Psychiatry is the medical specialty that studies disorders of behavior and experience, both affective and cognitive. Like other branches of medicine, it considers 1) the phenomenology of the normal and abnormal, 2) systems of classification and epidemiological information, 3) etiology, 4) diagnosis, and 5) prevention and treatment. Because human behavior is complex, psychiatry draws on many fields of knowledge, ranging from biochemistry, genetics, and neuroscience to psychology, anthropology, and sociology, in order to understand its subject matter.

The interview is a basic technique of psychiatry and most other clinical specialties. Other methods may also be employed, such as biological or psychological tests, symptom rating scales, or pharmacological or physical treatments, but even these usually occur within the context of a clinical interview. The psychiatric interview is by far the most important diagnostic tool of today’s psychiatrist. With our current knowledge, physiological and biochemical studies of behavior offer little assistance in understanding interviews, whereas psychodynamic concepts have proved valuable.

In the psychodynamic frame of reference, behavior is viewed as the product of hypothetical mental processes, wishes, fears, emotions, internal representations, and fantasies and the psychological processes that regulate, control, and channel them. Subjective experience, thoughts, and feelings are of central importance, and overt behavior is understood as the product of inner psychological processes that can be inferred from the patient’s words and acts.

A psychodynamic formulation offers a description of mental experience, underlying psychological processes, their hypothetical origins,
and their clinical significance. It provides a rational basis for the patient. As long as the interview is the central tool of psychiatry, psychodynamics will remain an essential basic science. At present it also provides the most comprehensive and clinically useful understanding of human motivation, pathology, pathogenesis, and treatment of many disorders.

This chapter presents the basic assumptions of psychodynamics and psychoanalysis, the school of psychodynamics started by Sigmund Freud that has been the source of most of our knowledge and has almost become synonymous with psychodynamics. In recent years alternative psychodynamic models have been found clinically useful and also are described briefly. It discusses basic psychodynamic models of psychopathology, various types of pathological formations, and those psychoanalytic concepts that are most crucial in understanding the interview. Space does not permit a complete consideration of psychoanalysis, which includes a theory of personality development, a technique of treatment, specific methods for obtaining information about the psychodynamic determinants of behavior, and a metapsychology or series of abstract hypotheses about the basis of mental functioning and the source of human motives. These aspects of psychoanalysis go beyond the scope of a book on interviewing and are discussed in the books on psychoanalytic theory listed in the bibliography at the end of the book.

**BASIC ASSUMPTIONS OF PSYCHODYNAMICS AND PSYCHOANALYSIS**

**Motivation**

Behavior is seen as purposeful or goal-directed and as a product of hypothetical forces—drives, urges, impulses, or motives. Motives are represented subjectively by thoughts and feelings and objectively by a tendency toward certain patterns of action. Hunger, sex, aggression, and the desire to be cared for are examples of important motives.

The early years of psychoanalysis were extensively concerned with the origins of basic human motives and, specifically, with developing a model that would relate them to their biological roots. Freud used the German term *trieb*, which has usually been translated as "instinct," to refer to these basic drives, which were assumed to involve a form of "psychic energy." This drive theory was helpful in focusing on the complex shifts or "vicissitudes" in motivations that occur in the course of development, and it was a useful framework for understanding the psychodynamic basis of neurotic behavior. For example, the idea of a sexual drive with many and varied manifestations makes it possible to
conceptualize the links among hysterical seizures, sexual inhibitions, and infantile sexual behavior. However, in recent years, some aspects of psychoanalytic drive theory have been criticized as tautological and unscientific hypotheses that cannot be tested or refuted. At the same time the attention of psychoanalysts has shifted from the origins of basic human motives to their psychological manifestations and the various means by which they are expressed. To many, the biological basis of motivations is a physiological problem that cannot be explored by psychoanalysis, a psychological method. In any event, it is an issue that has little direct bearing on the interview. By the time a child is able to talk, he has strong psychological motives that will be present for the rest of his life, motives represented by the wishes that form the basis of our psychodynamic understanding. The extent to which their origin is constitutional or acquired is of great theoretical, but little immediate clinical, importance.

Dynamic Unconscious

Many of the important inner determinants of behavior occur outside the individual's subjective awareness and are normally not recognized by him. The existence of unconscious mental activity was apparent long before Freud—events that are forgotten but later remembered are obviously stored in some form during the interim. However, this would be of little clinical importance were it not for the dynamic significance of these unconscious mental processes—that is, the great influence they exert on behavior and particularly the important role they play in determining both pathological and normal behavior.

The early history of psychoanalysis is a record of the progressive discovery of the role of unconscious mental processes in determining almost every area of human behavior—neurotic symptoms, dreams, jokes, parapraxes, artistic creations, myths, religion, character structure, and so forth.

Psychic Determinism

Science in general—and late-nineteenth-century positivist science in particular—views all phenomena as determined in accordance with "laws" of nature. If one knows these laws, and the initial conditions, one can predict subsequent conditions. However, commonsense psychology and the romantic tradition largely exempted subjective experience from such determinism. One of Freud's central contributions was to apply strict determinism to the realm of subjective experience. Men-
tal events were determined, and were set in motion by prior mental events (not simply by neural events, as in currently popular neurobiological reductionist models). The challenge for psychoanalysis as a science was to discover the psychological laws that governed these processes and to develop the methods necessary to apply them to our understanding of human mental life.

Regulatory Principles

Behavior is regulated in accordance with certain basic principles. These organize the expression of specific motives and determine priority when they come into conflict with each other or with external reality. For example, someone may feel angry or violent, but his awareness of the painful consequences of a direct expression of these feelings leads to a modification of his behavior. This illustrates the pleasure-pain principle (or simply, “pleasure principle”), which states that behavior is designed to pursue pleasure and to avoid pain. Although this seems obvious, much of the behavior that psychiatry studies appears to violate this principle. Pathological or maladaptive behavior frequently seems destined to lead to pain, and often even a casual observer will tell the patient that he is acting “foolishly” and that he would be much happier if he simply changed his ways. Every paranoid person has been told that his suspiciousness is self-defeating, every obsessive that his rituals are a waste of time, and every phobic that there is no reason to be frightened. Perhaps one of the major contributions of dynamic psychiatry has been to demonstrate that these apparent paradoxes are really confirmations of the pleasure principle once the underlying unconscious emotional logic is revealed, and that even the individual with an apparently inexplicable desire to be beaten or tortured can be seen to be following the basic pleasure principle when his unconscious wishes and fears are understood.

