The Psychoanalytic Model of the Mind

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Core Dimensions of Psychoanalytic Models of the Mind

This chapter defines five core dimensions emphasized in all psychoanalytic models of the mind: topography, motivation, structure/process, development, and psychopathology/treatment. It also provides a quick tour of four leading psychoanalytic models of mental functioning: the Topographic Model, the Structural Model, Object Relations Theory, and Self Psychology. The reader is introduced to the basic outline of the book, which is organized around a chart showing how each psychoanalytic model conceptualizes each of the core dimensions of mental functioning and psychopathology/treatment. The goal of the book is to work toward a unified psychoanalytic model of the mind. Vocabulary introduced in this chapter includes the following: *adaptational perspective, developmental lines, developmental point of view, epigenesis, genetic perspective, hedonic principle, motivational/dynamic point of view, nature and nurture, pleasure/unpleasure principle, reality principle, structural point of view,* and *topographic point of view.*

In Chapter 2, we described how Freud arrived at the concept of the dynamic unconscious, the foundation for the psychoanalytic model of the mind. In Chapter 3, we discussed the concept of the unconscious in greater depth, exploring how we experience aspects of unconscious mental functioning in moments of ordinary introspection, how philos-

ophers and psychologist throughout history thought about the unconscious, how contemporary psychologists think about it, and finally why, in the face of so much evidence, many continue to deny the possibility of unconscious mental functioning. The idea that hidden motivational forces—feelings, thoughts, memories, wishes, fears, fantasies, and patterns of personal meaning that are kept out of awareness because they are unacceptable—continuously influence our experience and behavior is a basic feature of the psychoanalytic model of the mind that, as we will see, is central to the topographic point of view. At the same time, there are four other basic features of all psychoanalytic attempts to model the mind, bringing the total to five. We begin this chapter by delineating these five key domains of the mind.

Key Domains of Mental Functioning

All psychoanalytic models of the mind will have much to say about the domains of topography, motivation, structure/process, development, and psychopathology/treatment. The first four of these are fundamental dimensions that any model of the mind must take into account. The last is a dual category that each model must formulate in depth in order to be useful to patients. On some occasions, these basic aspects of mental life are referred to as *points of view* (Rapaport and Gill 1959). By providing a strategy for reframing observations about mental life in terms of general principles, these five key domains allow the clinician to turn information about the patient into knowledge about the patient's mind and, ultimately, about his or her suffering. Delineating the core dimensions of the mind makes the psychoanalytic model of the mind easier to understand, easier to integrate, and easier to use in the task of helping patients.

Topography

The notion that the mind, whether normal or pathological, is always divided into conscious and unconscious parts is often called the *topographic point of view.* Descriptions of the mind's topography—or what is conscious and what is unconscious—are part of every psychoanalytic model of the mind. Because the topographic point of view is so fundamental, we list it first among the basic features of the psychoanalytic model of the mind. As we will see, the earliest psychoanalytic model of the mind was itself called the Topographic Model (Freud 1900/1962). This early model relied heavily on the topographic point of view of mental functioning but included the other four points of view as well.

Motivation

Motivation is the second feature shared by all psychoanalytic models of the mind. *Motivation* is another word for the impetus for mental and/or physical activity. It may take the form of needs, fears, wishes, purposes, and intentions. In the psychoanalytic model of the mind, the search to understand motivation is called the *dynamic* or *motivational point of view.* Put simply, the motivational point of view addresses the question "Why do people do what they do?" or "What makes people tick?" The motivational point of view is almost as important as the topographic point of view in the evolution of the psychoanalytic model of the mind. As we have seen, inherent in the concept of dynamic unconscious is the idea that behavior results from an interaction of two motivational forces—a wish to express unconscious mental content and a wish to keep this content hidden. In other words, mental content can be unconscious because we do not want to know about it, or "from the motive of defense" (Breuer and Freud 1893/1895/1962, p. 285).

There is ongoing debate within psychoanalysis about the basic nature of human motivation. We will explore this debate further in each successive chapter of the book. Nevertheless, despite differences, there are several aspects of the theory of motivation about which most psychoanalysts agree. First, in contrast to the case in behaviorism or social learning theory, in the psychoanalytic model, **experience and action are understood as being motivated from within the mind.** In other words, behavior is not simply a collection of responses to stimuli from the external world. The mind is viewed as capable of spontaneous activity and is not merely reactive to the environment. Indeed, as we shall see, when Freud abandoned his *seduction hypothesis* in favor of a view of motivation as arising from within the mind of the child, psychoanalysis became increasingly committed to the study of internal mental life (see Chapter 7, "The Oedipus Complex"). In any case, whether motivation is seen as originating from biological imperatives or from the internalization of cultural mandates, in the psychoanalytic model, motivation always has a mental component that plays a causal role in determining behavior.

Second, in addition to seeing motivation as originating in the mind, **the psychoanalytic model sees motivation as guided by the *pleasure/unpleasure principle.*** This principle asserts that behavior and mental activity always seek to maximize feelings of pleasure and to escape from feelings of unpleasure or pain. In general psychology, this principle is known as the *hedonic principle* (Schacter et al. 2011, p. 326). The history of psychoanalysis can be told as a long argument about the nature of the basic pleasures that guide human mental life. For example, Freud

emphasized the pleasure that accompanies the satisfaction of sexual and aggressive drives, and he saw all other pleasures as transformations of these more basic pleasures (see Chapter 9, "The Id and the Superego," for an exploration of drive theory). Other theorists have pointed to the pleasures inherent in attachment, dependency, and feelings of safety, arguing that these satisfactions cannot be reduced to those already mentioned (see Chapter 11, "Object Relations Theory"). Still other theorists have emphasized the pleasures that accompany autonomy, mastery, and self-actualization (see Chapter 12, "Self Psychology"). Despite this ongoing debate, most psychodynamic psychiatrists agree that the pleasure/unpleasure principle provides the basic compass that guides human behavior. The pleasure principle is not unique to the psychoanalytic model; it forms the basis of many kinds of psychology. However, by keeping this principle in awareness, clinicians can understand even the most painful behavior as serving a hidden pleasure, or as defending against even worse pain.

Third, **the psychoanalytic model of the mind takes into account the fact that motivation develops in an interaction between the mind and the external environment.** In other words, the mind operates according to the *reality principle* in addition to the pleasure principle. The search within the psychoanalytic model to understand those aspects of individual human behavior and mental life that represent efforts to cope with the reality of the external world is called the *adaptational perspective*. Because the psychoanalytic model of the mind understands motivation as both originating within the organism and adapted to the environment, it is able to consider both internal and external factors in the development of human desire. Much debate within psychoanalysis focuses on the relative emphasis placed on internal versus external contributors to motivation. For example, Freud conceptualized basic motivations as derivatives of biologically rooted drives that unfold in a largely predetermined maturational sequence. Other theorists have emphasized wishes, fears, and desires that are socially and culturally determined. Most contemporary psychodynamic psychiatrists see motivation as resulting from a complex interplay of *nature* and *nurture*, wherein inborn preferences are shaped by interactions with the environment, especially by the social matrix.

Finally, **the psychoanalytic model of the mind includes the idea that the mind is always working to reconcile conflicting motivations.** It is impossible for any given behavior or mental experience to satisfy both the pleasure principle and the reality principle. Indeed, there are even many competing imperatives for various kinds of pleasure, not to mention many competing imperatives created by fears and moral constraints. As a result, the psychoanalytic model of the mind includes the concept of *conflict* (also called *psychic conflict*). In this view, the mind seeks to reconcile its conflicting wishes, fears, and moral constraints with the demands imposed by reality through *compromise formation*. Every conscious experience and/or behavior represents a compromise among competing demands. In psychodynamic psychotherapy, the clinician seeks to explore the wide variety of compromises made by people as they seek to reconcile these competing demands. Psychological health can be assessed by evaluating compromises in terms of adaptation to reality and yield of pleasure. Psychodynamic psychotherapy seeks to expand the range of compromises available to the patient.

Structure and/or Process

Structure is the third feature of the psychoanalytic model of the mind. A mental structure can be defined as a relatively stable mental configuration with a slow rate of change (Rapaport and Gill 1959). The *structural point of view* arises from the observation that the motivational forces controlling mental life, along with the processes by which they are modulated, are not fleeting or erratic, but instead represent enduring patterns that are stable over time. Although, again, there is considerable argument about the best description of psychic structure, all psychoanalytic models of the mind draw on this important concept, with different schools of thought defined in part by what each sees as the basic structure of the mind. The term *structure* has been used to refer to mental events and processes at varying levels of abstraction, ranging from fantasies, memories, ideals, moral standards, character traits, and representations of self and other to more abstract and/or complex concepts such as mental agency or modes of function such as defense. Freud's well-known tripartite model of the mind, which divides mental life into *id*, *ego*, and *superego*, is only one example of how the broader concept of psychic structure has been used to create a model of the mind (Freud 1923/1962).

An important aspect of the concept of structure is its built-in historical component. For example, whereas the concept of wish can be conceived of as existing only in the present, the concept of structure allows us to talk more easily about the history and development of the inner world. By talking about development, we can talk about the possibility of change. If we can understand how stable configurations in the mind are formed, how they are threatened, and what makes them change, we can build a theory that encompasses both psychopathology and psychological change. This needed theory of change provides a rational basis for all approaches to psychotherapy.

Another important aspect of the concept of structure is that every structure has certain capacities, or processes. It is often hard to separate these processes—for example, primary process, secondary process, defense, reality testing, and so forth—from the structure itself. Indeed, sometimes we see a process that is itself defined as a structure. For this reason, we include process with structure and discuss both concepts together.

Development

The *developmental point of view* is the fourth important feature of the psychoanalytic model of the mind. It seeks to understand behavior and mental life as part of a meaningful progression from infancy to adulthood. It assumes that an adult can be understood as a psychological being only by exploring his or her history. The developmental point of view seeks to understand the origins of the patient's wishes, fears, ideals, values, attitudes, and adaptive strategies. It also explores how all of these change over time. The developmental aspects of the psychoanalytic model of the mind borrow extensively from developmental psychology, given that these overlapping fields share an interest in the mental life of the child (Gilmore and Meersand 2013).

Unique to psychoanalysis, the *genetic perspective* takes as its focus the patient's subjective story of his or her past as told to the therapist in treatment. The word *genetic* here refers not to the molecular basis of heredity but rather to the idea of *genesis*, or "the story of origins" (Hartmann and Kris 1945). By contrast, the developmental point of view is not unique to psychoanalysis. The developmental dimension seeks to understand the history of psychological life from the point of view of an objective observer, often through use of empirical methodology.

Initially Freud's developmental theory focused on describing *wishes*, which are organized into *drives* and which emerge according to an inborn, biologically determined plan consisting of oral, anal, phallic, and oedipal/genital phases (see Chapter 9, "The Id and the Superego"). However, most contemporary psychodynamic psychiatrists prefer the notion of *developmental lines* along which one can trace the history of any number of aspects of mental life, including wishes, fears, morality, the self, the quality of object relatedness, and all dimensions of ego functioning, to mention only a few (A. Freud 1981).

In addition, for the most part, psychodynamic psychiatrists adopt an epigenetic perspective of development. The concept of *epigenesis* views the formation of structure as the result of successive transactions between the individual and the environment. The outcome of each phase depends on the outcomes of all previous phases, as each new

phase integrates previous phases and each has a new level of organization. The concept of epigenesis allows for a tension between the fact that wishes, fears, and conflicts from earlier years are preserved in the mind and that they are also, to some extent, transformed and superseded. The concept of epigenesis also allows for *regression*, by which certain phenomena represent a return to earlier states of development. Indeed, many aspects of psychopathology can be understood as representing a regression to strategies that were adaptive at earlier stages of development but now appear inappropriate.

The developmental point of view adds depth to the adaptational perspective by asserting that what may be been adaptive for a child at one phase of development may be maladaptive in the same person as an older child or as an adult. Finally, the developmental point of view allows us to understand how the mind of a child may be preserved in the mind of an adult, so that we are forever influenced by our childhood wishes, fears, and ways of thinking.

Theory of Psychopathology and Treatment (Therapeutic Action)

Every psychoanalytic model of the mind includes both a theory of psychopathology and an associated theory of therapeutic action. The theory of psychopathology attempts to account for how and why the mind of the patient causes suffering. The theory of treatment attempts to explain how psychodynamic psychotherapy might help the patient find relief. Freud's famous statements that psychodynamic psychotherapy seeks to "make conscious everything that is pathogenically unconscious" (Freud 1901/1962, p. 238; Freud 1916–1917/1962, p. 282) and that "where id was, there ego shall be" (Freud 1923/1962, p. 56; Freud 1933/1962, p. 80) are examples of how he conceptualized psychopathology and treatment within the model of the mind he was using at the time. Although theories of psychopathology and treatment have grown vastly more complex than they were in Freud's day, all clinicians must use these theories in their work in order for their aims and strategies to be coherent.

For a detailed review of the psychoanalytic approach to psychopathology, readers are referred to *Psychodynamic Psychiatry in Clinical Practice*, 4th Edition (Gabbard 2005), and *Psychodynamic Diagnostic Manual* (Psychodynamic Diagnostic Manual Task Force 2006). There are also several good textbooks about psychodynamic psychotherapy (Cabaniss et al. 2011; Caligor et al. 2007; Dewald 1964; Gabbard 2004; Summers and Barber 2009).

Four Foundational Psychoanalytic Models of the Mind

The four psychoanalytic models of the mind examined in this book are the Topographic Model, the Structural Model, Object Relations Theory, and Self Psychology. These four models have emerged over the past 120 years of psychoanalytic thought and represent major ways of thinking about mental functioning. Soon after Freud elaborated his first model of the mind, he became dissatisfied with it; he subjected both this early model and all subsequent models to continuous revision. In doing so, he established a tradition in which models of the mind are questioned and changed in response to new data (Arlow and Brenner 1964). Evolving clinical experience demands modification of each existing model, leading to the development of new models. As mentioned in the Introduction, the result is that the contemporary psychoanalytic model of the mind is a composite of several models, each of which attempts to address the insufficiencies of the others. As we will see, each of the four psychoanalytic models of the mind has much to say about the five core dimensions of mental functioning. Each of these models looks at the core dimensions slightly differently, and each emphasizes different aspects. Throughout this book, these four models will be explained in relation to each other, with the ultimate goal of integrating them into a single contemporary model of the mind.

Topographic Model

The Topographic Model was Freud's first model of the mind, introduced in 1900. It posited a basic structure of *conscious*, *preconscious*, and *unconscious* domains separated by a barrier of defense, or repression. Although this model contained rudimentary ideas about motivation, structure, development, and psychopathology/treatment, its main focus was the topography of the mind. The basic features of the Topographic Model, as well as its lasting impact on theories of psychopathology and treatment, will be explored in Part II (Chapters 5, 6, and 7) of this book.

Structural Model

Increasingly dissatisfied with his Topographic Model, Freud introduced his Structural Model in 1923. In this model, the mind is divided into three parts, *ego*, *id*, and *superego*, each differing in structure and motivational aims and each having unconscious features. As Freud and his followers became increasingly interested in the functioning of the ego, the Structural Model came to be known as Ego Psychology. The basic features of the Structural Model, in addition to the work of well-known ego psychology theorists such as Anna Freud, Heinz Hartmann, and Erik Erikson, will be explored in Part III (Chapters 8, 9, and 10) of this book.

Object Relations Theory

Object Relations Theory was developed in the 1940s, after the death of Freud. In contrast to previous models, Object Relations Theory views the mind as organized by internal *object relations*—self and object representations linked by an interaction between self and object. Object Relations Theory seeks to understand basic motivations such as attachment and separation, positing that infants are object seeking from the beginning of life. It explores how object relations develop over time under the influence of various pressures and how different configurations in these object relations can lead to psychopathology and can suggest associated treatment strategies. The basic features of Object Relations Theory, in addition to the work of well-known object relations theorists such as Melanie Klein, Wilfred Bion, D.W. Winnicott, Margaret Mahler, John Bowlby, and Otto Kernberg, will be explored in Part IV (Chapter 11) of this book.

Self Psychology

Introduced by Heinz Kohut in the 1960s, Self Psychology looks at mental functioning as representing the functioning of a basic structure called the *self*. Kohut explored basic inborn *narcissistic* needs in all of us, positing that we all seek recognition and encouragement from caregivers, whom he described as *selfobjects*. Self Psychology proposes that during childhood, in interactions with *empathic* caregivers, each of us developed a self that was more or less robust in terms of agency, energy, and ability to form ideals. It also describes a treatment strategy based on an understanding of the selfobject function of the therapist. The basic features of Self Psychology, in addition to the work of well-known self psychology theorists such as Kohut and his followers, will be explored in Part IV (Chapter 12) of this book.

Core Dimensions Across the Four Models

In Part II ("The Topographic Model") of this book, readers will be introduced to a chart that will help them with the task of understanding the psychoanalytic models of the mind. In this chart, the core dimensions

emphasized by all psychoanalytic models of mental functioning—Topography, Motivation, Structure/Process, Development, and Psychopathology/Treatment—are plotted for each of the four foundational models of the mind examined in this book—the Topographic Model, the Structural Model, Object Relations Theory, and Self Psychology. Table 4–1 shows the form that the master chart will take.

As each model of the mind is introduced, the chart will become filled in. In the process of watching the chart grow, the reader will learn how concepts that are familiar but may be difficult to grasp or to integrate—for example, libido or separation-individuation—can be understood as an approach to motivation, structure/process, development, and/or psychopathology/treatment. In addition, aspects of the four component models of the mind can be understood in relation to one other, pointing the way to useful integration. The ultimate goal is for the reader to arrive at a usable composite psychoanalytic model of the mind. How to do this will be discussed in Chapter 13, "Toward an Integrated Psychoanalytic Model of the Mind."

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TABLE 4–1. Core Dimensions of Psychoanalytic Models of the Mind

	Topography	Motivation	Structure/ Process	Development	Psychopathology	Treatment
Topographic Model						
Addressed in Part II (Chapters 5, 6, and 7)						
Structural Model						
Addressed in Part III (Chapters 8, 9, and 10)						
Object Relations Theory						
Addressed in Part IV (Chapter 11)						
Self Psychology						
Addressed in Part IV (Chapter 12)						

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PART II

The Topographic Model

CHAPTER 5

The Mind's Topography

This chapter describes the Topographic Model of the mind. In this model, the mind consists of conscious, preconscious, and unconscious domains separated by a barrier of repression. All psychodynamic approaches to psychopathology and treatment draw upon aspects of the Topographic Model, with the aim of bringing pathogenic unconscious wishes, fears, and feelings into awareness. Vocabulary introduced in this chapter includes the following: *censor, condensation, conscious, descriptive unconscious, displacement, insight, interpretation, neurosis, overdetermination, parapraxis, preconscious, primary process, psychic reality, reconstruction, repetition compulsion, resistance, return of the repressed, secondary process, symbolization, transference,* and *wish.*

The Topographic Model was Freud's first fully developed psychoanalytic model of the normal mind. As discussed earlier, after introducing the concept of the dynamic unconscious in his work on hysteria, Freud immediately began work on a model of the mind that would apply to everyone, not just those suffering from psychopathology. Introduced more than 100 years ago, the Topographic Model of the mind seems primitive or antiquated to us when judged by the standards of contemporary psychology. Nevertheless, it continues to exert a profound influence on the contemporary psychoanalytic model of mind and treatment.

Freud first introduced this Topographic Model of the mind in Chapter 7 of *The Interpretation of Dreams* (Freud 1900/1962), but he did not

formally designate it as reflecting a *topographic point of view* until 15 years later (Freud 1915/1962). The word *topographic* is derived from the Greek word *topo,* meaning "place." The choice of this word represents Freud's conception of the mind as consisting of structures, each of which occupies a particular psychical locality and functions in a particular spatial relation to the others (Freud 1900/1962, p. 536). Having abandoned his earlier efforts to establish a brain-based psychology, Freud made it clear that he did not intend for these "places" in the mind to refer to any existing brain anatomy. The idea of a psychic locality was intended to serve as a metaphor for an imaginary mapping of the mental terrain in which the unconscious is conceived of as lying "beneath" the domain of consciousness as a kind of psychic underworld.

As we can see by its name and by our brief introductory description, the Topographic Model of the mind looks at the mind largely from the *topographic* point of view, emphasizing which mental contents are allowed access to consciousness. However, the Topographic Model also includes a description of the ongoing *motivational* (or dynamic) interactions among the three regions of the mind, which work both together and in conflict, each influencing the others. In addition, the Topographic Model also includes a description of the *structural* properties of each part of the mind, including the characteristics and modes of functioning of each. Finally, the Topographic Model of the mind is tied to a *developmental* point of view that accounts for how the psychological life of the child lives on in the adult.

Mental Topography: The Mind's Three Layers

In the Topographic Model, the mind is divided into three regions, conceptualized on a vertical axis from the surface of the mind to its depth, differentiated from one another by their relationship to consciousness. These three regions of the mind are the *conscious* mind, the *preconscious* mind, and the *unconscious* mind. Consciousness lies on the surface of the mind and includes mental experience that is within awareness at any given moment. Just beneath consciousness is the preconscious, which includes mental contents that are in the *descriptive unconscious,* meaning that although they are not within awareness at any given moment, they can easily be brought to awareness if attention is applied to them. Beneath the preconscious lies the unconscious, buried in the deepest region of the mind. In contrast to the preconscious, which is only descriptively unconscious, the unconscious is *dynamically unconscious,* meaning that its contents cannot be brought to awareness by a simple act of attention but are actively denied access to consciousness by the force of repression.

Motivation

The most significant feature of the Topographic Model of the mind is the dynamic interaction among the unconscious, preconscious, and conscious regions of the mind. Indeed, as we explored in Part I of this book, the Topographic Model of the mind grew directly out of the concept of the *dynamic unconscious,* which is made up of wishes. A *wish* is defined by Merriam-Webster as an act of desire.[1] In the psychoanalytic model of the mind, a wish is a striving to experience some kind of satisfaction. According to the Topographic Model, the most important interaction in the mind is the ongoing struggle between the preconscious and the unconscious, which are separated by a *censor* with the authority to decide which wishes are socially or morally acceptable. During this early period, Freud became increasingly convinced that wishes of a sexual nature are the most important wishes in the mind. He also believed that sexual wishes are the most unacceptable. In Chapter 9, when we explore the Structural Model of the mind and the concept of the id, we will see how Freud organized wishes into libidinal and aggressive drives, developing drive theory to explain how these different types of motivations worked.

