A Fundamental Polarity in Psychoanalysis: Implications for Personality Development, Psychopathology, and the Therapeutic Process

SIDNEY J. BLATT, PH.D.

Interpersonal relatedness (attachment) and self-definition (separation) are fundamental psychological dimensions that are central to psychoanalytic thought, beginning with Freud, as well as in a wide range of nonpsychoanalytic formulations. These constructs provide a theoretical matrix that facilitates identifying continuities among personality development, variations in normal personality or character formation, concepts of psychopathology, and mechanisms of therapeutic action. The identification of these continuities enables us to consider many forms of psychopathology, not as diseases with assumed but as yet undocumented biological origins, but as distortions that derive from variations and disruptions of normal psychological development. Likewise, the identification of these continuities enables us to consider the relationship of mechanisms of therapeutic action to psychological development more generally. Validation of aspects of these formulations have been found in studies of depression and personality disorders as well as in systematic investigations of therapeutic change.

Sidney J. Blatt, Ph.D. is Professor, Psychiatry and Psychology, Yale University; Chief, Psychology Section, Department of Psychiatry, Yale University School of Medicine; Faculty, Western New England Institute of Psychoanalysis.

MANY OF FREUD'S THEORETICAL FORMULATIONS WERE BASED ON A fundamental polarity—a polarity of attachment and individuation, or interpersonal relatedness and self-definition. He conceptualized human existence in terms of this fundamental polarity. Freud (1930) observed, for example, in *Civilization and Its Discontents* that "the development of the individual seems … to be a product of the interaction between two urges, the urge toward happiness, which we usually call 'egoistic', and the urge toward union with others in the community, which we call 'altruistic'" (p. 140). He further noted that each individual struggles with these two urges, that these "two processes of individual and of cultural development … stand in hostile opposition … and mutually dispute the ground" (p. 141).

This fundamental polarity is also expressed in Freud's oft-quoted statement that the two major tasks in life are "to love and to work" (Erikson, 1963) as well as in his distinctions between object and ego libido (Freud, 1914, 1926), between libidinal instincts in the service of attachment and aggressive instincts necessary for autonomy, mastery, and self-definition; and between an anaclitic choice based on the mother who feeds and/or the father who protects and a narcissistic choice based on what one is, was, or wants to be (Freud, 1914, 1926). An anaclitic choice involves object libido and the development of affectionate, need-satisfying relationships, whereas a narcissistic choice involves ego libido and the use of others to enhance the self. Freud (1930) further extended this polarity of relatedness and self-definition (attachment and individuation) by distinguishing anxiety that derives from the internalization of superego authority, involving feelings of guilt and fears of punishment that are related to ego instincts and issues of mastery that oppose the progress of civilization, from social anxiety that involves the fear of loss of love and contact with others.

Freud (1914, 1926) also differentiated four primary dangers at different developmental levels: two relational traumas—helplessness and the loss of the mother—and two self-definitional dangers—the loss of superego approval and the fear of punishment. Separation from a loved object creates a sense of helplessness (Freud, 1905, 1926) that is related to aspects of feminine development; loss of superego approval and the threat of punishment involving issues of self-reproach and guilt are more characteristic of masculine development (Freud, 1914, 1923, 1926).

Impressed with the extent to which this fundamental polarity pervaded Freud's wide-ranging contributions, Loewald (1962) noted that "these various modes of separation and union … [identify a] polarity inherent in individual existence of individuation and 'primary narcissistic union'—a

polarity that Freud attempted to conceptualize by various approaches and that he recognized and insisted upon from beginning to end [in] … his dualistic conception of instincts, of human nature, and of life itself" (p. 490). Loewald observed that this duality or polarity of individuation and primary union underlies the significance of separation and internalization as basic mechanisms in psychological development (see also Behrends and Blatt, 1985; Blatt and Behrends, 1987).[1]

The sections to follow will consider the potential contributions of this fundamental polarity for understanding personality development, variations in normal personality organization, psychopathology, and the therapeutic process.

The Polarity and Personality Development

Blatt and colleagues (e.g., Blatt 1974, 1990, 1991, 1995a, b; Blatt and Shichman, 1983; Blatt and Blass, 1990, 1996) proposed a theoretical model in which personality development evolves, from infancy to senescence, through a complex dialectic transaction between two fundamental developmental processes: (a) *relatedness*—the development of increasingly mature, intimate, mutually satisfying, reciprocal, interpersonal relationships and (b) *self-definition*—the development of an increasingly differentiated, integrated, realistic, essentially positive sense of self or identity. These two

[1]In an earlier discussion of the contributions of these theoretical formulations for understanding and treating depression (Blatt, 1998), I noted that these psychoanalytic formulations of personality development are consistent with a wide range of personality theories, from psychoanalytic conceptualizations to empirically derived formulations. A number of theorists throughout psychoanalytic thought (e.g., Abraham, Jung, Adler, Rank, Horney, Tausk, Bowlby, Balint, Shor and Sanville, Sullivan, Kohut, M. Slavin and Kriegman) as well as many nonpsychoanalytic personality theorists (e.g., Angyal, Bakan, L. Benjamin, Carson, Deci and Ryan, Foa, Gilligan, Hogan, L. Horowitz, Leary, McClelland, McAdams, Winter, Hegelson, Markus and colleagues, Maddi, Spiegel and Spiegel, White, Wiggins) have articulated similar distinctions and made them central to their formulations. Spiegel and Spiegel (1978) drew a parallel between these two psychological dimensions of relatedness and self-definition (of attachment and separation) and two fundamental forces in nature—fusion and fission or integration and differentiation. In more poetic terms, Martin Buber (1970) discussed the development of I and Thou—how "Man becomes an I through a You … [how] bonds are broken and [the] I confronts its detached self for a moment like a You—and then it takes possession of itself and henceforth into relations in full consciousness" (p. 80).

fundamental developmental processes normally evolve through a complex synergistic, hierarchical, dialectic transaction such that progress in one developmental line usually facilitates progress in the other. An increasingly differentiated, integrated, and mature sense of self emerges out of constructive interpersonal relationships and, conversely, the continued development of increasingly mature interpersonal relationships is contingent on the development of a more differentiated and integrated self-definition and identity. Meaningful and satisfying relationships contribute to the evolving concept of self, and a revised sense of self leads, in turn, to more mature levels of interpersonal relatedness.

An extension of Erikson's epigenetic psychosocial model illustrates how these two fundamental developmental lines of relatedness and self-definition evolve and how they are eventually integrated in an identity. If, as proposed by Blatt and Shichman (1983), one expands the Erikson model by including an additional psychosocial stage, *cooperation versus alienation,* around the time of the Oedipal crisis and the development of cooperative peer play (i.e., at about four to six years of age) and places this stage at the appropriate point in the developmental sequence between the phallic stage of "initiative versus guilt" and the latency stage of "industry versus inferiority," Erikson's epigenetic formulations define a relatedness developmental dimension as well as a self-definitional dimension and implicitly denotes the dialectic transaction between these two dimensions.

In this dialectical rendering of Erikson's formulations, one developmental line, *self-definition or individuality,* evolves from early experiences of separation and *autonomy* from the mother to a capacity to *initiate,* at first in opposition to an other and later proactively, to *industry* with sustained, goal-directed activity that has direction and purpose to the emergence of individuality and the attainment of self-identity.

