the time, and even today, one can see the influence of this system in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and contemporary analytic thinking of about personality pathology (McWilliams, 1994; *PDM* Task Force, 2006; Shedler & Westen, 2004a, 2004b; Westen & Shedler, 1999a, 1999b).

Kernberg (1970) identified three types of character organization. In the higher level of organization individuals have relatively well-developed psychic structures (id, ego, and superego), but their superego tends to be overly punitive and too severe. Typically, such individuals use repression and related defenses, which are primarily avoidant of unwanted impulses. Socially, individuals are relatively well adapted, but their conflicts may limit their general satisfaction. Individuals at the higher level have meaningful object relations, but the expression of drives and impulses is partly inhibited. Personality pathology at this level is seen in hysterical, obsessive-compulsive, and depressive-masochistic personalities.

At the intermediate level of organization, patients have an even more punitive superego, but it is less well integrated into the personality. As such, persons show inconsistent patterns of behavior, in which there may be some failures of effective impulse regulation and appropriate adaptation while at other times there may be very high ideals and standards for behavior and ways of being. While repression is still an important defense, there are some trends toward splitting, projection, and denial. Oral-stage conflicts are commonly observed, such as conflicts over dependency, relatedness, and trust. The ability for stable relationships is there, but there is much ambivalence or conflict associated with such relationships. Included here are passive aggressive, sadomasochistic, "better functioning infantile personalities" (Kernberg 1970, p. 807), and certain narcissistic personalities. Kernberg (1970) added that well-established sexual deviations are indicative of this type of organization, provided that object relations remain stable.

At the lower level of character pathology, there is minimal integration of the superego into everyday life; as such, persons are freer to act on their aggressive and sadistic desires. There is little capacity to experience guilt, and persons have much difficulty looking critically at themselves. Defenses tend to be reactive as opposed to avoidant; projection and projective identification are commonly observed, as is splitting, denial, and the unconscious use of a fantasy of omnipotence to ward off evidence to the contrary. Good and bad representations of self and other are very much separated, and others are treated for their need-gratifying abilities. Not surprisingly, empathy is sorely impaired. Individuals at this level have infantile, narcissistic, antisocial, and "impulse-ridden character disorders" (Kernberg, 1970, p. 809). Prepsychotic personalities are seen here, such as hypomanic, schizoid, and paranoid personalities. Individuals who self-mutilate or who have multiple sexual deviations or a sexual deviation and drug addiction often are organized at this level.

Anaclitic and Introjective Configurations of Development and Psychopathology

Besides being a prolific researcher on psychoanalytic and psychodynamic theory and their application to psychotherapy, Sidney Blatt has expanded the understanding of developmental processes as they affect later functioning and psychopathology. Blatt's early work focused on schizophrenia and depression. Blatt and colleagues (Blatt, 1974; Blatt, D'Afflitti, & Quinlan, 1976; Blatt, Wein, Chevron, & Quinlan, 1979) identified and described two types of depression that were based on early experiences with caregivers. In *anaclitic depression*, individuals experienced significant deprivation or loss of caregivers in childhood. These experiences led to feelings of neediness and unrequited dependency, where individuals became particularly sensitive to the presence or absence of caregivers and significant others. When these important people were unavailable, children were vulnerable to and could easily experience depressive episodes. This type of depression was centered on the need for relatedness and connection, which was experienced as painfully absent. In its more pathological forms, even slight levels of deprivation or unavailability of others could trigger severe depression.

In *introjective depression*, individuals were vulnerable to depression when their sense of identity and esteem was threatened. This form of depression resulted when individuals failed to meet an important goal or experienced some threat to their sense of effectiveness, agency, or abilities. Such individuals often have high levels of perfectionism and are very achievement oriented, as these qualities and achievements help individuals retain a favorable sense of self, which, when compromised or attacked, leads to depression. Introjective depression is believed to originate in childhood experiences with caregivers who are perceived as critical or lacking in praise and encouragement. Because criticism and a lack of nurturing was absent, individuals sought to perform or act in ways that captured the attention of the caregiver, who would then provide the praise and encouragement that was so much desired.