As we discussed in our description of the dynamic unconscious, in this model, the unconscious is dynamic in two senses. First, it is dynamic in that unconscious wishes seek to express themselves all of the time, affecting all that we experience and do. Second, it is dynamic in that unconscious wishes are repressed, or held outside of awareness, because we do not want to know about them, having judged them to be unacceptable. An example of unacceptable content might be a young woman's wish to have the love, sexual attention, and admiration of everyone, and/or her wish to do away with all rivals. The censor may judge these wishes to be unacceptable in terms of social norms. Such a judgment may lead this young woman to repress these unacceptable wishes or to banish them from consciousness. However, repressed wishes are not destroyed; instead, they are preserved in the unconscious and continue to exert an active effect on all of mental life and

[1] See http://www.merriam-webster.com/dictionary/wish (accessed January 9, 2012).

behavior. In other words, this young woman may have repressed her unacceptable wishes, but these wishes are still active in that she feels extremely anxious to the point of panic whenever the unacceptable wishes are stirred up. Furthermore, she avoids all efforts to make herself more attractive, such as dressing up or getting her hair and nails done. Despite being decidedly dowdy, she is preoccupied with how other women express their femininity. In the sections below, we will learn more about how a therapist, by bringing her patient's unacceptable wishes into awareness, can help relieve this young woman of suffering.

In the Topographic Model, there is little dynamic interaction between consciousness and the preconscious. Indeed, as we mentioned earlier, the contents of the preconscious are not within awareness at the moment but can easily be brought to consciousness if attention is paid to them. For example, the preconscious might include the answers to questions such as the following: "How many windows are in your bedroom?" or, more relevant here, "Where is your local nail salon or beauty parlor?" If the young woman mentioned above attends to these questions, she can access the information to answer them correctly, by turning attention to what had been preconscious. However, she does not know the answer to the question of why she is so anxious when she thinks about having a manicure. The thoughts, feelings, and/or wishes associated with her anxiety are unconscious, or repressed.

Structure/Process

In the Topographic Model of the mind, the unconscious, preconscious, and conscious regions of the mind each have a characteristic structure, and each operates in a characteristic way. As we have seen, the unconscious consists exclusively of unacceptable wishes that have been separated from the rest of the mind by repression. In addition, according to the Topographic Model, the unconscious operates according to what has been called *primary process*, in which wishes strive for immediate expression or satisfaction through whatever means possible, obeying the pleasure principle without regard for consequences. As a result, the unconscious is incapable of social judgment or moral concern. Freud believed at this point that primary process also accounts for the peculiar form that thoughts take in the unconscious, which is unperturbed by logical contradictions and operates without a sense of time. Primary process is also responsible for the fact that unconscious ideas are often represented by highly personal and idiosyncratic concrete symbols

rather than words (*symbolization*). *Visual symbolism* is especially pronounced in dreams, which reflect the predominance of the primary process. The specific organizing mechanisms of primary process include *condensation* (wherein a single idea is capable of representing many related ideas, linked by private, idiosyncratic associations) and *displacement* (wherein an idea is capable of representing another idea, again linked by personal, often *symbolic* association). An example of unacceptable wishes represented in primary process form might be a dream image recounted by our same young woman (dreamer) in which, as she is getting a manicure, "the bottle of nail polish is suddenly filled with blood." Through exploration of this young woman's associations, the nail polish and the manicure appear to represent both a wish to be "the most glamorous of all women" and a wish to "polish off" all rivals in a bloody attack (see Chapter 6, "The World of Dreams," for a more in-depth discussion of dreaming and dream theory). As we can see here, primary process is responsible for the phenomenon of *overdetermination*, often seen in dreams and symptoms, in which a single idea or symbol may represent many ideas.

The preconscious is the seat of reason. In other words, the preconscious operates according to *secondary process*, which obeys the reality principle. It includes the capacity to judge mental contents and censor those judged to be unacceptable according to conventional mores. It includes the capacities for assessment of external reality, delayed gratification, and planned action for the purpose of solving problems. Preconscious thoughts, organized by the secondary process, are logical, goal directed, and language based. They rely on the stable, conventional, or culturally shared meaning of words, as opposed to the highly personal and idiosyncratic symbolic language of primary process.

Freud theorized that primary process was the original, or earliest mode of mental functioning, with secondary process developing only after the child learns through experience that wishing alone does not bring satisfaction and that more advanced forms of thought and action are necessary for gratification. Indeed, the word *primary* here refers to what comes first in the development of the mind. However, contemporary psychodynamic theorists no longer adhere to this view, arguing instead that both kinds of mental organization develop simultaneously in the mind and that primary process should not be confused with immature cognition. Contemporary theorists also understand that there are probably multiple ways of encoding experience, which are best studied by cognitive psychologists (Bucci 1997).

The conscious mind is the same as the preconscious mind in terms of structure. Consciousness also functions according to secondary pro-

cess, using the logical processes with which we are all familiar. Indeed, most of the time we are aware only of secondary process, and we are used to conscious, purposeful thought. However, under conditions in which censorship is relaxed, or when mental life is especially dominated by unconscious wishes, feelings, and thoughts (as in dreams, daydreams, slips of the tongue, the play of children, art, poetry, neurotic symptoms, or any highly emotional state), it becomes possible to observe the penetration of primary process into conscious mental life. For example, we see this in the dream recounted above by the young woman with extreme anxiety who avoids going to a nail salon. When awake, this young woman had no realization of her unacceptable wishes but was aware only of her own anxiety at the thought of doing anything to improve her appearance, including getting a manicure, going shopping, or fixing her hair.

Development

Finally, the Topographic Model of the mind is attached to a view of development. We have seen how the unconscious consists of unacceptable wishes. We have seen how Freud came to believe that the most important of these wishes were sexual. He also came to understand that many of them date from infancy and childhood. Again, we will explore what is called *infantile sexuality* more thoroughly in Chapter 7 ("The Oedipus Complex") and Chapter 9 ("The Id and the Superego"). In any case, as the child grows older, his or her childhood wishes become increasingly unacceptable in terms of conventional morality and the surrounding society, and these wishes are repressed. Indeed, the self-centered and competitive wishes of our young woman are appropriate for a very little girl but not for a young adult. However, despite repression, this young woman's childhood wishes have not gone away but continue to be active in her mind.

At the same time as the censoring capacities of the child develop, other mental processes develop as well (see Chapter 7, "The Oedipus Complex," and Chapter 8, "A New Configuration and a New Concept: The Ego"). However, contemporary psychodynamic practitioners know that everyone possesses an unconscious mind, ruled in part by primary process, which continues to be active even in adulthood. In other words, the Topographic Model describes a mind that is divided, from the earliest days of life, forever and permanently into two domains of psychological life—one layered on top of the other—that are separated by a censor. The upper layer of the mind constitutes a reality oriented, rational, and

morally constrained domain of reason, responsive to the constraints of society. The lower layer is in part a pleasure-seeking, illogical, and amoral domain of childhood wishes, subject to highly idiosyncratic forms of symbolic representation. The upper layer partially obscures the lower layer but is not able to control it completely. Indeed, the two domains of the psyche coexist in dynamic relationship with one other, each making its own unique contribution to psychological life.[2]

What Can the Topographic Model Help Us to Understand?

Psychic Reality and Subjective Experience

Although the Topographic Model of the mind is flawed in ways (see Chapter 8, "A New Configuration and a New Concept: The Ego"), it is useful in understanding many aspects of human mental life and behavior, both normal and pathological. According to this model, all experience is the result of the continuous interaction of unconscious and preconscious/conscious regions of the mind, as our experience of inner wishes and fears interacts with our experience of external social reality. Indeed, Freud described the unconscious as a *psychic reality* with importance equal to—if not greater than—external reality in terms of influence on our experience (Freud 1916, p. 444). The Topographic Model of the mind helps us to understand the idiosyncratic, personal, and often not-so-rational private world of personal meaning that constitutes each

[2]In the early days of the Topographic Model of the mind, Freud was uncertain about what was included in the unconscious. He talked about repressed memories (*reminiscences*), unacceptable thoughts/feelings, and wishes (Breuer and Freud 1893/1895/1962; Freud 1900/1962). Over time, he came to see that repressed wishes are forged in childhood and often involve an element of sexuality. The oedipus complex, one of the most famous scenarios imagined by Freud, which many readers may have already detected in the clinical material mentioned above, involves Freud's ideas about the oedipus complex. Indeed, the oedipus complex is so well known that we will devote the whole of Chapter 7 to exploring this idea, both how it developed alongside the early Topographic Model of the mind and how it is used by psychodynamic clinicians today. In later chapters of this book, we will also see how elements other than wishfulness are included in unconscious mental functioning. We will explore these elements, examining what contemporary psychodynamic practitioners think about how the mind functions, with particular attention to what we now think might be included in the unconscious.

individual's ongoing subjective experience. As each of us develops, inner experience interacts with the experience of external reality, and unconscious interacts with conscious, in a matrix of subjectivity, as past and present desires, feelings, fears, hopes, expectations, prejudices, and attitudes shape every new experience, even as they are in turn being shaped by new experience. Some aspects of subjective experience are universal, in that we are all human beings who have many things in common. Other aspects of subjective experience are highly idiosyncratic, as each of us develops in a unique way, under unique circumstances.

Transference

In the formation of subjective experience, unconscious wishes, hopes, and fears evade the censor by assuming many forms of disguise, so that every aspect of mental life represents a mixture of unconscious wish and disguise. In describing how this mixture of wish and disguise comes about, Freud proposed the concept of *transference*, first introduced as part of the Topographic Model. In any mental state, an unconscious wish may transfer, or displace, some of its intensity to an unobjectionable preconscious thought with which it might have some symbolic or associative connection (Freud 1900/1962). Returning again to the young woman described earlier, we find an example of this phenomenon in her intense interest in helping her best friend "look great" whenever she goes to a party. In this instance, the young woman's interest in "looking glamorous" is displaced onto her investment in her friend's appearance, which is more acceptable to her than interest in her own. This transference of intensity is the mechanism behind the well-known clinical phenomenon in which a patient transfers strong feelings from a person of emotional importance (often from the patient's childhood) to the therapist (Freud 1905a/1962). For example, in psychotherapy, this same young woman monitors her female therapist carefully for evidence that the therapist is trying to look beautiful. Throughout this book, we will see how transference phenomena are useful in all kinds of psychodynamic psychotherapy as a way to understand the unconscious mind of the patient. For now, we see that in the Topographic Model of the mind, transference is an ongoing process connecting the wishes of the unconscious system to the language-based thoughts of the preconscious/conscious system, explaining how all experience comes to represent a blend of unconscious and conscious influences.

Slips of the Tongue, Jokes, and Dreams

As noted earlier in our discussion of primary and secondary process, in any situation in which censorship is relatively relaxed, we can see the influence of the unconscious on aspects of mental life. Indeed, excited by the possibilities presented by his new theories, Freud enjoyed entertaining himself and his readers by demonstrating the contribution of his Topographic Model to our understanding of all kinds of phenomena. In *The Psychopathology of Everyday Life* (Freud 1901/1962), he wrote about how slips of the tongue and bungled actions, or *parapraxes*, reveal unconscious life when the mind is relatively relaxed by intense feeling or fatigue. For example, when a committee chairman announces at a public meeting that Mr. X will make a "stupor" (rather than "super") new member of the committee, he is revealing a hidden and forbidden opinion that the man in question is both boring and stupid. In the same vein, when a political candidate declares himself to be "on the side of anti-bias, anti-hatred, and anti-Semitism," he cannot expect to win the endorsement of the Anti-Defamation League (Motley and Baars 1979). In addition, we can see the contribution of the dynamic unconscious when a young woman heading out for dinner in a flashy, revealing dress mishears her doorman yelling "Sexy! Sexy!" as he hails her a taxi cab. In another example, a young man, angry in the aftermath of an argument with his boss, misreads a street sign as saying *murder* when it really says *Maeder* (Arlow 1969, p. 9).

A collector of humorous puns and jokes, Freud also enjoyed demonstrating that jokes achieve their desired effect by introducing forbidden, unconscious ideation into previously innocuous situations. For example, to quote from one of Freud's favorites, "A wife is like an umbrella; sooner or later one takes a cab." Freud analyzed this joke as drawing a laugh because we all know, but do not "venture to declare aloud and openly, that marriage is not an arrangement calculated to satisfy a man's sexuality" (Freud 1905b/1962, p. 77).

Finally, as we have seen earlier, in the world of dreams we are also able to observe the interactions of the unconscious and preconscious mind under circumstances in which the censor is a bit more relaxed, or "asleep at the switch." Dreams are so central to the development of the Topographic Model and so important to the work of psychodynamic psychotherapy that we will devote the whole of Chapter 6 to exploring the purpose and meaning of these phenomena.

Theory of Psychopathology in the Topographic Model: The Concept of Neurosis

The Topographic Model of the mind has made a lasting contribution to the study of psychopathology. As discussed above, the Topographic Model posits that all experience is the result of a mixture of unconscious and preconscious elements, as inner unconscious experience combines with the experience of external and social reality to form subjectivity. This formula applies to pathological as well as normal mental phenomena. Indeed, it is important to remember that the concept of the dynamic unconscious was first invented for the purpose of understanding human mental suffering, allowing Freud and his followers to talk about the role of unconscious mental forces in the formation of the symptoms of hysteria, and soon, of other kinds of psychopathology.

Pathological phenomena best accounted for by the psychoanalytic model of the mind are described with the concept of neurosis. *Neurosis* is defined as any inflexible, maladaptive behavior that represents a solution to unconscious conflict. In all human experience there is ongoing conflict between efforts to satisfy unconscious wishes and efforts to repress these same wishes when they are judged to be unacceptable. Therefore, in neurosis also, wishes are always both partially expressed and partially hidden. However, in neurosis, unlike more ordinary experience, there is a cost to the solution in terms of the suffering that accompanies symptoms. In the field of psychiatry, the term *neurosis* has been decried as being vague, overinclusive, and impossible to verify empirically, and in 1980 it was dropped from the official psychiatric nomenclature in favor of the word *disorder*, a term more easily defined with the purely descriptive approach favored by the DSM system (American Psychiatric Association 1984). However, despite its relative disuse as a formal nosological category in psychiatry, neurosis remains one of the most important concepts in psychodynamic psychiatry, because all psychodynamic treatment seeks to help patients gain freedom from neurotic suffering. As we progress through this book, we will see how our developing model of the mind adds to the theory of psychopathology and/or neurosis.

The word *neurosis* did not originate with psychoanalysis or with Freud. It was coined by the Scottish physician William Cullen in the 1770s to designate functional disturbances of the nervous system for which there was no demonstrable structural lesion in the afflicted organ. In the nineteenth century, the neuroses included a wide variety of diverse ailments, including many that are now considered neurological, such as epilepsy and Parkinson's disease. The term also included hysteria. Writing extensively as he did about hysteria, Freud co-opted the word *neurosis* so that nowadays this word has little meaning outside the context of psychodynamic psychiatry. Although Freud first used the term as a purely nosological category, he soon expanded and redefined the concept in his discussion of what he called *the neuropsychoses of defense* (which included hysteria, obsessional neurosis, phobias, and some kinds of paranoia) (Freud 1894/1962). Freud explained these ailments as representing *the return of the repressed*—that is, the reappearance of unacceptable ideas, disguised in the form of symptoms (Freud 1896/1962, p. 161). In other words, in a view that was radical at the time, neurotic symptoms do not differ from aspects of ordinary experience, in that both represent the mixed impact of unconscious wishes and social reality. However, in neurosis we find unacceptable wishes "returning" disguised as symptoms, whereas in nonpathological experience, the mixture causes less distress.

Let us turn to some examples of how the Topographic Model helps us to understand various kinds of neurotic psychopathology. A young woman with hysterical conversion disorder may suffer from the symptom of a paralyzed arm, evincing no neurological disorder upon exam. We will say that her symptoms comprise a neurosis if they represent her fear of the emergence of forbidden unconscious wishes to strike out at her mother, or to masturbate to satisfy forbidden sexual wishes. In this young woman's case, the symptom of the paralyzed arm represents the solution to a conflict between wishing to attack her mother, or to masturbate, and feeling that this wish is unacceptable.

Unconscious conflict may be expressed not only in the form of neurotic symptoms but also in the form of troubling neurotic personality traits, such as difficulties in work, troubles in love relationships, crippling life patterns, or disturbances in mood and/or self-esteem. For example, a self-effacing young man may exhibit the character traits of timidity and deference. In his case, these character traits may be understood to represent the young man's fear of his own unconscious wish to strike out at authority figures, so that he always "pulls his punches." We will return to this same young man to learn a great deal about the expression of conflict in character when we explore the Structural Model (see Chapter 10, "Conflict and Compromise"). In the young woman who felt anxious, especially whenever she thought of a nail salon, we see both symptoms (anxiety and avoidance) and character traits (excessive goodness and asexuality) caused by disguised unacceptable unconscious wishes.

The Topographic Model of the mind enables us to understand not only the content but also the peculiar form in which symptoms often

appear. All symptoms are symbolic communications that, like dreams, make use of primary process mechanisms such as condensation, displacement, and symbolization to represent personal and idiosyncratic hidden thoughts and feelings. Indeed, the similarity between the organization of symptoms and the organization of dreams was one of Freud's first brilliant observations. His contribution included the ability to read symptoms and character traits as texts in which we can see the partial expression of a patient's forbidden unconscious wishes and his or her fears. In the example of the young woman with the paralyzed arm, we see how some patients make use of body parts to express more complex thoughts. Even the strange and fragmented thoughts of many psychotic patients can be better understood if we understand the "logic" of primary process. Although psychotic symptoms are caused mainly by disordered brain processes, we see in them the exposure of primary processes in a situation where secondary processes are destroyed or severely fragmented. For example, a psychotically depressed young man who is struggling with unacceptable anger may feel that his body is filled with "poison" or that his brain is being taken over by "malignancy." Another psychotic schizophrenic young woman may spend hours collecting and eating "teeny pieces of tin" so as to feel closer to her mother, whose name is Christina.

Finally, a last important contribution made by the concept of the dynamic unconscious to the understanding of neurotic psychopathology is that it allows us to understand not only the hidden content and complex form of symptoms, character traits, and problematic patterns but also their striking inflexibility. Indeed, neurosis is characterized, and even defined, by its failure to respond to the demands of common sense or current reality. For the person suffering from neurotic problems, the advice of friends and family, the reading of self-help books, and even the most determined efforts of willpower fail to provide relief or bring about change. Our understanding of the nature of the dynamic unconscious helps us to understand this rigidity by suggesting that repressed ideas are not just hidden but take on new qualities by virtue of having been repressed. In other words, repressed ideas, feelings, and motivation have become sequestered from the rest of the personality. As we have seen, in describing this sequestered aspect of the repressed unconscious, Freud was fond of using metaphors from archeology. He suggested that when unconscious ideas/wishes/feelings become separated from the rest of the mind by repression, they are not "worn away" by exposure to the reality of new experience. Instead, they continue to exist, timeless and unchangeable, maintaining their childish, timeless, and irrational qualities in the same way the artifacts from ancient civilizations are preserved from erosion by their burial in the depths of the earth (Freud 1909b/1962).

In contrast to ancient artifacts, however, repressed wishes and fantasies do not remain inert but continue to be active in mental life. They contribute to the *repetition compulsion* of neurotic patients, who repeatedly enact specific scenarios during the course of their lives without ever recognizing the relationship of these scenarios to unconscious memories or wishes. For example, a young woman whose sister died from traumatic brain injury during their childhood came to treatment with a chief complaint of feeling "brain dead." Despite unusually high intelligence, she had long been unable to fully use her mind. She also proved to be highly accident prone, especially with regard to accidents endangering the cranium. In treatment, this young woman endangered herself by failing to follow the low-tyramine diet appropriate for those on monoamine oxidase inhibitors. Although none of her neurotic patterns was connected consciously with memories or feelings about her sister's death, the exposure of this link led ultimately to a resolution of her self-destructive feelings and behaviors.

Theory of Therapeutic Action in the Topographic Model: Psychodynamic Psychotherapy

The Topographic Model of the mind is central to our understanding not only of how people develop symptoms or fixed ways of feeling/acting that lead to suffering but also of how psychodynamic psychotherapy can bring about relief. Although modern conceptions of the therapeutic action of psychodynamic psychotherapy no longer view exploration of the unconscious as the only aim of treatment, the goal of making the unconscious conscious is part of most treatments (Freud 1901/1962, p. 238; Freud 1916–1917/1962, p. 282). Many of the clinical techniques used in psychodynamic psychotherapy were developed with the aim of bringing unconscious mental contents into conscious awareness. As we have seen, Freud developed free association in the hope that if the patient abandons conscious control of his or her thought processes, it will be easier to observe the unconscious determinants of his or her subjective experience. In psychodynamic psychotherapy, the patient is still asked to "say whatever comes to mind," speaking as candidly as possible. The patient and the therapist work together to infer the nature of unconscious determinants in the sequencing, patterning, and content of the patient's flow of ideas and feelings, the nature of his or her avoid-

ance of engaging in exploration, and the transferences he or she experiences or enacts in the process. *Resistance* is the word that psychodynamic psychiatrists use to describe the clinical phenomenon of a patient's active but unconsciously motivated avoidance of knowing his or her own mind. Exploration of resistance leads patient and therapist directly to the heart of the patient's most intense struggles between the unconscious wishes and feelings seeking expression and the effort to avoid awareness of these unconscious wishes and feelings. As we have also seen, *transference* is the word Freud used to describe the automatic, unconsciously determined repetition within the therapist-patient relationship of unconscious feelings/thoughts involving other people, often important caretakers from childhood. Exploration of transference allows for examination of emotionally intense feelings about the patient's experience in relation to important others. Exploration of both resistance and transference takes place in the controlled setting of psychotherapy, where both phenomena are emotionally alive, yet subject to a degree of detached observation on the part of both the patient and the therapist.

In the language of psychodynamic psychotherapy, an explicit inference about the working of the dynamic unconscious is called an *interpretation.* An interpretation that makes inferences about the forgotten or repressed past is called a *reconstruction.* Knowledge about the unconscious gained through interpretation is called *insight.* The Topographic Model of the mind proposes that insight is useful to patients because when wishes, feelings, thoughts, and memories are made conscious, they become subject to secondary process thinking rather than to primary process thinking. In other works, when conscious, they become subject to rational assessment and judgment. Patients become more able to choose how to act in the face of inner demands and less at the mercy of a rigid, stereotyped tendency to act out unconscious scenarios. Although psychodynamic psychiatrists no longer see insight as the only—or even at times the most important—element in treatment, it is still a central part of all psychodynamic psychotherapy, as the patient gains increased awareness of and mastery over the unconscious factors that affect his experiences or his choices, or about unconscious barriers to becoming the person he wants to be. (We provide a more extensive discussion of the value of consciousness in the next section, "The Nature and Function of Consciousness.")