Each individual has his own personal hierarchy of pleasure and pain. For example, people who have been raised in painful circumstances develop a view of life as a series of inevitable choices among painful alternatives. Their pursuit of the lesser of two evils conforms to the pleasure principle. The self-defeating personality provides an illustration. The little girl who was scolded more than she was praised received love and affection when she was sick or in danger from the same parent who scolded her. Scolding thus became the symbol of love. Years later, her predilection for abusive relationships seems incomprehensible until one recognizes their unconscious meaning of love, affection, and security.
With maturity, the capacity for abstract symbolic thought provides the basis for mental representations of the distant future. The elementary pleasure–pain principle, rooted in the immediate present, is modified as reason dictates that one tolerate current discomfort in order to achieve future greater pleasure. This is called the reality principle, which is basically a modification of the pleasure principle. However, at an unconscious level, much behavior continues to be regulated by the more primitive pleasure principle.

Fixation and Regression

Childhood experiences are critical in determining later adult behavior. Neurotic psychopathology can often be understood as the persistence or reemergence of fragments or patterns of behavior that were prevalent and often adaptive during childhood but that are maladaptive in the adult. Fixation describes the failure to mature beyond a given developmental stage, whereas regression refers to the return to an earlier adaptive mode after one has progressed beyond it. Both are selective processes and affect only certain aspects of mental functioning. The result is that the neurotic individual has a mixture of age-appropriate and more childish behavior patterns. For example, his cognitive functioning might be unimpaired, but his sexual fantasy life may be immature. Of course, psychological development is complex, and even the most disturbed adult patient has many aspects of mature functioning, whereas healthy people have many aspects of behavior that are characteristic of earlier developmental stages. For example, all adults have a proclivity for wishful or magical thinking. Rituals related to good luck, such as “knocking on wood” or avoiding the number 13, are everyday examples.

Fixation and regression can affect motives, ego functions, conscience mechanisms, or any combination of these. Often the most important marker of pathology, especially in children, is not the extent of the regression but the unevenness with which it has affected some psychological processes while sparing others. Regression is universal during illness, stress, sleep, intense pleasure, love, strong religious feeling, artistic creativity, and many other unusual states, and it is not always pathological. Creativity, sexual pleasure, and spiritual experiences all involve regressive aspects, as suggested by the concept of “adaptive regression in the service of the ego.” In fact, the capacity to regress and to make adaptive use of regressive experiences is an essential prerequisite for creative thinking and empathic understanding and thus also for conducting a psychiatric interview. To be able to feel what the patient
feels while at the same time observing and studying that feeling is the essence of the psychiatrist's skills and is an example of regression in the service of the most mature aspects of the personality.

**Emotions**

Emotions are states of the organism that involve both the mind and the body. They include characteristic physiological responses; subjective affects, thoughts, and fantasies; modes of interpersonal relations; and styles of overt action. Anxiety, a key emotion in the development of psychopathology, serves as an example. The anxious individual is aware of inner feelings of diffuse, unpleasant anticipatory fear or dread. His cognitive functioning is impaired, and he is likely to be preoccupied with fantasies of magical protection, retaliation, or escape. His overt behavior is dominated by his own characteristic response to threat—fight, flight, or helpless surrender. There are alterations in pulse, blood pressure, respiratory rate, gastrointestinal functioning, bladder control, endocrine function, muscle tone, the electrical activity of the brain, and other physiological functions. No one of these phenomena is itself the emotion, but the syndrome as a whole constitutes the organismic state that we call anxiety. Emotions proliferate and differentiate with development, so that the adult has a much larger and more subtle array of emotions than the young child. These play a critical role in the development of the personality as a whole, and especially of symptoms, which will be explored in greater detail later.

**Fantasies of Danger**

The newborn infant has no internal psychological conflict about seeking pleasure from drive gratification; it is only that he needs the understanding and assistance of a caretaker in order to do so. When this is available, he is "as happy as a baby." However, frustration is inevitable regardless of the caretaker’s skill. Overstimulation can interfere with pleasure seeking, the child may be separated from the caretaker, or the caretaker may be experienced as disinterested or hostile, and as development proceeds, the child may come to fear loss of pleasure-seeking capacity or experiences of inner psychological anguish in the form of shame or guilt. In time virtually every wish is accompanied by one of the fears that develop in the context of the child–caretaker relationship. The result is that, in the adult, we rarely see pure wishes or pure fears but rather conflicts between wishes and the fears that accompany them, with the former sometimes and the latter usually unconscious.
Representations

Subjective experience involves patterns, images, or representations as well as drives or wishes and emotions or feelings. Foremost among these are representations of one's self and of important others such as parents or primary caretakers. Current developmental theory suggests that these self and other representations differentiate out of an original amorphous subjectivity—that, in Winnicott's words, there is no such thing as a baby but rather from the beginning a mother–baby constellation. The representation of the self evolves throughout development and is a core feature of the personality, whereas the representations of others in relation to the self also evolve, are shaped and refined, and become the templates of the various transference phenomena that are central to psychodynamic thinking and that are discussed throughout this book. Whereas Freud’s original hypothesis placed drives in a central position and viewed representation born of self and of others as secondary, several post-Freudian thinkers have reversed this model, with self and object representations seen as central and drives as secondary.

