

# 09 - 4 Theories of Personality and Psychopathology

- [01 - 4.1 Sigmund Freud Founder of Classic Psychoan](#)
- [02 - 4.2 Erik H. Erikson](#)
- [03 - 4.3 Other Psychodynamic Schools](#)
- [04 - 4.4 Positive Psychology](#)

# 01 - 4.1 Sigmund Freud

## Founder of Classic Psychoan

### 4.1 Sigmund Freud: Founder of Classic Psychoanalysis

Theories of Personality and Psychopathology 4.1 Sigmund Freud: Founder of Classic Psychoanalysis

Psychoanalysis was the child of Sigmund Freud's genius. He put his stamp on it from the very beginning, and it can be fairly stated that, although the science and theory of psychoanalysis has advanced far beyond Freud, his influence is still strong and pervasive. In recounting the progressive stages in the evolution of the origins of Freud's psychoanalytic thinking, it is useful to keep in mind that Freud himself was working against the background of his own neurological training and expertise and in the context of the scientific thinking of his era. The science of psychoanalysis is the bedrock of psychodynamic understanding and forms the fundamental theoretical frame of reference for a variety of forms of therapeutic intervention, embracing not only psychoanalysis itself but various forms of psychoanalytically oriented psychotherapy and related forms of therapy employing psychodynamic concepts. Currently considerable interest has been generated in efforts to connect psychoanalytic understandings of human behavior and emotional experience with emerging findings of neuroscientific research. Consequently, an informed and clear understanding of the fundamental facets of psychoanalytic theory and orientation are essential for the student's grasp of a large and significant segment of current psychiatric thinking. At the same time, psychoanalysis is undergoing a creative ferment in which classical perspectives are constantly being challenged and revised, leading to a diversity of emphases and viewpoints, all of which can be regarded as representing aspects of psychoanalytic thinking. This has given rise to the question as to whether psychoanalysis is one theory or more than one. The divergence of multiple theoretical variants raises the question of the degree to which newer perspectives can be reconciled to classical perspectives. The spirit of creative modifications in theory was inaugurated by Freud himself. Some of the theoretical modifications of the classic theory after Freud have attempted to reformulate basic analytic propositions while still retaining the spirit and fundamental insights of a Freudian perspective; others have challenged and abandoned basic analytic insights in favor of divergent paradigms that seem radically different and even contradictory to basic analytic principles. Although there is more than one way to approach the diversity of such material, the decision has been made to organize this material along roughly historical lines, tracing

the emergence of analytic theory or theories over time, but with a good deal of overlap and some redundancy. But there is an overall pattern of gradual emergence, progressing from early drive theory to structural theory to ego psychology to object relations, and on to self psychology, intersubjectivism, and relational approaches. Psychoanalysis today is recognized as having three crucial aspects: it is a therapeutic technique, a body of scientific and theoretical knowledge, and a method of investigation. This section focuses on psychoanalysis as both a theory and a treatment, but the basic tenets elaborated here have wide applications to nonpsychoanalytic settings in clinical psychiatry. LIFE OF FREUD Sigmund Freud (1856–1939) was born in Freiburg, a small town in Moravia, which is now part of the Czech Republic. When Freud was 4 years old, his father, a Jewish wool merchant, moved the family to Vienna, where Freud spent most of his life. Following medical school, he specialized in neurology and studied for a year in Paris with JeanMartin Charcot. He was also influenced by Ambroise-Auguste Liébeault and HippolyteMarie Bernheim, both of whom taught him hypnosis while he was in France. After his education in France, he returned to Vienna and began clinical work with hysterical patients. Between 1887 and 1897, his work with these patients led him to develop psychoanalysis. Figures 4.1-1 and 4.1-2 show Freud at age 47 and 79, respectively. FIGURE 4.1-1 Sigmund Freud at age 47. (Courtesy of Menninger Foundation Archives, Topeka, KS.)