Blatt also provided a template by which cognitive abilities and object relations develop in early childhood and how these are related to later psychopathology. Based on the ideas of Piaget (1954) and Werner (1948), Blatt (1974) suggested that object relations undergo a series of changes in how they become represented. His model describes five stages (with four intermediate or transitional stages) beginning with *sensorimotor-preoperational* representations, in which significant others are represented as existing solely for the needs of the other. Sensorimotor-preoperational representations reveal little appreciation for the separate existence of others apart from the gratification that they provide or the frustration that they cause. The next level of development involves *concrete-perceptual* representations. At this stage, individuals are represented in concrete ways with little appreciation for their inner qualities and experiences. At the *external iconic* level, others are represented in terms of what they do and the functions that they serve rather than who they are as people. *Internal iconic* representations are ones that begin to include internal psychological dimensions such as thoughts, feelings, beliefs, and values. And finally, *conceptual*-level representations integrate previous levels of the others' external and internal dimensions and qualities. Descriptions of others at the *conceptual* level may include inner conflicts that one has toward the person but are done so in a complex and integrated manner so that the richness of an individual's personality is captured.

To assess object relations, Blatt and colleagues developed the Concept of Object Scale (Blatt, Brenneis, Schimek, & Glick, 1976), which is used to assess the way representations of human and human-like

figures are described on the Rorschach Inkblot Test. In a series of multiple studies with children, adolescents, and adults, Blatt and colleagues found evidence to support the idea that the severity of psychopathology was related to the quality of the object representation (reviewed in Huprich & Greenberg, 2003).

Blatt and colleagues also developed a set of procedures for evaluating the content of open-ended descriptions of self and significant others as a way to investigate object representations. These procedures have been slightly modified through the years but have come to be known as the Object Relations Inventory (Blatt, Chevron, Quinlan, Schaffer, & Wein, 1988, 1992; Blatt et al., 1979; Diamond, Kaslow, Coonerty, & Blatt, 1990). Like the Concept of Object Scale, these procedures are rooted in cognitive developmental theory, which posits that object representation changes over development. Studies with this measure have demonstrated an association between level of psychopathology and level of object relations, with more mature object relations being characterized by less psychopathology (see Huprich & Greenberg, 2003, for a recent review of this literature).

In addition to his work on cognitive development and object relations theories, Blatt and colleagues have offered an expansive description of two developmental trajectories that may become associated with various forms of psychopathology (Blatt and Shichman, 1983). These lines, or configurations, are based on the ideas of Anna Freud (1963, 1965), Fairbairn (1952), Jacobson (1964), and Shapiro (1965, 1981), who focused on the cognitive, affective, and interpersonal styles related to certain personality configurations. Blatt and Shichman, (1983) identified anaclitic and introjective configurations of development and related psychopathologies. In the *anaclitic configuration*, the predominant concerns are about interpersonal relationships and the desire to be close and intimate with another person. Defenses of this configuration are primarily avoidant, such as denial and repression. Cognitively, individuals focus on images and affects, and have thought processes that center on the simultaneous, interactive nature of relating to each other. Because there have been depriving, rejecting, or unpredictable relationships, individuals in this configuration are conflicted around libidinal issues of care, affection, love, and sexuality. The individual's sense of self is not given attention, as seeking and obtaining satisfying relationships consumes one's mental energy. More severe pathology in this configuration is associated with disruptions in the mother–infant dyad, while less severe pathology is associated with relatedness in the triadic, Oedipal period (mother–father–child).

In the *introjective configuration*, individuals focus on self-definition, self-worth, and identity. The typical defenses used are counteractive, such as projection, splitting, externalization, doing and undoing, reaction formation, isolation, intellectualization, rationalization, and overcompensation. Cognitively, individuals tend to be more literal than symbolic and focus more on thoughts and deeds rather than on people and interpersonal concerns. Such individuals tend to be analytical, critical, and linear in their thinking. They do not like contradictions or uncertainty and, subsequently, are quite focused on control. Attempts to secure and establish one's identity are key and supersede relationship desires. More severe psychopathology is associated with more extreme forms of criticism and hostility, while less severe is associated with criticism and inconsistency experienced during the Oedipal period.