The addition of an intermediate stage of cooperation, derived from Sullivan, to Erikson's formulations enables us to also define a sequence in the development of *interpersonal relatedness* that evolves from the sharing of affective experiences between mother and infant (e.g., Stern, 1985; Beebe and Lachmann, 1988) with a concomitant sense of *basic trust* to a capacity for *cooperation and collaboration* with peers to the evolution of a *close friendship* with a same-sex chum (Sullivan, 1940, 1953) to the development of mutual, reciprocal, enduring *intimacy.*

This broadened Eriksonian model also enables us to articulate the potential dialectic transaction between relatedness and self-definition (attachment–separation or communion–agency). The evolving capacities

for autonomy, initiative, and industry in the self-definitional developmental line progress in an alternating sequence with the stages in the growth of relational capacities. For example, one needs a sense of basic trust to venture in opposition to the need-gratifying other in asserting one's autonomy and independence, and later one needs a sense of autonomy and initiative to establish cooperative and collaborative relationships with peers. Development begins with a focus on interpersonal relatedness—specifically with the stage of trust versus mistrust—before proceeding to two early self-definitional stages: autonomy versus shame and initiative versus guilt. These early expressions of self-definition are then followed by the newly identified stage of interpersonal relatedness, cooperation versus alienation, and then by two later stages of self-definition, industry versus inferiority and identity versus role diffusion. These more mature expressions of self-definition are followed by the more advanced stage of interpersonal relatedness, intimacy versus isolation, before development proceeds to two mature stages of self-definition, generativity versus stagnation and integrity versus despair (Blatt and Shichman, 1983). Though these two developmental lines interact throughout the life cycle, they also develop relatively independently from infancy through the early developmental years until adolescence, at which time the developmental task is to integrate these two developmental dimensions into the comprehensive structure Erikson called self-identity (Blatt and Blass, 1990, 1996).

Although self-identity is, as noted by Blatt and Blass (1990, 1996), partly a stage in the development of self-definition, it is also a cumulative integrative stage in which the capacity to cooperate and share with others is coordinated with a sense of individuality that has emerged from the development of autonomy, initiative, and industry—the capacity for sustained goal-directed, task-oriented, activity. Self-identity develops out of a synthesis and integration of individuality with relatedness—that is, of the internality and intentionality that develops as part of autonomy, initiative, and industry with the capacity and desire to participate in a social group. Thus, Erikson's advanced stage of self-identity involves a synthesis and integration of more mature aspects of the relatedness and self-definitional developmental lines (Blatt and Blass, 1990, 1992, 1996), and this integration is expressed in the formation of a self-identity or what other theorists have called a "self-in-relation" (Gilligan, 1982; Surrey, 1985), "ensembled individualism" (Sampson, 1985, 1988), or a sense of "we" (Klein, 1976; Emde, 1981). One can now participate fully in a relationship with appreciation of what one can uniquely contribute to as well as gain from

relationships with others, without losing one's individuality. The capacity to establish a mutual and reciprocal relationship with another is based on an appreciation that one has unique and special qualities to share with the other, based partly on a sense of self-worth, pride, and competence that has emerged during the earlier stages of the self-definitional developmental line, as well as a growing appreciation of one's own needs and limitations and of the enrichment that can occur in a reciprocal relationship.

The Polarity and Variations in Personality Organization

Well-functioning personality organization involves a relative integration of or a balance between issues of interpersonal relatedness and of self-definition. But, as Freud (1930) noted, each individual struggles with these two dimensions because they stand "in opposition to each other and mutually dispute the ground" (p. 140). Each individual, even within the normal range, places a somewhat different emphasis on each of these dimensions and this relative emphasis enables us to delineate two basic personality or character styles, each with a particular experiential mode; preferred forms of cognition, defense, and adaptation; unique aspects of interpersonal relatedness; and specific forms of object and self-representation. Freud (1930), in fact, distinguished between "the man who is predominantly erotic" and gives "first preference to his emotional relationships to other people … [and] the narcissistic man, who inclines to be self-sufficient … [and] seek[s] his main satisfactions in his internal mental processes" (pp. 83–84).

Spiegel and Spiegel (1978), influenced by Friedrich Nietzsche (1872), presented a similar distinction in their formulation of Dionysian and Apollonian personality styles. They describe Dionysians as sensitive to interpersonal issues, more distractible, intuitive, passive and dependent, emotionally naive and trusting, and focused more on feelings than ideas. They are open to and easily influenced by new ideas and others, place greater value on tactile and kinesthetic experiences, and are more action oriented. Dionysians tend to suspend critical judgment, live primarily in the present instead of the past or the future, and value affiliation and interpersonal relationships.

Apollonians, in contrast, are described by Spiegel and Spiegel as very ideational, organized, and critical; they value control and reason over emotions. They are very steady, responsible and reliable, unemotional, highly organized individuals who employ critical reason to plan for the

future. Apollonians value their own ideas, use them as a primary reference point, and seek to influence others to accept and confirm their ideas. They seek to be in control and often are very critical about the ideas of others. They are very cautious and methodical, comparing and contrasting alternatives and evaluating ideas and situations piece by piece before they arrive at a final decision and take action. They often pride themselves on being extremely responsible and are hesitant about making commitments, which, once made, they feel obligated to carry out. They are highly reliable and steadfast and often, to stick to a decision, relatively uninfluenced by others. They are concerned that things are correct and precise, and they plan logically and systematically. Spiegel and Spiegel (1978) succinctly summarize the differences between these two personalities or character styles by noting that Dionysians are oriented to and influenced by the heart, whereas Apollonians are organized and influenced by the head.

Blatt (1974) and Blatt and Shichman (1983) independently linked the fundamental polarity of relatedness and self-definition to personality organization and used the term anaclitic for the personality organization that focuses predominantly on interpersonal relatedness. The term anaclitic was taken by Freud (1905, 1915) from the Greek *anklitas*—to rest or lean on—to characterize all interpersonal relationships that derive from dependency experienced in "satisfying nonsexual drives such as hunger" or from dependency experienced initially "with a pregenital love object such as the mother" (Webster, 1960; Laplanche and Pontalis, 1974). Blatt (1974) and Blatt and Shichman (1983) used the term introjective for the personality organization primarily focused on self-definition. The term introjective was used by Freud (1917) to describe the processes whereby values, patterns of culture, motives, and restraints are assimilated into the self (e.g., made subjective), consciously or unconsciously, as guiding personal principles through learning and socialization (Webster, 1960).

Thinking in the anaclitic (or Dionysian) personality style is more figurative and focused primarily on affects and visual images. It is characterized by simultaneous, rather than sequential, processing and an emphasis on the reconciliation and synthesis of elements into an integrated cohesion, rather than a critical analysis of separate elements and details (Szumotalska, 1992). The anaclitic personality style is characterized by a predominant tendency to seek fusion, harmony, integration, and synthesis. The focus is upon personal experiences—on meanings, feelings, affects, and emotional reactions. These individuals are primarily field dependent (Witkin, 1965) and very aware of and influenced by environmental factors.

Thinking in the introjective personality style, in contrast, is much more literal, sequential, linguistic, and critical. Concerns are focused on action, overt behavior, manifest form, logic, consistency, and causality. These individuals tend to place emphasis on analysis rather than on synthesis, on the critical dissection of details and part properties rather than on achieving a total integration and an overall gestalt (Szumotalska, 1992). These individuals are predominantly field independent (Witkin et al., 1962; Witkin, 1965), thus their experiences and judgments are primarily influenced by internal, rather than environmental, factors. Extensive research (see summaries in Blatt and Zuroff, 1992; Blatt, 2004) demonstrates the validity of the distinction of anclitic (Dionysian) and introjective (Apollonian) personality styles in studies of personality differences in nonclinical samples.

The differentiation of relatedness and of self-definition as two fundamental psychological dimensions has enabled investigators from different theoretical orientations (e.g., Blatt, 1974, 1998, 2004; Blatt, D'Afflitti, and Quinlan, 1976; Arieti and Bemporad, 1978; 1980; Beck, 1983; Bowlby, 1988; Luyten, 2002; Corvelyn, Luyten, and Blatt, in press) to identify two types of depression (Blatt and Maroudas, 1992)—an anaclitic depression centered on feelings of loneliness, abandonment, and neglect and an introjective depression focused on issues of self-worth and feelings of failure and guilt (e.g., Blatt, 1974, 1998; Blatt et al., 1976; Blatt, Quinlan, Chevron, McDonald and Zuroff, 1982).