FIGURE 4.1-2 Sigmund Freud at age 79. (Courtesy of Menninger Foundation Archives, Topeka, KS.) BEGINNINGS OF PSYCHOANALYSIS In the decade from 1887 to 1897, Freud immersed himself in the serious study of the disturbances in his hysterical patients, resulting in discoveries that contributed to the beginnings of psychoanalysis. These slender beginnings had a threefold aspect: Emergence of psychoanalysis as a method of investigation, as a therapeutic technique, and as a body of scientific knowledge based on an increasing fund of information and basic theoretical propositions. These early researches flowed out of Freud's initial collaboration with Joseph Breuer and then, increasingly, from his own independent investigations and theoretical developments. THE CASE OF ANNA O Breuer was an older physician, a distinguished and well-established medical practitioner in the Viennese community (Fig. 4.1-3). Knowing Freud's interests in hysterical pathology, Breuer told him about the unusual case of a woman he had treated for approximately 1.5 years, from December 1880 to June 1882. This woman became famous under the pseudonym Fräulein Anna O, and study of her difficulties proved to be one of the important stimuli in the development of psychoanalysis.

FIGURE 4.1-3 Joseph Breuer (1842–1925). Anna O was, in reality, Bertha Pappenheim, who later became independently famous as a founder of the social work movement in Germany. At the time she began to see Breuer, she was an intelligent and strong-minded young woman of approximately 21 years of age who had developed a number of hysterical symptoms in connection with the illness and death of her father. These symptoms included paralysis of the limbs, contractures, anesthasias, visual and speech disturbances, anorexia, and a distressing nervous cough. Her illness was also characterized by two distinct phases of consciousness: One relatively normal, but the other reflected a second and more pathological personality. Anna was very fond of and close to her father and shared with her mother the duties of nursing him on his deathbed. During her altered states of consciousness, Anna was able to recall the vivid fantasies and intense emotions she had experienced while caring for her father. It was with considerable amazement, both to Anna and Breuer, that when she was able to recall, with the associated expression of affect, the scenes or circumstances under which her symptoms had arisen, the symptoms would disappear. She vividly

described this process as the “talking cure” and as “chimney sweeping.”

Once the connection between talking through the circumstances of the symptoms and the disappearance of the symptoms themselves had been established, Anna proceeded to deal with each of her many symptoms, one after another. She was able to recall that on one occasion, when her mother had been absent, she had been sitting at her father’s bedside and had had a fantasy or daydream in which she imagined that a snake was crawling toward her father and was about to bite him. She struggled forward to try to ward off the snake, but her arm, which had been draped over the back of the chair, had gone to sleep. She was unable to move it. The paralysis persisted, and she was unable to move the arm until, under hypnosis, she was able to recall this scene. It is easy to see how this kind of material must have made a profound impression on Freud. It provided convincing demonstration of the power of unconscious memories and suppressed affects in producing hysterical symptoms. In the course of the somewhat lengthy treatment, Breuer had become increasingly preoccupied with his fascinating and unusual patient and, consequently, spent more and more time with her. Meanwhile, his wife had grown increasingly jealous and resentful. As soon as Breuer began to realize this, the sexual connotations of it frightened him, and he abruptly terminated the treatment. Only a few hours later, however, he was recalled urgently to Anna’s bedside. She had never alluded to the forbidden topic of sex during the course of her treatment, but she was now experiencing hysterical childbirth. Freud saw the phantom pregnancy as the logical outcome of the sexual feelings she had developed toward Breuer in response to his therapeutic attention. Breuer himself had been quite unaware of this development, and the experience was quite unnerving. He was able to calm Anna down by hypnotizing her, but then he left the house in a cold sweat and immediately set out with his wife for Venice on a second honeymoon. According to a version that comes from Freud through Ernest Jones, the patient was far from cured and later had to be hospitalized after Breuer’s departure. It seems ironic that the prototype of a cathartic cure was, in fact, far from successful. Nevertheless, the case of Anna O provided an important starting point for Freud’s thinking and a crucial juncture in the development of psychoanalysis.