In both configurations, the most extreme psychopathologies are schizophrenia and borderline conditions. In the anaclitic form, nonparanoid (i.e., Type II, negative symptoms) schizophrenia and hysterical, attentional seeking borderline pathologies are observed, while the introjective form includes paranoid schizophrenia and overideational borderline pathology. Pathologies in a less severe range, though still causing clinically significant distress, range along a continuum of neurotic symptoms and personality types. In the anaclitic continuum of neuroses, hysterical forms of disorders are seen, from more severe histrionic (infantile) personalities to hysterical symptoms or tendencies, which are predominated by concerns of how to relate to different kinds of people (e.g., mother figures, father figures, those for whom sexual desire is experienced). In the introjective continuum of neuroses, paranoia, obsessive-compulsive, introjective/depressive personalities, and phallic/overt narcissism are observed. Throughout this continuum, the sense of preserving one's integrity is the focus, in which others may be represented as hostile and malevolent (paranoia) or, in less extreme forms, as being competitors who might expose one's inferiority or limitations. In the case of phallic narcissism, this may be seen as inferiority regarding one's bodily assets.

Sadomasochism and Two Systems of Self-Regulation

Patients who present with sadomasochistic conflicts pose a real challenge for clinicians. Here, patients have come to associate pleasure with pain, something that seems counterintuitive to the

assumption of the pleasure principle. Some very interesting work on sadomasochism has been done by Jack and Kerry Kelly Novick. In developing their ideas, they noted Freud's (1940) difficulty in understanding masochistic pathology: "We are specially inadequate in dealing with masochistic patients (p. 180)" (cited in Novick & Novick, 2004, p. 235). Furthermore, they suggested that each major shift in psychoanalytic theory, including the development of the idea of a superego as one of three psychic structures, was associated with Freud's experience of sadomasochistic phenomena (Novick & Novick, 1996). Having expanded these ideas over the years, Novick and Novick's ideas about sadomasochistic pathology are understood by many as being quintessential to successful treatment.

Though they initially began their writing and theoretical developments on the treatment of sadomasochistic pathology, the Novicks suggest that at the heart of virtually all psychopathology is embedded in some kind of sadomasochistic conflict, specifically based in how to resolve conflict and self-regulate (Novick & Novick, 1987, 1996, 2001, 2004). These systems of self-regulation and conflict management may be described as closed and open systems. In the *closed system*, individuals turn away from reality to preserve a sense of safety. Such a strategy originates in childhood, in which the child is faced with some internal or external overwhelming experience. Very often, this is the result of extreme demands from the parents or insensitivity to the needs of the children, which force the children into a painful experience that is not wanted. If the outer world of reality (i.e., appropriately attuned parents) does not help resolve this distress, children turn inward to some idea, fantasy, or belief that helps maintain a sense of safety in the face of such overwhelming helplessness. These fantasies include the ideas that they deserve this kind of mistreatment and that extraordinary standards of behavior and conduct are necessary to please others. Hence, a very strong superego develops. However, the fantasy of tolerating the mistreatment goes further, in that children who experience rage toward the abusive parent or caregiver also believes that were their anger to be expressed, it would conquer and overtake the caregiver. In developing this kind of fantasy, children feel a sense of *omnipotence* in being able to conquer such upsetting material. It, therefore, becomes very resistant to change because it is highly rewarding to feel such omnipotence against such upsetting feelings of helplessness. According to the Novicks, if personality does not develop adequately, this strategy may become a more permanent structure that provides feelings of control, safety, excitement, power, and a favorable self-esteem. By contrast, an *open system* of self-regulation is "competent and effective, based on mutually respectful, pleasurable relationships formed through realistic perceptions of self and others, open to experience from inside and outside and thus generative of creativity in life and work" (Novick & Novick, 2001, pp. 100–101). Open systems are created through parenting that involves appropriate levels of attunement to children's emotional state and desires, the capacity to tolerate children's anger and aggression (while also providing love and adaptive alternatives to such aggression), and fostering children's autonomy and independence with oversight and availability for emotional and physical comfort when needed. Novick and Novick (2003) noted that how the open system develops has been elaborated in the psychoanalytic literature by many others, such as John Bowlby, Erik Erikson, Anna Freud, Sigmund Freud, Heinz Hartmann, and Donald Winnicott.

The Novicks recognize the importance of mastering masochistic experiences throughout the lifetime, particularly salient in early life. Here, all children must come to learn that a certain amount of pain or discomfort is necessary for living adaptively in the world. But the need to adapt may transform into an unhealthy preoccupation or reliance on pain for one to feel capable of mastery and efficacy. This is the essence of masochism, which Novick and Novick (1987, p. 381) defined as "the active pursuit of psychic or physical pain, suffering, or humiliation in the service of adaptation, defense, and instinctual gratification at oral, anal, and phallic levels." It is when pain, suffering, or humiliation helps to meet needs associated with dependency, nurturing, control, submission, jealousy, competition, or desire (sexual or aggressive) that masochism results.