Colleagues and I (Blatt, 1974, 2004; Blatt et al., 1976; Blatt et al., 1982; Blatt, Quinlan, and Chevron, 1990) based on an integration of relational, ego psychoanalytic, and cognitive developmental perspectives, differentiated between an "anaclitic" (dependent) and an "introjective" (self-critical) depression. Anaclitic or dependent depression is characterized by feelings of loneliness, helplessness, and weakness; these individuals have intense and chronic fears of being abandoned and left unprotected and uncared for. They have deep longings to be loved, nurtured, and protected. Because of the lack of internalization of the experiences of gratification or of the qualities of individuals who provided satisfaction, others are valued primarily for the immediate care, comfort, and satisfaction they provide. Separation from others and object loss create considerable fear and apprehension and are often dealt with by denial and/or a desperate search for substitutes (Blatt, 1974). Anaclitically depressed individuals often express their depression in somatic complaints, frequently seeking the care and concern of others, including physicians. Depression in these patients is often precipitated by

object loss, and they often make suicidal gestures by overdosing on prescribed antidepressant medication (Blatt et al., 1982).

Introjective or self-critical depression, by contrast, is characterized by feelings of unworthiness, inferiority, failure, and guilt. These individuals engage in constant and harsh self-scrutiny and evaluation and have a chronic fear of criticism and of losing the approval of significant others. They strive for excessive achievement and perfection, are often highly competitive and work hard, make many demands on themselves, and often achieve a great deal, but with little lasting satisfaction. Because of their intense competitiveness, they can also be critical and attacking toward others. Through overcompensation they strive to achieve and maintain approval and recognition (Blatt, 1974, 1995a, b, 2004). This focus on issues of self-worth, self-esteem, failure, and guilt can be particularly insidious. Individuals who are highly self-critical and feel guilty and worthless are at considerable risk for serious suicide attempts (Blatt, 1974, 1995a, 1998; Blatt et al., 1982; Beck, 1983). Numerous clinical reports as well as accounts in the mass media,[2] illustrate the considerable suicidal potential of highly talented, ambitious, and very successful individuals who are plagued by a severe superego—by intense self-scrutiny, self-doubt, and self-criticism. Powerful needs to succeed and to avoid public criticism and the appearance of defect force some individuals to work incessantly to achieve and accomplish. But they are always profoundly vulnerable to the criticism of others and to their own self-scrutiny and judgment.

Arieti and Bemporad (1978, 1980), from an interpersonal perspective, distinguished two types of depression, a dominant other and a dominant goal type. When the dominant other is lost or the dominant goal is not achieved, depression can result. Arieti and Bemporad (1978) discussed two intense and basic wishes in depression: "to be passively gratified by the dominant other" and "to be reassured of one's own worth, and to be free of the burden of guilt" (p. 167). In the dominant other type of depression, the individual desires to be passively gratified by developing a relationship that is clinging, demanding, dependent, and infantile. In the dominant goal type, the individual seeks to be reassured of his or her worth and to be free of guilt by directing every effort toward a goal that has become an end in itself.

[2]Blatt (1995a) presented accounts of three very talented and successful, but highly self-critical, individuals, who committed suicide, including Vincent Foster, former White House counsel.

Congruent with these earlier psychoanalytic formulations of depression (e.g., Blatt, 1974; Blatt et al., 1976, 1982; Arieti and Bemporad, 1978, 1980), Beck (1983) from a cognitive–behavioral perspective distinguished between "sociotropic" (socially dependent) and "autonomous" types of depression. Sociotropy, according to Beck, "refers to the person's investment in positive interchange with other people … including passive–receptive wishes (acceptance, intimacy, understanding, support, guidance)" (p. 273). Highly sociotropic individuals are "particularly concerned about the possibility of being disapproved of by others, and they often try to please others and maintain their attachments" (Robins and Block, 1988, p. 848). Depression is most likely to occur in these individuals in response to perceived loss or rejection in social relationships.

Individuality (autonomy), according to Beck (1983), refers to the person's "investment in preserving and increasing his independence, mobility, and personal rights; freedom of choice, action, and expression; protection of his domain … and attaining meaningful goals" (p. 272). An autonomously depressed individual is "permeated with the theme of defeat or failure," blaming "himself continually for falling below his standards," and being "specifically self-critical for having 'defaulted' on his obligations" (p. 276). Highly autonomous, achievement-oriented individuals are very concerned about the possibility of personal failure and often try to maximize their control over the environment to reduce the probability of failure and criticism. Depression most often occurs in these individuals in response to a perceived failure to achieve or a lack of control over the environment.

Extensive empirical and clinical investigations (see Blatt and Zuroff, 1992; Luyten, 2002; Blatt, 2004) indicates consistent differences in the current as well as early life experiences of these two types of depressed individuals (Blatt and Homann, 1992) as well as major differences in their basic character style and their clinical expression of depression (Blatt, 2004; Blatt and Zuroff, 2005).

The differentiation between individuals preoccupied with issues of relatedness and with issues of self-definition has also enabled investigators to identify an empirically derived taxonomy for integrating the diversity of personality disorders described in Axis II of DSM-IV. Systematic empirical investigation of outpatients (Ouimette, Klein, Anderson, Riso, and Lizardi, 1994; Morse, Robins, and Gittes-Fox, 2002) and of inpatients (Levy et al., 1995) found that the various Axis II personality disorders can be organized into two primary configurations—one organized around issues of relatedness

and the other around issues of self-definition. Ouimette et al. and Morse et al. with outpatients, and Levy et al. with inpatients, found that Dependent, Histrionic, and Borderline Personality Disorders[3] (anaclitic patients) had significantly greater preoccupation with issues of relatedness than with issues of self-definition. Conversely, individuals with Paranoid, Schizoid, Schizotypic, Antisocial, Narcissistic, Avoidant, Obsessive– Compulsive, and Self-Defeating Personality Disorders (introjective patients) had significantly greater preoccupation with issues of self-definition than with issues of relatedness (Blatt and Levy, 1998).

Thus, the fundamental polarity of relatedness and self-definition has facilitated the differentiation of two primary configurations of psychopathology—anaclitic and introjective—based on differences between an excessive preoccupation with issues of relatedness and an excessive focus on issues of self-definition (Blatt and Shichman, 1983; Blatt, 1990, 1995b). Research (e.g., Blatt, 1992; Blatt and Ford, 1994; Blatt et al., 1995; Blatt and Shahar, 2004; Blatt and Zuroff, 2005) has demonstrated the differential role of these two forms of personality organization (anaclitic and introjective) in therapeutic process and outcome in both brief as well as in long-term, intensive treatment.

The Polarity and Psychopathology

The two developmental lines of interpersonal relatedness and self-definition develop through the life cycle, and each contributes to the shape and meaning given to psychological experiences. As discussed earlier, these developmental lines evolve in normal psychological development in a parallel and integrated form. Biological predispositions and severely disruptive environmental events, however, can interact in complex ways to

[3]Ouimette and colleagues (1994) found that BPD patients had elevated concerns on issues of both relatedness and self-definition. Blatt and Auerbach (1988), in an earlier clinical–theoretical contribution, differentiated between highly dependent borderline patients who conform to the BPD diagnosis as described in DSM, and a more overideational, introjective type of borderline patient with obsessive–compulsive and paranoid features. Blatt and Auerbach suggested that the more dependent borderline patient, who is vulnerable to profound feelings of abandonment, would have greater concerns about issues of relatedness, whereas the more overideational obsessive–paranoid borderline patient would have greater concerns about issues of more troubled and symptomatic and experience greater levels of disturbance.

disrupt this integrated developmental process and lead to defensive, markedly exaggerated, emphasis on one developmental dimension at the expense of the other. These deviations can be relatively mild as in normal character variations, as discussed above, but these deviations can also be quite extreme. The more extensive the deviation, the greater the exaggerated emphasis on one developmental line at the expense of the other, the greater the possibility of psychopathology. Exaggerated distortion of one developmental line to the neglect of the other reflects compensatory or defensive maneuvers in response to developmental disruptions. The differentiation of the two personality configurations discussed above provides the basis for considering the relationships of different types of psychopathology to exaggerations of either of the two fundamental developmental dimensions of interpersonal relatedness and self- definition.