#### THE INTERPRETATION OF DREAMS

In his landmark publication *The Interpretation of Dreams* in 1900, Freud presented a theory of the dreaming process that paralleled his earlier analysis of psychoneurotic symptoms. He viewed the dream experience as a conscious expression of unconscious fantasies or wishes not readily acceptable to conscious waking experience. Thus, dream activity was considered to be one of the normal manifestations of unconscious processes. The dream images represented unconscious wishes or thoughts, disguised through a process of symbolization and other distorting mechanisms. This reworking of unconscious contents constituted the dream work. Freud postulated the existence of a “censor,” pictured as guarding the border between the unconscious part of the mind and

the preconscious level. The censor functioned to exclude unconscious wishes during conscious states but, during regressive relaxation of sleep, allowed certain unconscious contents to pass the border, only after transformation of these unconscious wishes into disguised forms experienced in the manifest dream contents by the sleeping subject. Freud assumed that the censor worked in the service of the ego—that is, as serving the self-preservative objectives of the ego. Although he was aware of the unconscious nature of the processes, he tended to regard the ego at this point in the development of his theory more restrictively as the source of conscious processes of reasonable control and volition. The analysis of dreams elicits material that has been repressed. These unconscious thoughts and wishes include nocturnal sensory stimuli (sensory impressions such as

pain, hunger, thirst, urinary urgency), the day residue (thoughts and ideas that are connected with the activities and preoccupations of the dreamer's current waking life), and repressed unacceptable impulses. Because motility is blocked by the sleep state, the dream enables partial but limited gratification of the repressed impulse that gives rise to the dream. Freud distinguished between two layers of dream content. The manifest content refers to what is recalled by the dreamer; the latent content involves the unconscious thoughts and wishes that threaten to awaken the dreamer. Freud described the unconscious mental operations by which latent dream content is transformed into manifest dream as the dream work. Repressed wishes and impulses must attach themselves to innocent or neutral images to pass the scrutiny of the dream censor. This process involves selection of apparently meaningless or trivial images from the dreamer's current experience, images that are dynamically associated with the latent images that they resemble in some respect. Condensation Condensation is the mechanism by which several unconscious wishes, impulses, or attitudes can be combined into a single image in the manifest dream content. Thus, in a child's nightmare, an attacking monster may come to represent not only the dreamer's father but may also represent some aspects of the mother and even some of the child's own primitive hostile impulses as well. The converse of condensation can also occur in the dream work, namely, an irradiation or diffusion of a single latent wish or impulse that is distributed through multiple representations in the manifest dream content. The combination of mechanisms of condensation and diffusion provides the dreamer with a highly flexible and economic device for facilitating, compressing, and diffusing or expanding the manifest dream content, which is derived from latent or unconscious wishes and impulses. Displacement The mechanism of displacement refers to the transfer of amounts of energy (cathexis) from an original object to a substitute or symbolic representation of the object. Because

the substitute object is relatively neutral—that is, less invested with affective energy—it is more acceptable to the dream censor and can pass the borders of repression more easily. Thus, whereas symbolism can be taken to refer to the substitution of one object for another, displacement facilitates distortion of unconscious wishes through transfer of affective energy from one object to another. Despite the transfer of cathetic energy, the aim of the unconscious impulse remains unchanged. For example, in a dream, the mother may be represented visually by an unknown female figure (at least one who has less emotional significance for the dreamer), but the naked content of the dream nonetheless continues to derive from the dreamer's unconscious instinctual impulses toward the mother. Symbolic Representation Freud noted that the dreamer would often represent highly charged ideas or objects by using innocent images that were in some way connected with the idea or object being represented. In this manner, an abstract concept or a complex set of feelings toward a person could be symbolized by a simple, concrete, or sensory image. Freud noted that symbols have unconscious meanings that can be discerned through the patient's associations to the symbol, but he also believed that certain symbols have universal meanings. Secondary Revision The mechanisms of condensation, displacement, and symbolic representation are characteristic of a type of thinking that Freud referred to as primary process. This primitive mode of cognitive activity is characterized by illogical, bizarre, and absurd images that seem incoherent. Freud believed that a more mature and reasonable aspect of the ego works during dreams to organize primitive aspects of dreams into a more coherent form. Secondary revision is Freud's name for this process, in which dreams become somewhat more rational. The process is related to mature activity characteristic of waking life, which Freud termed secondary process. Affects in Dreams Secondary emotions may not appear in the dream at all, or they may be

experienced in somewhat altered form. For example, repressed rage toward a person's father may take the form of mild annoyance. Feelings may also appear as their opposites. Anxiety Dreams  
Freud's dream theory preceded his development of a comprehensive theory of the ego. Hence, his understanding of dreams stresses the importance of discharging drives or wishes through the hallucinatory contents of the dream. He viewed such mechanisms as condensation, displacement, symbolic representation, projection, and secondary revision primarily as facilitating the discharge of latent impulses, rather than as