As their ideas have developed, Novick and Novick (1996, 2004) suggested that masoschism and sadism are always connected. Masochistic suffering gives way to acting out the sadistically the fantasy of destruction that comes from the omnipotent belief that one's anger could destroy those who induce suffering. It is not hard to imagine, then, that sadomasochistic conflicts could have significant effects on the therapeutic alliance. Sadomasochistic conflicts could easily set up transference dynamics in which therapists are approached as the ones who could inflict pain or punishment; patients, therefore, are oriented toward the fantasy of omnipotence

in being able to tolerate the demands of their therapist (which could be distortions of basic requests of the therapist, such as saying more about a topic or to look with curiosity at why they find themselves in such frustrating relationships). The therapist also may be one who must be conquered in some way by patients' sadism (Novick & Novick, 1998). Since patients with these kinds of conflicts operate within a closed system, the idea of working together "is incompatible with sadomasochism" (ibid., p. 832). Thus, treatment needs to focus on working with the patient within the open system, in which the open system of patients' ego is aligned to the treatment process. Staying within the open system, therapists can highlight for patients ways the closed system presents conflicts and challenges to a satisfying life (Novick & Novick, 2003). Closed-system mechanisms, however, are highly effective for patients with sadomasochistic conflicts. Hence, they are difficult to change. Recognizing and accepting the value of the patients' closed system approach is highly important, as is being curious with the patient about the ways these solutions have affected them, so that patients do not perceive the therapist's interest in the maladaptivity of the system as an attack.

Attachment Theory

In developmental psychology, the study of the attachment process of the young to their parents has been a topic of study for decades. Beginning with Harry Harlow's (1958) work with baby monkeys and Rene Spitz's (1945, 1946a, 1946b) important papers on the life-or-death nature of touch and affection for the infant's survival, the evolutionary importance and necessity of good attachment—and consequences of a not-so-good attachment—is now common knowledge and accepted as a core developmental process (Bowlby, 1977, 1988). More specifically, Bowlby wrote that attachment "has its own internal motivation distinct from feeding and sex, and of no less importance for survival" (Bowlby, 1988, p. 27). Thus, in the tradition of Fairbairn and Winnicott, relatedness to another person is seen as a fundamental motivating force in human behavior. Bartholomew, Kwong, and Hart (2001) indicated that the goal of attachment—besides the fundamental necessity of basic care—is to provide children with a *sense of safety* such that they can explore, learn, and understand the environment yet have

support and help when the environment becomes too difficult to understand on their own.

Implicit to attachment theory are two major premises:

1. Responsible and accessible caregivers need to create a secure base for children, thus providing children with the sense that the caregivers are accessible and dependable.
2. The way the emotional bond develops becomes internalized, and internal working models—or representations—are formed.

Infants are not passive in this regard. They actively construct a basic understanding of the attachment relationship (Bowlby, 1977). To assess these representations, Mary Ainsworth and colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) created the *strange-situation technique.* This involved a period in which the mother and infant are in a playroom alone. Then, a stranger comes into the room, and after a few minutes the stranger begins to interact with the child. The mother then goes away for brief intervals. In the first interval, the infant is left just with the stranger, and in the second interval, the child is left alone. What is assessed in this technique is the infant's response to the mother when she returns. It is in this interval that a child's conception or representation of the mother as a source of comfort can be detected.

Based on the infants' behavior in this situation, Ainsworth et al. (1978) described three kinds of attachment. *Secure* infants are happy to see their mother return to the room and go to them for brief comfort. They quickly return to play. *Anxious-resistant* (or ambivalent) infants show a mix of comfort seeking and anger toward the mother when she returns to the room. They are less confident in their exploration of the playroom and are not readily comforted. *Avoidant* infants do not make contact with the mother when she returns. They do not seek comfort from the mother, and mothers of such children are often seen to be rejecting or affectively bland with their child. Other patterns of attachment were added to the theory later, including an *avoidant/ambivalent* pattern (Crittenden, 1988) and a *disorganized-disoriented* pattern (Main & Solomon, 1986), in which infants showed contradictory or disoriented strategies for going to the mother for seeking comfort. This type of attachment is found in 80% of maltreated infants (Carlson, Cicchetti, Barnett, & Braunwald, 1989, as cited in Schore, 2002).