Exaggerated and distorted preoccupation with satisfying interpersonal relations, to the neglect of the development of concepts of self, defines the psychopathologies of the anaclitic configuration—infantile and hysterical personality disorders. In contrast, exaggerated and distorted concerns about the definition of the self, at the expense of establishing meaningful interpersonal relations, defines the psychopathologies of the introjective configuration—paranoid, obsessive–compulsive, introjective–depressive, and phallic–narcissistic disorders. Psychopathological disorders within the anaclitic configuration are interrelated and share a preoccupation with intense struggles to establish satisfying interpersonal relations with feelings of trust, intimacy, cooperation, and mutuality. Because of an exaggerated emphasis upon interpersonal relatedness, the self is defined primarily in terms of quality of interpersonal experiences. Psychopathological disorders within the introjective configuration, in contrast, are interrelated in their focus on struggles to achieve and maintain a sense of self-definition, to the neglect of developing interpersonal relations. The primary preoccupation in these disorders with self-definition shapes and distorts the quality of interpersonal experiences.

Based on these distinctions, many forms of psychopathology can be clustered into two primary configurations, each containing several levels of organization that can range from more primitive to more integrated attempts to establish and maintain meaningful interpersonal relations or a consolidated self-concept. These various levels of psychopathology within the anaclitic and the introjective configurations define lines along which patients can progress or regress. Thus, an individual's difficulties can be predominantly in one or the other configuration, at a particular developmental level, and with a

differential potential to regress or progress to other developmental levels within that configuration. Thus, the various forms of psychopathology are no longer isolated, independent diseases, but rather are interrelated modes of adaptation, organized at different developmental levels within two basic configurations, predominantly preoccupied with either issues of interpersonal relations or self-definition.

Psychopathologies within the anaclitic configuration share a basic preoccupation with libidinal issues such as closeness and intimacy. These patients have a better capacity for affective bonding and a greater potential for developing meaningful interpersonal relations. Psychopathologies within the anaclitic configuration also have a similar defensive style, with a predominant use of avoidant defenses like denial, repression, and displacement. Psychopathologies in the introjective configuration share a basic focus on aggression and themes of self-definition, self-control, and self-worth. They also share a similarity in defensive style with the use of counteractive defenses like isolation, doing and undoing, intellectualization, reaction formation, introjection, identification with the aggressor, and overcompensation. Cognitive processes in the introjective configuration are more fully developed, with a greater potential for the development of logical thought. Although most forms of psychopathology are organized primarily around one configuration or the other, some patients may have predominant features from both the anaclitic and introjective dimensions, and their psychopathology could derive from both configurations (see Shahar, Blatt, and Ford, 2003, for an investigation of patients with mixed anaclitic and introjective characteristics).[4]

Disorders of the introjective configuration occur with greater frequency in men, whereas disorders of the anaclitic configurations occur with greater frequency in women. Western society appears to place more manifest emphasis on the need for self-definition for men and greater emphasis for women on the capacity for relatedness—for care, affection,

[4]Mature functioning is based on an integration or relative balance of investment in relatedness and self-definition. Most forms of psychopathology are expressions of a distorted and exaggerated preoccupation with only one of these dimensions with the relative neglect of the other dimension. An occasional patient may have marked preoccupation with both dimensions in which each of these dimensions serve as independent sources of conflict and stress. Thus, these patients with both predominant anaclitic and introjective features are often more troubled and symptomatic and experience greater levels of disturbance. Interestingly, recent evidence (Shahar et al., 2003) suggests that his "mixed" type of patient may be more responsive to therapeutic interventions.

and love. Developmental disruptions, therefore, are often expressed in males and females along the predominant psychological tasks defined by cultural expectations. But this gender difference is also a function of fundamental developmental psychological processes. Both females and males have their initial bonding to the mother, and thus a primary normative developmental task for a young girl is to maintain her primary object of identification with her mother but to shift her primary object of affection to her father. Thus, issues of relatedness are of central concern in the early development of women. The converse occurs with a young boy who normatively maintains his primary object of affection with his mother but has to normatively shift his primary object of identification to his father. Thus, issues of identification or self-definition are of central importance in the early development of men (see Chevron, Quinlan, and Blatt, 1978; Golding and Singer, 1983 for empirical evidence demonstrating this differential emphasis in females and males). Thus, it is not surprising that psychopathology in males is most often expressed in symptoms that indicate predominant struggles to consolidate their self-concept, whereas in females, psychopathology is most often expressed in predominant struggles to achieve satisfying interpersonal relatedness.[5]

Thus the fundamental polarity of relatedness and self-definition has facilitated the differentiation of two primary configurations of psychopathology—an anaclitic and an introjective configuration—based on differences between an excessive preoccupation with issues of relatedness or excessive focus on issues of self-definition (Blatt and Shichman, 1983; Blatt, 1990, 1995b). Anaclitic psychopathology involves exaggerated preoccupations with establishing and maintaining satisfying intimate relationships—with feeling loved and being able to love. Anaclitic patients are desperately concerned about trust, closeness, and the dependability of others as well as with their capacity to receive and give love and affection. The development of the self is disrupted by these intense conflicts about feeling deprived of care, affection, and love. This excessive preoccupation with establishing and maintaining satisfying interpersonal relatedness can occur at several developmental levels, in a lack of differentiation between self and other, in intense dependent attachment, to difficulties in more mature, reciprocal

[5]Smith, O'Keefe, and Jenkins (1988) found, among college students, that gender-incongruent students (i.e., anaclitic males and introjective females, but especially anaclitic males) were most vulnerable to stress. Subsequent research should be directed toward examining further differences among females and males with gender-congruent and gender-incongruent personality organization.

types of relationships. Anaclitic disorders, ranging developmentally from more to less disturbed, include nonparanoid schizophrenia, borderline personality disorder, infantile (or dependent) personality disorder, anaclitic depression, and hysterical personality disorders. Patients with these disorders use primarily avoidant defenses (e.g., withdrawal, denial, repression) to cope with psychological conflict and stress and to avoid intense erotic longings and competitive strivings because these intense feelings potentially threaten their tenuous interpersonal relations.

Introjective psychopathology involves an excessive preoccupation with issues of self at varying developmental levels that range from a basic sense of separation and differentiation from others, through concerns about autonomy and control of one's mind and body, to more internalized issues of self-worth, identity, and integrity. The development of interpersonal relations is interfered with by exaggerated struggles to establish and maintain a viable sense of self. Introjective patients are more ideational, and issues of anger and aggression, directed toward the self or others, are usually central to their difficulties. Introjective disorders, ranging developmentally from more to less severely disturbed, include paranoid schizophrenia, the overideational borderline, paranoia, obsessive–compulsive personality disorder, introjective (guilt-ridden) depression, and phallic narcissism. Patients with introjective disorders use primarily counteractive defenses (e.g., projection, rationalization, negativism, isolation, intellectualization, doing and undoing, reaction formation, and overcompensation) such that the underlying impulse and conflict are partially expressed, but in disguised form. The basic issue for introjective patients is to achieve separation, control, independence, and self-definition, and to be acknowledged, respected, and admired. Conflicts within the introjective configuration usually involve profound feelings of inadequacy, inferiority, worthlessness, guilt, and difficulty managing affect, especially anger and aggression, toward others and the self (Blatt, 1974, 1990, 1991, 1995a, b; Blatt and Shichman, 1983).