protecting dreamers from anxiety and pain. Freud understood anxiety dreams as reflecting a failure in the protective function of the dream-work mechanisms. The repressed impulses succeed in working their way into the manifest content in a more or less recognizable manner. Punishment Dreams  
Dreams in which dreamers experience punishment represented a special challenge for Freud because they appear to represent an exception to his wish fulfillment theory of dreams. He came to understand such dreams as reflecting a compromise between the repressed wish and the repressing agency or conscience. In a punishment dream, the ego anticipates condemnation on the part of the dreamer's conscience if the latent unacceptable impulses are allowed direct expression in the manifest dream content. Hence, the wish for punishment on the part of the patient's conscience is satisfied by giving expression to punishment fantasies. TOPOGRAPHICAL MODEL OF THE MIND  
The publication of *The Interpretation of Dreams* in 1900 heralded the arrival of Freud's topographical model of the mind, in which he divided the mind into three regions: the conscious system, the preconscious system, and the unconscious system. Each system has its own unique characteristics. The Conscious  
The conscious system in Freud's topographical model is the part of the mind in which perceptions coming from the outside world or from within the body or mind are brought into awareness. Consciousness is a subjective phenomenon whose content can be communicated only by means of language or behavior. Freud assumed that consciousness used a form of neutralized psychic energy that he referred to as attention cathexis, whereby persons were aware of a particular idea or feeling as a result of investing a discrete amount of psychic energy in the idea or feeling. The Preconscious  
The preconscious system is composed of those mental events, processes, and contents that can be brought into conscious awareness by the act of focusing attention. Although most persons are not consciously aware of the appearance of their first-grade teacher, they ordinarily can bring this image to mind by deliberately focusing attention on the memory. Conceptually, the preconscious interfaces with both unconscious and conscious regions of the mind. To reach conscious awareness, contents of the unconscious must become linked with words and thus become preconscious. The preconscious system also serves to maintain the repressive barrier and to censor unacceptable wishes and desires.

The Unconscious  
The unconscious system is dynamic. Its mental contents and processes are kept from conscious awareness through the force of censorship or repression, and it is closely related to instinctual drives. At this point in Freud's theory of development, instincts were thought to consist of sexual and self-preservative drives, and the unconscious was thought to contain primarily the mental representations and derivatives of the sexual instinct. The content of the unconscious is limited to wishes seeking fulfillment. These wishes provide the motivation for dream and neurotic symptom formation. This view is now considered reductionist. The unconscious system is characterized by primary process thinking, which is principally aimed at facilitating wish fulfillment and instinctual discharge. It is governed by the pleasure principle and, therefore, disregards logical connections; it has no concept of time, represents wishes as fulfillments, permits contradictions to

exist simultaneously, and denies the existence of negatives. The primary process is also characterized by extreme mobility of drive cathexis; the investment of psychic energy can shift from object to object without opposition. Memories in the unconscious have been divorced from their connection with verbal symbols. Hence, when words are reapplied to forgotten memory traits, as in psychoanalytic treatment, the verbal recathexis allows the memories to reach consciousness again. The contents of the unconscious can become conscious only by passing through the preconscious. When censors are overpowered, the elements can enter consciousness. Limitations of the Topographical Theory Freud soon realized that two main deficiencies in the topographical theory limited its usefulness. First, many patients' defense mechanisms that guard against distressing wishes, feelings, or thoughts were themselves not initially accessible to consciousness. Thus, repression cannot be identical with preconscious, because by definition this region of the mind is accessible to consciousness. Second, Freud's patients frequently demonstrated an unconscious need for punishment. This clinical observation made it unlikely that the moral agency making the demand for punishment could be allied with anti-instinctual forces that were available to conscious awareness in the preconscious. These difficulties led Freud to discard the topographical theory, but certain concepts derived from the theory continue to be useful, particularly, primary and secondary thought processes, the fundamental importance of wish fulfillment, the existence of a dynamic unconscious, and a tendency toward regression under frustrating conditions. INSTINCT OR DRIVE THEORY After the development of the topographical model, Freud turned his attention to the complexities of instinct theory. Freud was determined to anchor his psychological theory in biology. His choice led to terminological and conceptual difficulties when he used