Bowlby (1980) believed that infant attachment patterns affect the types of affective bonds they make with others later in life. Not surprisingly, some have assessed adult attachment patterns based on their reports of past family relationships or current romantic relationships. Mary Main and colleagues (George, Kaplan, & Main, 1985; Main, Kaplan, & Cassiday, 1985) described secure, dismissing, and preoccupied attachment patterns in adults, which were derived from their descriptions of their childhood family relationships during the Adult Attachment Interview. Cindy Hazan and Philip Shaver (1987) were interested in adult romantic relationships and developed a brief, self-report measure of attachment style. They described secure, ambivalent (or preoccupied), and avoidant adults, who were found, respectively, to have comfort with trust, anxiety or overdependency, or distrust and distance in their closest adult relationships. Subsequent research with this measure has found that it predicts adult relationship patterns rather well and is related to expected patterns of experience in relationships (Shaver & Clark, 1994).

Having evaluated the attachment styles reported by Main and colleagues (1985) and by Hazan and Shaver (1987), Brennan, Clark, and Shaver (1998) suggested that two dimensions underlie attachment patterns observed in both infants and adults: *anxiety* and *avoidance*. Anxiety relates to the individual's fear of rejection, separation, and abandonment and is a dimension related to representations of the self in relationships. Avoidance relates to how well others can and will provide comfort and reassurance. This dimension is related to representations of others. As a means of combining these dimensions with the types, Kim Bartholomew and colleagues (e.g., Bartholomew & Horowitz, 1991) described a two-dimension, four-category model of attachment. Low anxiety and low avoidance characterize secure attachments; high anxiety and high approach characterize preoccupied attachments; low anxiety and high avoidance characterize dismissing attachments; and high anxiety and avoidance characterize fearful attachments. What is appealing about this model is that self and other representations are described, as is the nature of an affect; hence, there is a strong parallel to object-relations theory and a categorization of individuals by their interpersonal relatedness. While there is not yet a consensus about which model of attachment is most representative of reality (Bartholomew et al., 2001), there is considerable empirical support

for this model, making it widely appealing to clinicians and researchers in their conceptualization of patients. Particularly impressive about the attachment literature in general is the evidence for the long-term stability of attachment patterns and the behavioral expressions of attachment into adulthood (e.g., Main et al., 1985; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000).

Fonagy (1999a) observed important similarities in attachment theory and psychoanalytic/psychodynamic theory. These include an interest in the internal psychic life of the child (particularly during events of the earliest years), maternal sensitivity and mirroring, the importance of relationships in human motivation, the representation of relationships, and the importance of the maternal relationship and its mentalization. Fonagy suggested that attachment theory would benefit by attending more to the distortions children have of their early experience, by de-emphasizing the categories of attachment and looking more at the situations and context in which certain attachment paradigms are in operation, and by putting greater emphasis on children's perception of the psychological and physical integrity of their caregivers.

The biological mechanisms of attachment and their implications for treatment have been described in much detail by Allan Schore (1994, 2000). In reviewing the work of Bowlby (1973), Schore (2000) noted that Bowlby saw attachment as being fundamentally rooted in a neurobiological process, much like Freud believed that neurobiological processes underlay unconscious processes. Bowlby (1973) speculated that the reticular formation, in conjunction with the midbrain nuclei and limbic system, plays an important role in self-regulation, which ultimately is the goal of the attachment system. He thought this attachment system was represented in the prefrontal lobes. In expanding these ideas, Schore (2000) suggested that it is the orbitofrontal cortex that is actively involved in the process of establishing attachment pattern representations. As children experience face-to-face interactions with their caregiver, Schore explained that the emotional matching of children by their mother affects the neural pathways laid down in the orbitofrontal cortex. Not only does this region have connections to the prefrontal regions, but it also is connected to autonomic pathways. Thus, one can see how patterns of attachment can become easily associated with sympathetic, parasympathetic, and autonomic patterns of behavior. Schore (1994, 2000) emphasized that the internal working models of

the child–caregiver relationship get represented in this region, as it is during the first 10–12 months of life when the orbitofrontal cortex pathways begin to mature the most (up to 2 years, which happens to coincide with the onset of the attachment patterns first described by Ainsworth et al., 1978). Schore (2000) noted that the orbitofrontal cortex is actively involved in emotional-related learning and that empirical studies have shown that there is a plasticity, or fluidity, to these processes, such that new kinds of emotional learning may occur. He suggested that understanding more about these processes may unlock the door to the biological mechanism of how psychoanalytic or psychodynamic therapy works.