In the case of the young woman whose sister died from traumatic brain injury, exploration of her complaints of not being able to use her brain, her communications during her session, her dreams, and her various moments of avoidance all contributed to understanding her unconscious memories and feelings about her sister's death. Originally, although the patient had recounted the fact of her sister's illness and death, her feelings about these events were not within her awareness. She complained about feeling "brain dead" herself but did not connect these feelings with the facts of her sister's brain injury. At the same time, she talked often about both angry and guilty feelings in reaction to friends who sought or needed help. Her dreams contained images of someone who was injured and/or dying. Exploration of all of these feelings, memories, and dreams led to deepening understanding. However, in this young woman's psychotherapy, the most important insight came from the exploration of transference. Patient and therapist were able to understand frightening interactions in which the patient misused medication in ways that might damage her brain, as a powerful window into her unconscious feeling of connection with her dead sister and her unconscious feelings of guilt and anger about her sister's injury and death. When her feelings were brought into awareness, she no longer needed to express them in the form of self-destructive symptoms and character traits.

In the same way, the anxious young woman who avoided the nail salon and who was anxious to the point of panic at the thought of any efforts to make herself beautiful, learned in her psychodynamic psychotherapy that her anxiety was connected to her repressed and unacceptable wishes to attack other beautiful women, beginning with her mother. When this young woman was able to consciously reflect on her wishes and fears and to integrate them with the rest of her mental life, she no longer felt severe anxiety in the face of her wishes to look more attractive.

The Nature and Function of Consciousness

Although neuroscientists and psychologists do not agree about the precise definition of consciousness, most include a quality of mental awareness in their definition (Hirst 1995). As used by neurologists, definitions of consciousness emphasize levels of arousal of brain centers. In contrast, as used by psychodynamic psychiatrists, definitions of consciousness emphasize the subjective aspect of experience, or self-awareness. In contemporary psychodynamic psychotherapy, we continue to use the technique of bringing unconscious mental contents into awareness, with the aim of increasing the patient's ability to choose a course of action in the face of conflicting imperatives. According to this practice, when patients are conscious or aware of their inner life, they are better able to regulate and control themselves and to make choices and

judgments about how to feel and act. How does this idea fit with what is going on in the rest of mind science?

As noted earlier, in contrast to earlier branches of psychology that equated mind with consciousness, the field of cognitive neuroscience is rapidly charting the unseen realms of unconscious mental life. This map-making endeavor began with exploration of information processing that takes place in the *cognitive unconscious* (Kihlstrom 1987, 1995) and has moved on to include processes of motivation and intention. Most recently, it has included processes of self-regulation such as attention, metacognition (self-monitoring), working memory, and other processes previously thought to be under conscious control (Uleman 2005). Indeed, this rapidly expanding map of unconscious mental function has left many wondering what the role of consciousness is. This question has plagued thoughtful scientists for many years, including Freud himself, who referred to "the long-looked-for evidence that consciousness has a biological function" (Freud 1909a/1962, p. 145).

Freud saw consciousness as part of "the superiority of humans over animals" (Freud 1900/1962, p. 617), strongly rejecting any idea that consciousness is a mere epiphenomenon or only "a superfluous reflected picture of the completed psychical process" (Freud 1900/1962, p. 616). He suggested that consciousness makes higher-order mental processes possible, contributing to self-regulation by playing a role in the capacity for reality testing, judgment, and "temperate and purposeful control" (Freud 1900/1962; Freud 1909a/1962, p. 145; Freud 1911/1962). In Freud's view, the reason for making the unconscious conscious is so that repression can be replaced by "condemning judgment carried out along the best lines" (Freud 1910/1962).

In contemporary psychodynamic psychiatry, questions about the relationship between consciousness, attention, language, integration, and higher-order mental functions such as self-reflection, self-monitoring, judgment, self-control, and volition are the subject of ongoing investigation (Klein 1959, 1970). For example, Shevrin (Shevrin et al. 1996), supported by Brakel (1997), argued that the role of consciousness is to categorize experience, deciding whether a mental event should be classified as perception, sensation, dream, thought, or memory. Consciousness thereby distinguishes experiences from one another and helps to organize the mind. Olds (1992) emphasized the feedback functions of consciousness, in which sense data are re-represented symbolically and thereby made independent of their sources. According to Olds, in self-reflective consciousness, the self and its interactions can be represented, making introspection possible. Levin (1997) and Rosenblatt and Thickstun (1977) also emphasized similar "re-entrant mechanisms" of consciousness that make possible many complex functions, such as empathy, insight, object relatedness, and psychological mindedness, allowing for flexibility in the ways human beings conceptualize themselves and make decisions (Auchincloss and Samberg 2012, p. 43–45).

As noted, in the rest of cognitive neuroscience we also see expanding research into the function of consciousness. In recent years, Posner and Rothbart (1998) have argued that aspects of self-regulation, such as volition, are dependent on elements of consciousness, including awareness, self-monitoring, and executive attention. Bargh (2005, p. 53), who otherwise argued for the recognition of unconscious self-regulation, asserted that consciousness serves the purpose of greater integration and coordination through its "assemblage" of various kinds of experience. Other aspects of consciousness emphasized by researchers include self-control offered by language (Bucci 1997), reconsolidation of memory (Nader and Hardt 2009; Sara 2000), modulation of emotion (Phelps 2005), access to a common narrative (Damasio 1984; Farber and Churchland 1996), and many other aspects of self-control (Hirst 1995; Pally 2000; Pally and Olds 1998; Payne et al. 2005).

In short, we see that psychodynamic psychiatry holds a view of the importance of conscious awareness that is in accord with what is going on in the rest of mind science. When clinicians discovered ways to enhance the self-regulation of patients by increasing their self-awareness, they discovered what many researchers are finding in the laboratory—that enhanced consciousness does indeed improve one's ability to choose how to live, even if unconscious factors are also seen to be increasingly powerful.

Chapter Summary and Chart of Core Dimensions

Table 5–1 introduces our Topographic Model chart of core dimensions, in which we have placed the following key concepts:

- **Topographic point of view:** The mind is divided into conscious, preconscious, and unconscious domains. The preconscious mind can be made conscious when attention is paid to its contents; the unconscious mind cannot by made conscious by the simple act of attention, but is denied consciousness by the forces of repression.
- **Motivational point of view:** The unconscious mind consists of wishes that continually strive for expression. The conscious/preconscious mind has the capacity for repression of these wishes when they are judged to be unacceptable.

- **Structural point of view:** The unconscious mind is characterized by *primary process;* the conscious/preconscious mind is characterized by *secondary process.* The unconscious mind and the conscious/preconscious mind are separated by a *censor* that has the task of judging wishes to be either acceptable or unacceptable.
- **Developmental point of view:** Primary process develops before secondary process. Wishes come from childhood and form the basis of *infantile sexuality.* Over time, they are judged to be increasingly unacceptable. Meanwhile, the capacity for repression (i.e., the *censoring capacity*) grows. The end result is an adult mind that is forever split between conscious/preconscious and unconscious domains.
- **Theory of psychopathology:** Neurosis—inflexible, maladaptive patterns of thought, emotion, or behavior—results from unconscious conflict between the conscious/preconscious domains and the unconscious domain. Neurosis is characterized by the *return of the repressed* (in which unacceptable wishes that have been repressed reappear in the form of symptoms) and often by the *repetition compulsion* (a tendency to reenact specific scenarios without awareness of their relationship to early repressed wishes or fantasies).
- **Theory of therapeutic action:** The goal of psychodynamic psychotherapy is for the patient to acquire more *insight* into the unconscious mind—to "make the unconscious conscious." Through the technique of *free association* (which operates according to the *fundamental rule* that the patient will say whatever comes to mind as candidly as possible to the therapist), the unconscious determinants of the patient's subjective experience gradually come to light. The therapist and patient then observe *transference* and *resistance,* using both to piece together a picture of the unconscious mind. The therapist also makes use of *interpretation,* defined as a statement about the unconscious mind. Interpretations about childhood are called *reconstructions.*

TABLE 5–1. Topographic Model Part 1: The Mind's Topography

Topography	Motivation	Structure/Process	Development	Psychopathology	Treatment
The mind is divided into three regions: Conscious Preconscious Unconscious	The unconscious mind consists of wishes always striving for expression Unacceptable wishes are kept in check by forces of repression from the preconscious/conscious mind	The unconscious operates according to primary process; the preconscious/conscious operates according to secondary process A censor separates the unconscious and the conscious/preconscious mind	Primary process is the earliest mode of mental functioning; secondary process develops later Wishes come from childhood and form the basis of infantile sexuality Wishes become increasingly unacceptable Censoring capacity grows	Neurosis arises from conflict between the conscious/preconscious domains and the unconscious domain Return of the repressed Repetition compulsion	Free association ("fundamental rule") Examination of transference and resistance Therapeutic interpretation and reconstruction Insight ("Make the unconscious conscious")

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CHAPTER 6

The World of Dreams

This chapter explains how dreams are understood and used in contemporary psychodynamic psychiatry. It also examines how dream theory has been updated and discusses dream theory from neighboring disciplines. Vocabulary introduced in this chapter includes the following: *activation-synthesis hypothesis, day residue, dream, dream work, latent dream thoughts, manifest dream,* and *self-state dreams.*

A *dream* is defined as a mental experience that occurs when the dreamer is asleep. It includes images, thoughts, and feelings that the dreamer remembers when he or she awakens. Dreams are reported by people living in every corner of the world. Since the beginning of time, people have wondered about the meaning of dreams, often using them to foretell the future or for religious ritual. Literature and poetry from all parts of history and all parts of the world are replete with stories about the importance of dreams. More recently, scientists have used empirical methods to understand how dreams are created and what they might mean.

Meanwhile, many patients in psychotherapy, and certainly many patients in psychodynamic psychotherapy, report their dreams to their therapists. Psychodynamic psychotherapists work with patients to explore their dreams as part of a shared search for better understanding of the patient's psychological life. There are many approaches to understanding dreams, including approaches from anthropology, sociology, and other branches of psychology. For example, we know that dream

states are produced by the brain, primarily during rapid eye movement (REM) sleep but also during other stages of sleep (Dement and Wolpert 1958). In their work with patients, psychodynamic psychotherapists may use many models from many disciplines to understand dreams, but when doing therapy, they call upon the psychoanalytic model of the mind to help them understand what the patient's dreams mean and how those dreams can help them to learn about the patient's inner life.

The Topographic Model, the Dynamic Unconscious, and the Psychoanalytic Theory of Dreams

Freud introduced the Topographic Model of the mind in 1900 at the same time that he offered the first psychoanalytic theory of dreams. We have seen how Freud turned from exploration of hysteria to development of the first model of the normal mind. In the process of doing this, he also turned from exploration of neurotic symptoms to the study of the normal phenomenon of dreaming. In *The Interpretation of Dreams,* Freud related how he became interested in dreams after observing that his patients invariably inserted dreams into their free associations (Freud 1900/1962). As he became increasingly immersed in dream interpretation (exploring his own dreams as well as those of his patients, children, family, friends, and colleagues), Freud found support for his concept of the dynamic unconscious. Indeed, Freud is well known for having written that "The interpretation of dreams is the royal road to knowledge of the unconscious activities of the mind" (Freud 1900/1962, p. 608). Although aspects of psychoanalytic dream theory have changed since it was first introduced in *The Interpretation of Dreams* in 1900, much of the theory, vocabulary, and practice of dream interpretation remains similar to Freud's first efforts.

Freud's theory of dreams addresses two issues: the purpose of dreams and the meaning of dreams. The second of these issues is most important to contemporary practitioners. Freud argued that the purpose of dreams is to protect sleep in the face of disturbing sensations, such as noise and thirst, or from mental preoccupations, including both current concerns (such as getting to work on time) and unacceptable unconscious wishes. Freud proposed that dreams manage these disturbing stimuli in ways that protect sleep. For example, a person who is late to work may dream that he is already at his desk, or a thirsty person may dream of drinking water. Freud also argued that both mental preoccupations and unconscious wishes are represented as being fulfilled in the dream, albeit in a disguised form. He went on to say that if unconscious wishes are not sufficiently disguised, they will arouse anxiety, so that the dream fails to protect sleep, and the dreamer awakens. Nowadays, psychodynamic psychiatrists do not attempt to account for the purpose of dreams, understanding that data from the clinical situation does not lend itself to the exploration of this important question. In fact, debate rages throughout mind science about how best to understand the purpose served by dreaming and dream states for human beings and other animals (Crick and Mitchison 1983).

In contrast to his ideas about the purpose of dreams, Freud's efforts to understand the meaning of dreams have persisted and are still in use today. Here's how the psychoanalytic theory explaining the meaning of dreams works. Freud used the term *manifest dream* to describe the dream as recalled and narrated by the dreamer on awakening. He understood that the manifest content of dreams often changes, because we remember different versions of the dream at different times. Freud distinguished the manifest dream from what he called *latent dream thoughts,* or underlying thoughts expressed by the dream. Finally, he used the term *dream work* to describe the process (within the dreamer) of transforming the latent dream thoughts into the manifest dream.

According to Freud, in the process of making a dream, the latent dream thoughts attach themselves through association to unconscious wishes from childhood. The latent thoughts and the childhood wishes, both of which are unacceptable to the censor, then attach themselves, again by association, to a bit of *day residue,* or an innocuous image and/or event from current experience, which then appears in the manifest dream. In other words, the power of forbidden unconscious wishes is transferred to unobjectionable day residues, or bits of conscious experiences from everyday life that serve as symbols for the formation of the dream. In this way, latent dream thoughts are altered or disguised for the purpose of evading the censor, which is charged with the task of keeping unacceptable thoughts out of awareness. As we can see, Freud argued that the structure of dreams resembles the structure of neurotic symptoms, which he understood as resulting from a struggle between the unacceptable thoughts seeking expression in consciousness and the forces of repression.

Dreams can be interpreted by the therapist by breaking them down into component parts, images, or phrases and asking the patient to associate to each component. As with exploration of a symptom, the patient's associations to parts of a dream provide both therapist and patient with a method for unraveling the dream work and finding the

latent dream thoughts hidden beneath the manifest content. In this process (or in some variant of this process), therapist and patient uncover unacceptable thoughts from present life, as well as thoughts from many stages of childhood. Indeed, if they work long enough on any dream, patient and therapist will discover very early childhood wishes.

In the example introduced in Chapter 5 ("The MInd's Topography"), the young woman with panic attacks who avoided the nail salon reported a manifest dream in which she was getting a manicure when the bottle of nail polish suddenly filled with blood. Through exploration of her associations to images in the dream, she and her therapist found latent dream thoughts of murdering other women. In another example, an unmarried young woman in psychotherapy reported a manifest dream that included the image of a plastic doll sitting on the uppermost shelf of a bookcase, which she "could not reach." The patient's associations to the dream led to her recounting that she had been "playing dolls" with her niece on the previous day and had wondered to herself what had become of the dolls of her own childhood. Further associations led to concerns that her need to feel "above it all" (on the uppermost shelf) would lead to her remaining unmarried. Her deepest concern, not previously conscious during the first telling of the dream, was that she too might be "left on the shelf" and, unlike her sister, never get married or have children of her own. There was also resonance between the image of the plastic doll and the patient's feelings about how her father had treated her during childhood. Finally, there was resonance between the patient's feeling that the doll was "out of reach" and her feeling that she could not recapture feelings from childhood that dated from before her mother's death when she was 4 years old. In Chapter 7 ("The Oedipus Complex"), we will see how this dream might reveal aspects of early childhood wishes and conflicts.

As we see in this example, this patient's dream of the plastic doll on the shelf involved harmless material, or day residue, from her everyday life (her bookshelves and her niece's dolls), which symbolized many layers of experience and thought from various stages of her life. When the patient (and her censor!) was awake, inhibitory and defensive mechanisms prevented unacceptable thoughts from gaining access to consciousness, in this case because they were too painful. When the patient was asleep, the censor relaxed a bit, and we see greater penetration of these painful (latent dream) thoughts into consciousness, albeit still disguised in the form of a dream.

We can also see that when the logical processes of mental life are relatively inactive during dream sleep, primary processes can be more easily observed in the unusual thought processes that characterize dreams.

As we have seen in Chapter 5, primary process includes condensation, displacement, and symbolism. For example, in the dream about the nail polish, we see the wish to be glamorous and the wish to "polish off" rivals represented in the symbol of the bottle of polish. In the dream of the doll on the shelf, we can also see many thoughts and wishes represented in just a few images (*condensation*). We see the patient's fear of not getting married represented in a doll "left on the shelf" (*displacement*), and we see the feeling of being superior or being "above it all" also represented by the doll on the shelf. In both cases, the representation makes use of the concrete, pictorial image of a doll (*symbolization*).

The Use of Dreams in Contemporary Psychodynamic Psychiatry

Most psychodynamic psychiatrists since Freud continue to see dreams as an important source of information about unconscious mental life. However, our focus on dreams is based on a newer understanding of the mind. Freud's early theory of dreams was based on the Topographic Model and was never updated when he improved on this model. For example, the idea of a censor that sits between the unconscious and the preconscious/conscious is an idea that has been discarded (see Part III). In addition, much of early dream theory is based on Freud's ideas about "psychic energy," which most contemporary psychodynamic psychiatrists think of as highly flawed. For example, in Freud's energy-based theory, only wishes have enough "energy" to cause a dream to be created, so that latent dream thoughts must attach themselves to wishes to gain enough energy to create a dream—hence Freud's famous assertion that "dreams are the fulfillment of a wish" (Freud 1900/1962, p. 121). Contemporary work with dreams has broadened to include exploration not only of unacceptable latent thoughts but also of the defensive modes of functioning that are revealed in dreams (see also Part III). Contemporary clinicians also use dreams to gather information about the state of the transference. Finally, as we will see when we examine Self Psychology in Chapter 12, Heinz Kohut (1977) proposed that certain *self-state dreams* are not founded on unconscious infantile wishes but rather are attempts to master threats to the self. However, diverse points of view share an understanding that sleeping patients are less vigilant about preventing themselves from becoming aware of aspects of psychological life. For that reason, dreams can be very useful in psychodynamic psychotherapy.

An example of another patient dream illustrates how a dream can be useful in psychodynamic psychotherapy. A young woman came to

therapy for help with "excessive sexual restraint" and trouble finding a romantic partner. She was very successful as a high-level administrator in her life at work, but she had never had a boyfriend. She reported having had a very traumatic childhood, filled with physical abuse at the hands of her father and brother. In the second session of psychodynamic psychotherapy, this young woman reported the following dream: "A huge grizzly bear, a ferocious tiger, and many snakes" threatened to come into the patient's house while she was "stirring her dinner on the stove." She had been "trying to relax," and yet she awoke in "terrible fear." Over time, as the patient and her therapist explored this dream, they understood that the wild animals who interrupt and threaten the patient represented her frightening memories and feelings, her father and brother who abused her when she was a child, and her therapist who threatened to "stir up trouble" by exploring these feelings. The dream, to which patient and therapist referred throughout the therapy, helped them both to better understand these important issues.

Freud's *The Interpretation of Dreams:* Why Is It Important?

Let us pause for a moment to explore a question that many readers have asked: Why is Freud's book *The Interpretation of Dreams* considered one of the most important works of the modern age? Most students have been told that it is, but few know why. *The Interpretation of Dreams* was written between 1895 and 1899 and was published in 1900. In Freud's estimation, it was his greatest book. Indeed, writing about this book many years later, Freud said, "Insight such as this falls to one's lot but once in a lifetime" (Freud 1900/1962, p. xx). What is *The Interpretation of Dreams* about, and what are the insights of which Freud was so proud?

The Interpretation of Dreams, as the title suggests and as we have explored in this chapter, is a treatise on the subject of dreams—their structure, function, and meaning. But it is also much more. From its very first page, Freud engages his readers with the promise of something both intriguing and potentially shocking. In his selection of a title, the German word *Traumdeutung,* meaning "dream interpretation," Freud chose a word familiar to readers that referred to the dream interpretations offered by Gypsy fortune tellers living at the fringes of society. In other words, Freud's choice of the title *Traumdeutung* was guaranteed to challenge, even provoke, a scientific audience and intrigue others (Ellenberger 1970, p. 452). Then, in his choice of a verse for his epigraph, Freud borrowed the lines from Virgil's *Aeneid* (Book VII, 312), again familiar to his readers and again guaranteed to ignite their curiosity:

Flectere si nequeo Superos, Acheronta movebo.
("If I cannot sway the Higher Powers, I will move the Underworld.")

These words are the battle cry of the goddess Juno, who, frustrated by her failure to enlist the help of Jupiter in her plan to destroy the Trojan warrior Aeneas, summons the Furia Alecto and her band of enraged women from Hades to assist in her attack on the young hero as he makes his way to found the city of Rome. At the end of *The Interpretation of Dreams,* Freud elegantly weaves these famous lines of ancient poetry into the intellectual plot of the book to represent the "fate of repressed ideas," which even when banished to the underworld by the "Higher Powers" of consciousness, are far from vanquished but instead find renewed power to influence—and, by implication, even to destroy—our lives (Freud 1900/1962, p. 608). By using these words, Freud offers his readers a dramatic and stirring bit of foreshadowing of the story he plans to tell. He promises his readers that he will in fact "raise hell."

The plot of *The Interpretation of Dreams* unfolds through the interplay of at least three subplots, which interact with and inform each other throughout the course of the book's seven chapters. As we have seen, the first subplot of the book is Freud's theory of dreams—what dreams mean, what they are for, and how they work. The second subplot is the presentation of Freud's first fully developed theory of the unconscious in the workings of the normal human mind—the Topographic Model of the mind. The third subplot is the story of Freud's own coming of age and his struggles with insecurity, self-doubt, and competition on the way to becoming a man, told through the recounting of his own dreams. The genius of *The Interpretation of Dreams* lies in the way Freud moves back and forth from one subplot to the others, developing each in relation to the others in a brilliant fugue, at once highly personal and vast in scope. The style of the book is both literary and scientific, the subject matter is both highly intimate and universal, and the preoccupations of the author are both mundane and existential, predicting the great tensions that enliven psychodynamic psychiatry to this day. It is no wonder that *The Interpretation of Dreams* is considered Freud's masterpiece.