terms derived from biology to denote psychological constructs. Instinct, for example, refers to a pattern of species-specific behavior that is genetically derived and, therefore, is more or less independent of learning. Modern research demonstrating that instinctual patterns are modified through experiential learning, however, has made Freud's instinctual theory problematic. Further confusion has stemmed from the ambiguity inherent in a concept on the borderland between the biological and the psychological: Should the mental representation aspect of the term and the physiological component be integrated or separated? Although drive may have been closer than instinct to Freud's meaning, in contemporary usage, the two terms are often used interchangeably. In Freud's view, an instinct has four principal characteristics: source, impetus, aim, and object. The source refers to the part of the body from which the instinct arises. The impetus is the amount of force or intensity associated with the instinct. The aim refers to any action directed toward tension discharge or satisfaction, and the object is the target (often a person) for this action. Instincts Libido. The ambiguity in the term instinctual drive is also reflected in the use of the term libido. Briefly, Freud regarded the sexual instinct as a psychophysiological process that had both mental and physiological manifestations. Essentially, he used the term libido to refer to "the force by which the sexual instinct is represented in the mind." Thus, in its accepted sense, libido refers specifically to the mental manifestations of the sexual instinct. Freud recognized early that the sexual instinct did not originate in a finished or final form, as represented by the stage of genital primacy. Rather, it underwent a complex process of development, at each phase of which the libido had specific aims and objects that diverged in varying degrees from the simple aim of genital union. The libido theory thus came to include all of these manifestations and the complicated paths they followed in the course of psychosexual development. Ego Instincts. From 1905 on, Freud maintained a dual instinct theory, subsuming sexual instincts and ego instincts connected with self-

preservation. Until 1914, with the publication of *On Narcissism*, Freud had paid little attention to ego instincts; in this communication, however, Freud invested ego instinct with libido for the first time by postulating an ego libido and an object libido. Freud thus viewed narcissistic investment as an essentially libidinal instinct and called the remaining nonsexual components the ego instincts. Aggression. When psychoanalysts today discuss the dual instinct theory, they are generally referring to libido and aggression. Freud, however, originally conceptualized aggression as a component of the sexual instincts in the form of sadism. As he became aware that sadism had nonsexual aspects to it, he made finer gradations, which enabled him to categorize aggression and hate as part of the ego instincts and the libidinal aspects of sadism as components of the sexual instincts. Finally, in 1923, to account for

the clinical data he was observing, he was compelled to conceive of aggression as a separate instinct in its own right. The source of this instinct, according to Freud, was largely in skeletal muscles, and the aim of the aggressive instincts was destruction. *Life and Death Instincts*. Before designating aggression as a separate instinct, Freud, in 1920, subsumed the ego instincts under a broader category of life instincts. These were juxtaposed with death instincts and were referred to as Eros and Thanatos in *Beyond the Pleasure Principle*. The life and death instincts were regarded as forces underlying the sexual and aggressive instincts. Although Freud could not provide clinical data that directly verified the death instinct, he thought the instinct could be inferred by observing repetition compulsion, a person's tendency to repeat past traumatic behavior. Freud thought that the dominant force in biological organisms had to be the death instinct. In contrast to the death instinct, eros (the life instinct) refers to the tendency of particles to reunite or bind to one another, as in sexual reproduction. The prevalent view today is that the dual instincts of sexuality and aggression suffice to explain most clinical phenomena without recourse to a death instinct. *Pleasure and Reality Principles* In 1911, Freud described two basic tenets of mental functioning: the pleasure principle and the reality principle. He essentially recast the primary process and secondary process dichotomy into the pleasure and reality principles and thus took an important step toward solidifying the notion of the ego. Both principles, in Freud's view, are aspects of ego functioning. The pleasure principle is defined as an inborn tendency of the organism to avoid pain and to seek pleasure through the discharge of tension. The reality principle, on the other hand, is considered to be a learned function closely related to the maturation of the ego; this principle modifies the pleasure principle and requires delay or postponement of immediate gratification. *Infantile Sexuality* Freud set forth the three major tenets of psychoanalytic theory when he published *Three Essays on the Theory of Sexuality*. First, he broadened the definition of sexuality to include forms of pleasure that transcend genital sexuality. Second, he established a developmental theory of childhood sexuality that delineated the vicissitudes of erotic activity from birth through puberty. Third, he forged a conceptual linkage between neuroses and perversions. Freud's notion that children are influenced by sexual drives has made some persons reluctant to accept psychoanalysis. Freud noted that infants are capable of erotic activity from birth, but the earliest manifestations of infantile sexuality are basically nonsexual and are associated with such bodily functions as feeding and bowel-bladder control. As libidinal energy shifts from the oral zone to the anal zone to the phallic zone, each stage of development is thought to build on and to subsume the accomplishments of the preceding stage. The oral stage, which occupies the first 12 to 18 months of life,