Schore (2002) also spoke about trauma and its impact on the developing person. In referring to the role of the orbitofrontal cortex again, Schore noted that severe abuse and neglect leads to deficits associated with right brain activity, such as a lack of empathy, an inability to read others' facial cues, a poor ability to read social cues, and difficulty understanding one's own internal bodily state. These deficits result from an inability of mothers or caregivers to appropriately identify the affective state of infants and to provide a soothing or comforting response. In other words, caregivers teach children about the nature of their inner response and impart an ability to remain secure despite the distress. This phenomenon may be understood as right-brain-to-right-brain communication between children and caregivers.

However, when caregivers are unable to attend to their children's cues, perhaps because of their own deficits in recognition and self-understanding, the child is left with a state of underlying and unremitting distress. When comfort does not come despite this despair, children can be seen to engage in dissociation from the world around them. This automatic, psychological removal of one's experience from the outer world to the inner world serves a protective function, but it comes with a price. Children have not internalized the sense of felt safety and security from experiencing distress; their right brain suffers the consequence of learning how to return to safety. Schore (2002) suggested that this overwhelming fear followed by extreme withdrawal is what Kohut (1971) understood as fear of disintegration. To some extent, all individuals experience some degree to which they are not appropriately mirrored or comforted; however, the absence of "good enough" caregiving produces significant structural changes in the brain, which can be seen in adults

who were severely abused in childhood or who have a diagnosis of posttraumatic stress disorder (PTSD). This phenomenon has been observed empirically. In an emotional processing task, individuals with PTSD have decreased activity in the right hemisphere (Galletly, Clark, McFarlane, & Weber, 2001; Raine et al., 2001) compared with controls. Therapeutically, Schore (2002) suggested it may be that patients can only express their internal distress through their transference and through projective identification. In this sense, therapists must "listen" with the right brain to understand what patients are trying to communicate. Subsequently, therapists can then provide an interpretation and help the patients reformulate their experience with a greater sense of mastery and felt security.

Mentalization and Reflective Functioning

Closely related to attachment theory is the concept of mentalization and its key activity, reflective functioning. These ideas were proposed by Peter Fonagy and Mary Target (Fonagy & Target, 1996, 1997, 2006; Fonagy, Gergely, Jurist, & Target, 2002). *Mentalization*, or *reflective capacity*, is the ability to conceive of and understand the mental states of self and others as explanations of behavior and experience, a process known as *interpersonal interpretive functioning*. Mentalization is necessary for the development of a fully developed sense of self and is acquired in the context of early attachments, specifically primary-object relationships. Inherent to developing mentalization is the development of self and other representations, or object relations: "The baby's experience of himself as having a mind or self is not a genetic given; it evolves from infancy through childhood, and its development critically depends upon interaction with more mature minds, assuming these are benign, reflective, and sufficiently attuned" (Fonagy & Target, 2006, p. 545). Thus, the role of the caretaker in developing the child's capacity for mentalization is crucial. Specifically, caretakers must be able to mirror accurately for children their mental state while at the same time doing so in a way that shows it is the children's state being expressed and not their own mental state. If mirroring is not accurate, Fonagy and Target (2006) suggested that the inner state as it is represented will not match the inner subjective state, which could lead to the development of a false self, as Winnicott (1965) described. If the mirroring does not differentiate children's emotions from

caregivers' emotions, individuals may come to experience emotions only through other people, such as is found in borderline personality disorder and other severe personality pathology.

Fonagy and Target (2006) described four points of interest in the course of development that delineate important process toward the development of mentalization:

1. Between 6 and 12 months, children begin to construct causal relationships in which persons' actions come from their own volition, or *agency*, and have an effect on the environment. It is not that children have an understanding of the mental state of others; rather, they detect simple cause-and-effect relationships in the physical world.
2. In the second year, children develop a psychological understanding of agency. Children then understand that they and others have intentions toward action that are caused by some preexisting motive or desire. These actions of self and other then bring about changes in the minds and bodies of self and others. However, children at this point do not yet have the capacity to separate the sense of mind from the sense of body. This is readily seen when a child becomes enraged toward another child who innocently takes away a toy, such that the child strikes out at the innocent offender.
3. Around 3–4 years, children begin to understand that agency comes from their own inner state of mind. What is seen about their own or another person's actions does not automatically reflect what is happening in their minds. In this time period, playing with peers becomes more important than playing with adults, as it is believed that for play children now do not require adults, who helped them understand their own experiences or the experiences of others when they did not have the skills, and subsequent ability to self-regulate, during earlier times.
4. Around age 6, children now have the capacity to recall times when their actions were caused by their agency or volition, which leads to a temporally stable sense of themselves as active and intentional persons.