Psychodynamic Dream Theory and Neuroscience

For a long time, Charles Fisher (1954, 1965; Fisher and Paul 1959) was one of the few psychoanalysts who applied empirical techniques from neuroscience to investigate the psychoanalytic approach to dreams. However, several important critiques of psychoanalytic dream theory have emerged from neuroscience and cognitive neuroscience. Among the most important of these is the work of John Allan Hobson and Robert W. McCarley, Harvard University sleep researchers who published a series of articles about dreaming (Hobson 1988; Hobson and McCarley 1977). Hobson and McCarley posited that REM sleep is instigated by the periodic firing of pontine reticular neurons, especially gigantocellular tegmental field cells. Discharges from these cells provide sensorimotor information, which activates the forebrain. The forebrain then constructs a dream by synthesizing random sensorimotor information from the pons with information stored in memory. Hobson and McCarley called their theory the *activation-synthesis hypothesis* of dream formation.

In many of his writings, Hobson points out that the activation-synthesis theory accounts for the instigation and the formal properties of dreams but has few, if any, implications for understanding the meaning of dreams. However, in other statements, Hobson has challenged theories about what dreams might mean, especially those derived from psychoanalysis (Hobson 1988; Hock 2009). At the same time, Hobson and McCarley have critiqued other aspects of dream theory, including the idea that dreams may be "forgotten" by patients because they reveal feelings that are upsetting, thereby instigating motivated forgetting, or repression. In contrast to this view, Hobson and McCarley argue that the forgetting of dreams results from changes in the ratio of neurotransmitters during REM sleep that affect forebrain neurons involved in memory. These changes impair long-term memory while leaving short-term memory intact. Therefore, a subject is more likely to have good recall—even of affectively charged dream material—on awakening from REM sleep in a laboratory than on awakening at home the following morning. In other words, Hobson and McCarley (1977; McCarley 1981) view the poor recall of dreams as being due to neuronal changes rather than to repression.

Some neuroscience research findings contradict Hobson's conclusions by suggesting that dreaming is generated by forebrain structures and/or that forebrain structures are involved with motivational circuitry, offering support to Freud's views of dreaming as connected to wish fulfillment (Braun 1999; Solms 1997, 2000). Other researchers review empirical evidence about dreams from both neuroscience and cognitive psychology, as well as from the clinical situation, discussing the many complex implications for Freudian and other psychoanalytic theories, exploring issues such as the dreams of different kinds of patients, including those with trauma, and how dreams are used in—and change with—treatment (Ellman 1992; Fonagy et al. 2012).

Many authors who support Hobson's findings have also pointed out that there need be no contradiction between his findings and those of psychoanalysis with regard to understanding the meaning of dreams. These authors argue that Hobson's theory and the theories of psychoanalysis represent two separate sets of findings that originate from different methods of study and emphasize different aspects of dream states, dreaming, and dreams. Hobson's theory explores the neural correlates of the dream state, and psychoanalytic theory explores the meaning of dreams. Findings in one theory should strive to be consistent with the other, but neither theory can be translated into the terms of the other. In other words, although Hobson's neuroscientific findings are very important to the project of developing a complete theory of dreaming, they shed no light on the question of whether meaning is present in dreams, or what that meaning might be. And likewise, although Hobson and McCarley's understanding of how memory functions in relation to dreams is very important, this understanding sheds no light on aspects of memory that are influenced by psychological factors. As many have argued, until we have a framework that connects brain and mind, we must be careful about making explanatory or causal statements that link these two realms. For now, brain and mind must be treated "as two distinct orders, each having its own peculiar language, conceptualizations, and levels of abstraction" (Labruzza 1978, p. 1537; Mancia 1999; Wasserman 1984).

As an example of how to usefully integrate findings from very different fields, we can link theories from neuroscience to those from psychoanalysis by understanding that the neurophysiological processes that occur during dreaming, such as motor paralysis or penile erection, are sometimes utilized by the dreamer as symbolic elements that can assist in representing important thoughts. As one theorist has written in an effort to link theories from neuroscience to those from psychoanalysis,

> a loose analogy can be made with the relatively random inkblots of a Rorschach test. The patient projects onto these the meanings that reflect his particular psychology. Since the pontine discharges would presumably be even more random than the inkblots of the Rorschach, there

would be even more room within the frame for the dreamer to project his psychological conflicts. (Wasserman 1984, p. 842)

Exploring the Meaning of Dreams

Exploration of the meaning of dreams and/or of motivated forgetting requires use of the correct methods. These methods must be in the domain of psychology, not neuroscience. Data from the clinical situation is an important source of such psychological data. Other psychological methods appropriate for the study of the meanings of dreams include those using computers and "data mining" techniques. For example, according to Kelly Bulkeley of the International Association for the Study of Dreams (of which Hobson is also a member), researchers have been using quantitative methods of analysis for many years to study the content of dreams. In collaboration with psychologist G. William Domhoff at the University of California, Santa Cruz, Bulkeley describes a technique he calls "blind analysis," which exploits advances in digital technology to explore recurring patterns in dreams. As Bulkeley writes, the findings from several studies "provide compelling evidence that dreaming is not meaningless 'noise' but rather a coherent and sophisticated mode of psychological functioning" (Bulkeley 2013, p. SR 14).

Bulkeley and others publish often in the journal *Dreaming*. This journal explores dreams from many points of view, including the neuroscience of dream states, the meaning of dreams and nightmares, and the relationship of dreams to trauma, coping, and stress, to mention a few important topics.[1] Indeed, as Bulkeley goes on to write, "From the American Indian ritual of the vision quest to the Muslim prayer and dream-incubation practice of *istikhara*, there have been cultural traditions of enhancing people's awareness of their dreams and deriving insights from them. Modern researchers can learn from such practices and combine them with today's technologies, using new tools to fulfill an ancient pursuit" (Bulkeley 2013, p. SR 14). Bulkeley's techniques, and those of many others, support the understanding of psychodynamic psychiatry that dreams have meaning and that investigation of this meaning can be very useful in the exploration of psychological life.

[1]For an index of topics, see the website of the International Association for the Study of Dreams (http://www.asdreams.org) and the journal *Dreaming*, published by the American Psychological Association (http://www.apa.org/pubs/journals/drm/index.aspx).

Chapter Summary and Chart of Core Dimensions

Table 6–1 shows our Topographic Model chart of core dimensions with the addition of key concepts for Structure/Process and Treatment.

- **Topographic point of view:** Dreams are both conscious/preconscious and unconscious. The manifest dream is conscious; the latent dream thoughts are unconscious.
- **Motivational point of view:** In dream sleep, latent dream thoughts combine with wishes from childhood to seek expression. The forces of repression are at work even during sleep.
- **Structural point of view:** In the dream-making process, latent dream thoughts linked with wishes from childhood attach themselves, by association, to *day residue* (an innocuous image and/or event from current experience), which then appears in the manifest dream. In this way, latent dream thoughts are altered or disguised for the purpose of evading the censor, which is charged with the task of keeping unacceptable thoughts out of awareness.
- **Theory of therapeutic action:** The exploration of dreams is part of almost all psychodynamic psychotherapies.

TABLE 6–1. Topographic Model Part 2: The World of Dreams

Topography	Motivation	Structure/Process	Development	Psychopathology	Treatment
The mind is divided into three regions: Conscious Preconscious Unconscious	The unconscious mind consists of wishes always striving for expression Unacceptable wishes are kept in check by forces of repression from the preconscious/ conscious mind	The unconscious operates according to primary process; the preconscious/ conscious operates according to secondary process A censor separates the unconscious and the conscious/ preconscious mind	Primary process is the earliest mode of mental functioning; secondary process develops later Wishes come from childhood and form the basis of infantile sexuality Wishes become increasingly unacceptable	Neurosis arises from conflict between the conscious/ preconscious domains and the unconscious domain Return of the repressed Repetition compulsion	Free association ("fundamental rule") Examination of transference and resistance Therapeutic interpretation and reconstruction Insight ("Make the unconscious conscious")
		Dreams	Censoring capacity grows		**Dream exploration**

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CHAPTER 8

A New Configuration and a New Concept: The Ego

This chapter introduces readers to the Structural Model of the mind, briefly defining the concepts id, ego, and superego. It reviews the reasons why the psychoanalytic model of the mind needed to be changed. It explores the concept of ego in greater depth. Vocabulary introduced in this chapter includes the following: *adaptation, autonomous ego functions, average expectable environment, ego, ego functions, ego identity/identity, ego psychology, ego strength, ego weakness, homeostasis, id, identification, internalization, reality testing, superego,* and *tripartite model.*

The Structural Model of the mind was the second version of the psychoanalytic model of the mind. Freud introduced the Structural Model in 1923, in his book *The Ego and the Id* (Freud 1923/1962). As we will see, Freud offered his revised model of the mind in response to his growing awareness that the Topographic Model of the mind had many theoretical inconsistencies, and most important, that it failed to help him explain the ever-wider range of clinical problems with which he was confronted. As a result of this awareness, Freud began to question whether the best way to understand the psychological struggles of his patients was to explore them along topographic lines. He proposed that mental life might be best understood not as the result of a struggle between unconscious and preconscious/conscious domains of the mind but instead as the result of the interaction between three structures of the mind, which he called *ego, id,* and *superego.* These structures

are distinguished from one another by their different motivations, structural properties, modes of operation, and development. To summarize briefly, *ego* is the name for the executive function of the mind responsible for maintenance of homeostasis and adaptation; *id* is the name for the motivational forces in human psychic life, called the *drives;* and *superego* is the name for the moral imperatives and ideals that we commonly call the *conscience.*

In the 1950s, especially in the United States, the Structural Model of the mind became the dominant model of mental functioning used by psychodynamic clinicians. Over time, it became synonymous with the term *ego psychology,* the branch of psychoanalysis that emphasizes the ego and its role in psychological functioning. In addition, the Structural Model of the mind is considered to be synonymous with the term *tripartite model of the mind* and also often with the term *conflict theory,* which emphasizes how the ego manages the competing aims of the id and the superego in accord with external reality by forging compromises that affect all of mental life. Finally, the Structural Model of the mind (and/or Ego Psychology/Conflict Theory) has often been considered to be synonymous with what has been called *classical psychoanalysis* or even simply *Freudian psychoanalysis.* Beginning in the 1970s and continuing into the present, the Structural Model of the mind (and Ego Psychology) has often been in competition with Object Relations Theory and/or Self Psychology (and, more recently, with Relational Psychoanalysis) for dominance in the world of psychodynamic psychiatry (see Part IV). Among the aims of this book is to show that these models can be combined (along with the Topographic Model) into an integrated point of view.

Problems Leading to Revision of the Topographic Model

What problems led Freud to revise his theory in the form of the Structural Model of the mind? Although we have seen that the Topographic Model is useful in many ways, Freud soon discovered that his division of the mind into unconscious and preconscious/conscious s was not adequate to describe all of the complexities of mental life. To review briefly, in the Topographic Model, conflict occurs between unconscious wishes seeking expression and preconscious/conscious forces of repression, which respond to the demands of reality, society, and morality. The unconscious is entirely wishful and uninhibited, and the preconscious/conscious includes all capacities for organization, appraisal, planning, and delay. This model presents several problems.

First of all, the model was challenged by Freud's observation, perhaps already obvious to the astute reader, that both the defenses against the emergence of unconscious wishes and the censor at whose behest these defenses operate are themselves unconscious. They cannot be brought to consciousness simply by attending to them, as we can with the preconscious. For the most part (with some exceptions), we are not aware of deliberately excluding thoughts from consciousness or of censoring them. Indeed, if we were, the whole purpose of a defense intended to produce "not knowing" would be defeated. In the clinical situation, the patient shows evidence of resistance, but this resistance is not mounted consciously. In other words, ***the psychoanalytic model of the mind must include an unconscious that is capable of appraisal and defense.***

Second, Freud began to observe that in more than a few instances, the thoughts and feelings defended against are not wishes at all; rather, they are moral concerns. Freud's work with patients suffering from *melancholia* (the term that he used for depression), obsessional symptoms, and masochism led to his understanding that moral imperatives and self-punitive tendencies can also operate unconsciously. These moral imperatives may include ideals, taboos, punishments, and rewards. In other words, ***the psychoanalytic model of the mind must include an unconscious that contains moral imperatives in addition to wishes.***

Finally, as we have seen in Chapter 7 in our exploration of the oedipus complex, the unconscious is replete with stories organized in narrative form. When Freud first began clinical work, he did not worry much about the structure or organization of psychological experience. However, as his theory developed, he began to recognize that certain mental contents are organized in ways that, in themselves, influence the nature of experience. As we have seen, Freud recognized early on that thoughts in the form of wishes had a special place in mental life. Soon, with the help of ideas borrowed from colleagues (including Carl Jung and others), Freud began to understand that these wishes are organized into *complexes*—groups of associated ideas, feelings, and wishes—that are stored together in the mind. He went on to develop the idea that mental experience, especially emotionally charged experience, is organized in the form of fantasies, or imaginative story-like narratives featuring the imagining subject in a major role. The concept of unconscious fantasy began to take on major importance in the psychoanalytic approach to understanding subjective experience (see Chapter 7, "The Oedipus Complex"). However, the idea that unconscious mental life is organized as a story contradicts the Topographic Model of the mind, which asserts that unconscious mental life can only be wishful, organized by primary process. In other words, ***the psychoanalytic model of***

the mind must include an unconscious that can be organized in narrative form. Ultimately, for these three reasons, the Topographic Model had to be revised (Arlow and Brenner 1964).

As the Topographic Model Collapses, the Unconscious Expands

Another way to look at the transition from the Topographic Model to the Structural Model of the mind is to recognize that the important concept of the unconscious has itself changed dramatically. Contemporary psychodynamic psychiatrists no longer refer to the original idea, central to the Topographic Model, of a unified unconscious domain of the mind characterized by a single type of childish, wishful content or a single kind of mental processing. We can see from our earlier look at the Topographic Model how the Freudian unconscious got its widespread and false reputation as a "cauldron full of seething excitations" (Freud 1933/1962, p. 73; Park and Auchincloss 2006). However, when Freud formulated the Structural Model of the mind, he dismantled the Topographic Model, with its "seething cauldron" view of the unconscious. This dismantling was largely in response to his own growing awareness that unconscious mental life includes not only peremptory wishes but also moral, strategic, and reality-oriented strivings, many organized in ways that are logical and goal directed. In other words, with the introduction of the Structural Model, the idea of the unconscious as an underworld full of primitive, irrational, and wishful strivings, hell-bent on seeking expression at all costs, was no longer viable. In the new model, the dynamic unconscious was envisioned as including strivings for self-preservation, capacities for appraisal and choice, and moral imperatives, as well as childish, pleasure-seeking wishes (see Chapter 3, "Evolution of the Dynamic Unconscious").

The Ego

This brings us to the new and important concept of the ego, or the executive agency of the mind. Among the most important novel features of the Structural Model of the mind is its greater emphasis on our psychological capacities for *self-regulation* (sometimes called *homeostasis*) and for *adaptation*. Although these capacities are implied in the Topographic Model, with a censor capable of judgment and delay, they are given vastly greater attention in the new Structural Model—all posited to be capacities of this new structure called the ego. The word *ego* was coined by

James Strachey in his translation of Freud's *das Ich* or "the I." Strachey was the editor in chief of the English language edition of Freud's writings, *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, published between 1956 and 1974. Strachey and his team of editors are responsible for coining familiar words such as *ego, id, parapraxis, cathexis*, and others. Prior to 1923, Freud had used the term *ego* in variety of ways, but mostly to designate the whole mind or the whole person. He did not formally assert that the ego is the executive function of the mind—or, as he put it, "a coherent organization of mental processes"—until his introduction of the Structural Model (Freud 1923/1962, p. 9).

When Freud developed this formal concept of the ego, he launched the beginning of an enormous interest in the processes of homeostasis and adaptation and in the *ego functions* that comprise these important processes. These ego functions include capacities previously attributed to the conscious/preconscious mind in the Topographic Model, such as censorship and defense, as well as characteristics assigned to secondary process in the Topographic Model, such as reason, logic, and judgment. The ego functions also include cognition, perception, memory, motility, affect, thinking, language, symbolization, reality testing, evaluation, impulse control, and affect tolerance, to mention an important few. Ego functions include the vital tasks of mediating conflict and forging compromise (see Chapter 10). They also include the key tasks of forming and maintaining mental representations, including representations of self and object (see Chapters 11 and 12). The ego has conscious, preconscious, and unconscious aspects; however, for the most part, ego functions operate outside of awareness. Only a few ego functions operate preconsciously and consciously (Auchincloss and Samberg 2012, p. 69).

Let us explore the processes of self-regulation/homeostasis and adaptation in greater detail. To begin with, *homeostasis* is a concept borrowed by psychoanalysis from general biology, which explores this important function in every organism. Recently, the field of cognitive science has contributed a great deal to our understanding of how this function works (see section "The Rise of Cognitive Psychology" in Chapter 3). We also mentioned some aspects of this function in Chapter 7 when we discussed contemporary views of the oedipus complex. As we saw then, the psychoanalytic model of the mind helps us understand the capacity to regulate conflicting motives by appraising them, deciding on priorities, and forging compromises among them.

The Structural Model of the mind marks a vast improvement over the Topographic Model in terms of delineating conflicting motivations, explaining how we at arrive at compromises, and explicating the ego functions necessary for forging these compromises. For example, in the

Structural Model, *defense* is defined as both a capacity of the ego and one of the most important elements of compromise. In the new model, the range of possible defenses expands beyond repression to include an almost infinite array of strategies by which the mind can manage conflict. Managing the subjective experience of psychic conflict requires additional ego functions, such as impulse control and affect tolerance. As noted previously, we will discuss conflict, defense, and compromise in greater detail in Chapter 10.

In addition to having the function of self-regulation, the ego is defined as the mental structure with the capacity for adaptation to external reality. *Adaptation* is another concept borrowed by psychoanalysis from general biology and refers to the survival needs of every organism and how these survival needs are met in interaction with the environment. Adaptation includes the fit between an individual and the environment and the psychological processes that enhance this fit by changing, controlling, and/or accommodating to the environment (Auchincloss and Samberg 2012, p. 6). When applied to psychoanalytic psychology, the concept of adaptation emphasizes the fact that human psychology is shaped not only by conflicting internal motivations but also by interactions with the relevant environment. For the most part, psychoanalysis stresses the caregiving environment, the family, and sometimes the surrounding culture. As we will see in Chapter 10, adaptation to external reality plays an important role in mediation of conflict and forging of compromise. As we will see in Part IV, in both Object Relations Theory and Self Psychology, exploration of how the growing child develops psychological structures in interaction with the care taking environment becomes ever more important as the psychoanalytic model of the mind develops.

The earlier Topographic Model of the mind does include some awareness of the importance of adaptation to external reality in psychological life. For example, the Topographic Model posited that unconscious wishes are in conflict with the demands of external reality or society as perceived by the preconscious/conscious. Furthermore, Freud argued that the secondary processes of the preconscious/conscious regions of the mind develop in response to the infant's growing awareness that the primary processes are not enough to achieve satisfaction in the real world. Finally, arguing within the Topographic Model of the mind, Freud also argued that motives for *self-preservation* (an early version of what would soon become the ego) were in conflict with unconscious wishes. However, the Topographic Model of the mind places strongest emphasis on the unconscious wishes themselves. Indeed, most of the writing of Freud consisted of his attempts to characterize the nature of the unconscious. In other words, although the Topographic Model of the mind did acknowledge the impact of the external world, as delineated above, this impact was poorly conceptualized.

The new Structural Model of the mind marked a vast improvement over the Topographic Model in terms of understanding the mind's capacity to adapt to external reality. For example, the capacity for *reality testing*, defined as an ego function, can now be studied in greater depth. In addition, we find a growing interest in processes of *internalization*, also an ego function, which can also be studied in greater depth. Internalization is another concept borrowed from general biology, defined (often in opposition to *externalization*) as an organism's tendency to take in aspects of the external world. Indeed, Freud first described the ego itself as developing under the impact of perceptual stimuli, or awareness of external reality. Later he described how the ego gains strength and *character* from the internalization of interpersonal relationships (see Chapters 9 and 10 for an introduction to the concept of *character*). For example, *identification* is defined as a modification of the self-image that results from internalizing the traits of others. We have seen how oedipal strivings are managed through the development of identifications with parents who have previously been experienced as rivals. Understanding the many aspects of internalization (including identification) will become increasingly important as the psychoanalytic model of the mind develops, and as we explore Object Relations Theory and Self Psychology in Part IV (Vaillant 1977, 1983).

Contribution of the Ego to Theory of Psychopathology and Therapeutic Action in the Structural Model

The Structural Model of the mind, and the concept of the ego in particular, has had a profound effect on how psychodynamic psychiatrists think about mental health, psychopathology, and treatment. Delineation of the various ego functions allowed clinicians to evaluate them individually and to thereby give a richer description of mental health expressed as *ego strengths*, and psychopathology expressed as *ego weaknesses*. Although these concepts have been refined over time, they are in widespread use in the contemporary mental health professions to describe the level at which our patients function.

In the Topographic Model of the mind, neurotic psychopathology was understood as resulting from the inflexible, stereotyped influence of unconscious wishes in situations where repression was too rigid or

wishes too strong. The goal of treatment was the search for hidden but pathogenic unconscious striving with the aim of "mak[ing] conscious everything that is pathogenically unconscious" (Freud 1901/1962, p. 238; Freud 1916–1917/1962, p. 282). What Freud meant by this statement was that by subjecting unconscious wishes to conscious judgment rather than to repression, the patient would have greater control over his or her mind (Freud 1905/1962). With the introduction of the Structural Model, neurotic psychopathology came to be understood as the result of inflexible or maladaptive efforts on the part of the ego to forge compromise among competing aims. Under the new model, the goal of treatment was to understand how the ego manages (or fails to manage) conflict, with the aim of strengthening the ego's adaptive capacity. With this in mind, we can better understand Freud's famous statement, "Where id was, there ego shall be" (Freud 1923/1962, p. 56; Freud 1933/1962, p. 80). These new ways of thinking about psychopathology and treatment will be explored in greater depth in Chapter 10 ("Conflict and Compromise").

The Work of Well-Known Ego Psychologists

Anna Freud

The Topographic Model of the mind was largely the creation of one man, Sigmund Freud. However, although introduced by Freud, the Structural Model of the mind was elaborated by many others. For example, Freud's youngest daughter, Anna Freud (1895–1982), explored the defensive capacities of the ego in her book *The Ego and the Mechanisms of Defense* (A. Freud 1936/1974). Anna Freud is probably best known as a major proponent of the field of psychodynamic child psychiatry and psychotherapy, but in this role, she also made many contributions to the study of normal and pathological ego development (A. Freud 1965/1975). We will not explore the field of psychodynamic child psychiatry in depth, or even the vast field of ego development, as such an exploration would take us far afield. However, it is useful to notice that Ego Psychology developed alongside the growth of psychoanalytic developmental theory and child observation and that the two are closely related (Gilmore and Meersand 2013).