Objects

The term object seems like the wrong word to refer to other people, or even the inner mental representations of other people, as is its meaning in psychodynamics. However, it makes sense in terms of the history of psychodynamic thinking. After an initial interest in neurosis as the result of childhood trauma, Freud's attention shifted to the centrality of drives and to psychological development as largely based on the maturation of innate drive predispositions, with the environment serving as the context for this maturation. Drives generally required some aspect of the external world for their gratification—hence their “object”—and this was often (but not always) another person—for example, a mother or a lover. The emphasis, however, was not on the human characteristics of the object but rather on its drive-gratifying potential. However, in time a number of psychoanalysts, especially those who worked with children, recognized that significant others in the child’s life were more than targets: they made a difference. The term object stuck, but it was increasingly recognized that the object had an active role in shaping the child’s growth and experience and that the maturational unfolding of innate predisposition was part of an interactive developmental process to which objects made important contributions.

Today some schools of psychodynamics continue to see drives as central, whereas others focus on relations between the child (or later...
adult) and important objects. Each group recognizes that both are aspects of any full account of personality. Conceptual models based on object relations have been particularly influential in the study of infants and children, of more serious psychopathology such as psychotic and borderline conditions, and of psychotherapy and interviewing, with their inescapable attention to the relationship between individuals.

Freud's original notion was that patients suffered from reminiscences—memories of earlier pathogenic experiences. He quickly decided, on the basis of his clinical experience, that these memories stemmed from childhood and were primarily sexual. Many of his patients had reported memories, often hazy, partial, or fragmented, of what seemed to be childhood sexual experiences—traumas—that Freud believed to be at the core of their neurotic symptoms. However, the nature of the memories, their omnipresence, and his discovery that at least some of them had to be "false" led to a basic revision of his theory beginning in 1897. He still believed that his patients suffered from memories, but no longer from memories of "real" events. Rather, they suffered from memories of childhood fantasies, fantasies that had the dynamic power of psychic reality and were rooted in the hitherto unrecognized psychosexual life of children. From that point on, psychodynamics was no longer primarily about the representation of external events; it was increasingly about the internal predisposition to formulate one's experience of the external world in terms of wishes, fears, and fantasies. The therapeutic process continued to emphasize the recovery of repressed memories, but these were now memories of fantasies, of subjective experience, rather than memories of the external events of childhood. As a corollary, psychoanalytic interest in developmental psychology continued, but the focus shifted to include not only how the growing child interacts with the world but also how the child's fantasies unfold and how they influence the processing and recording of interactions with the world.

Contemporary psychodynamic thinking, like Freud's, is interested in childhood. However, in working with adult patients it recognizes that it has no direct access to the "facts" of childhood, and indeed that even if it did, they might not be very useful. Rather, it is interested in the adult patient's memories, beliefs, and fantasies about childhood, both unconscious and conscious. It recognizes that, like all memories, these are contemporary constructions, or perhaps reconstructions—the adult reworking of the adolescent reworking of the childhood reworking of the infantile interpretation of the experience. These memories are dynamically powerful, and one way of understanding the mechanism of action of psychodynamic treatment is that it uncovers them; explores
them; understands the extent to which they are creations influenced by
the patient's developmental stage, major conflicts, and character struc-
ture rather than veridical copies of reality; and therefore recognizes that
although they are memories they can be changed. In effect, the treat-
ment succeeds to the extent that the patient can change his history, or at
least loosen the grip that the particular version of his history that has
controlled him continues to exert on his life.

The psychodynamic psychotherapist's interest is not simply in the
events of childhood but much more in the memories that adults have of
childhood, the memories that serve as the templates for their neurotic
patterns and transference responses. For the most part, in all but the
most disturbed patients, these memories are compatible with what "re-
ally" happened, but they are only one of the many possible versions of
what "really" happened. The well-educated therapist knows something
about what developmental psychologists have learned about childhood
and even more about the impact of development on the recording of
childhood memories and the kinds of transformations that occur with
each subsequent developmental step. He knows the familiar narratives
of childhood, the memories that are frequently associated with specific
syndromes or character types, and also knows that when these are trans-
formed into hypotheses about developmental dynamics, although in
theory they may be testable, for the most part they have not yet been
tested. However, he further knows that their clinical value and their
therapeutic leverage depend not on their historical validity but rather on
their fit with the subjective mental lives of patients and their ability to fa-
cilitate the patients' reformulation of their personal histories.

PSYCHODYNAMICS OF
PSYCHOPATHOLOGICAL CONDITIONS

Normality and Pathology: The Nature of Neurotic Behavior

There are no generally accepted definitions of the terms normal and
pathological or health and disease, and yet the daily practice of medicine
requires frequent decisions based on these concepts. Psychopathology re-
ers to behavior that is less than optimally adaptive for a given individ-
ual at a given stage of his life and in a given setting. Psychodynamics
studies the mental processes that underlie all behavior, adaptive and
maladaptive, healthy and pathological. There is, of course, psychopa-
thology that cannot be understood in psychodynamic terms alone—the
automatic behavior of a psychomotor seizure and the hallucinations
that result from taking a psychedelic drug are examples. Psychodynam-
ics may help to understand the content but has little to do with the form of such behavior. The description of a given behavior as resulting from the resolution of an inner conflict or as the product of mental mechanisms of defense does not distinguish whether it is normal or pathological. The critical question is whether the individual, in resolving his conflict, has unnecessarily impaired his capacity to adapt to his environment or interfered with his capacity for pleasure. Everyone has inner psychological conflicts, and everyone responds to the anxiety that they evoke by the use of mental mechanisms. A discussion of the psychodynamics of a piece of behavior is independent of whether it is normal or pathological. This is somewhat more complex in practice because some psychodynamic constellations and some mental mechanisms are more often associated with psychopathology. In general, any defense that threatens the individual's contact with reality, the maintenance of interpersonal relationships, or the possibility of pleasurable affects is likely to be pathological. However, there is no defense mechanism that is never found in healthy individuals.

In clinical practice, the physician is not primarily concerned with assessing whether the patient's interview behavior is healthy or sick. He is more interested in what it means and what it tells him about the patient. Psychiatrists are frequently called upon to interview, and even to treat, healthy individuals who may be coping with major crises or facing extraordinary circumstances. Knowledge of psychodynamics is vital for the skillful conduct and thorough understanding of interviews with these psychiatrically normal individuals. However, it is important for every clinical interviewer to study psychopathology as well as psychodynamics, not only to understand interviews with patients who are not psychiatrically normal but also to understand psychodynamic principles, which are learned most easily from individuals with emotional difficulties.