These formulations of psychopathology are different from the conventional view of psychopathology as a series of diseases defined primarily by differences in manifest symptoms, as in recent versions of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. In contrast, in these formulations, various forms of psychopathology are viewed as interrelated forms of maladaptation that occur in response to serious disruptions in various phases of normal psychological development. In this view, psychopathology occurs as a consequence of disruptions of the normal integrative, dialectic development of interpersonal relatedness and

self-definition in which individuals, as a consequence of severe disruptions of the normal developmental process, come to place exaggerated emphasis, at different developmental levels, on establishing and maintaining a defensive preoccupation with issues of either self-definition or interpersonal relatedness.

In contrast to the atheoretical DSM diagnostic scheme based primarily on differences in manifest symptoms, the anaclitic–introjective (or relational–self-definitional) distinctions of psychopathology derive from dynamic considerations including differences in instinctual focus (libidinal versus aggressive), types of defensive organization (avoidant versus counteractive), and predominant character style (e.g., emphasis on an object versus a self-orientation and on affects versus cognition). Thus, various forms of psychopathology are no longer considered as discrete diseases but as interrelated disturbances that are the consequence of disruptions of normal psychological development. Continuity is thus maintained in these theoretical formulations among normal psychological development, variations in normal character or personality organization, and among different forms of psychological disturbance. Even further, continuity is maintained within clusters of various disorders so that pathways of potential regression and progression as well as the nature of therapeutic change can be understood more fully. This view of psychopathology has important consequences for understanding aspects of the therapeutic process.

The Polarity and the Therapeutic Process

Several prominent research methodologists (e.g., Cronbach, 1953) for many years have noted that much of the difficulty in identifying significant differences among different types of therapeutic intervention may be a function of the assumption of a "homogeneity" of patients (Kiesler, 1966) in which no differentiations are made among patients, assuming all patients are equivalent at the beginning of treatment (Blatt and Felsen, 1995). The failure to differentiate effectively among patients limits a study's potential to address more complex questions like whether certain treatments are more effective with certain kinds of patients, possibly resulting in different kinds of change (Blatt, Shahar, and Zuroff, 2001, 2002).

Consistent with the long-standing call by Cronbach (e.g., 1953) and others (e.g., Colby, 1964; Kiesler, 1966; Beutler, 1976, 1979) to introduce patient differences into psychotherapy research, Blatt and colleagues introduced the anaclitic–introjective distinction into the evaluation of data

from two major studies of long-term, intensive, psychodynamically oriented treatment—in outpatients in the Menninger Psychotherapy Research Project (MPRP) and in inpatients at the Austen Riggs Center (the Riggs-Yale Project [R-YP]), as well as in analyses of data from an extensive study of the brief outpatient treatment of major depression (the NIMH-sponsored Treatment for Depression Collaborative Research Program [TDCRP]). In the study of long-term intensive treatment in the MPRP and the R-YP, experienced clinical judges were able to reliably differentiate between anaclitic and introjective patients based on clinical case records prepared at the outset of treatment (see Blatt et al., 1988; Blatt, 1992; Blatt and Ford, 1994).

Blatt and colleagues (Blatt; 1992; Blatt and Shahar, 2004; Shahar and Blatt, 2004) introduced the distinction between anaclitic and introjective patients into the comparison of psychoanalysis (PSA) with supportive–expressive psychotherapy (SEP) in the MPRP and found significant treatment differences as a function of patients' pretreatment personality structure. The results indicated that SEP was significantly more effective than PSA in reducing the intensity of maladaptive object representation, but only with anaclitic patients, whereas PSA was significantly more effective than SEP in facilitating both the reduction of maladaptive object representation in introjective patients as well as the development of more adaptive object representation in both anaclitic and introjective patients. These results indicate that PSA is unique in its facilitation of the development of adaptive capacities and that both forms of treatment (PSA and SEP) are effective in reducing maladaptive tendencies but with different types of patients. Overall, introjective patients in the MPRP showed significantly greater clinical improvement than anaclitic patients in the MPRP, independent of the type of treatment (Blatt, 1992; Blatt and Shahar, 2004).

These findings are consistent with findings from the study of long-term, intensive, psychodynamically oriented inpatient treatment in the R-YP (Blatt et al., 1988; Blatt and Ford, 1994) in which seriously disturbed, treatment-resistant, introjective patients had greater improvement than anaclitic patients as evaluated on a number of assessment procedures that were based on ratings of independently prepared clinical case records and psychological test protocols. Ratings made at the outset of treatment and again much later in the treatment process on these two independent sources of evaluation indicated that therapeutic change (progression and regression) in anaclitic and introjective patients occurred primarily in congruent modalities; that is, therapeutic change was most consistently

expressed in introjective patients in changes in their manifest symptoms, as reliably rated from their clinical case records, and in the efficacy of their cognitive processes, as assessed by changes in intelligence and the level of thought disorder in the psychological test protocols. Therapeutic change in anaclitic patients, in contrast, was most consistently indicated by changes in their interpersonal relationships, as reported in the clinical case records and in the quality of their representations of human figures on the Rorschach. Thus, anaclitic and introjective patients expressed therapeutic change in the modalities that were most relevant to their psychopathology and their basic character structure.

These findings of constructive therapeutic gain, especially with introjective patients in long-term psychodynamic treatment of inpatients in the R-YP and of outpatients in the MPRP are consistent with the findings of Fonagy et al. (1996) and with the conclusions by Gabbard and colleagues (1994) about the constructive response of introjective borderline patients to long-term, insight oriented, psychodynamic treatment. Thus, findings from several studies indicate that long-term, intensive, psychodynamic treatment is effective, especially with introjective patients.

The constructive response of introjective patients to long-term psychodynamic treatment in the MPRP and the R-YP stand in contrast to findings in our analyses (e.g., Blatt, Quinlan et al., 1995; Blatt et al., 1996) of data from the extensive study of brief (16 weeks of once weekly) outpatient treatment for severe depression in the NIMH-sponsored Treatment of Depression Collaborative Research Program (TDCRP), a carefully designed randomized clinical trial that compared three manually directed brief outpatient treatments for depression: Cognitive–Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Imipramine with clinical management (IMI-CM) with a double blind, passive placebo with clinical management (PLA-CM). While IMI-CM resulted in a significantly more rapid reduction of symptoms at midtreatment (after 8 weeks) than the other treatments (Elkin et al. 1995), no differences were found in the level of symptom reduction among the three active treatment conditions at termination (Elkin et al., 1985; Elkin et al., 1989; Elkin, 1994) or at a follow-up evaluation conducted 18 months after the termination of treatment (Shea et al., 1992; Blatt et al., 2000).

It was difficult to introduce the anaclitic–introjective distinction into the TDCRP based on the initial clinical intake evaluation because these very brief clinical case reports focused primarily on the neurovegatative symptoms of depression rather than experiential aspects of the patients' lives. Fortunately,

however, patients in the TDCRP had been administered the Dysfunctional Attitudes Scale (DAS; Weissman and Beck, 1978), which comprises two primary factors: Need for Approval and Perfectionism (e.g., Oliver and Baumgart, 1985; Cane et al., 1986), which are respectively closely related to measures of anaclitic and introjective dimensions of depression (e.g., Blaney and Kutcher, 1991; Enns and Cox, 1999; Dunkley and Blankstein, 2000; Powers, Zuroff, and Topciu, 2004). Thus, the anaclitic–introjective distinction was introduced into analyses of data from the TDCRP using patients' pretreatment scores on the two factors of the DAS.