Heinz Hartmann

Another important contributor to the field of Ego Psychology was Heinz Hartmann (1894–1970), whose book *Ego Psychology and the Problem of Adaptation* (1939/1958) made explicit the importance of the mind's capacity for adaptation to external reality. In Hartmann's view, the ego develops in the course of interactions between the mind's inborn potential and what he called the *average expectable environment*. The average expectable environment includes aspects of the usual caregiving environment, such as love, nurturing, and safety. Hartmann was also important for having described *autonomous ego functions*—inborn capacities of the mind that develop independently, or autonomously, from conflict and that include thought, memory, perception, cognition, and motility. As we have seen in some of the examples in Chapter 7 on the oedipus complex, autonomous ego functions can be drawn into conflict and become distorted. As we will see below, the delineation of autonomous ego functions, and the concept of the ego in general, allows psychoanalytic psychology to develop in close contact with the rest of psychology, including cognitive neuroscience.

Erik Erikson

A final ego psychologist familiar to most of our readers is Erik Erikson (1902–1994), who after Sigmund Freud is possibly the best known psychoanalyst in the United States (Park and Auchincloss 2006). Erikson is famous for his eight-stage theory of human development throughout the life cycle, which includes the stages *trust/mistrust, autonomy/shame and doubt, initiative/guilt, industry/inferiority, identity/role confusion* (or *diffusion*), *intimacy/isolation, generativity/stagnation,* and *ego integrity/despair.* In the successful negotiation of each of these stages, the developing individual acquires the psychological capacity for which each stage is named (e.g., trust); if this capacity is not attained, a pathological state of mind ensues (e.g., mistrust). Capacities result from interactions among inborn capacities, external reality, interpersonal relationships, and the surrounding culture. One of Erikson's most important contributions was the concept of *ego identity,* later shortened to *identity,* which is defined as the consolidation of a stable sense of oneself as a unique individual in society (Erikson 1950, 1956, 1959; see also Auchincloss and Samberg 2012, p. 70). Erikson's argument that ego development can only be understood in the context of the surrounding culture has allowed psychoanalytic psychology to develop in close contact with the rest of the social sciences, including sociology, anthropology, and others. In addition, Erikson's interest in the importance of the object in each stage and the importance of developing a healthy sense of identity presages the development of Object Relations Theory and Self Psychology (see Chapters 11 and 12).

Points of Convergence Between the Structural Model and General Psychology

As we have seen, the Structural Model of the mind and Ego Psychology brought with them an interest in a wide array of mental processes and capacities. Some of these capacities—such as many related to the management of conflict (see Chapter 10)—operate outside of awareness because they are repressed. However, the ego also includes many processes and capacities that operate outside of awareness not because they are repressed but because they are designed to operate this way. These capacities are part of what Freud called the descriptive unconscious (see Chapters 3 and 5). Indeed, with the emphasis of the Structural Model on the mind's capacities for homeostasis and adaptation, Ego Psychology brings the psychoanalytic model of the mind into closer contact with the rest of general psychology (Kagan 1983; Mischel et al. 1989; Piaget and Inhelder 1969; White 1959). The Structural Model of the mind also brings the psychoanalytic model of the mind into contact with aspects of neuroscience (Casey et al. 2011; Ochsner and Gross 2005; Ochsner et al. 2002). The National Institute of Mental Health, which aims to arrive at a new way of classifying psychopathology based on dimensions of observable behavior and neurobiological measures, has introduced Research Domain Criteria that include the domain "Cognitive Systems," which in the psychoanalytic model of the mind are defined as ego functions (Cuthbert and Insel 2013).[1]

During a period in the development of the psychoanalytic model of the mind in the 1950s and 1960s, proponents of Ego Psychology, including Hartmann and others, went so far as to argue that psychoanalysis was on its way to becoming a "general psychology" (Hartmann 1964). These ego psychologists understood that a complete psychology should include many things, including findings from the clinical situation, experimental psychology, developmental psychology, cognitive neuroscience, and the social sciences. They argued that the Structural Model of the mind, especially the concept of the ego with its autonomous functions, brought psychoanalysis closer to developing such a general psychology, or a complete understanding of the mind. For those readers interested in history, this view of psychoanalysis coincides with a period of relative hegemony of psychoanalysis in American psychiatry. However, this broad, expansive view of the possibilities of the psychoanalytic model of the mind has fallen out of favor. Most contemporary psychoanalysts (the author included) feel that psychology is a composite field that includes many kinds of knowledge, from experimental psychology, developmental psychology, cognitive psychology, linguistics, artificial intelligence, philosophy of mind, neuroscience, and others. This book seeks not to delineate a complete theory of mind, but rather to delineate the special contributions of the psychoanalytic model of the mind to a theory of mind. It also seeks to outline a psychoanalytic model of the mind that is consistent with information from neighboring disciplines, especially from the cognitive neurosciences. At the same time, as we saw in Part I, the rest of general psychology is slowly but surely inching its way toward the psychoanalytic model of the mind, in a quiet process that continues to this day. In the next chapter we will discuss the other components of the Structural Model of the mind: the id and the superego, emphasizing how in these structures, also, we can find links to neighboring disciplines.

[1]See nimh.nih.gov/research-priorities/rdoc/index.shtml (accessed January 12, 2014).

Chapter Summary and Chart of Core Dimensions

Table 8–1 introduces our Structural Model chart of core dimensions, in which we have placed the following key concepts:

- **Topographic point of view:** The ego and superego have both conscious/preconscious and unconscious aspects. The id is defined as entirely unconscious.
- **Motivational point of view:** The ego seeks both *homeostasis* (self-regulation) and *adaptation*. The id is the seat of our basic pleasure-seeking motives, called *drives*. The superego is concerned with *moral imperatives*. These motivations are always in conflict; as a result, compromise among them must be forged.
- **Structural point of view:** The mind is divided into three structures: ego, id, and superego. The ego has capacities—termed *ego functions*—that include faculties previously attributed to primary process in the Topographic Model, such as censorship and defense, as well as characteristics associated with secondary process, such as cognition,

perception, memory, evaluation (encompassing reality testing), affect and impulse tolerance, and the ability to form mental representations. The ego also has capacities for *internalization* (an organism's tendency to take in aspects of the external world), *identification* (modification of the self-image that results from internalizing the traits of others), and the formation of *ego identity* (the consolidation of a stable sense of oneself as a unique individual in society).

- **Developmental point of view:** The ego develops throughout the life cycle, especially during childhood. In Erikson's eight-stage theory of human development, each stage represents a specific psychological capacity that must be acquired for the ego to develop successfully: *trust/mistrust, autonomy/shame and doubt, initiative/guilt, industry/inferiority, identity/role confusion* (or *diffusion*), *intimacy/isolation, generativity/stagnation,* and *ego integrity/despair.*
- **Theory of psychopathology:** In the Structural Model, mental health is assessed in terms of ego strength, and psychopathology in terms of ego weakness.
- **Theory of therapeutic action:** Exploration of the strategies by which the ego maintains homeostasis and adaptation in the face of conflict is part of every psychodynamic psychotherapy—hence the phrase "Where id was, there ego shall be."

TABLE 8–1. Structural Model Part 1: A New Configuration and a New Concept: The Ego

Topography	Motivation	Structure/Process	Development	Psychopathology	Treatment
The ego and the superego have both conscious/preconscious and unconscious aspects	The ego, superego, and id each have separate aims: The ego—homeostasis and adaptation The superego—moral imperatives	The mind is divided into three structures: ego, superego, and id The ego Ego functions Defense Internalization Identification Ego identity	Ego development Erikson's stages	Ego strength/ego weakness serves as an index of mental health/illness	Strengthening the ego "Where id was, there ego shall be"
The id is entirely unconscious	The id—drives Conflict is always present because of competing aims				

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CHAPTER 9

The Id and the Superego

This chapter describes the concepts of id and superego in greater detail. It also explains drive theory, libido theory, and psychosexuality. The advantages and disadvantages of a drive view of motivation are explored. Vocabulary introduced in this chapter includes the following: *aggression, aggressive drive, anal stage, autoerotic, drive, drive theory, ego ideal, erotogenic zone, fixation, genital stage, guilt, infantile sexuality, instinct, latency, libido, libido theory, object seeking, oedipal period, oral stage, phallic stage, preoedipal period, psychic energy, psychosexual stages, psychosexuality, reaction formation, regression, separation anxiety, sexuality, shame, stranger anxiety,* and *sublimation.*

To understand how the Structural Model of the mind helps us to understand normal and pathological mental functioning, we must move on to explore the id and the superego. As noted in Chapter 8 ("A New Configuration and a New Concept: The Ego"), the ego has the job not only of self-regulation/homeostasis and adaptation but also of mediating conflict and forging compromise between the demands of id and superego, in accord with external reality. What are the id and the superego? How do they function, and what do they help us to understand about the mind?

The Id

In the Structural Model of the mind, the id is the part of the mind that contains our basic pleasure-seeking motives. In the Structural Model, the

forces of the id are called *drives*. These drives consist of the drive for psychosexual satisfaction and the drive for aggression. Drive theory was the first fully developed theory of motivation in the psychoanalytic model of the mind. In this chapter, we explain what *drive theory* is, along with its well-known corollary *libido theory*. We also explain what the *aggressive drive* is. We explain which aspects of drive theory are important and how this theory has been updated in contemporary psychoanalysis.

The word *id* (like the word *ego*) was coined by James Strachey in his translation of Freud's term *das Es* (literally "the *It*"[1]). The *id* is the structure of the mind most closely associated with biological needs of the human organism, including sexual and aggressive urges. The id is defined as entirely unconscious. It is made up of inborn needs and acquired passions, both of which can be repressed.

In the Structural Model of the mind, the concept of the id inherits almost all of the properties of the unconscious as described in the Topographic Model of the mind. For example, the id includes the quality of wishfulness, it is often unacceptable to consciousness, and it is kept from awareness by the force of repression. It operates according to the primary process mode of functioning, seeking satisfaction and pleasure without concern for the consequences. Finally, it seeks always to escape repression and to influence thought and behavior. In the service of this escape from repression, the id assumes many disguises. We will explore all of these features in greater detail here and also in Chapter 10, where we discuss how the id contributes to conflict and compromise.

The id is always in close contact with the ego, with which it functions in a tight symbiosis. Each structure is dependent on the other. The id lacks the organizational and rational capacities of the ego, and unlike the ego, it cannot recognize the world outside the mind. Therefore, the id can express itself only through the activities of the ego. The ego lacks the motivational power of the id. Therefore, in order to accomplish anything, the ego must borrow this power from the id. Freud represented the tight relationship between ego and id in his famous metaphor of the rider (ego) and the horse (id). In the functioning of this team, most of the power is provided by the horse, and most of the planning is provided by the rider. However, the uneasiness of their relationship is also represented in the metaphor. Imagine what happens when the rider is unable to direct the horse to go where he wants it to go. If the rider fails, the team runs into trouble. In other words, if the ego fails, the person develops psychopathology (Freud 1923/1962). Again, we will explore the contributions of the id (and of the ego and the superego) to psychopathology in both this chapter and Chapter 10.

[1]Here Freud acknowledged his adaptation of the term from the German psychiatrist Georg Groddeck (1923/1949), who employed *das Es* to describe the way that man is "lived by" unknown and uncontrollable forces. Freud also linked this use with Friedrich Nietzsche, who used *das Es* to refer to the component of human nature that is under the control of natural law (Auchincloss and Samberg 2012).

For several reasons, most contemporary psychoanalytic practitioners do not use the word *id* very much anymore. First of all, the id is defined as consisting of wishful desires alone, without any organization beyond that of the primary process. Therefore, we cannot experience the contents of the id directly; we can only infer its existence from its contribution to compromises forged by the ego. In addition, the id and the drives are associated with the language of *psychic energy* in which these concepts were first described by Freud. This language has been much criticized both within and outside of psychoanalysis (Brenner 1982; Holt 1976; Klein 1976; Rosenblatt and Thickstun 1970; Schafer 1976). In other words, in the Structural Model of the mind, the id is conceived of as a place in the mind made up of purely wishful drive energy. For these reasons, even theorists who use the word *drive* rarely invoke the term *id*. However, work in the neurosciences has provided some support for the concept of a deep level of motivation and reward that seems to correspond to aspects of the concept of id (LeDoux 1996; Olds and Forbes 1981; Panksepp 1998). There are also links between the concept of id and the domain "Positive Valence Systems" of the National Institute of Mental Health Research Domain Criteria.[2] The concept of id (and drive) is also still useful as a way of conceptualizing important aspects of motivation. We will say more about these below.

Freud's Drive Theory

Let us turn now to the concept of *drive*, without which we cannot understand the id. As we have said above, the id consists of the sexual and aggressive drives. A *drive* is defined as a psychological representation of a motivational force that emerges from the body as a result of an individual's biological needs. Indeed, we cannot improve on Freud's own definition of *drive* as "a concept on the frontier between the mental and the somatic, as the psychical representative of the stimuli originat-

[2]See nimh.nih.gov/research-priorities/rdoc/index.shtml (accessed January 12, 2014).

ing from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body" (Freud 1915/1962, p. 122). A drive exerts a constant pressure on the psychological system, continuously stimulating mental activity. It serves as the motivating force behind all human psychological experience and activity (Auchincloss and Samberg 2012, pp. 65–67). The term *instinct*, with which *drive* is often confused, is defined in general biology as a species-specific, inherited pattern of behavior that does not have to be learned, rather than as an inborn motivational force (Lorenz 1937, 1949/1979; Tinbergen 1951).

Where does the concept of *drive* come from? At first, in the Topographic Model of the mind, the psyche is forced into action by wishes, many of which are unacceptable to the censor. In the Structural Model, these same wishes are unacceptable to the ego. In 1905, in his book *Three Essays on the Theory of Sexuality*, Freud (1905/1962) organized his observations about wishes into his new and more elaborate *drive theory*. Drive theory includes discussion of the role of drive in development, in normal functioning, and in psychopathology. Because Freud formulated drive theory in 1905, when the Topographic Model of the mind was still new and the Structural Model of the mind had not yet been developed, the concept of drive spans both models and is important to both. Originally, in the Topographic Model of the mind, Freud conceptualized only one drive, which he called *libido*. Later, with the introduction of the Structural Model, he added a second drive, *aggression* (Freud 1920/1962). As we will see, the concept of drive was modified in later versions of the psychoanalytic model of the mind. For example, we will see some of these modifications when we study Object Relations Theory in Chapter 11. The concept of drive is not used at all in Self Psychology (discussed in Chapter 12). Certainly the concept of *motivation* has moved beyond sexuality and aggression as the only two forces active in the human mind. Nevertheless, an aim of this book is to show how the concept of drive continues to be useful, even if our view of motivation has expanded.

The Sexual Drive

Libido and Psychosexuality. *Libido* is the name that Freud gave to the drive for sexual pleasure. The word *libido* is derived from the Latin for "wish" or "desire." Sometimes Freud used the word *libido* in much the same way we do today, to mean sexual desire or sexual appetite. However, the term also has a more specific use in the psychoanalytic model of the mind, where it is synonymous with the drive for sexual satisfaction. Ideas about the origins, transformations, and effects of libido have been collectively referred to as *libido theory*. When we discuss libido theory, it might be helpful to refer to Appendix A. Almost everyone associates Freud with the idea that "Everything we do is because of sex." In other words, by explaining what libido is, we can explain why Freud has the reputation for thinking so much about sex, and, more important, what his ideas actually were.

In order to understand what is meant by libido, we need to understand what Freud meant by *sexuality* (or what he often called *psychosexuality*). In Freud's view, sexuality meant much more than the sexual coupling of adults during intercourse. Freud equated psychosexuality with the human search for sensual bodily pleasure in all its forms. In his view, this search begins immediately at birth and reflects an inborn tendency to seek bodily pleasure. Bodily pleasure is attached to the survival needs of the organism, which vary with each stage of development. For example, in the infant's earliest days, the search for bodily pleasure is centered in the mouth or oral cavity, thus ensuring that the infant will find nourishment; next, the search becomes centered in the anus (and urethra), ensuring that the child will defecate and urinate; and finally the search becomes centered in the genitals, ensuring that the child (or adolescent) will become interested in his or her genitals, ultimately using them to have sexual intercourse and thereby procreate. In other words, throughout development, the search for bodily pleasure takes different forms, depending on what is most important at each stage of life.

We will discuss the oral, anal, and genital stages in greater detail later in this chapter. However, according to libido theory, the quest for pleasure at every stage is always fueled by the same drive, called *libido*. In other words, when Freud talked about sexuality, he meant a great deal more than just adults engaging in sexual liaisons. We are correct when we say that Freud asserted that everything we do is caused by our interest in sex. However, we are not correct when we say that Freud asserted that everything we do is the result of our interest in sexual intercourse. In Freud's view, sexual intercourse is merely one manifestation of the workings of libido and is far too narrow a term to capture all that is meant by the concept of psychosexuality. As we will see, in this early period Freud did use the concept of libido to explain just about everything, from adult sexual behavior, to neurosis and character, to culture. Indeed, libido theory is Freud's early "theory of everything," which has led to most people's associating Freud with sex (Freud 1915/1962) (see Appendix A, "Libido Theory").

Psychosexual Phases of Development. Let us go on to explain more about how libido develops. According to libido theory, libido has its source in any one of a number of *erotogenic zones*, which develop according to a predetermined maturational sequence. These erotogenic zones are the *oral zone*, the *anal zone*, the *phallic zone*, and the *genital zone*. In response to the continuous demand for pleasure created in each of these zones, the mind creates wishes, fantasizes about how these wishes will be satisfied, and ultimately plans for how satisfactions will be achieved. These plans are called *libidinal aims*. Libidinal aims reflect the influence of each zone on a series of psychosexual phases—also named oral, anal, phallic, and oedipal/genital—that each child must transverse. By the way, when Freud delineated a stage/zone that he called *phallic*, he named it that way because he believed that both sexes conceived of only one type of (male) genitalia; in response to revisions in theory, this phase was renamed the *early genital phase*. (For further discussion of the problems in Freud's views of female development, see Chapter 7, "The Oedipus Complex".) Libidinal aims may be directed toward the child's own body (*autoerotic*) or toward another person (*object seeking*). Because stimulation of the erotogenic zones by parents or other caretakers occurs in the course of normal childhood, caretakers always become the first *libidinal objects* of the child's libidinal aims.

The first evidence of the libido at work is the infant's obvious pleasure and satisfaction while sucking either his mother's breast or his own thumb (in what is known as the oral phase). Pleasurable pursuit of anal and genital satisfactions is also easily observed in the activities of young children, who often play games with their own feces (during the anal phase) and who love to show off their genitals (during the early genital [phallic] phase). The early genital/phallic phase is followed by the genital/oedipal phase, which (as we have seen in Chapter 7) reflects the child's erotic/romantic interest in his or her caretakers. Indeed, as we can see, the oedipus complex has the distinction of being the first scenario about infantile sexuality to be invented by Freud, but it is not the first in terms of the development of the child. The oral, anal, and early genital (phallic) phases are often referred to collectively as the *preoedipal* stage of development. The preoedipal and oedipal stages of development are often referred to collectively as *infantile sexuality*. The oedipal period is followed by the stage of *latency*, a period of relative quiescence during which the force of repression holds the sexual drive in check until the hormonal changes of adolescence bring it to the fore again. The many aspects or components of libido finally come together in the service of reproduction at a relatively late stage of development, adolescence and/or adulthood.

Although originally attached to the survival needs of the species, libidinal aims quickly become independent of these needs. Through complex transformations, they become a powerful source of motivation in their own right, serving as a constant source of stimulation to which the mind must respond. In other words, as with the oedipus complex (see Chapter 7), libidinal aims from all stages of development do not go away, but continue to act in the mind of the adult, influencing later psychological experience and activity. First of all, we detect clear evidence of the influence of libidinal aims from the oral, anal, and early genital (phallic) zones during adult sexual activity and foreplay. If infantile sexuality is totally repressed, we see sexual inhibition (see Appendix A). However, most often we see the influence of early psychosexual stages in more disguised forms. Indeed, among the most intriguing aspect of libido theory is that it alerts us to the existence of sexual pleasure hidden in behavior that is apparently nonsexual. Many neurotic symptoms represent forbidden sexual fantasies in a disguised form. For example, hysterical difficulties swallowing or eating may reflect fellatio fantasies; obsessional rituals involving touching may reflect conflicts over masturbation (see Appendix A, "Libido Theory").

Infantile sexuality is transformed not just into neurotic symptoms but also into character traits through the processes of sublimation and reaction formation, new defenses that Freud described for the first time in relation to the development of character (Freud 1908/1962). In *sublimation*, a forbidden wish is deflected from its original aim to one with a higher social value. For example, a "voracious reader" may satisfy an oral wish to devour food through a love of reading. In *reaction formation*, a forbidden wish is transformed into its opposite. For example, the anal pleasure that accompanies playing with feces may be transformed into character traits such as fastidious cleanliness and compulsive orderliness. If a person evinces symptoms or character traits that reflect the overwhelming influence of a particular stage, he or she is often said to have a *fixation* on that stage. Fixation may be caused by either overstimulation or deprivation during a particular stage. If a person substitutes pleasures from an earlier stage for those at a later stage that are either frightening or forbidden, he or she is said to be showing evidence of *regression*. For example, a woman who always picks a fight with her husband on Friday night because "he isn't helping her clean the bathroom" may be *regressing* to a preoccupation with anal concerns in order to avoid the possibility of a sexual encounter at the genital/oedipal level. We find here the basis for Karl Abraham's (1877–1925) oral, anal, early genital/phallic, and genital character types to which we still refer today (Abraham 1921/1948, 1924/1948, 1925/1948). We often describe people with *oral character* as those

who appear fixated on finding satisfaction or pleasure in being cared for or fed, or in eating and/or drinking too much. We describe people with *anal character* in much the same way as Freud did, as characterized by "parsimony, orderliness, and obstinacy" (Freud 1908/1962). Finally, we often encounter people who seem to have an excessive interest in exaggerated displays of genital prowess without being much interested in relationships; we are likely to refer to these people with the later term *phallic narcissistic character* (Reich 1933/1945). In Chapter 10 ("Conflict and Compromise"), we will explore the concept of character in greater depth, discussing how Ego Psychology improved upon this early theory. Later, in Chapters 11 and 12, we will see how the concept of character is improved upon even more by the advances of Object Relations Theory and Self Psychology. Later in this chapter we will see how Freud goes on with libido theory to explain aspects of culture itself (again, see Appendix A, "Libido Theory").