The Structure of Neurotic Pathology

Basic motives, such as sex, aggression, the quest for power, or dependency, impel the individual toward behavior that would lead to their gratification. However, because of internal psychological conflict, the expression of this behavior may be partially or completely blocked, with a resulting increase of intrapsychic tension. The opposing forces in this conflict result from the anticipation of both the pleasant and the unpleasant or dangerous consequences of acting on the motive involved. In the simplest situation, common in childhood, external danger is real and its perception leads to an emotional state, fear. For example, a boy may feel
angry and want to attack the adult whom he feels is treating him unfairly; however, his fear of retaliation will lead him to control and suppress his rage. In this example, the outcome is highly adaptive, and it makes little difference whether the perception of danger and the resulting inhibition of the impulse occurred consciously or unconsciously.

The situation becomes more complex when the dangerous consequences that are feared are neither real nor immediate but rather fantasies, imaginary fears that have resulted from formative experiences in childhood—when the shadow of the past falls on the present. Such fears are almost always unconscious, and since they result from dynamically significant unconscious memories rather than conscious current perception, they are not easily corrected even by repeated exposure to a contradictory reality. It is difficult to unlearn attitudes that are rooted in unconscious mental processes. The fear of an unconsciously imagined danger, called anxiety, leads to an inhibition of the relevant motive. In this case, the inhibition is not a response to the real world in which the individual is currently living and therefore is more likely to be maladaptive or pathological. However, there are exceptions. Inhibitions of basic motives that stem from unconscious fantasies of imagined dangers may be highly adaptive if the original unconscious fantasies themselves developed in a situation that is closely analogous to the individual's current reality. In simple terms, if one's current situation is similar to the world of one's childhood, seemingly neurotic patterns may actually be adaptive.

An example will illustrate this. A man who has warm and loving feelings toward his wife has unconscious fears of being castrated should he participate in adult sexual activity. A potency disturbance and inhibition of sexual impulses result, an obviously maladaptive solution in his current life, however understandable it might have been in the childhood setting in which it originally developed. Another man who is momentarily sexually attracted to a woman at a party loses interest when he learns that she is his boss's wife. This may also be the result of an inhibition of sexual impulses based on the unconscious fear of castration, but the result is now adaptive, because the setting closely parallels that of his fantasy, which stems from early childhood, when the expression of such impulses was clearly limited.

The anxiety that results from a conflict between a wish and an unconscious fear is one of the most common symptoms of psychological distress. It is the dominant feature of the classic anxiety disorder and is also found in many of the symptomatic neuroses. Patients may become anxious about the possibility of future anxiety—that is, “anticipatory anxiety,” particularly characteristic of phobic disorders. They also may
experience brief, circumscribed episodes of severe anxiety, "panic," with no conscious precipitant or mental content. Many investigators believe that this suggests an altered neurobiological threshold to anxiety, and both pharmacological and psychological interventions have been effective in its treatment. Some people with symptomatic neurotic psychopathology, and many individuals with personality or character disorders, experience little or no conscious anxiety. Their problems are manifested by neurotic symptoms such as phobias, obsessions, compulsions, or conversion phenomena or by various character traits, and anxiety may be a less important part of the clinical picture or may even be absent altogether.

The psychoanalyst understands these more complex conditions as the result of defense mechanisms. These are automatic unconscious psychological patterns elicited by conflicts that threaten the individual's emotional equilibrium. The resulting threat or anticipation of anxiety, called signal anxiety, never becomes conscious because of the mental mechanisms that defend the individual from it. In other words, the individual responds to the unconscious threat of anxiety resulting from a psychological conflict by utilizing mechanisms that lead to a symptom or behavior pattern in order to ward off that anxiety. A clinical example illustrates this theory:

A young woman who had had a somewhat restrictive and puritanical upbringing developed a phobia, a fear of going outdoors alone. She recalled a brief period of anxiety at the time that her phobia began. However, she experienced no anxiety at present as long as she remained indoors. When asked why she was afraid of going outdoors, she described episodes of palpitations and dizziness and her concern about what would happen if these occurred while she was on the street. Later, she told of women in her neighborhood who had been accosted by strange men and of her fear of being attacked. She had repressed sexual impulses toward attractive men whom she saw on the street, and she feared disapproval and punishment for these impulses, although both her wish and her fear were unconscious.

Here we see a number of defenses: repression of sexual wishes, the displacement of a fear of sex to a fear of the outdoors, avoidance of the outdoors, and the projection of sexual impulses onto strange men. These mechanisms were effective in controlling the patient's anxiety, but at the price of sexual inhibitions, frigidity, and the restriction of her freedom to travel. This inhibition of healthy behavior is a constant feature of symptom formation. It is often the "secondary loss" from the symptom that elicits the patient's feeling of inadequacy, helplessness, or even depression.
Symptoms not only defend against forbidden wishes; they also serve, symbolically and partially, to gratify them. This is necessary if symptoms are to be effective in protecting the individual from discomfort, because the ungratified wish would continue to press for satisfaction until the psychological equilibrium was disturbed and the fear and anxiety returned. An example of the gratification provided by symptoms is seen in the case of the woman just described. She was only able to venture outdoors in the company of her older brother, who had always been a romantic partner in her unconscious fantasies. Symptoms may also provide symbolic punishment related to the original unconscious fear. As a small child, the same young lady had been punished for naughtiness by being locked in her room, and her phobic symptom re-created that experience.

**Symptom and Character**

Neurotic psychopathology represents a compromise between a repressed unacceptable wish and an unconscious fear. Although all behavior represents an attempt to compromise between the demands of inner drives and external reality, neurotic behavior is a second-best solution, reflecting the individual’s effort to accommodate not only to the external world but also to the restrictions imposed by inner unconscious fears. The two basic ways in which these neurotic patterns can be integrated into the personality are described by the terms *symptom* and *character*.