In contrast to the lack of significant differences in symptom reduction at termination and follow-up among the three active treatments in the TDCRP, analyses of the TDCRP data, based on the introduction of patients' pretreatment characteristics into the data analyses, revealed a host of significant findings indicating that patients' personality characteristics have a major effect on treatment outcome and on aspects of the therapeutic process (Blatt et al., 1995; Blatt et al., 1996; Blatt et al., 1998; Zuroff et al., 2000; Blatt et al., 2001; Shahar et al., 2003; Shahar et al., 2004). Specifically, these analyses indicate that patients' pretreatment levels of perfectionism or self-criticism (i.e., an introjective personality organization) resulted in poorer therapeutic outcome at termination and at follow-up in all three forms of brief treatments for depression evaluated in this extensive investigation. In addition, these analyses indicated that the introjective personality dimension interfered with therapeutic progress primarily in the second half of the treatment process (in the last 8 weeks) by disrupting patients' development of interpersonal relationships both within and external to the treatment process (Zuroff, Blatt et al., 2000; Shahar et al., 2004; Zuroff and Blatt, in review). Thus, introjective patients appear not to benefit extensively from brief treatment in the TDCRP or from long-term SEP in the MPRP but appear to be particularly responsive to long-term, intensive, dynamically oriented treatment, including psychoanalysis, in the MPRR and the R-YP.

Taken together, these findings from the study of long-term intensive, psychodynamic treatment in the MPRP and the R-YP, as well as the results from analyses of data from the brief outpatient treatment of severe depression in the TDCRP, provide strong confirmation of Cronbach's (e.g., 1953) formulations that pretreatment characteristics of patients are important dimensions that influence therapeutic response (Blatt and Felsen, 1993). This mounting evidence of the crucial role of patients' pretreatment characteristics reflect a major shift in psychotherapy research in which data analyses are now going beyond the comparison of two

forms of treatment for the reduction of a particular symptom (e.g., depression or anxiety) and are beginning to address more complex questions like what types of treatment are more effective, in what kinds of ways, with which types of patients (Blatt et al., 2002).

Findings from our further analyses of data from the MPRP and the R-YP also indicate that introjective patients do better in PSA and that anaclitic patients do better in SEP, possibly because these two types of treatment have a differential effect on associative activity (Blatt and Shahar, 2004; Fertuck et al., 2004) Affectively labile, emotionally overwhelmed, anaclitic patients, who usually have a preoccupied insecure attachment style, do better in SEP because it contains their affective lability, possibly by reducing their associative activity. Introjective patients, who usually have an avoidant or dismissive attachment style, make significantly greater progress in treatment if they have more referential activity (Fertuck et al., 2004) and if they are in intensive long-term psychoanalytically oriented treatment (Blatt and Ford, 1994; Fonagy et al., 1996) that helps them overcome their interpersonal and emotional detachment (Mallinckrodt, Gantt, and Coble, 1995; Eames and Roth, 2000; Meyer et al., 2001) through interpretations (Hardy et al., 1999). Emotionally and interpersonally detached introjective patients do better in PSA than in psychotherapy because PSA appears to liberate their associative processes.

These findings from the MPRP, R-YP, and TDCRP provide considerable support for the call by Cronbach many years ago to include patient variables in studies of psychotherapy process and outcome. These findings suggest that we may be ready to begin to address more complex questions in treatment research like what kind of treatment is best for what kind of patient and with what kind of therapist, leading to what kinds of therapeutic change. Our findings indicate that PSA and SEP are different types of therapeutic interventions that involve different mechanisms of therapeutic change and are differentially effective, sometimes in different ways, with different types of patients (Blatt and Shahar, 2004).

Summary

The polarity of relatedness and self-definition, fundamental to the development of psychoanalytic theory and consistent with a number of other approaches to personality theory, provided the basis for articulating aspects of personality development, variations in normal personality organization,

the organization of a wide-range of psychopathology, and aspects of the therapeutic process in both short- and long-term intensive treatment. The contributions of this fundamental polarity to these various aspects of personality theory—from understanding normal development to clinical interventions—speak to the validity of this theoretical model and the importance of the fundamental polarity of relatedness and self-definition. The formulations and findings discussed in this paper indicate that there is much to be gained by going beyond the symptom focus of contemporary diagnostic nosology, presented in the DSM manuals, and seeking instead to identify underlying principles of personality organization. The polarity of relatedness and self-definition appears to be one of these underlying principles through which we can understand more fully normal psychological development, the etiology of psychological disturbances, as well as the nature of the mutative processes in psychotherapeutic interventions.

Acknowledgment

This article derives from a book in preparation tentatively titled *Relatedness and Self-Definition: Fundamental Dimensions of Personality Development, Psychopathology, and the Therapeutic Process.*

REFERENCES

Arieti, S., & Bemporad, J. R. (1978), *Severe and Mild Depression: The Therapeutic Approach.* New York: Basic.

_____ & _____ (1980), The psychological organization of depression. *Amer. J. Psychiat.,* 137:1360–1365.

Beck, A. T. (1983), Cognitive therapy of depression: New perspectives. In: *Treatment of Depression: Old Controversies and New Approaches,* ed. P. J. Clayton & J. E. Barrett. New York: Raven, pp. 265–290.

Beebe, B., & Lachmann, F. M. (1988), The contribution of the mother–infant mutual influence to the origins of self- and object representations. *Psychoanal. Psychol.,* 5:305–338.

Behrends, R. S., & Blatt, S. J. (1985), Internalization and psychological development throughout the life cycle. *Psychoanal. Study Child,* 40:11–39.

Beutler, L. E. (1976), *Psychotherapy: When What Works with Whom.* Paper presented at the meeting of the Society for Psychotherapy Research, June, San Diego, CA.

_____ (1979), Toward specific psychological therapies for specific conditions. *J. Consult. Clin. Psychol.,* 47:882–897.

Blaney, P. H., & Kutcher, G. S. (1991), Measures of depressive dimensions: Are they interchangeable? *J. Personal. Assess.,* 56:502–512.

Blatt, S. J. (1974), Levels of object representation in anaclitic and introjective depression. *Psychoanal. Study Child,* 29:107–157.

_____ (1990), Interpersonal relatedness and self-definition: Two personality configurations and their implications for psychopathology and psychotherapy. In: *Repression and Dissociation: Implications for Personality Theory, Psychopathology & Health,* ed. J. L. Singer. Chicago: University of Chicago Press, pp. 299–335.

_____ (1991), A cognitive morphology of psychopathology. *J. Nervous Mental Disease,* 179:449–458.

_____ (1992), The differential effect of psychotherapy and psychoanalysis on anaclitic and introjective patients: The Menninger Psychotherapy Research Project revisited. *J. Amer. Psychoanal. Assn.,* 40:691–724.

_____ (1995a), The destructiveness of perfectionism: Implications for the treatment of depression. *Amer. Psychol.,* 50:1003–1020.

_____ (1995b), Representational structures in psychopathology. In: *Rochester Symposium on Developmental Psychopathology, Vol. 6: Emotion, Cognition, and Representation,* ed. D. Cicchetti & S. Toth. Rochester, New York: University of Rochester Press, pp. 1–33.

_____ (1998), Contributions of psychoanalysis to the understanding and treatment of depression. *J. Amer. Psychoanal. Assn.,* 46:723–752.

_____ (2004), *Experiences of Depression: Theoretical, Clinical and Research Perspectives.* Washington, DC: American Psychological Association.

_____ & Auerbach, J. S. (1988), Differential cognitive disturbances in three types of "borderline" patients. *J. Personality Disorders,* 2:198–211.

_____ & Behrends, R. S. (1987), Internalization, separation–individuation, and the nature of therapeutic action. *Internat. J. Psychoanal.,* 68:279–297.

_____ & Blass, R. B. (1990), Attachment and separateness: A dialectic model of the products and processes of psychological development. *Psychoanal. Study Child,* 45:107–127.