The Aggressive Drive

Whereas Freud originally attempted to describe aggressive thoughts and actions as expressions of the libidinal drive, eventually he modified this theory of motivation by adding a separate aggressive drive (Freud 1920/1962). Freud was moved to make this change by his clinical observations of patients in whom aggressive motives appeared to predominate, as well as by his observations of the fighting that engulfed Europe during World War I. By the time that Freud introduced the Structural Model, he argued that the aggressive drive is of equal importance to libido as a motivational force in human psychology. Although theorists disagree about the extent to which the aggressive drive is innate (as opposed to being a response to frustration), all agree that aggression is a ubiquitous force in mental life.

Aggression can be expressed in many forms, both normal and pathological. These expressions vary in intensity, ranging from self-assertion and mastery through irritation, anger, and resentment and on to extreme fury, overt sadism, combat, and murderous rage. As with libido, aggressive "aims" can be expressed in oral, anal, or genital/phallic form. As with libido, aggressive objects are most often caretakers from the child's early life. For example, during the oral phase, aggression may be expressed as biting and/or spitting; during the anal phase, aggression may be expressed in power struggles over control; during the early genital/phallic phase, aggression may be expressed as wishes to dominate others with displays of genital prowess. We find remnants of preoedipal aggression in our language: aggression is often described in such phrases as "biting sarcasm," treating someone "like shit," "pissing" on someone, or "fucking [someone] over." Many developmental psychologists have explored how aggression is expressed during childhood (Parens 1979). Many have also explored the factors contributing to the intensity of aggression, including early experiences of intense pain, deprivation, loss, abuse, enforced passivity, overstimulation, and/or sexual abuse (Furst 1998).

Like libido, aggression is subject to repression and is often expressed in disguised form. Examples of common disguises are jokes or seemingly harmless pranks. Another example is *passive aggressive behavior*, which often includes procrastination that interferes with the aims of other people. Aggression can be *turned against the self*, as in self-hatred (see Appendix B, "Defenses"). Extreme forms of self-hatred may appear as self-mutilation or suicide. Like libido, aggression also makes a contribution to character style. For example, aggression can be sublimated in the form of initiative and ambition and/or intense demands for morality and justice. It can be observed in activities such as some kinds of organized sports, military service, police work, and of course medical practice. In an example from psychopathology, the paranoid personality is organized around the projection onto others of one's own aggression. Finally, aggression plays a prominent role in many kinds of severe psychopathology, such as borderline personality disorder, perversions, and violence (Auchincloss and Samberg 2012, pp. 11–13).

Contribution of the Drives (the Id) to Theory of Psychopathology and Therapeutic Action in the Structural Model

Understanding every individual's relationship to the search for bodily pleasure and/or the expression of aggression plays an important role in psychodynamic psychotherapy. As id demands make a contribution to every kind of psychopathology, all psychodynamic psychotherapy must include an exploration of how each patient experiences and manages his or her most primitive urges. The fantasies through which urges are expressed should be explored, as should any points of fixation and/or regression. Fantasies about sexual and aggressive urges are often a source of resistance, or not knowing about oneself. In addition, the patient often turns to the therapist in his or her quest to express these urges. In other words, exploration of transference wishes for the gratification of libidinal wishes or for the expression of aggressive impulses constitutes an important part of every psychodynamic psychotherapy. In Chapter 10, when we explore the concepts of conflict and compromise, we will learn more about the contributions of libido and aggression to both normal mental life and psychopathology, as well as how these forces are expressed in the clinical situation.

Role of the Drives in Human Motivation

There are many problems with the drive theory of motivation as expressed in the Structural Model. The most obvious problem is that we no longer think of human beings as struggling with only two motivational forces—sexuality and aggression. Indeed, explaining all of human activity as representing the vicissitudes of these two urges is difficult. In Part IV, we will consider additional motives, such as needs for attachment, separation, and all varieties of self-enhancement. We will see how these motives are described in Object Relations Theory and Self Psychology in Chapters 11 and 12. In addition, contemporary psychodynamic theorists know that even with this greater complexity in our understanding of motivation, a compete theory of motivation requires a broad interdisciplinary dialogue among all kinds of psychologists, neuroscientists, evolutionary biologists, as well as social and political scientists.

Nevertheless, despite the limitations of this conceptualization, there is much to be gained from the idea of motivation conceptualized as a drive. This conceptualization allows us to talk about three important observations that clinicians have made about human motivation: 1) human beings appear to be under continuous pressure from certain kinds of desire; 2) human beings express desire in many forms, which can often be substituted for each other; and 3) human beings have desires that seem to derive from the body. Let us talk about these three observations one by one.

First, the concept of drive captures what appears to be a continuous and demanding force in the human mind to achieve its aims. In other words, human motivation does not appear to be a sporadic or intermittent force; instead, it seems to be ongoing. In addition, human motivation often seems imperative, demanding satisfaction at every turn. The drive concept captures this aspect of human desire, stressing the ongoing peremptory nature of the pressure for mental activity created by some motivational forces. Efforts to meet this demand can be seen in character traits and life patterns that are enduring, repetitive, and stable. Indeed, the ongoing quest for pleasure underlies some of the most basic aspects of personality, such as a sense of "aliveness," vivacity, or enjoyment and appreciation of the "spice of life." Too much dampening of this quest can lead to inertia, inhibition, or feelings of "deadness." The ongoing wish to express aggression underlies such basic aspects of personality as initiative, assertiveness, and activity. Again, too much dampening of this wish can lead to excessive meekness or passivity. (In Chapter 10, we will see an example of how this passivity might be expressed in a man who suffers from a marked inhibition of aggression.)

Second, the concept of drive captures the fact that human strivings appear in many forms and can be substituted for one another. Indeed, Freud's expansion of the concept of sexuality beyond sexual intercourse in adults was one of his most revolutionary contributions to the understanding of human psychology. By postulating that a single drive—libido—lies behind such disparate phenomena as sucking, defecating, and genital interest, Freud asserted that pleasure-seeking behaviors in children are on a continuum. Pleasure-seeking behaviors in children are also on a continuum with pleasure-seeking behaviors in adults, including sexual activity such as foreplay, sexual intercourse, and atypical sexual activities (which are often called "perversions"). When we assert that these diverse behaviors result from a single motivational force, it follows that they can be substituted for one another. Such substitutions take place when one form of pleasure seeking (or aggression) is deemed to be unacceptable. Pleasure seeking and aggression may also disguise themselves in the form of apparently nonsexual or nonaggressive behavior, including symptoms (in neurotic people) and character traits (in all people). Finally, pleasure seeking and aggression can disguise themselves in the form of culturally acceptable activities such as art, science, or religion. In other words, widely diverse phenomena such as sexuality and aggression in children, sexuality and aggression in adults, perverse sexuality, neurotic symptoms, character traits, and cultural activities, which appear to be dissimilar, are all related to each other, in that each represents a disguised form of libido or aggression, or more usually, a combination of the two. The fact that Freud pointed to the similarities among these widely disparate phenomena is responsible for the fact that his ideas are considered so revolutionary. This fact is also responsible for much of why Freud's ideas have been so controversial. People still have trouble accepting that children have sexual wishes, that the division between "normal" and "perverse" sexuality is arbitrary, and that character traits and cultural activities might have sexual and/or aggressive origins (see Appendix A, "Libido Theory").

Finally, the concept of drive allows us to talk about aspects of the important connection between the mind and the body. Indeed, as noted in Chapter 1 ("Overview: Modeling the Life of the Mind"), a feature of the psychoanalytic model of the mind important to the rest of mind science is its emphasis on *embodiment*. The concept of embodiment includes the idea that the mind is intrinsically shaped by its connection to the body, or that the body is an essential determinant of the nature of mind. The drive theory of motivation asserts that all motivational forces in the mind derive from bodily needs. In other words, the id emerges from and is shaped by the experience of the body, as in the experience of the

erotogenic zones. Indeed, the Structural Model asserts that the ego also is shaped by its contact with the body. For example, as we have already seen in our description of bodily expressions of aggression, metaphor is a powerful way that we organize thought and language; in metaphor, the body literally provides us with "food for thought" (Lakoff and Johnson 1980, 1999; Melnick 1997). Finally, as we will see in our next discussion, even the superego is shaped by its relationship to the body.

The Superego

In the Structural Model of the mind, the superego is the part of the mind that is commonly known as the conscience. In stark contrast to the id, which represents the pleasure-seeking aspect of mental life, the superego represents those aspects of mental life that are concerned with morality. The superego consists of a set of values and ideals by which we measure ourselves, called the *ego ideal.* It also includes a set of prohibitions and commands that guide our behavior. For the most part, the superego operates unconsciously, although many of its derivatives can be observed easily with simple introspection. Indeed, almost all of us are aware of a large part of our experience that deals with our ideas and feelings about right and wrong.

When we measure up to the ideals held by our superego, we have a sense of well-being and self-esteem. In other words, we feel good about ourselves. When we fail to meet our ideals or violate a superego prohibition, we feel a painful sense of inferiority, *shame* (the feeling that "I am judged to be bad by other people"), or *guilt* (the feeling that "I judge myself to be bad") (Lansky 1994). The superego also prescribes punishment for bad thoughts or behaviors. Some of these punishments are overt, as in acts of appeasement or reparation. Many are disguised, participating in the formation of symptoms, character traits, and other activities. Feelings of shame, guilt, and self-punishing behavior are a unique aspect of self-regulation. Indeed, Freud argued often that the superego is the aspect of psychic functioning that most clearly differentiates human beings from other animals (Auchincloss and Samberg 2012, pp. 252–255; Freud 1900/1962).

The concept of morality played an important role in the Topographic Model, long before the Structural Model (and the concept of the superego) was invented. In this earlier model of the mind, we see morality at work in the fact that unconscious wishes are often judged to be "unacceptable" by the censor. However, in the Topographic Model, morality was only vaguely defined, as roughly equivalent to the injunc-

tions imposed by society, transmitted from generation to generation by parental authority. In the Structural Model, this vague description gives way to a more sophisticated view of morality. Superego development is understood to be a complex process involving several aspects of experience, including the internalization of parental ideals, demands, and threats; the structuring of the child's primitive fantasies about these parental ideals, demands, and threats; and the harnessing of the child's own aggressive wishes, all in the service of policing the self.

Originally, the superego was thought to emerge at the end of the oedipal stage and to represent an admixture of the child's internalization of parental prohibitions and the child's own aggression toward the rival parent. As Freud said, the superego is "the heir to the Oedipus complex" (Freud 1923/1962, p. 48) (see Chapter 7). However, it is more common for contemporary psychodynamic practitioners to see the oedipal stage not as marking the first appearance of the superego, but rather as marking an important consolidation of many earlier experiences and feelings, both positive and negative, that play a role in the development of thinking about morality. Contemporary psychodynamic theory draws from the observations of developmental psychologists, who trace superego development back to infant–caregiver affective communications beginning immediately at birth. Children between 18 and 36 months of age have already internalized some superego functions, as demonstrated by empathy for others, affective reactions to wrongdoing, prosocial behaviors and attitudes, and the capacity to struggle with moral dilemmas (Blum and Blum 1990; Decety and Ickes 2009; Emde and Buchsbaum 1990; Gilmore and Meersand 2013). Other theorists stress the development and change of the superego throughout the rest of the life cycle (Blos 1979; Bornstein 1951, 1953; A. Freud 1936/1974; Gilmore and Meersand 2013; Sarnoff 1976). In any case, because the superego so obviously results, in part, from the internalization of the relationship with caregivers, it points the way to the next model of the mind, Object Relations Theory (described in Chapter 11), in which the process of internalization of relationships plays a central role in the establishment of all psychological structures.

The Superego and the Mind of the Child

Because the superego develops during childhood, it bears the imprint of the child's immature mind. For example, because it develops in the course of our interactions with our parents, the superego never completely loses its personal quality. We tend to experience our conscience as an inner "voice" or "eye" that monitors and judges our behavior. We

also tend to experience our conscience as omnipresent and omniscient, like we do our parents. Indeed, we often treat our conscience as we would a parent whom we can make deals with, hide from, or seduce. The superego also includes archaic irrational elements that correspond to the fantasy life of the child. For example, our ideals often lie far beyond what is realistic for us to achieve. This fact reflects both our nostalgia for feelings of omnipotence from infancy and our wish to hang onto an idealized view of our parents from childhood.

Fears of judgment and punishment are also archaic and irrational. They include fears of castration, mutilation, or abandonment, which correspond to the greatest fears of children. Usually these threats are considerably more savage than the behavior of the average parent, a fact that reflects the input into the superego of the child's own untamed aggressive fantasies (Freud 1923/1962). The superego judges thoughts and actions as though they are the same, reflecting the fact that young children cannot easily distinguish between thoughts and deeds. Indeed, this is a major reason why Freud felt that human beings are usually "discontent" (Freud 1930/1962). Superego imperatives are often contradictory, and are therefore impossible to meet. For example, as a lingering effect of the oedipus complex, many men struggle with conflicting demands, both emanating from the superego: the demand to live up to the image of the father as a successful male, and, at the same time, the threatening injunction that being too much like the father will lead to punishment. In other words, the superego has qualities that make it difficult to feel 100% good about oneself, no matter what one does!

Because we recognize these archaic and primitive aspects of the superego, we often speak about the conscience as if it were an animal, or in metaphors that refer to animals. Think of the book *Pinocchio*, with the puppet's conscience incarnated as "Jiminy Cricket!" Thus, a person might complain that his conscience is "buzzing like a mosquito" in the back of his mind, or she may experience her conscience as "gnawing" or "nipping" at her. We remember that Freud depicted the id as a horse in the famous metaphor of the horse and rider by which he represented the relationship between id and ego, and we are not surprised to find him representing the id as our "animal nature." We may be more surprised to realize that we also represent the superego as an animal. The fact that we often compare both the id and the superego to an animal makes us understand more clearly what Freud meant when he argued that id and superego are closely related to each other (Freud 1923/1962). He meant that they share primitive origins in childhood and that the superego is fueled by aggression from the id. Indeed, Freud's argument that we use our own aggression, turned against the self, to police and

control ourselves in the form of morality was another one of his most useful contributions to the study of psychology.

Contribution of the Superego to Theory of Psychopathology in the Structural Model

Under normal circumstances, over the course of development, the superego becomes more impersonal, more temperate, and more realistic, resulting in a coherent and manageable set of ideals. These ideals can be met well enough with a reasonable degree of self-monitoring and self-control. Under pathological circumstances, the superego may be poorly structured and weak, resulting in psychopathic and criminal behavior. The superego may also be overly harsh and sadistic, resulting in excessive self-punishment or moralistic rigidity. Self-punishment is easily observed in the form of self-mutilation or suicidal behaviors, inhibition of pleasure, depression, and masochism of all kinds (Brenner 1959). Superego pathology is seen in almost every character style, including several famous "types" described by Freud, such as "Those Wrecked by Success" (people with intense unconscious guilt who punish themselves by stumbling on the threshold of accomplishment), "The Exceptions" (people who feel that because they have had an unfair life and have suffered so much already, they need not adhere to the usual moral standards), and "Criminals Out of a Sense of Guilt" (people with intense unconscious guilt who commit crimes so that they will be caught and punished) (Freud 1916/1962). In Chapter 10, we will explore the concepts of conflict and compromise, learning more about how the superego (and the id) contributes to normal mental life and to psychopathology.

However, again, it is important to notice that most of the examples cited here emphasize the effects of the harsh, punitive aspects of the superego. Indeed, Freud himself was most aware of this negative, punishing side of the conscience, writing rarely about the positive side (Freud 1927/1962). He has often been criticized for failure to theorize much about other, more loving aspects of the superego, which are equally important. Other, more recent theorists, including many from Object Relations Theory, have emphasized the importance of the loving superego (Schafer 1960) or (as we will see in Chapter 11) an internalized good object that makes us feel good about ourselves when we do the right thing, which, arguably, is most of the time. Indeed, when we discuss the impact of Object Relations Theory on our theories of psychopathology and psychodynamic technique, we will learn more about the importance of the ability to maintain a good internal object in the face of negative feelings. When we discuss Self Psychology (in Chapter 12),

we will see how the concept of the ego ideal is amplified, as we learn how positive feelings between mother and child lead to the development of goals and ideals that are central to a healthy self.

Contribution of the Superego to Theory of Therapeutic Action in the Structural Model

Psychodynamic psychotherapists spend a lot of time trying to understand the workings of the patient's superego. The superego makes a contribution to almost every thought, feeling, and behavior, big or small, in everyone. Irrational superego demands as well as irrational and contradictory ideals make a contribution to almost every kind of psychopathology. Sometimes, as we have seen, superego pathology dominates the presentation of psychopathology, as in masochism, depression, and many kinds of inhibitions.

Therefore, all psychodynamic psychotherapy must include an exploration of the patient's attitudes toward morality, the patient's ideals, and the circumstances that lead to feeling guilt or shame, or to feeling good about the self. The circumstances leading to self-punishment must also be understood. The complex consequences of shame, guilt, and self-punishment must be explored. Because the superego so obviously develops in the context of relationships with caregivers, it is prone to being externalized onto authority figures, including the therapist. This fact is of particular clinical significance in understanding the transference because the therapist is frequently experienced as the arbiter of right and wrong, or as someone who is likely to disapprove, forgive, and/or otherwise judge the patient. Indeed, one of the most influential early views of the therapeutic action in psychodynamic psychotherapy argues that over time, the patient's superego is modified through internalization of interactions with the therapist, whose attitudes toward the patient's wishes are often less harsh and moralistic (Strachey 1934). When we move on to Chapter 10, we will learn more about how the superego (and the id) is expressed in the clinical situation and how psychodynamic psychotherapy works by helping the patient find better ways to regulate morality in the forging of compromise.

Understanding Moral Development: Contributions From General Psychology and Cognitive Neuroscience

Contemporary psychodynamic practitioners recognize that a complete theory of morality (or of any important aspect of mental life) requires input from many disciplines, including social psychology (Appiah 2008; Blasi 1980; Haidt 2008), anthropology (Gilmore 1991), and developmental psychology (Eisenberg 2000; Emde et al. 1991; Gilligan and Wiggins 1988; Kohlberg 1963, 1976; Turiel 1998; Zahn-Waxler et al. 1992). Indeed, the famous thought experiment called the "trolley problem," introduced by philosopher Philippa Foot, which asked subjects whether, under a variety of circumstances, they would act to save people endangered by a runaway trolley, has spawned a whole generation of "trolleyologists" who are interested in using empirical methods to study how we handle issues of right and wrong (Grimes 2010). For example, in studies related to the concept of the superego, social psychologists have found that individuals who are encouraged to imagine that authority figures are "watching you from the back of your mind" have lower self-esteem (Baldwin et al. 1989); in studies related to the concept of the ego ideal, social psychologists have found that individuals' self-worth is highly contingent and varied (Crocker and Wolfe 2001) and that whether or not people behave according to their ego ideal affects their self-esteem (Higgins 1987). Neuroscientists, too, are interested in the study of morality, offering strong evidence for the biological basis of the sense of right and wrong, or the lack of it, in studies of brain function and genetics (Delgado et al. 2005; Greene et al. 2001; Grigsby and Stevens 2000; Koenigs et al. 2007; Weston and Gabbard 2002). (For an interesting review of evidence from both general psychology and neuroscience on the development and functioning of morality, see Paul Bloom's book *Just Babies: The Origins of Good and Evil* [2013].)

Chapter Summary and Chart of Core Dimensions

Table 9–1 shows our Structural Model chart of core dimensions with the addition of key concepts for Motivation, Structure/Process, and Development.

- **Topographic point of view:** The id is defined as entirely unconscious. The superego has both conscious/preconscious and unconscious aspects.
- **Motivational point of view:** The id is the seat of the *drives—libido* and *aggression*. A *drive* is the mental representation of a bodily need or urge; it exerts a continuous demand on the mind for satisfaction. Drive aims can appear in disguised forms and can be substituted for one another. Superego aims include all motivations concerned with morality.

- **Structural point of view:** The id is the structure of the mind most closely associated with biological needs of the human organism. It operates according to the primary process mode of functioning, seeking satisfaction and pleasure without concern for the consequences. The superego—the part of the mind commonly known as the conscience—consists of prohibitions and commands that guide our behavior; it also contains a set of values and ideals by which we measure ourselves, called the *ego ideal*.
- **Developmental point of view:** Libido develops according to a hard-wired set of psychosexual phases: the oral, anal, and early genital (phallic) phases (comprising the preoedipal period); the genital/oedipal phase (i.e., the oedipal period); the latency phase; and adolescence. The preoedipal and oedipal stages of development are often referred to collectively as *infantile sexuality*. Infantile sexuality can sometimes manifest as symptoms or character traits, especially when transformed by defenses such as sublimation or reaction formation. Both symptoms and character traits can show evidence of *fixation* (the overwhelming influence of a particular stage) or of *regression* (the substitution of pleasures from an earlier stage for those of a later stage). Aggression also undergoes stages of development.

  Whereas the superego was originally considered to emerge at the end of the oedipal stage, contemporary theorists commonly view superego development as beginning considerably earlier, with the oedipal stage marking not the first appearance of the superego, but rather a period of important consolidation of earlier experiences and feelings that play a role in the development of thinking about morality. Other theorists believe that the superego undergoes development and change throughout the life cycle.
- **Theory of psychopathology:** The primitive urges of the id—both the search for bodily pleasure and the expression of aggression—make a contribution to every kind of psychopathology. Under pathological circumstances, the superego may be poorly structured and weak, resulting in psychopathic and criminal behavior, or may be overly harsh and sadistic, resulting in excessive self-punishment or moralistic rigidity.
- **Theory of therapeutic action:** All psychodynamic psychotherapies include exploration of the id (e.g., transference wishes for gratification of libidinal wishes or for expression of aggressive impulses) and the superego (e.g., attitudes toward morality, ideals, and circumstances leading to feeling guilt or shame).