Neurotic *symptoms* are relatively sharply delineated behavior patterns that are experienced by the individual as undesirable “ego-alien” phenomena, not truly part of his self or personality. He consciously desires to be free from them, and they not infrequently lead him to seek help. Anxiety, depression, phobias, obsessions, compulsions, and conversion phenomena are typical examples. In time the patient may adjust to his symptoms and learn to live with them and even to exploit them (“secondary gain”), but they always remain foreign to the self—fundamentally experienced as “not me.”

*Character traits* are more generalized behavior patterns that merge imperceptibly into the individual’s total personality. They are ego-syntonic because he sees them as part of himself and either fails to recognize them as pathological or, realizing that they are undesirable, simply feels that they reflect his “nature.” These traits rarely lead the individual to seek assistance, although their indirect secondary social consequences are frequent precipitants of psychiatric consultations. Mistrust, stinginess, irresponsibility, impulsiveness, aggressiveness, compuls-
siveness, and timidity are illustrations of troublesome character traits, whereas perseverance, generosity, prudence, and courage are more desirable ones.

Although the underlying psychodynamic structures of symptoms and character traits are closely related, they present quite different technical problems in psychiatric interviews and in treatment. In general, when treating patients who seek relief from symptoms, the clinician considers the underlying character structure along with such factors as motivation and life setting in planning the therapy, since it is only by viewing the symptoms in terms of the individual's overall functioning that a rational program for treatment can be developed. For instance, two men may experience depressive symptoms of the same severity. One is single, young, articulate, and intelligent; has an obsessive personality structure; and has considerable motivation for treatment, some flexibility, and few irreversible life commitments. Intensive exploratory, analytically oriented psychotherapy may be recommended for this person, with the goal of modifying predisposing character traits as well as relieving symptoms. The other person is older and has married a woman whose personality problems complement his, and they have several children. She responded quite negatively to an earlier attempt at treatment on his part. He is now suspicious and mistrustful of psychiatry and has little interest in his inner life, focusing on concrete externals. For this person, a more symptom-focused treatment is preferable. Symptom relief is an important goal with both patients, and pharmacological interventions may be useful with either, but psychodynamic considerations are important in evaluating the potential benefits and risks of employing a character-focused psychotherapy.

Conversely, with individuals who present with predominantly characterological pathology, the interviewer searches for symptoms that the patient may have not recognized or acknowledged. Improvement of such symptoms may enhance the patient's motivation for treatment. As therapy progresses, in a sense, the clinician tries to shift the patient's attitude toward his character problems to that seen with symptoms, attempting to help the patient experience his pathological character traits as separate from his "self." This has led to the often misunderstood maxim that treatment is not really working until the patient becomes symptomatic. It would be more accurate to say that as a patient with a character disorder begins to gain some insight into his pathology, he experiences it as more ego-alien. The tragedy of certain character traits is not in what the patient suffers but rather in what he misses.

An extremely obsessive man prided himself on his punctuality and his general perfectionism. One day he arrived at his session exactly on
the hour, proudly explaining to the therapist that he had timed it perfectly, just glancing at his watch in time to make the train. Later he revealed that he had been lunching with his daughter, an unusual event, and that she had been somewhat surprised and hurt when he had left so abruptly. He had offered her neither an explanation nor an apology. The therapist agreed that he had made the appointment on time but suggested that he had traded a potential experience of intimacy and warmth for a “perfect record.” The patient became quite gloomy at the suggestion that his treasured virtue could be seen as the surface manifestation of an underlying pervasive psychological problem—in effect, that his traits were symptomatic. As the treatment proceeded, they explored the many possibilities for combining his punctuality and precision, obsessional traits that he valued, with warmth and intimacy, newly acquired values that he was no longer willing to sacrifice, thus preserving the adaptive aspects of his traits while diminishing the pathological effects that he now experienced as symptomatic.

In the interview, symptoms are most clearly reflected in what the patient talks about; character traits are revealed in the way he talks and the way he relates to significant other people, particularly to the interviewer. From another point of view, the patient describes his symptoms, whereas his character traits are observed by the clinician. The beginning interviewer tends to focus on symptoms, since they are emphasized by the patient, are similar to the focus of interviews in other areas of medicine, and are easiest to recognize and to understand. The more experienced interviewer will also listen to the patient’s description of symptoms, but more of his attention is directed to the patient’s character structure as it emerges during this discussion. One of the major contributions of psychoanalysis is the recognition of the importance of dealing with the patient’s characterological structure if the interview is to be maximally productive.

**Neurosis and Psychosis**

There is no single criterion that differentiates psychotic from neurotic patients. In general, psychotic patients are sicker—that is, they have more pervasive and widespread difficulties in adaptation. More specifically, areas of functioning that are considered to be essential for a minimal level of adaptation and that are usually intact in neurotic patients may be impaired in psychotic patients. These would include the perception and testing of reality, the capacity for sustained interpersonal relations, and the maintenance of autonomous ego functions such as memory, communication, and motor control. The distinction between
psychotic and nonpsychotic organic brain syndromes is based on related criteria and is discussed in Chapter 15, "The Cognitively Impaired Patient."

Studies of the psychological processes involved in neuroses and psychoses have repeatedly raised the question of whether these are qualitatively different or merely quantitative variations of the same basic mechanisms. Those who hold the former view may suggest that one or another basic defect is primary in the psychotic process (usually viewed as genetic or neurobiological in origin) and that the other phenomena of the illness can then be explained as the result of defensive and reparative psychological responses similar to those seen in neuroses. For example, in schizophrenia this central defect has variously been described as a diminished capacity for affectivity, a disturbance in the perception or testing of reality, abnormal cognitive processes, poor interpersonal relations, or a primary deficit in the synthetic function of the ego, which integrates other mental functions into a harmonious whole.