centers on the mouth and lips and is manifested in chewing, biting, and sucking. The dominant erotic activity of the anal stage, from 18 to 36 months of age, involves bowel function and control. The phallic stage, from 3 to 5 years of life, initially focuses on urination as the source of erotic activity. Freud suggested that phallic erotic activity in boys is a preliminary stage leading to adult genital activity. Whereas the penis remains the principal sexual organ throughout male psychosexual development, Freud postulated that females have two principal erotogenic zones: the vagina and the clitoris. He thought that the clitoris was the chief erotogenic focus during the infantile genital period but that erotic primacy shifted to the vagina after puberty. Studies of human sexuality have subsequently questioned the validity of this distinction. Freud discovered that in the psychoneuroses, only a limited number of the sexual impulses that had undergone repression and were responsible for creating and maintaining the neurotic symptoms were normal. For the most part, these were the same impulses that were given overt expression in the perversions. The neuroses, then, were the negative of perversions. Object Relationships in Instinct Theory Freud suggested that the choice of a love object in adult life, the love relationship itself, and the nature of all other object relationships depend primarily on the nature and quality of children's relationships during the early years of life. In describing the libidinal phases of psychosexual development, Freud repeatedly referred to the significance of a child's relationships with parents and other significant persons in the environment. The awareness of the external world of objects develops gradually in infants. Soon after birth, they are primarily aware of physical sensations, such as hunger, cold, and pain, which give rise to tension, and caregivers are regarded primarily as persons who relieve their tension or remove painful stimuli. Recent infant research, however, suggests that awareness of others begins much sooner than Freud originally thought. Table 4.1-1 provides a summary of the stages of psychosexual development and the object relationships associated with each stage. Although the table goes only as far as young adulthood, development is now recognized as continuing throughout adult life. Table 4.1-1 Stages of Psychosexual Development

Concept of Narcissism According to Greek myth, Narcissus, a beautiful youth, fell in love with his reflection in the water of a pool and drowned in his attempt to embrace his beloved image. Freud used the term narcissism to describe situations in which an individual's libido was

invested in the ego itself rather than in other persons. This concept of narcissism presented him with vexing problems for his instinct theory and essentially violated his distinction between libidinal instincts and ego or self-preservative instincts. Freud's understanding of narcissism led him to use the term to describe a wide array of psychiatric disorders, very much in contrast to the term's contemporary use to describe a specific personality disorder. Freud grouped several disorders together as the narcissistic neuroses, in which a person's libido is withdrawn from objects and turned inward. He believed that this withdrawal of libidinal attachment to objects accounted for the loss of reality testing in patients who were psychotic; grandiosity and omnipotence in such patients reflected excessive libidinal investment in the ego. Freud did not limit his use of narcissism to psychoses. In states of physical illness and hypochondriasis, he observed that libidinal investment was frequently withdrawn from external objects and from outside activities and interests. Similarly, he suggested that in normal sleep, libido was also withdrawn and reinvested in a sleeper's own body. Freud regarded homosexuality as an instance of a narcissistic form of object choice, in which persons fall in love with an idealized version of themselves projected onto another person. He also found narcissistic manifestations in the beliefs and myths of primitive people, especially those