TABLE 9–1. Structural Model Part 2: The Id and the Superego

Topography	Motivation	Structure/Process	Development	Psychopathology	Treatment
The ego and the superego have both conscious/preconscious and unconscious aspects The id is entirely unconscious	The ego, superego, and id each have separate aims: The ego—homeostasis and adaptation The superego—moral imperatives The id—drives **Libido** **Aggression** Conflict is always present because of competing aims	The mind is divided into three structures: ego, superego, and id The ego Ego functions Defense Internalization Identification Ego identity **The superego** **Ego ideal** **The id**	Ego development Erikson's stages **Superego development** **Development of the drives (Id)** **Psychosexual phases (oral, anal, early genital [phallic], genital/oedipal, latency, adolescence)** **Fixation** **Regression**	Ego strength/ego weakness serves as an index of mental health/illness	Strengthening the ego "Where id was, there ego shall be"

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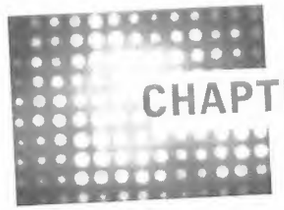

Conflict and Compromise

This chapter introduces readers to the concepts of conflict and compromise. It explores the concept of defense. It also surveys important concepts related to appraisal and defense from neighboring mind sciences. Vocabulary introduced in this chapter includes the following: *affect, character, character disorder, compromise/compromise formation, conflict, danger situations, defense, defense mechanism, defensive style, deficit, ego dystonic, ego syntonic, intersystemic conflict, intrasystemic conflict, mentalization, metacognition, observing ego, reflective function, signal affect/signal anxiety,* and *somatic marker hypothesis.*

In Chapters 8 ("A New Configuration and a New Concept: The Ego") and 9 ("The Id and the Superego"), readers were introduced to the three components of the Structural Model of the mind: the *ego,* the *id,* and the *superego.* We looked at each component from the topographic point of view, learning that each has an unconscious aspect. We saw how these three components differ from each other in terms of motivation and structure. Finally, we also learned a bit about their development. Because the Structural Model was derived from the Topographic Model of the mind, all three components have inherited aspects of the previous model. The id is conceptually close to the unconscious of the Topographic Model. The ego and the superego both include aspects of the conscious/preconscious, especially if we include the censor and the concept of defense.

CHAPTER 11

Object Relations Theory

This chapter introduces readers to Object Relations Theory. It outlines the basic assertions of this model of the mind, comparing it with previous models. It discusses some famous object relations theories, pointing to similarities and areas of overlap with neighboring disciplines and fields of research. Finally, it explores the contributions of Object Relations Theory to our understanding of psychopathology and treatment. Vocabulary introduced in this chapter includes the following: *Adult Attachment Interview, attachment, attachment behavioral system, attachment theory, borderline personality organization, co-created experience, container/contained, corrective emotional experience, countertransference, depressive anxiety, depressive position, differentiation, envy, good-enough mother, holding environment, identity diffusion, individuation, internal working models of attachment, interpersonal, Mentalization-Based Treatment, midlife crisis, need-satisfying object, object, object permanence, object relations, on the way to object constancy, paranoid position, part object, persecutory anxiety, position, practicing, rapprochement, rapprochement crisis, representation, schema, schizophrenogenic mothering, self constancy, separation, separation-individuation, Strange Situation, therapeutic alliance, Transference-Focused Psychotherapy,* and *whole object.*

After its introduction in the early 1920s, the Structural Model, along with Ego Psychology, dominated thinking about the psychodynamic approach to mental heath in America for almost half a century. However, in the 1960s and 1970s, it gradually became clear to many theorists that some behavior and many states of mind are best described not in terms of conflict among the structures of ego, id, and superego but

rather in terms of internal representations of self and other. It also became increasingly clear to developmental psychologists that many mental capacities previously attributed to the ego could be better understood as developing in the infant–caregiver matrix. In the midst of these two developments, Object Relations Theory was invented.

Object Relations Theory: Terms and Concepts

Object Relations Theory models the mind in terms of internal representations of self and other. *Object* is the word that psychoanalytic theorists use mainly to describe another person. An *object relation* is defined as a psychological configuration consisting of three parts: a self representation, an object representation, and a representation of an affectively charged interaction between the two. The word *representation* as used in psychoanalysis is roughly analogous to the word *schema* as used in cognitive psychology; both mean "an organized and persistent pattern of thought" (Weinberger and Weiss 1997). When we use the term *object relations*, we are referring to psychological representations. In other words, object relations must be distinguished from interpersonal relationships, a term that refers to the interactions between an individual and another person in the outside world. The term *object relations* is often erroneously assumed to be synonymous with interpersonal relationships.

Object Relations Theory attempts to understand how self and object representations develop in childhood, how they are maintained throughout life, how they influence and are influenced by other structures and motivations, and how they affect psychic functioning and behavior. The basic tenets of Object Relations Theory may be summarized as follows:

- Object relations are largely unconscious.
- Human beings are object seeking from birth; object seeking is not reducible to any other motivation.
- All psychological phenomena, from the most fleeting experience to the most stable structure, are organized by object relations.
- Object relations evolve through internalization of the infant's interactions with the object world, developing from an admixture of innate factors (including affect dispositions and cognitive capacities) and interactions with caregivers.
- Interpersonal relationships reflect internalized object relations; psychopathology, especially serious psychopathology, is best conceptualized in terms of disturbances in object relations.

In placing object relations at the center of psychological life, Object Relations Theory emphasizes the fact that psychic life develops in the context of the social or interpersonal environment and is adapted to that environment.

Comparison of Object Relations Theory With the Topographic and Structural Models

Sigmund Freud used the term *object* throughout his writing life. In fact, there is no aspect of either the Topographic Model or the Structural Model—including those related to motivation, structure, development, and psychopathology/treatment—that does not include understanding of the role of the object. For example, in our discussion of oedipal conflict (see Chapter 7, "The Oedipus Complex"), we saw how early objects, including father and mother, are important in the developing mind of the child. When drive theory was introduced (see Chapter 9, "The Id and the Superego"), we explored how almost all forms of libido and aggression (except those that are autoerotic) require an object for the attainment of satisfaction. Throughout our discussion of the Structural Model, we saw how both the ego and the superego develop in interaction with caregivers. In addition, in the developmental sequence of danger situations important in the mediation of conflict, loss of the object—or of the love of the object—is an important fear (see Chapter 10, "Conflict and Compromise"). Finally, in all models of the mind, theories of therapeutic action emphasize the role of the transference as revealing important aspects of the mind. It should not be surprising to us then that there is considerable overlap between the earlier models of the mind and Object Relations Theory. Indeed, it is important to remember that maintenance of stable and realistic self and object representations is defined as an ego function. In other words, one way of conceptualizing Object Relations Theory is to think of it as a model of the mind that specifically focuses on the ego functions responsible for developing and maintaining object relations.

A brief comparison of several of the basic tenets of Object Relations Theory with those of the Structural Model of the mind may be useful in clarifying how the Object Relations model of the mind differs from the earlier model:

- **Topographic point of view**—In Object Relations Theory, object relations are conceptualized as being largely unconscious. By contrast, in the Structural Model, the id was defined as unconscious, and the ego

and superego were conceptualized as having both unconscious and conscious/preconscious aspects.

- **Motivational point of view**—According to Object Relations Theory, the pursuit of objects is not reducible to the pursuit of bodily and/or aggressive pleasure (as is asserted in the Structural Model). In other words, we do not seek attachment to our mother because she is a source of pleasure; rather, we seek the attachment for its own sake. Wish and drive may be important motivators in psychic life, but they must always be as embedded in self and object representations.
- **Structural point of view**—In Object Relations Theory, the basic unit of experience is a package consisting of a self representation, an object representation, and the interaction between the two—an *object relation*—rather than a package consisting of a conflict between a wish and a prohibition (as in the Structural Model). All psychic structures—not just the superego—are made up of object relations.
- **Developmental point of view**—In Object Relations Theory, infant–caregiver interactions are central to all aspects of the developing mind, not just the superego (as is posited in the Structural Model); preoedipal interactions involving the infant–mother relationship are just as important to the development of the mind as are oedipal interactions; and the establishment of stable object relations during the preoedipal period of development is a necessary forerunner to development of the oedipal phase. In other words, Object Relations Theory places more emphasis on the preoedipal period than does the Structural Model.
- **Theory of psychopathology and theory of therapeutic action**—In Object Relations Theory, psychopathology is conceptualized primarily in terms of disturbances in object relations, rather than in terms of oedipal conflict (neurosis) (as in the Structural Model). In regard to the mechanism of therapeutic action, Object Relations Theory posits that it is the patient–therapist relationship itself that brings about change, as opposed to insight derived from interpretation (per the Structural Model). Contributions of the Object Relations model to psychoanalytic theories of psychopathology and therapeutic action are discussed in greater detail later in this chapter (see sections "Object Relations Theory and Adult Psychopathology" and "Object Relations Theory and Psychodynamic Treatment").

The Birth of Object Relations Theory

The most important object relations theorists are Klein, Mahler, Bowlby, and Kernberg. Bion and Winnicott are discussed briefly in this chapter and will be mentioned again in Chapter 12 when we talk about Self Psychology. Each of these theorists emphasized a different aspect of Object Relations Theory.

Anna Freud: The Need-Satisfying Object

After Sigmund Freud's death in 1939, the psychoanalytic model of the mind developed in several directions, in large measure differentiated from the Freudian model by the place given to the role of the object and object relations in psychological life. Anna Freud (1895–1982), Freud's youngest child, remained loyal to her father's Structural Model of the mind, broadening this model (later called Ego Psychology) through her work with children and the study of defense. However, her interest in development led her to study object relations in childhood, although she did not use that term. In her work, Anna Freud described a natural progression from object dependency to self-reliance. She posited a series of predictable stages through which normal children pass: an early stage of undifferentiated self and object representations; a stage in which the object is experienced as *need-satisfying;* a stage marked by the attainment of *object constancy,* in which stable object representations are maintained even in the face of feelings of anger; an oedipal stage marked by conflicts over rivalry and possessiveness; and a stage marked by the adolescent struggle to find new, nonincestuous objects (A. Freud 1963). We will discuss the important concepts of *need-satisfying object* and *object constancy* in greater depth in a moment.

Melanie Klein: The Paranoid and Depressive Positions

At roughly the same time that Anna Freud was doing her work, Melanie Klein (1882–1960) proposed a very different theory, which has had a lasting effect on the psychoanalytic model of the mind. Klein's theory is considered the first real Object Relations Theory.[1] Building on ideas about the development of the superego, understood as resulting from internalization of interactions between child and caregiver, Klein proposed that the entire mind is built out of similar internalizations, which

[1]Although the term itself—*object relations theory*—was invented by Ronald Fairbairn (1954), who was a student of Klein's.

lead to the formation of representations of both self and object. Let us explain a bit more about how Klein's theory works.

In her theory, Klein described the feelings and thoughts of young children that influence the development of object relations. For example, if the young child experiences the object as "bad," this experience of "badness" is as much the result of projection of the child's angry thoughts and feelings onto the representation of the object as it is the result of any actual bad qualities of the object. By the same token, if the young child experiences the object as "good," this "goodness" is the result of an admixture of the projection of the child's experience of happy satisfaction onto the object and the object's own good qualities. According to Klein's Object Relations Theory, the child's efforts to manage the good and bad aspects of experience lead to the development of his or her inner world. As we can see, Klein adhered to Sigmund Freud's concept of drive (libido and aggression); however, in Klein's theory, drive is always experienced in the context of relationships with others.

In the process of managing these good and bad experiences, every child must progress through what Klein called *positions,* analogous to Sigmund Freud's and Anna Freud's developmental stages. These positions—the *paranoid position* (also known as the *paranoid-schizoid position*) and the *depressive position*—are defined as stable configurations of self and object representations built from the combined influence of wishes, thoughts, and feelings; and interactions with caregivers. In Klein's view, successful development is defined as the capacity to tolerate conflicting feelings of love and hate toward the same object, as expressed in movement from the paranoid to the depressive position.

The paranoid position is the earliest organization of the psyche. It is characterized by the splitting apart of good (satisfying and loving) from bad (frustrating and aggressive) aspects of experience, accompanied by the use of projection and projective identification of bad aspects of experience onto the object. *Splitting* and *projection/projective identification* serve to protect the good self and good object from angry, hostile feelings. (We will say more about splitting and projective identification in a moment when we talk about patients with borderline psychopathology.) In the paranoid position, the child fears that he or she is in danger of being destroyed by the bad object, who has become the repository for all of the child's own projected aggression. The child is also threatened by his or her own experience of envy, which is also projected onto the object. In other words, the paranoid position is marked by *persecutory anxiety.*

During the course of normal development, in the context of supportive maternal care and the absence of too much frustration, the child begins to move into the depressive position. This movement progresses as

the child develops the capacity to tolerate conflicting feelings of love and hate toward the same object, so that he or she does not have to resort to splitting and projective identification to manage bad experience. In the depressive position, a child fears that his or her own angry feelings may threaten the object, now experienced as loved and needed. In other words, the depressive position is marked by *depressive anxiety.* However, the child's new capacity for gratitude toward the object, along with growing confidence that envy can be overcome and damage to the relationship can be repaired, reassures him or her that love will prevail over hate and that loving relationships can be maintained (Klein 1932, 1975a, 1975b; Segal 1946).

Two Views of the Major Developmental Challenge of Childhood: Anna Freud Versus Melanie Klein

If we pause for a moment to compare the views of Melanie Klein with those of Anna Freud, we see that for Klein, the major developmental challenge facing children is the integration of contradictory feelings about the object, whereas for Freud, the major developmental challenge facing children is the achievement of relative independence from the object with the internalization of regulation in the form of a strong ego. These two theorists had other disagreements as well. Indeed, the struggle between Anna Freud and Melanie Klein and their followers for dominance and influence in psychoanalysis in the aftermath of Sigmund Freud's death is legendary in the history of psychoanalysis in Great Britain, where they both lived and worked (King and Steiner 1991). Nowadays, however, we do not have to be caught up in their conflict but can draw upon the best from both these theories in our view of the mind.

Wilfred Bion and D.W. Winnicott: The Container/Contained, the Good-Enough Mother, and the Holding Environment

Among the students of Melanie Klein were two other British psychoanalysts, Wilfred Bion (1897–1979) and D.W. Winnicott (1896–1971). Bion is known for his concept of the container and the contained. In this view, the mother must help the child manage intolerable and painful experience. Through the mother's caretaking acts, which include soothing and verbalizing (or what Bion called *reverie*), the infant's chaotic, unbearable experience is transformed into something more tolerable, so that the child can successfully move from the paranoid to the depressive position. In Bion's terms, the mother acts as a *container* for the infant's chaotic experience, which must be *contained.* Bion's theory has obvious implications for the theory of therapeutic action (Bion 1962,

1963, 1967, 1970), which we will touch on later in this chapter (see section "Object Relations Theory and Psychodynamic Treatment"). In Chapter 12 ("Self Psychology"), we will revisit Bion's theories about the role of the containing mother in helping the child to develop affect tolerance and other key capacities.

Winnicott proposed a theory of object relations that also describes the infant's capacity to relate to others, which develops in interaction with the mother. Winnicott is famous for his concepts of the *good-enough mother* (who provides the infant with the optimal amount of comfort and frustration) and the *holding environment* (created by a caregiver who is "good enough"). This holding environment is necessary for development of the child's capacity to experience *concern for the object* instead of merely using the object as a repository for the projection of bad experience (Winnicott 1954/1958, 1958, 1965, 1971). Like Klein, Winnicott saw successful development as representing the ability to integrate feelings of love and hate toward the object. Unlike Klein, Winnicott placed emphasis (as did Bion) on the role of the mother in providing the environment where this can happen.

Later in this chapter we will examine the contribution of the concept of the holding environment to the theory of therapeutic action in psychodynamic psychotherapy (see section "Object Relations Theory and Psychodynamic Treatment"). We will also discuss Winnicott's ideas in greater detail in Chapter 12 ("Self Psychology"), when we look at his theories about how the interactions between infant and mother are important for the development of an authentic sense of self in the child, as well as for the development of the child's capacity for play, fantasy, and a rich inner life.[2]

Margaret Mahler: Separation-Individuation

Meanwhile, in America, a psychoanalyst named Margaret Mahler (1897–1985) was doing important work based on her observations of young children and their mothers. Although Mahler saw herself as writing within the tradition of Ego Psychology and the Structural Model, her ideas drew from those of both Anna Freud and Melanie Klein and have contributed a great deal to our understanding of the

[2]Winnicott was heavily influenced by his studies with Klein. Working in the United Kingdom at the time of the Freud–Klein controversies, Winnicott helped to found the British Middle School, later known as the Independent Group (King and Steiner 1991).

child's interaction with caregivers. Mahler is best known for her most important idea, the process of *separation-individuation.*

In Mahler's theory, *separation* is a psychological process by which the child forms a representation of the self that is distinct or separate from the representation of the object. *Individuation* is a psychological process by which the child develops specific characteristics, so that the self becomes not only distinct from the object but also unique and autonomous (Mahler et al. 1975). In Mahler's view, the process of separation-individuation occurs between the ages of 9 months and 4 years. Mahler delineated four subphases of the separation-individuation process: *differentiation, practicing, rapprochement,* and *on the way to object constancy.* She proposed two other, earlier phases: the autistic phase (birth to 2 months), in which the infant is unresponsive to external stimuli, and the symbiotic phase (2–9 months), in which the infant is attached to the mother but imagines him- or herself to be merged with the mother. The autistic phase and the symbiotic phase have been largely discredited by studies indicating that even the youngest infants have highly developed capacities that allow for both contact with the outside world and differentiation between self and object (Stern 1985).[3] However, Mahler's views about separation-individuation have stood the test of time.

According to Mahler, the separation-individuation process begins with the *differentiation* subphase (6–9 months). In this subphase, the infant begins to take more interest in his or her surroundings and starts to

[3]Mahler's autistic and symbiotic stages of development, now no longer in use, represent a common and serious problem in some psychodynamic theory making in which adult psychopathology is seen as reflecting difficulty at an early stage of development. In this case, Mahler posited that "autistic schizophrenia" was the result of difficulties in the autistic stage of development and that "symbiotic schizophrenia" was the result of difficulties in the symbiotic stage of development. Mahler's work in this area is related to some of the most damaging errors in psychodynamic theory making, in which the difficulties of psychotic patients were blamed on problematic or "schizophrenogenic" mothering (Fromm-Reichmann 1950). Nowadays, schizophrenia is no longer conceptualized as reflecting difficulties in mother–infant interactions (Willick 2001). (In addition, as we have seen, infants are no longer thought to be either "autistic" or "symbiotic" in the first months of life.) Reexamination of these and other errors highlights the need for theory makers to avoid the "genetic fallacy" in which present-day functioning is conceptualized as reflecting difficulties in development, often in parent–child interactions (Willick 1983) (see also Chapter 7 ["The Oedipus Complex"] for a discussion of errors made in thinking about female development and about homosexuality).

interact more and more with the environment. The relationship to the mother is firmly established, as indicated by the frequent use of the social smile and the appearance of stranger anxiety (Mahler 1972; Mahler et al. 1975).

In the *practicing* subphase (10–15 months), the child experiments with distance by moving away from the mother, enjoying his or her newly developed capacities for crawling and walking. In this subphase, the child explores his or her expanding world at increasingly greater distances but still requires the mother to be available for *emotional refueling*, especially when the child is tired or upset. The practicing subphase is characterized by feelings of omnipotence and elation, because the child seems to be in a "love affair with the world" (Mahler 1972; Mahler et al. 1975).

The practicing subphase is followed by the *rapprochement* subphase (15–24 months). During rapprochement, the child experiences conflicting feelings brought on by a new awareness of him- or herself as a separate individual. In this subphase, the child begins to feel increasingly vulnerable, often showing intense separation anxiety. In the face of feeling more vulnerable and anxious, the child returns to the mother, often in a demanding and controlling way. At the same time, the child's clingy behavior arouses the fear that his or her newfound separateness and independence will be lost. The conflict between the wish to depend on the mother and the wish for autonomy from her creates a *rapprochement crisis*. This crisis is accompanied by feelings of anger and hostility; it is also accompanied by wide fluctuations in mood, as feelings of omnipotence alternate with feelings of vulnerability (Mahler 1972; Mahler et al. 1975). Indeed, anyone who has spent time with a young child in the rapprochement stage of development knows why this stage has been called "the terrible twos."

The Importance of Object Constancy

Mahler called the final subphase of separation-individuation by the term *on the way to object constancy*. *Object constancy* is one the most important concepts in the psychoanalytic model of the mind. It is defined as the ability to maintain a positively tinged feeling toward the mother (or anyone else) in the face of feelings of frustration, anger, and/or disappointment. A related concept is *self constancy*, defined as the ability to maintain a positive self representation in the face of failure or threats to self-esteem. Object constancy depends on the achievement of *object permanence* (usually by 6 months), defined as the ability to maintain a representation of an object (animate or inanimate) even when it is not within perceptual awareness (Piaget 1954/1990; Schacter et al. 2011,

p. 477). Object constancy, an emotional capacity, is often confused with object permanence, a purely cognitive capacity. Mahler borrowed the term *object constancy* from fellow ego psychologists Anna Freud and Heinz Hartmann, the latter of whom coined the term to describe object representations that remain stable and permanent "independent of the state of needs" (Hartmann 1953, p. 180). In other words, as we have seen, prior to the achievement of object constancy, the object is experienced as *need-satisfying*, or as existing only to meet the infant's needs (Hartmann 1952, 1953). In Klein's terms, the need-satisfying object is a *part object*, meaning that only one aspect of the relationship is experienced (and represented) by the child, as opposed to a *whole object*, which is experienced as complete, or integrated with respect to all its qualities, both good and bad. Mahler, like Klein, believed that the capacity for object constancy is achieved when the child is able to integrate bad representations of the mother with good representations of the mother, so that the object can retain its identity as a "good person" even when the mother does something that the child finds frustrating. In other words, Mahler's final stage of separation-individuation is roughly equivalent to the depressive position as described by Klein.

While Mahler argued that object constancy is fairly firmly established in the normal 3-year-old child, she called this final stage in the separation-individuation process *on the way to object constancy*, reflecting her feeling that the attainment of object constancy is a lifelong process. Klein also understood that the attainment of object constancy waxes and wanes throughout life. Although in her view, maturity is reflected in the movement from the paranoid to the depressive position, the two positions fluctuate in everyone. Indeed, in Klein's view, retreat to the paranoid position is often a defense against unbearable depressive anxiety, or the fear that one's own aggression will destroy the object.

Indeed, throughout the life cycle we face continual threats to object constancy posed by any event that causes separation from loved ones or feelings of vulnerability and anger. Actually, object constancy can be threatened by just about any strong feeling. Obvious examples of such threats include adolescence (often called "the second separation-individuation"), when we face the challenges of leaving home and finding new people with whom to identify (Blos 1967); parenthood, when we face the many feelings that come with having a baby (Anthony and Benedek 1970); the *midlife crisis*, when we face the fact that life does not go on forever (Jacques 1965); and many others (Akhtar 1994). When we discuss the contributions of the Object Relations model to psychoanalytic theories of psychopathology and therapeutic action (see sections "Object Relations Theory and Adult Psychopathology" and "Object Relations

Theory and Psychodynamic Treatment" later in this chapter), we will see that the concept of object constancy—including failures of object constancy (and of self constancy)—is at the root of all kinds of severe personality disorders.