Specific mechanisms of defense are neither psychotic nor neurotic, or for that matter, neither pathological nor healthy. However, some mental mechanisms, such as projection and denial, interfere with autonomous ego functions and the relationship with reality and are therefore commonly associated with psychotic processes. Hallucinations and illusions are gross disorders in the perception of reality, and delusions represent severe disturbances in reality testing; all three of these symptoms are usually associated with psychosis. However, subtler disturbances in the subjective sense of the "real" world, such as derealization or depersonalization, are common in neuroses as well as in psychoses. Furthermore, all neurotic symptoms, insofar as they are maladaptive, are in some sense "unrealistic." However, the defective contact with reality found in neurosis is more sharply circumscribed, usually unconscious, and most areas of the patient's life are unaffected.

The disturbance in interpersonal relations found in psychotic disorders may stem from earlier stages of the patient's development, because the beginnings of the child's capacity for perception and testing of reality, thought, language, and affectivity all grow out of the early relationship with the mother. The neurotic patient tends to force current relationships into the mold created by later childhood experiences, and the result can be a serious disturbance in friendships and love lives. However, the neurotic patient does have the capacity to develop and maintain relationships with others, and if the neurotic problems are overcome, these are major sources of gratification. Many psychotic individuals (particularly those with schizophrenia) have more basic defects in
their capacity for relating to others. This is seen clinically in their tendency toward isolation and withdrawal, having few lasting friendships and a shallowness and superficiality in those that do develop. Friends and acquaintances will often find them less stable and less reliable parts of their lives.

The clinician may experience this defect in the nature of the patient’s relationships during the interview. The psychotic patient may “feel” different; it is harder to make contact with him and to empathize with his emotional responses. For example, if the clinician is unable to remember the patient several hours after the first visit, it may reveal in retrospect that little real contact was established. The patient’s shifting sense of personal identity may leave the clinician feeling that there is not a specific other person there with him. Experienced psychiatrists detect psychosis by this kind of feeling as well as by the psychopathological criteria that are used to justify the diagnosis. However, every relationship that the psychotic patient establishes need not be shallow or superficial. There are striking exceptions, and often there is one person with whom the patient has an intense symbiotic relationship that is far more all-encompassing than any that the neurotic develops. This person may be the psychotherapist, and therefore this has special relevance to the interview.

When sufficient information about the patient’s life is available, most neurotic psychopathology can be understood in great detail within the psychodynamic frame of reference. Even with this information, however, much psychotic psychopathology is difficult to understand. This has led to the view that psychoses have major nonpsychodynamic determinants, whereas neuroses do not. In any case, the psychodynamic explanation of any type of pathology is more helpful in understanding its meaning than in clarifying its etiology. Indeed, it should be recalled that Freud felt that there was a biological basis to neuroses as well as to psychoses.

Psychotic patients can, and usually do, have neurotic problems in the form of both symptoms and character traits in addition to their more basic psychopathology. Thus the interviewer must take into account both the psychotic and the neurotic pathology of the psychotic patient. This may be quite difficult, since the psychotic disturbance can interfere with the capacity of the patient to participate in the interview itself. The patient’s tendency to be mistrustful of others may make it difficult for him to feel comfortable with the interviewer, and his diminished capacity for interpersonal relations, together with his disturbed thought processes, leads to major problems in communication.

Psychosis is not a constant phenomenon, and many psychotic pa-
patients move in and out of psychotic states over a span of days, weeks, or even within a single interview. Often the dilemma in treatment is to work on the patient's conflicts and problems while providing enough emotional support that the stress of the therapy does not push him further into psychosis. Two clinical examples may help to illustrate these issues:

A young man arrived at a hospital emergency room in a state of extreme anxiety. He believed that he had had a heart attack and was dying and complained of chest pains and a choking sensation. Although cooperative, he was sweating and trembling with fear. He denied any psychological or emotional difficulties. There had been several similar episodes in the past, each ending quickly and without incident. The remainder of the brief initial history was unremarkable, and as the interviewer proceeded, the patient's symptoms subsided and he began to feel better. A normal electrocardiogram offered further reassurance, and after the intern told him that he seemed to be in good physical health, the patient began to relax and to speak more comfortably. He spoke of his family and early life experiences and revealed that he had led a sheltered and protected childhood. He was still closely tied to his family, and particularly to his mother, who strongly disapproved of the girl he had been seeing recently. It was while on his way to visit the girl that the attack occurred.

A second young man also arrived at the hospital in a panicky state. He complained of strange feelings in his back and "electric shocks" in his legs, which he thought might be related to physical exhaustion. He had not slept for several days, staying up in order to protect his apartment and possessions from attack. He was vague about who might want to hurt him but felt certain that he had been followed on the street in recent days. As he discussed these thoughts, he lowered his voice and leaned forward to tell the interviewer that several men had made homosexual advances toward him earlier that day. The doctor, inexperienced in psychiatry, asked if the patient had ever had homosexual experiences. The patient became agitated, screaming that the doctor was trying to frame him, and tried to run from the examining room. Later, after he had received some tranquilizing medication, he readily agreed to hospitalization in order to protect himself from his enemies.

The first patient had a classic panic attack with hyperventilation, and the second had an early psychotic paranoid schizophrenic break, although they both had virtually the same initial complaints.
PSYCHOANALYTIC MODELS OF MENTAL FUNCTIONING

Structural Model and Ego Psychology

As psychoanalytic theory has been applied to the study of psychopathology, personality development, dreams, art, culture, and other areas of human activity, a number of theoretical models have been developed. The earliest of these, the so-called topographic model, described mental activity as conscious, preconscious, or unconscious. Although this scheme was easy to apply, it soon became apparent that it was not helpful in discussing a central psychodynamic issue, that of intrapsychic conflict. Many conflicts in clinical practice are entirely unconscious, with the patient unaware of the basic drive or motive, the fantasized danger, and the psychological strategy employed to resolve them.