_____ & _____ (1992), Relatedness and self-definition: Two primary dimensions in personality development, psychopathology, and psychotherapy. In: *The Interface of Psychoanalysis and Psychology,* ed. J. Barron, M. Eagle, & D. Wolitsky. Washington, DC: The American Psychological Association, pp. 399–428.

_____ & _____ (1996), Relatedness and self definition: A dialectic model of personality development. In: *Development and Vulnerabilities in Close Relationships,* ed. G. G. Noam & K. W. Fischer. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc. pp. 309–338.

_____ D'Afflitti, J. P., & Quinlan, D. M. (1976), Experiences of depression in normal young adults. *J. Abnormal Psychol.,* 85:383–389.

_____ & Felsen, I. (1993), "Different kinds of folks may need different kinds of strokes": The effect of patients' characteristics on therapeutic process and outcome. *Psychother. Res.* 3:245–259.

_____ & Ford, R. (1994), *Therapeutic Change: An Object Relations Perspective.* New York: Plenum.

_____ _____ Berman, W., Cook, B., & Meyer, R. (1988), The assessment of change during the intensive treatment of borderline and schizophrenic young adults. *Psychoanal. Psychol.,* 5:127–158.

_____ & Homann, E. (1992), Parent–child interaction in the etiology of dependent and self-critical depression. *Clin. Psychol. Rev.,* 12:47–91.

_____ & Levy, K. N. (1998), A psychodynamic approach to the diagnosis of psychopathology. In: *Making Diagnosis Meaningful,* ed. J. W. Barron. Washington, DC: American Psychological Association Press, pp. 73–109.

_____ & Maroudas, C. (1992), Convergence of psychoanalytic and cognitive behavioral theories of depression, *Psychoanal. Psychol.,* 9:157–190.

_____ Quinlan, D. M., & Chevron, E. (1990), Empirical investigations of a psychoanalytic theory of depression. In: *Empirical Studies of Psychoanalytic Theories, Vol. 3.* ed. J. Masling. Hillsdale, NJ: Analytic Press, pp. 89–147.

_____ _____ Chevron, E. S. McDonald, C., & Zuroff, D. (1982), Dependency and self-criticism: Psychological dimensions of depression. *J. Consulting Clin. Psychol.,* 50:113–124.

_____ _____ Pilkonis, P. A., & Shea, T. (1995), Impact of perfectionism and need for approval on the brief treatment of depression: The National Institute of Mental Health Treatment of Depression Collaborative Research Program revisited. *J. Consulting Clin. Psychol.,* 63:125–132.

_____ & Shahar, G. (2004), Psychoanalysis: For what, with whom, and how: A comparison with psychotherapy. *J. Amer. Psychoanal. Assn.,* 52:393–447.

_____ _____ & Zuroff, D. C. (2001), Anaclitic (sociotropic) and introjective (autonomous) dimensions. *Psychotherapy,* 38:449–454.

_____ _____ & _____ (2002), Anaclitic (sociotropic) and introjective (autonomous) dimensions. In: *Psychotherapy Relationships That work: Therapist Contributions and Responsiveness to Patients,* ed. John C. Norcross. New York: Oxford University Press, pp. 306–324.

_____ & Shichman, S. (1983), Two primary configurations of psychopathology. *Psychoanal. Contemp. Thought,* 6:187–254.

_____ & Zuroff, D. C. (1992), Interpersonal relatedness and self-definition: Two prototypes for depression. *Clin. Psychol. Rev.,* 12:527–562.

_____ & _____ (2005), Empirical evaluation of the assumptions in the identification of evidence based treatments. *Clin. Psychol. Rev.,* 25:459–486.

_____ _____ Bondi, C. M., & Sanislow, C. A. (2000), Short and long-term effects of medication and psychotherapy in the brief treatment of depression: Further analyses of data from the NIMH TDCRP. *Psychother. Res.,* 10:215–234.

_____ _____ _____ _____ & Pilkonis, P. A. (1998), When and how perfectionism impedes the brief treatment of depression: Further analyses of the NIMH TDCRP. *J. Consul. Clin. Psychol.,* 66:423–428.

_____ _____ Quinlan, D. M., & Pilkonis, P. A. (1996), Interpersonal factors in brief treatment of depression: Further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *J. Consult. Clin. Psychol.,* 64:162–171.

Bowlby, J. (1988), *A Secure Base: Clinical Applications of Attachment Theory.* London: Routledge & Kegan Paul.

Buber, M. (1970), *I and Thou,* 3rd ed. trans. W. Kaufmann. New York: Scribners.

Cane, D. B., Olinger, L. J., Gotlib, I. H., & Kuiper, N. A. (1986), Factor structure of the Dysfunctional Attitude Scale in a student population. *J. Clin. Psychol.,* 42:307–309.

Chevron, E. S., Quinlan, D. M., & Blatt, S. J. (1978), Sex roles and gender differences in the experience of depression. *J. Abnormal Psychol.,* 87:680–683.

Colby, K. M. (1964), Psychotherapeutic processes. *Annual Rev. Psychol.,* 15:347–370.

Corveleyn, J., Luyten, P., & Blatt, S. J., eds. (in press), *Theory and Treatment of Depression: Towards Integration?* Leuven, Belgium: Leuven University Press.

Cronbach, L. J. (1953), Correlation between persons as a research tool. In: *Psychotherapy: Theory and Research,* ed. O. H. Mowrer. New York: Ronald, pp. 376–389.

Dunkley, D. M., & Blankstein, K. R. (2000), Self-critical perfectionism, coping, hassles, and current distress: A structural equation modeling approach. *Cognitive Therapy Research,* 24:713–730.

Eames, V., & Roth, A. (2000), Patient attachment orientation and the early working alliance: A study of patient and therapist reports of alliance quality and ruptures. *Psychother. Res.,* 10:421–434.

Elkin, I. (1994), The NIMH Treatment of Depression Collaborative Research Program: Where we began and where we are now. In: *Handbook of Psychotherapy and Behavior Change,* 4th ed., ed. A. E. Bergin & S. L. Garfield. New York: Wiley, pp. 114–135.

_____ Gibbons, R. D., Shea, M. T., Sotsky, S. M., Watkins, J. T., Pilkonis, P. A., & Hedeker, D. (1995), Initial severity and differential treatment outcome in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *J. Consult. Clin. Psychol.,* 63:841–847.

_____ Parloff, M. B., Hadley, S. W., & Autry, J. H. (1985), NIMH Treatment of Depression Collaborative Research Program: Background and research plan. *Arch. Gen. Psychiat.,* 42:305–316.

_____ Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., Glass, D. R., Pilkonis, P. A., Leber, W. R., Dockerty, J. P., Fiester, S. J., & Parloff, M. B. (1989), NIMH Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Arch. Gen. Psychiat.,* 46:971–983.

Emde, R. N. (1981), Changing models of infancy and the nature of early development. *J. Amer. Psychoanal. Assn.,* 29:179–220.

Enns, M. W., & Cox, B. J. (1999), Perfectionism and depressive symptom severity in major depressive disorder. *Behavioral Research Therapy,* 37:783–794.

Erikson, E. H. (1963), *Childhood and Society,* 2nd ed. New York: Norton.

Fertuck, E., Bucci, W., Blatt, S. J., & Ford, R. Q. (2004). Verbal representation and therapeutic change in anaclitic and introjective patients. *Psychother. Theory Prac. Res. Training,* 41:13–25.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M., & Gerber, A. (1996), The relation of attachment status, psychiatric classification, and response to psychotherapy. *J. Consul. Clin. Psychol.,* 64:22–31.

Freud, S. (1905), Three essays on the theory of sexuality. *Standard Edition,* 7:123–243. London: Hogarth Press, 1953.