John Bowlby: Attachment Theory

While Anna Freud and Melanie Klein were locked in struggles over Sigmund Freud's legacy and Margaret Mahler was studying babies and their mothers in New York City, the British psychoanalyst John Bowlby (1907–1990) was developing a different kind of object relations–based theory called *attachment theory* (Bowlby 1969/1982, 1973, 1980). Attachment theory is another theory of early development based on the study of interactions between infant and caregiver. Bowlby defined *attachment* as "lasting psychological connectedness between human beings" (Bowlby 1969/1982, p. 194). The central premise of attachment theory is that the infant's motivation to develop an attachment with the caregiver is an innate feature of the human mind dictated by evolutionary pressure, or by the survival needs of the species. The quest for attachment precedes—and is not reducible to—the quest for libidinal gratification (Auchincloss and Samberg 2012, pp. 20–22).

Bowlby argued that the motivation for attachment is realized through an inborn *attachment behavioral system* operating between infant and mother. He identified five components of the attachment behavioral system that regulate distance between infant and mother: sucking, smiling, clinging, crying, and following. When the infant becomes distressed (either by an internal stimulus, such as feeling hungry, or by an external stimulus, such as distraction in the mother), the attachment system is activated and the infant seeks physical contact with the mother. In return, the mother responds to the infant's signals with behaviors that increase closeness and nurturing. By contrast, when the infant feels secure, the attachment system is deactivated; attachment behaviors in both infant and mother cease.

For Bowlby, the nature of the child's earliest tie to the mother establishes the child's basic attitude toward others and the child's basic sense of self. The bond with the mother is represented in what Bowlby called *internal working models of attachment*, which are established by 1 year of age. Internal working models of attachment are analogous to the object relations that we have seen in the theories of Klein and Mahler in that they include a self representation, an object representation, and a representation of the interaction between the two. As with object relations, these internal models serve as a template for all future interactions with

others. Internal working models of attachment also play a role in the development of cognitive capacities, affect regulation, impulse control, and other ego functions that we explored in the Structural Model. However, internal working models of attachment differ from object relations in that theories about their development place less emphasis on the emotional state of the child and more emphasis on the interactions between child and caregiver. As we have seen, Klein and Mahler both emphasized the influence of the young child's inner experiences of love and hate in the development of his or her object relations. In contrast, Bowlby placed greater emphasis on the nature of the interaction with the actual mother (Fonagy 2001; Johnson et al. 2007).

In the development of his theories, Bowlby was heavily influenced by work from a variety of neighboring disciplines, including biology, evolution, and ethology. He was influenced by Darwin's theory of evolution, understanding that the attachment behavior that links the dependent infant to the caretaking mother improves survival. Bowlby was also inspired by Konrad Lorenz's (1903–1989) research on *imprinting* in geese (Lorenz 1949/1979) and by Harlow's research on maternal deprivation in primates (Harlow and Zimmermann 1958), as both of these investigators explored aspects of inborn needs for a relationship. Indeed, because Bowlby's theory emphasized the importance of inborn behavioral patterns and of real relationships, he was often at odds with other psychoanalysts of the time, who tended to emphasize the internal workings of the mind rather than external behaviors (Coates 2004).

Mary Ainsworth and Mary Main: The Strange Situation and the Adult Attachment Interview

In any case, attachment theory did not enter the psychoanalytic mainstream until the 1970s and 1980s, with the important research of Mary Ainsworth (1913–1999) and Mary Main (1943–) (Fonagy 2001). Ainsworth developed a research procedure called the Strange Situation, which she used to assess individual differences in attachment organization. In the Strange Situation, the child is observed playing while caregivers and strangers enter and leave the room. An independent observer rates the child's behavior on several factors, including the following: the amount of exploration engaged in by the child, the child's reaction to the departure of the caregiver, the amount of stranger anxiety shown by the child when alone with the stranger, and the child's reunion behavior with the caregiver. Ainsworth described distinct patterns of attachment that she called *secure attachment*, *anxious-avoidant attachment*, and *anxious-resistant attachment* (Ainsworth et al. 1978). A fourth pattern, *disorga-*

nized/disoriented attachment, was added by Mary Main (Main and Solomon 1986). Main developed what she called the Adult Attachment Interview, used to investigate patterns in adult recollections of early childhood experience related to attachment. She described similar patterns, including the following: secure-autonomous, dismissing, preoccupied, and unresolved/disorganized (Main et al. 1985). The Adult Attachment Interview has been used by dozens of investigators to study the many complex effects of patterns of attachment.

Object Relations Theory and Adult Psychopathology

All psychodynamic clinicians agree that the quality of object relations, including a secure internal working model of attachment, is an important parameter along which to evaluate mental health. In general, object relations are assessed as mature when an individual is able to sustain loving attachments. This ability requires recognition that the object is distinct from the self and that one's own needs may sometimes conflict with those of the object. It also requires the capacity to accept some degree of dependence on the object, as well as some separation from the object. Mature object relations additionally require the acknowledgement, acceptance, and tolerance of *ambivalence* toward the object. Finally, mature object relations are marked by self and object constancy, allowing for the feeling that the self and the object are "good enough."

Using empirical research techniques, investigators have shown that disruptions in infant–caregiver relationships correlate with psychopathology both in early life and later on (Beebe and Lachmann 2003; Beebe and Stern 1977; Beebe et al. 1992, 2008; Bowlby 1944; Cassidy 2008; Deklyen and Greenberg 2008; Lyons-Ruth and Jacobvitz 2008; Spitz 1945; Spitz and Wolf 1946; Tronick 1989). In addition, investigators have explored the complex correlates in many mind/brain systems of these disruptions. For example, Allan Schore (1994) has summarized work investigating the development of affect regulation in the context of infant–caregiver relationships, integrating this work with findings from neurobiology (Eisenberg 1995; Hofer 1984, 1995). Schore (1994) posited that the function of emotion regulation, which develops in interaction with the parents, is eventually taken over by mental representations—internalized aspects of the caretaking environment that enable the child to independently regulate affect states. Drew Westen and others have attempted to integrate Object Relations Theory with aspects of attachment theory, social psychology, and cognitive neuroscience (Bandura 1986; Blatt and Lerner 1983; Calabrese et al. 2005; Smith et al. 2013; Wegner and Vallacher 1977; Westen 1990, 1991). More recently, in studies that promise to revolutionize our understanding of mental health, Avshalom Caspi and colleagues have reported that the experience of early deprivation and loss may interact with genetic vulnerability to produce psychopathology in later life (Uher et al. 2011; Zimmerman et al. 2011). Finally, Barbara Milrod and colleagues have suggested that "separation anxiety and its treatment could provide an important window to neural circuits and other biological processes associated with internalization of social supports" (Milrod et al. 2014, p. 40). Object Relations Theory interfaces with the National Institute of Mental Health Research Domain Criteria domain "Social Processes" and with the construct "Affiliation and Attachment" (Cuthbert and Insel 2013).[4] (Readers interested in a recent summary of correlations between neurobiology and Object Relations Theory are referred to Kernberg 2014.)

In the clinical situation we see disturbances in object relations in many kinds of adult psychopathology (Nigg et al. 1992). In healthier patients, establishment of mature object relations during the preoedipal period of development is a necessary forerunner to successful navigation of the oedipal stage (Klein 1945). For example, the young woman who was "afraid to be left on the shelf," whom we discussed in Chapters 6 ("The World of Dreams") and 7 ("The Oedipus Complex"), suffered terrible loss at the time of her mother's death, leaving her even more afraid than usual that strong feelings of competition aroused in the oedipal stage would lead to abandonment. As we have seen, this young woman treated most romantic opportunities with a feeling of being "above it all." The young doctor who was obsequious in the presence of authority, whom we discussed in Chapter 10 ("Conflict and Compromise"), was also raised in difficult circumstances by parents whose own struggles with illness led them to demand that their son be a "good boy" who showed little aggression. As a result, he came into the oedipal stage already afraid of confrontation and competition.

In more seriously ill patients, failure to successfully differentiate self from object is reflected in psychotic experiences of all kinds, including those resulting from severe mental illness (e.g., schizophrenia, affective disorder) or from organic conditions, toxic states, or trauma. Although it is possible to describe psychotic experience in terms of ego weakness

[4]See nimh.nih.gov/research-priorities/rdoc/index.shtml (accessed January 12, 2014).

(such as disturbances in reality testing and/or the use of denial), many aspects of psychosis are best described in terms of self and object representations. For example, in the case of hallucinations or delusions, the patient may be unable to tell whether thoughts or voices originate in his or her own mind or the minds of other people.

Inability to tolerate ambivalence, or to maintain object constancy, is reflected in severe personality disorders, including borderline, paranoid, and some narcissistic conditions. Again, although it is possible to describe serious personality disorders in terms of ego weakness (such as impulse dyscontrol and affect intolerance), a better way of understanding these disorders may be to conceptualize them as reflecting an inability to maintain loving relationships in the face of frustration. Many patients with severe personality pathology do not form attachments at all because they are afraid of the intense feelings that will be stirred up by an intimate attachment; others are unable to tolerate separation and loss. Many suffer from problems with both attachment and separation.

Otto Kernberg: Integration of Object Relations Theory With the Structural Model

The American psychoanalyst Otto Kernberg has done important work integrating many of the best aspects of Object Relations Theory with the best aspects of the Structural Model. For example, although Kernberg adheres to a concept of *drive*, which he uses to describe the peremptory, superordinate search for pleasure (or impulse for aggression) guiding all behavior, he conceptualizes drive somewhat differently than do many who adhere more fully to the Structural Model. In Kernberg's view, the experience of drive results not from the body's innate demand for pleasure but rather from an innate disposition to experience pleasure in the context of relationships, which leads people to seek similar pleasurable relationships in an ongoing way. In other words, pleasurable (or good) experiences in the context of relationships become organized as drives.

Kernberg developed an important system for classifying personality organization (Kernberg 1970) and a theory for understanding borderline personality disorder (Kernberg 1975). These theories reflect his efforts to integrate Ego Psychology with Object Relations Theory (Kernberg 1976) and have been highly influential in the field of mental health.

Kernberg's Classification of Personality Disorders

According to Kernberg, in the development of healthy object relations, every individual must succeed at two basic tasks. The first task is the ability to differentiate self from object, or to construct self and object representations with clear boundaries. The second task is the ability to integrate self and object representations with respect to their good (pleasurable) and bad (frustrating) aspects. Kernberg saw the successful development of object relations as the attainment of object constancy, or the ability to maintain a positive attachment to an object even in the face of frustration or anger. Included in Kernberg's concept of *object constancy* is the concept of *self constancy*.

The twin tasks of separating self from object and of integrating good and bad aspects of self and object are closely related. This relationship is seen in many instances of psychological stress. For example, in the common experiences that involve separation from loved ones, we all face difficulty managing feelings, which often include frustration and anger. We must be able to withstand these feelings without losing either the capacity for self and object differentiation (task 1) or the capacity for object constancy (task 2). According to Kernberg's classification of personality disorders, patients who frequently fail at the task of differentiating self from object (task 1) are prone to psychotic pathology; patients who frequently fail at the task of integrating good and bad experience (task 2) but who mainly succeed at the task of differentiating self from object (task 1) are prone to borderline psychopathology; and patients who usually succeed at tasks 1 and 2 are prone to neurotic psychopathology (Kernberg 1970). Kernberg is most famous for his descriptions of the second group, or those with borderline personality organization (Kernberg 1975).

Kernberg's Conceptualization of Borderline Personality Organization

Kernberg's borderline personality organization (BPO) is a psychoanalytic diagnosis marked by nonspecific ego weaknesses (such as poor impulse control and affect intolerance) and by disturbances in object relations. In Kernberg's view, BPO is characterized by object relations in which there are poorly integrated good and bad self and object representations. BPO is also characterized by the use of defense mechanisms based on *splitting*, such as *projective identification* and *omnipotent control*. These defenses are based on a need to separate positive from negative experience, get rid of negative experience through projection onto the

object, and control the object, who is now experienced as bad and potentially dangerous. In other words, the defenses characteristic of BPO reflect the underlying disturbances in object relations. As described by Kernberg, BPO corresponds to Klein's concept of the paranoid position, which (as we recall) is characterized by the splitting off and projection of all-bad experiences onto the object, in contrast to Klein's depressive position, where love and hate are integrated.

In BPO, a failure to integrate good and bad aspects of experience underlies the inability to experience a coherent picture of oneself and/or of others. Patients with BPO often manifest wide fluctuations in mood, which represent the activation of self and object representations that are split apart or experienced as all-good or all-bad. The patient's mood fluctuates according to which part of this poorly integrated representation is activated. An incoherent picture of the self, which Kernberg (borrowing from Erikson 1956) called *identity diffusion*, leaves patients with BPO at risk for extreme swings in self-experience and self-esteem. An incoherent picture of others leaves patients with BPO at risk for misinterpretation of the actions of others and interpersonal chaos. BPO is found in borderline personality disorder as defined by DSM-5 (American Psychiatry Association 2013), as well as in other severe personality disorders, such as paranoid personality disorder, schizoid personality disorder, and some types of narcissistic personality disorder.

Other Perspectives on the Etiology of Borderline Psychopathology

As we saw in Chapter 10 when we discussed differing ways of understanding ego weakness (see section "Theories of Ego Weakness: Defense Versus Deficit"), a key debate among psychoanalytic theorists focuses on whether psychopathology is best explained as resulting from defenses against intrapsychic conflicts (i.e., the defense/conflict model) or as resulting from deficits due to failure of the early environment to provide the necessary ingredients for optimal psychological development (i.e., the deficit/developmental failure model). Kernberg's view of BPO emphasizes the role of aggression in distorting internalized object relations, as "all good" and "all bad" self and object representations are actively kept apart by defenses based on splitting. In other words, Kernberg's theory of BPO is a *defense/conflict model*. In contrast to Kernberg's emphasis on defense as the cause of BPO, other theorists argue that failures in infant–caregiver interactions during childhood are the major cause of deficits in the psychic structure of patients with borderline personality disorder. In other words, these theorists hold to a *deficit/developmental failure model* of psychopathology. For example, some have argued that experiences of abandonment by parents lead to the borderline individual's inability to tolerate aloneness (Adler and Buie 1979; Masterson 1981) or failure to achieve object constancy (Akhtar 1992, 1994). More recently, Peter Fonagy and Mary Target (1996) have proposed that borderline psychopathology results from deficits in the capacity for self-reflection and/or *mentalization*, which in turn result from impaired infant–caregiver interactions (Auchincloss and Samberg 2012, p. 28; Fonagy and Target 1996; Fonagy et al. 1993b, 2002). We will see another example of the defense/conflict versus the deficit/developmental failure debate in Chapter 12 when we explore differences in how Kernberg and Kohut conceptualized narcissistic problems.

Contemporary understanding of borderline psychopathology is informed by research from many fields, including social cognitive psychology and cognitive neuroscience (Depue and Lenzenweger 2001/2005; Donegan et al. 2003; Fertuck et al. 2006; Graham and Clark 2006; Lenzenweger et al. 2004; Minzenberg et al. 2006; Posner et al. 2002). This research supports a view of borderline psychopathology as resulting from the interaction of temperament and environmental risk factors, including abuse or neglect, which leads to an incoherent sense of self and other, insecure working models of attachment, deficits in mentalization, and poor systems of self-control.

Object Relations Theory and Psychodynamic Treatment

Object Relations Theory has made major contributions to our understanding of how psychodynamic psychotherapy works. We see these contributions most obviously in the specific psychodynamic psychotherapies developed for the treatment of borderline personality disorder. For example, Kernberg's own treatment for borderline personality disorder, called Transference-Focused Psychotherapy (TFP) (Clarkin et al. 2006), is based on his Object Relations Theory of borderline personality disorder. TFP is based on the premise that underlying object relations are activated in patient–therapist interactions. Therefore, it emphasizes work in the transference as offering the most effective means of addressing these underlying object relations. A primary task of the TFP therapist is to observe and interpret pathological object relations as they are activated in the patient–therapist relationship (Clarkin et al. 2006). In contrast to Kernberg's TFP, Anthony Bateman and Peter Fonagy have developed Mentalization-Based Treatment (MBT) for psy-

chotherapy with patients with borderline personality disorders, which focuses on developing mentalizing capacity in these patients (Bateman and Fonagy 2004, 2006).

However, we see the influence of Object Relations Theory in all psychodynamic psychotherapies, not just those designed for severe personality disorders (Caligor et al. 2007). The most obvious influence is a change in the goals of therapy to include not just the aim of understanding wishes, prohibitions, and ideals and the habitual modes of managing conflict (Structural Model) but also the aim of building strong relationships with other people. Therapists using Object Relations Theory are very interested in how each patient finds attachments and intimate connections that are sustaining and how each patient maintains a sense of separateness. They are also interested in how each patient does (or does not) have internal structures marked by self and object constancy, which support a sense of being "good enough."

In addition, we see the influence of Object Relations Theory on how psychotherapy is conducted. For example, we see this influence in the strong emphasis on use of *countertransference* (defined as the therapist's feelings about the patient) as a primary source of information about the patient's inner life (Heimann 1950, 1956). We also see the influence of Object Relations Theory on theories of therapeutic action (Blatt et al. 1994; Fonagy et al. 1993a; Mayes and Spence 1994). For example, over time, theories have begun to emphasize the importance of the patient–therapist relationship not just as a source of information but also as a force for change. In general, over the years, we have seen a shift from early theories of therapeutic action emphasizing change resulting from *insight* derived from *interpretation* to more recent theories emphasizing change resulting from the relationship with the therapist. Various theorists have emphasized different aspects of the therapeutic relationship using different terminology, including the following: *corrective emotional experience* (Alexander and French 1946), *new object* (Loewald 1960); *real relationship* (Greenson and Wexler 1969), *therapeutic alliance* (Zetzel 1956), *holding environment* (Modell 1976), and *container/contained* (Bion 1963, 1970). Indeed, in our Preface and Introduction to this book, we mentioned the importance of the *therapeutic alliance* in all psychoanalytic treatments, a concept that has been increasingly well understood as a result of Object Relations Theory (Krupnick et al. 1996; Zetzel 1956).

A relatively recent school of psychoanalysis called Relational Psychoanalysis emphasizes that the meaning of the patient–therapist interaction is "co-created" and urges exploration of this co-creation process as a major emphasis of the work (Greenberg and Mitchell 1985). We will not discuss Relational Psychoanalysis in this book, as it consists mainly

of theories about the clinical situation and how best to understand what goes on between patient and therapist. Many relational theorists have so stressed the phenomenon of co-created meaning that the concept of a model of the mind unique to the patient rather than co-created in the clinical situation is difficult to grasp.

The debate continues over which aspect of psychotherapy—the therapist's interpretations or the relationship between patient and therapist—is more important to therapeutic change. However, according to Glen Gabbard and Drew Westen (2003), this debate is of less relevance today than it was in the past. Nowadays, we must integrate many theories of therapeutic action, including the role of interpretation and the role of the relationship, which work together. Nevertheless, readers should keep this debate in mind as we move on to Chapter 12 ("Self Psychology"), where we will explore yet another model of the mind with a somewhat different view on how the therapeutic relationship helps the patient.

Chapter Summary and Chart of Core Dimensions

Table 11–1 introduces our Object Relations Theory chart of core dimensions, in which we have placed the following key concepts:

- **Topographic point of view:** Object relations are largely unconscious.
- **Motivational point of view:** People are object seeking from birth; object seeking is not secondary to other motivations. Wishes for *separation* from the object and for autonomy (*individuation*) are also inborn. There is inevitable conflict between wishes for affiliation and wishes for separation, accompanied by ambivalent feelings of love and hate for the object. If successful compromises are forged between these wishes and feelings, the individual acquires the ability to experience gratitude toward the object, along with growing confidence that envy can be overcome and damage to the relationship can be repaired.
- **Structural point of view:** The basic unit of experience is the *object relation*—an intrapsychic structure consisting of a self representation, an object representation, and the representation of an affectively charged interaction between self and object. Object relations can be either fleeting or enduring. Enduring object relations serve as templates for all psychic structures (such as ego, id, and superego) and for all future relationships. Related concepts include need-satisfying object, object constancy, self constancy, attachment behavioral system, internal working models of attachment, and mentalization.

- **Developmental point of view:** Object relations are largely formed in interaction with caregivers during childhood. Anna Freud, Klein, Bion, Winnicott, Bowlby, Mahler, Fonagy, and Kernberg have offered overlapping developmental models for object relations. Each of these developmental models ends in attainment of the capacity for *object constancy*, or the ability to maintain strong, positive ties to an object even in the face of separation, frustration, or anger.
- **Theory of psychopathology:** The quality of object relations serves as an index of mental health/illness. Strong, realistic object relations marked by object constancy are the hallmark of mental health. In contrast, disturbed object relations manifested by an inability to maintain object constancy are seen in many kinds of adult psychopathology, including severe personality disorders such as borderline, paranoid, and some narcissistic conditions, or any disorder characterized by borderline personality organization.
- **Theory of therapeutic action:** In psychodynamic psychotherapy, object relations are activated in the therapist–patient relationship, which is then used to understand them. As a result, Object Relations Theory leads to therapies that emphasize the transference, and especially the *countertransference*. It also leads to theories of therapeutic action that emphasize the role of *the therapist as a new object* (as opposed to theories that emphasize insight). Two well-known psychodynamic psychotherapies developed specifically for the treatment of borderline personality disorder are Kernberg's Transference-Focused Psychotherapy and Bateman and Fonagy's Mentalization-Based Treatment.

TABLE 11–1. Object Relations Theory

Topography	Motivation	Structure/Process	Development	Psychopathology	Treatment
Object relations are largely unconscious	Conflicting wishes for affiliation and for separation-individuation	Object relation Self representation Object representation	Attachment Separation of self from other	The quality of object relations serves as an index of mental health/illness	Activation of object relations in the therapist–patient relationship
	Love/hate/ambivalence Envy/gratitude/repair	Representation of interaction between the two Need-satisfying object	Paranoid position and depressive position Container/contained	Borderline personality organization (BPO)	Countertransference The therapist as a new object
		Object constancy Self constancy	Good-enough mother Holding environment		Transference-Focused Psychotherapy
		Attachment behavioral system	Separation-individuation Differentiation Practicing		Mentalization-Based Treatment
		Internal working models of attachment	Rapprochement On the way to object constancy		
		Mentalization	Parenthood Midlife crisis		
			Development of mentalization		

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