As a result, Freud developed a later "structural" theory that has largely supplanted his earlier topographic one and that remains one of the most commonly used models in contemporary psychoanalytic thought. In it the mind is viewed as consisting of more or less autonomous structures that are most sharply defined at times of conflict. Each structure consists of a complex array of psychological functions that act in concert during conflict. Therefore most (but not all) conflict is seen as occurring between these structures. Three structures are generally recognized: the id, which consists of the basic drives, impulses, and needs; the ego, which includes the psychological functions that control and regulate these drives, the defenses, as well as all other psychological adaptive and coping strategies and all relationships with the external world; and the superego, which is a specialized aspect of the ego that develops in the early relationship with the parents and embodies the conscience and the conscious and unconscious ethical, moral, and cultural standards acquired during socialization. The ego ideal, usually considered a component of the superego, refers to the goals and aspirations that the individual develops through identification with parents and that are elaborated and modified through his later contact with peers and the larger culture. Most conflicts of clinical significance occur between one of these structures and the other two, with each of the three combinations possible. Thus anxiety and guilt over sexual impulses that were forbidden in childhood would be an example of ego and superego against id; sadistic revenge against a friend who has been guilty of a minor infraction would be superego and id against ego; and an ascetic self-denying lifestyle would be the characterological manifestation of superego against ego and id.
Ego

The term ego describes those psychological functions that help the individual to adapt to the environment, respond to stimuli, and regulate basic biological functions while ensuring survival and the satisfaction of needs. Historically, the concept originated from studies of psychological conflict in which the ego represented those forces that opposed and controlled basic biological drives. Later it was extended to include functions that were not involved with conflict and that could even operate in concert with basic drives to serve the organism's adaptive needs. The ego is the executive organ of the mind, mediating between the internal demands of the biologically determined motives (the id), the socially determined goals and values (the superego), and the external demands of reality. It is the final common pathway that integrates all of these determinants and then controls the organism's response. The ego develops through interaction of the maturing infantile psyche with external reality, particularly that portion of external reality that consists of significant other humans. There is on the one hand an unfolding biological potential that leads to the maturation of memory, learning, perception, cognition, communication, and other vital adaptive functions and on the other hand a highly specialized environment composed of a need-gratifying and stimulus-controlling object, a good-enough, attentive, and responsive mother or caretaker.

The ego includes both conscious and automatic unconscious psychological processes. Before Freud the conscious portion was considered to be the subject matter of psychology. The ego also includes the unconscious defense mechanisms and the forces of repression that Freud discovered in his early work. Although they operate outside the patient's awareness, they are directed against the expression of basic needs and drives and are therefore considered part of the ego.

Id

The term id describes the biologically based drives and motives that are at the source of much behavior. Sex, aggression, and the craving for security are examples of such motives. Other needs develop as the result of exposure to society and are determined by the demands of that society. Status, prestige, and power are examples of the goals related to such needs. Classic psychoanalytic theory believed that these needs could directly be traced to biologically determined origins. As these motives press for satisfaction, they become one of the major factors impinging on the ego and therefore determining the individual's behavior. Freud's early explorations of the unconscious determinants
of neurotic symptoms uncovered the phenomena encompassed by the term *id*. Evolutionary biologists postulate that earliest primates lived in groups that were organized for the purpose of survival. The acquisition of food was more efficient when it was hunted by an organized group, as was protection from natural enemies and from rival bands of primates. These groups were run by the strongest members so that a hierarchy evolved. The hierarchical order determined who ate first and who had preferred mating rights. Despite the enormous complexity of human beings, these same basic instincts in both real and symbolic forms still drive much of our behavior.

In more recent years, psychoanalytic investigation has been directed toward the psychology of unconscious mechanisms of adaptation and patterns of behavioral integration in addition to the influence of unconscious drives. In other words, there has been a shift from a primarily *id* psychology to a more balanced view that includes ego psychology. This shift became possible as the unconscious determinants of behavior were better understood, and it was paralleled by a growing clinical interest in psychiatric problems that involve ego pathology, such as character disorders and psychoses.

Freud described the primitive mental activity of the *id* and the unconscious ego with the phrase "primary process," in contrast to the "secondary process" thinking of the conscious adult ego. Primary process thinking is childlike, prelogical, and self-centered. It is controlled by the pleasure principle, tolerates contradictions and inconsistencies, and employs such mental mechanisms as symbolization, condensation, and displacement. Secondary process thinking, in contrast, is logical, rational, reality-centered, goal-directed, and relatively free of emotional control. Most thought processes combine elements of both. One of the clinically important discoveries of psychoanalysis is the astonishing extent to which even the most rational-seeming behavior may involve unconscious primary process.

**Superego**

*Superego* refers to psychological functions that involve standards of right and wrong together with the evaluation and judgment of the self in terms of these standards. In general usage, it also includes the ego ideal, the psychological representation of what a person wishes to be like, his ideal self. The superego was originally considered to be a portion of the ego, but it operates independently of, and often at odds with, other ego functions, particularly in conflict situations and pathological conditions. It develops out of the young child's relationship with his
parents, who initially provide him with external judgments, criticism, and praise for his behavior. As he grows away from his parents, he nevertheless maintains a relationship with his internalized psychological representation of them, establishing an internal mental structure, a dynamically significant psychic agency—the superego—that carries on those functions that formerly belonged to the parents.

The superego is further influenced by parental surrogates such as teachers, by peers, and by society at large. This is even more true of the ego ideal, which at the age of latency is often concretely symbolized by popular cultural heroes.

Reality

At first it might seem superfluous to include a section on reality in a discussion of psychological functioning, but a distinction must be made between psychic reality and the more familiar concept of physical reality. The real world influences psychological functions only as it is registered and perceived by the individual. This can be illustrated by considering the most important aspect of external reality: the social reality of important other people. An individual reacts not to his real mother or father but rather to his internal representations of them, which inevitably involve selections, distortions, and constructions. There has been repeated misunderstanding of this critical distinction, even by Freud himself. During their childhoods, neurotic patients frequently experienced adults as either highly seductive or callously indifferent. It took Freud some time to recognize that this was not necessarily an accurate portrayal of their “real” experiences. However, it is even more misleading to disregard this internal psychic reality because it may not be historically valid, for without it, both the child’s fears and the adult’s neuroses are meaningless. The conclusion is that reality must be considered as a psychic structure that is responsive to the external environment but that involves a creative personal interpretation of that environment. When we tell someone “Don’t be silly” (i.e., “You’re crazy”), it usually means that we do not perceive that person’s psychological reality but only our own. One of the central tenets of psychoanalysis is that behavior that seems irrational from the perspective of the observer makes sense in the context of the other person’s own (usually unconscious) psychic reality.