_____ (1914), On narcissism. *Standard Edition,* 14:67–102. London: Hogarth Press, 1957.

_____ (1915), Instincts and their vicissitudes. *Standard Edition,* 14:109–140. London: Hogarth Press, 1957.

_____ (1917), Mourning and melancholia. *Standard Edition*, 14:243–258. London: Hogarth Press, 1957.

_____ (1923), The ego and the id. *Standard Edition,* 19:12–66. London: Hogarth Press, 1961.

_____ (1926), Inhibitions, symptoms and anxiety. *Standard Edition,* 20:87–174. London: Hogarth Press, 1959.

_____ (1930), Civilization and its discontents. *Standard Edition*, 21:64–145. London: Hogarth Press, 1961.

Gabbard, G. O., Horowitz, L., Allen, J. G., Frieswyk, S., Newson, G., Colson, D. B., & Coyne, L. (1994), Transference interpretation in the psychotherapy of borderline patients: A high-risk, high-gain phenomenon. *Harvard Review of Psychiatry,* 2:59–69.

Gilligan, C. (1982), *In a Different Voice.* Cambridge, MA: Harvard University Press.

Golding, J. M., & Singer, J. L. (1983), Patterns of inner experience: Daydreaming styles, depressive moods, and sex roles. *J. Personal. Soc. Psychol.,* 45:663–675.

Hardy, G. E., Aldridge, J., Davidson, C., Rowe, C., Reilly, S., & Shapiro, D. (1999), Therapist responsiveness to patient attachment styles and issues observed inpatient-identified significant events in psychodynamic–interpersonal psychotherapy. *Psychother. Res.,* 9:36–53.

Kiesler, D. J. (1966), Some myths of psychotherapy research and the search for a paradigm. *Psychol. Bulletin,* 65:110–136.

Klein, G. S. (1976), *Psychoanalytic Theory.* New York: International University Press.

Laplanche, J., & Pontalis, J. B. (1974), *The Language of Psycho-Analysis,* trans. D. Micholson-Smith. New York: Norton.

Levy, K. N., Edell, W. S., Blatt, S. J., Becker, D. F., Quinlan, D. M., Kolligan, J., & McGlashan, T. H. (1995), Two configurations of psychopathology: The relationship of dependency, anaclitic neediness, and self-criticism to personality pathology. Unpublished manuscript.

Loewald, H. W. (1962), Internalization, separation, mourning, and the superego. *Psychoanal. Quart.,* 31:483–504.

Luyten, P. (2002), *Normbesef en depressie: Aanzet tot een integratief theoretisch kader en een empirisch onderzoek aan de hand van de depressietheorie van S. J. Blatt* [Personal standards and depression: An integrative psychodynamic framework, and an empirical investigation of S. J. Blatt's theory of depression]. Unpublished doctoral dissertation, University of Leuven, Leuven, Belgium.

Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995), Attachment patterns in the psychotherapy relationship: Development of the Patient Attachment to Therapist Scale. *J. Counsel. Psychol.,* 42:307–317.

Meyer, B., Pilkonis, P. A., Proietti, J. M., Heape, C. L., & Egan, M. (2001), Attachment styles, personality disorders, and response to treatment. *J. Personality Disorder,* 15:371–389.

Morse, J. Q., Robins, C. J., & Gittes-Fox, M. (2002), Sociotropy, autonomy, and personality disorder criteria in psychiatric patients. *J. Personality Disorders,* 16:549–560.

Nietzsche, F. (1872/1972), *The Birth of Tragedy.* Berlin: Walter de Gruyter.

Oliver, J. M., & Baumgart, B. P. (1985), The Dysfunctional Attitude Scale: Psychometric properties in an unselected adult population. *Cognitive Theory Research,* 9:161–169.

Ouimette, P. C., Klein, D. N., Anderson, R., Riso, L. P., & Lizardi, H. (1994), Relationship of sociotropy/autonomy and dependency/self-criticism to DSM-III-R personality disorders. *J. Abnormal Psychol.,* 103:743–749.

Powers, T. A, Zuroff, D. C., & Topciu, R. A. (2004), Covert and overt expressions of self-criticism and perfectionism and their relation to depression. *European J. Personality,* 18:61–72.

Robins, C. J., & Block, P. (1988), Personal vulnerability, life events, and depressive symptoms: A test of a specific interactional model. *J. Personal. Soc. Psychol.,* 54:847–852.

Sampson, E. E. (1985), The decentralization of identity: Toward a revised concept of personal and social order. *Amer. Psychol.,* 40:1203–1211.

_____ (1988), The debate on individualism: Indigenous psychologies of the individual and their role in personal and societal functioning. *Amer. Psychol.,* 43:15–22.

Shahar, G., & Blatt, S. J. (2004), Benevolent interpersonal schemas enhance outcome in long term psychotherapy. Manuscript under review.

_____ _____ & Ford, R. Q. (2003), The identification of mixed anaclitic–introjective psychopathology in young adult inpatients. *Psychoanal. Psychol.,* 20:84–102.

_____ _____ Zuroff, D. C., Krupnick, J., & Sotsky, S. M. (2004), Perfectionism impedes social relations and response to brief treatment of depression. *J. Soc. Clin. Psychol.,* 23:140–154.

_____ _____ _____ & Pilkonis, P. A. (2003), Role of perfectionism and personality disorder features in response to brief treatment for depression. *J. Consult. Clin. Psychol.,* 71:229–233.

Shea, M. T., Elkin, I., Imber, S. D., Sotsky, S. M., Watkins, J. T., Collins, J. F., Pilkonis, P. A., Beckham, E., Glass, D. R., Dolan, R. T., & Parloff, M. B. (1992), Course of depressive symptoms over follow-up: Findings from the National Institute of Mental Health treatment of depression collaborative research program. *Arch. Gen. Psychiat.,* 49:782–787.

Smith, T. W., O'Keefe, J. C., & Jenkins, M. (1988), Dependency and self-criticism: Correlates of depression or moderators of the effects of stressful events? *J. Personality Disorders,* 2:160–169.

Spiegel, H., & Spiegel, D. (1978), *Trance and Treatment: Clinical Uses of Hypnosis.* New York: Basic Books.

Stern, D. N. (1985), *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology.* New York: Basic.

Sullivan, H. S. (1940), *Concepts of Modern Psychiatry.* New York: Norton.

_____ (1953), *The Intepersonal Theory of Psychiatry.* New York: Norton.

Surrey, J. L. (1985), Self-in-relation: A theory of women's development. Unpublished manuscript, Stone Center for Developmental Services and Studies, Wellesley College, Wellesley, MA.

Szumatolska, E. (1992), *Severity and Type of Depressive Affect As Related to Perceptual Styles: Relationship of Anaclitic Versus Introjective Depressive Configuration to Holistic Versus Analytic Similarity Judgment.* Unpublished doctoral dissertation, New School for Social Research, New York, NY.

Webster, N. (1960), *Third New International Dictionary.* Springfield, MA: Merriam.

Weissman, A. N., & Beck, A. T. (1978, August-September), *Development and Validation of the Dysfunctional Attitudes Scale: A Preliminary Investigation.* Paper presented at the 86th Annual Convention of the American Psychological Association, Toronto.

Witkin, H. A. (1965), Psychological differentiation and forms of pathology. *J. Abnormal Psychol.,* 70:317–336.

_____ Dyk, R. B., Faterson, H. I., Goodenough, D. R., & Karp, S. A. (1962), *Psychological Differentiation.* New York: Wiley.

Zuroff, D. C., & Blatt, S. J. (in review), Brief treatment of depression: Contributions of the therapeutic relationship to clinical improvement, reduced vulnerability, and enhanced resilience.

_____ _____ Sotsky, S. M., Krupnick, J. L., Martin, D. J., Sanislow, C. A., & Simmens, S. (2000), Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment of depression. *J. Consult. Clin. Psychol.,* 68:114–124.

Department of Psychiatry
Yale University
25 Park Street, Room 613
New Haven, CT 06519–1110
Sidney.blatt@yale.edu