All of these events introduce another important concept: *intersubjectivity*. This is the ability of individuals to recognize that they have a perception of reality and that when engaging in experiences with others, they, too, have a perception of reality. Early recognition of this intersubjectivity is very narcissistic—what children know

and experience is believed to be known and experienced in exactly the same way by other people. As development proceeds, including the growing capacity for mentalization, children now recognize that what they know and experience is not the same as what other people know—hence, a greater capacity for children to relate to others and to tolerate slightly different desires or goals is experienced, as is an appreciation of the uniqueness of what other people may be able to share.

What are the implications of these theoretical developments for the conceptualization and understanding of psychopathology? When the attachment process goes awry, mentalization does not occur in an optimal manner. Most problematic is the disorganized pattern of attachment. Here, individuals live in a mode that predates the representation of others as being able to accurately define and mirror their inner state. This sets up an orientation toward self-protection, in which others are seen as potentially hostile to individuals' own sense of self, albeit frail and incomplete. Trauma histories in the attachment upset the mentalization process. Playfulness, which fosters the interpersonal interpretive function, is decreased; affect regulation and attentional processes are impaired; and an unconscious defensive avoidance of mentalization processes occurs. This avoidance protects the individual from the fearful states of mind experienced in the hands of an abusive caregiver; subsequently, differentiation of self and other's inner world and experience is compromised. Research has supported these ideas. For example, Fonagy et al. (1996) found that patients with borderline personality disorder have difficulty with mentalization after experiencing maltreatment. Fonagy, Stein, Allen, and Fultz (2003) also found that difficulty detecting facial emotional expressions was positively associated with more severe maltreatment.

Intersubjectivity: Two-Persons and Constructed Reality in Psychotherapy

Modifications of theory have also had an effect on issues surrounding treatment. As noted already, Fonagy and colleagues (1996, 1997, 2002, 2006) discussed the importance of intersubjectivity in the development of healthy relatedness and a definition of one's sense of self and one's agency. Related to these ideas, and as an outgrowth

of interest in object relations and self psychology theories, Stolorow, Atwood, and Brandchaft (1994) described an *intersubjective view* of the treatment situation. Intersubjective approaches to treatment recognize that there are two persons in the treatment room and that the actions and behaviors of the treatment provider have an effect on the patient. In other words, not only is the unconscious mind of the patient operating, but so is the unconscious mind of the therapist. If one is to take seriously the significant role of the unconscious in determining conscious thoughts, feelings, attitudes, judgments, and behaviors, then one must consider that the same processes work in the mind of the therapist and that these processes can and do have an effect on what the therapist says and does with the patient. This means that, in Fonagy's sense of intersubjectivity, what the therapist attends to from the verbal and nonverbal aspects of the patient reflects the therapist's ability to see, hear, recognize, and respond to the needs and desires of the patient (Fonagy et al., 2002). It also means that what becomes understood in the conscious minds of the patient and therapist is a construction of their making. Consequently, no longer can transference be viewed just as the product of the patient's mind; rather, transference reflects "the patient's here-and-now experience" of the treatment provider (Mitchell & Black, 1995, p. 166). This issue will be revisited in chapter 7 when discussing mechanisms of therapeutic effectiveness.

Cognitive Experiential Self-Theory

Seymour Epstein (1973, 1991, 1994) sought to integrate psychoanalytic theory with more recent findings from cognitive psychology. He suggested that the Freudian unconscious does not make sense from an evolutionary perspective; that is, why would an unconscious that is so maladaptive and powerful have such a strong influence on behavior? How could it have evolved (and remained) throughout human history? For Epstein (1994, p. 709), the suggestion of secondary process thinking was an "ad hoc solution" to this problem. Instead, he suggested that the cognitive unconscious, as identified in cognitive psychology research, is a more adaptive system. This system contains multiple, automatic processes that occur effortlessly, is more palatable from an evolutionary perspective, and, by Epstein's account, is better suited for psychodynamic theory.