Behavior results from the interaction of innate and socially determined motives, the goals and standards acquired during early socialization, the subjective experience of external reality, and the individual’s own unique temperament, personality, talents, defensive style,
and integrative capacity. In terms of the structural theory, it is the product of id, ego, superego, and psychic reality.

This framework provides a means of thinking about clinical data in general and about psychiatric interviews in particular. One can consider the patient's predominant wishes or motives, his unconscious fears, and his characteristic defenses. How are these integrated, and what symptoms or character traits are present? How do these interfere with adaptation, and what secondary adjustments have been necessary? Each individual is unique, but there are certain typical patterns of drive, fear, and defense; symptoms; and character style that have led to the description of well-known clinical syndromes in psychiatry. Our discussion of more specific problems in the psychiatric interview includes the most common patterns seen in clinical practice.

Some contemporary psychoanalysts collaborating with neurobiologists are developing alternative models of "mind" that attempt to bridge psychology and neuroscience.

Object Relations Models

Freud's earliest model emphasized motivational forces and particularly their biological roots—the instincts or drives. The organism matured, and the environment was little more than the setting or context for this maturation. The term object originally stemmed from the view that various external "objects" were targets of the drives and essential for their discharge. The fact that among the most important early objects were the people critical for the child's development, particularly the mother, and that these "objects" had major influence on the child's developing personality, was largely ignored. However, several factors led to an interest in the child's relationship with "objects" and with the development of internal representations of objects; this eventually led to a major reformulation of psychoanalytic theory with a central focus on object relations and representations rather than drives and their discharge.

These factors included 1) studies of children and of child development, and the recognition of the immense importance of the caretaker; 2) studies of more severe psychopathology—psychotic and borderline conditions—that was understood as involving disturbance in the capacity to construct internal objects as much as conflicts regarding the discharge of drives, and; 3) new views of the treatment process that emphasized the relationship of patient to therapist (reflecting the new models of development) as well as the patient's insight into intrapsychic conflict.
Object relations models conceive of psychic structures as developing through the child's construction of internal representations of self and others. These representations are originally primitive and fantastic, often combining several individuals into a single representation or splitting a single individual into several representations. With time, they gradually become more realistic. They are associated with widely varying affects (e.g., anger, sadness, feelings of safety, fear, pleasure) as well as with various wishes and fantasies (e.g., of sex, of control, or of devouring and being devoured). The growing child struggles with contradictory representations and feelings of self and others, tending to separate good and bad experiences, constructing all-good and all-bad internal objects. At this early level of development, one may feel that one has two different mothers, for example—a good, gratifying one and a bad, frustrating one. In the more mature individual, these images are integrated into coherent representations with multiple complex qualities, selected and formed in part to help self-esteem, make affects tolerable, and satisfy wishes. Traditional fairy tales and ancient myths clearly depict figures such as the fairy godmother, the wicked witch, the all-good god, and the all-evil devil.

Psychodynamic formulations that employ this model focus on the nature of the self and object representations and the prominent conflicts and contradictions among them. A special emphasis is given to developmental failures in integrating the various partial and contradictory representations of self and others and to the displacement and defensive misattribution of aspects of self or others. Object relations models are especially useful for formulating the fragmented inner world of psychotic and borderline patients who experience themselves and others as unintegrated parts; however, the models may be less useful for relatively healthier patients in whom conflict may more easily be described in terms of traditional ego psychology. These models have also been influential in studies of patterns of attachment and in studies of the role of early relationships in the development of mentalization and a theory of the mind, the awareness that others have an independent existence and that both oneself and others have minds (wishes, fears, thoughts, and feelings) and that individuals make constant inferences about the minds of others.

Self Psychological Model

The self psychological model postulates a psychological structure, the self, that develops toward the realization of goals that are both innate and learned. Two broad classes of these goals can be identified: one con-
sists of the individual’s ambitions, the other of his or her ideals. Normal
development involves the child’s grandiose idealization of self and others, the exhibitionistic expression of strivings and ambitions, and the empathic responsiveness of parents and others to these needs. Under these conditions, the child’s unfolding skills, talents, and internalization of empathic objects will lead to the development of a sturdy self with capacities for creativity, joy, and continuing empathic relationships. In this model, genetic formulations trace character problems to specific empathic failures in the child’s environment that distorted and inhibited the development of the self and the capacity to maintain object ties. These formulations also describe how the individual has defensively compensated for these failures of self-development and suggest therapeutic strategies needed to support the resumption of self-development that had been arrested in the past, emphasizing the special transference needs of the patient. The self psychological model is especially useful for formulating the narcissistic difficulties present in many types of patients (not only those with narcissistic personality disorder); however, the model lacks a clear conception of intrapsychic structure, and it is less useful for formulating fixed repetitive symptoms that arise from conflicts between one’s conscience and sexual or aggressive wishes.

In many ways these three models can be seen as logically contradictory. However, the clinician is not disturbed by such contradictions. He draws on insights garnered from each of them—from his own life and from clinical experience; from teachers, supervisors, and colleagues; from the professional literature; from myths; and from works of art and literature—in order to understand his patients and the meaning of his interaction with them. Different models may be useful for different clinicians, for different patients, or for different phases of contact with a single patient. Many believe that the conviction that behavior is meaningful, the process of collaboration with the patient in the attempt to discover or construct that meaning, and the understanding of unconscious processes such as transference and resistance are far more important than the specific model of psychological processes that the clinician employs. Our discussions draw most heavily on structural models and often employ notions from object relations or self psychological models, but, most importantly, view all of these models as tools to be employed when useful and to be discarded when they interfere with the clinician’s relationship with the patient.