According to Epstein (1994, p. 715), *cognitive-experiential self theory* (CEST) holds that "people automatically construct an implicit model of the world, or a "theory of reality," that has two major divisions—a world theory and a self-theory—and connecting propositions .... A theory of reality is not developed for its own sake, but in order to make life as livable, meaning as emotionally satisfying, as possible." CEST proposes that there are two major psychological systems in place: the rational and the experiential. The ideas of the self and the world contain *beliefs*, which are contained in the rational system, and *implicit beliefs* (or schema), which are contained in the experiential system.

The rational system operates with logic and analytic thinking. It works to make logical connections among symbols, words, and numbers, and it processes information more slowly than the experiential system. However, it can change course more rapidly than the experiential system, as seen in the rapid pace by which thoughts can change. Behavior is mediated in this system through conscious understanding of events.

The experiential system is oriented toward judging experience by pleasure and pain. It forms associative connections among experiences, which affect behavior in either nonconscious or preconscious ways (i.e., "I had a sense that things were not right here"). It processes experience more quickly than the rational system but is slower to change, as repetitive or intense experiences are needed to change the associations that have been laid down. Epstein noted that this theory encompasses four different motivating principles that have been espoused in prior analytic and dynamic theorists: (1) the need to maximize pleasure and to minimize pain; (2) the need to maintain a relatively stable internal state and sense of self; (3) the need for relatedness; and (4) the need to overcome feelings of inferiority and to enhance self-esteem. Resulting behavior can be understood as a compromise among the four needs, and the needs work to moderate each other.

Epstein (1994) highlighted three implications from CEST for how therapeutic change can occur:

1. The rational system can be used to influence the experiential system, such as is found in cognitive therapy.
2. Learning about emotionally significant experiences can occur in working through troublesome life experiences or by understanding the relationships individuals have with others or with the therapist.
3. Using fantasy could help to understand components of the experiential system that are not readily discernible.

In short, Epstein's (1994) approach appears to be an integrative hybrid of theory both inside and outside of psychoanalytic and psychodynamic theory.

Summary

In this chapter, I have reviewed more recent advances in the development of psychoanalytic and psychodynamic theory. There are many individuals who have advanced theory that were not discussed, and it was not my intention to provide a comprehensive overview. Rather, I sought to demonstrate that psychoanalytic and psychodynamic theory have evolved quite a bit since the life and times of Sigmund Freud. Most obvious in this evolution has been the increasing importance of the psychological life of the individual as it exists in relationship to others. Even in the practice of psychoanalysis, the importance and meaning of the relationship takes on tremendous importance, more so than in the days of analysis when the "blank screen" singularity of clinical practice dominated.

As I noted in chapter 2, psychoanalytic and psychodynamic ideas have been under attack for some time (see Bornstein, 2001, 2002b, 2005). Some of this criticism reflects the fact that psychoanalysts were rather insular and avoidant of those with different theoretical points of view. It may be that another reason for this disdain, particularly in the professional community, is that evidence was accruing in psychotherapy research, indicating that, regardless of theoretical orientation, the *therapeutic relationship* was the best predictor of the progress and outcome of psychotherapy (Lambert & Barley, 2002). Although psychoanalysts and proponents of psychoanalytic and psychodynamic theory are far from disinterested in the therapy relationship—in fact, they arguably are more interested in the relationship than most schools of therapy—it may have been the case that the failure to acknowledge the success of other modes of treatment was the result of their theory not evolving more quickly to the place that it now is. That is, the nature of the intimate relationship between one person and another has a profound influence on a person's development and that the earliest types of intimate relationships set templates for all future relationships. Perhaps it could be said that "good enough" relationships produce "good enough" outcomes.

Nonetheless, there are multiple strengths that psychoanalytic and psychodynamic theory offers to the practice of psychotherapy that are not found in other schools of thought. Among these are the richness and comprehensiveness of the theory, a century's worth of clinical practice and empirical support, and the countless lives of those who have benefited from the practice of psychoanalytic or psychodynamic therapy. The next chapters discuss basic principles of treatment, what mechanisms account for therapeutic effectiveness, and what the research suggests about the effectiveness of psychoanalytic and psychodynamic therapy. Contrary to the skepticism of many academically oriented psychologists and psychiatrists, Freud's ideas are not dead; they are quite alive, and they are supported by good empirical research.