involving the ability to influence external events through the magical omnipotence of thought processes. In the course of normal development, children also exhibit this belief in their own omnipotence. Freud postulated a state of primary narcissism at birth in which the libido is stored in the ego. He viewed the neonate as completely narcissistic, with the entire libidinal investment in physiological needs and their satisfaction. He referred to this selfinvestment as ego libido. The infantile state of self-absorption changes only gradually, according to Freud, with the dawning awareness that a separate person—the mothering figure—is responsible for gratifying an infant’s needs. This realization leads to the gradual withdrawal of the libido from the self and its redirection toward the external object. Hence, the development of object relations in infants parallels the shift from primary narcissism to object attachment. The libidinal investment in the object is referred to as object libido. If a developing child suffers rebuffs or trauma from the caretaking figure, object libido may be withdrawn and reinvested in the ego. Freud called this regressive posture secondary narcissism. Freud used the term narcissism to describe many different dimensions of human experience. At times, he used it to describe a perversion in which persons used their own bodies or body parts as objects of sexual arousal. At other times, he used the term to describe a developmental phase, as in the state of primary narcissism. In still other instances, the term referred to a particular object choice. Freud distinguished love objects who are chosen “according to the narcissistic type,” in which case the object resembles the subject’s idealized or fantasied self-image, from objects chosen according to the “anaclitic,” in which the love object resembles a caretaker from early in life. Finally, Freud also used the word narcissism interchangeably and synonymously with self-esteem.

**EGO PSYCHOLOGY** Although Freud had used the construct of the ego throughout the evolution of psychoanalytic theory, ego psychology as it is known today really began with the publication in 1923 of *The Ego and the Id*. This landmark publication also represented a transition in Freud’s thinking from the topographical model of the mind to the tripartite structural model of ego, id, and superego. He had observed repeatedly that not all unconscious processes can be relegated to a person’s instinctual life. Elements of the conscience, as well as functions of the ego, are clearly also unconscious.

**Structural Theory of the Mind** The structural model of the psychic apparatus is the cornerstone of ego psychology. The three provinces—id, ego, and superego—are distinguished by their different functions.

**Id.** Freud used the term id to refer to a reservoir of unorganized instinctual drives. Operating under the domination of the primary process, the id lacks the capacity to delay or modify the instinctual drives with which an infant is born. The id, however, should not be viewed as synonymous with the unconscious, because both the ego and the superego have unconscious components.

**Ego.** The ego spans all three topographical dimensions of conscious, preconscious, and unconscious. Logical and abstract thinking and verbal expression are associated with conscious and preconscious functions of the ego. Defense mechanisms reside in the unconscious domain of the ego. The ego, the executive organ of the psyche, controls motility, perception, contact with reality, and, through the defense mechanisms available to it, the delay and modulation of drive expression. Freud believed that the id is modified as a result of the impact of the external world on the drives. The pressures of external reality enable the ego to appropriate the energies of the id to do its work. As the ego brings influences from the external world to bear on the id, it simultaneously substitutes the reality principle for the pleasure principle. Freud emphasized the role of conflict within the structural model and observed that conflict occurs initially between the id and the outside world, only to be transformed later to conflict between the id and the ego. The third component of the tripartite structural model is the superego. The

superego establishes and maintains an individual's moral conscience on the basis of a complex system of ideals and values internalized from parents. Freud viewed the superego as the heir to the Oedipus complex. Children internalize parental values and standards at about the age of 5 or 6 years. The superego then serves as an agency that provides ongoing scrutiny of a person's behavior, thoughts, and feelings; it makes comparisons with expected standards of behavior and offers approval or disapproval. These activities occur largely unconsciously. The ego ideal is often regarded as a component of the superego. It is an agency that prescribes what a person should do according to internalized standards and values. The

superego, by contrast, is an agency of moral conscience that proscribes—that is, dictates what a person should not do. Throughout the latency period and thereafter, persons continue to build on early identifications through their contact with admired figures who contribute to the formation of moral standards, aspirations, and ideals. Functions of the Ego Modern ego psychologists have identified a set of basic ego functions that characterizes the operations of the ego. These descriptions reflect the ego activities that are generally regarded as fundamental. Control and Regulation of Instinctual Drives. The development of the capacity to delay or postpone drive discharge, like the capacity to test reality, is closely related to the early childhood progression from the pleasure principle to the reality principle. This capacity is also an essential aspect of the ego's role as mediator between the id and the outside world. Part of infants' socialization to the external world is the acquisition of language and secondary process or logical thinking. Judgment. A closely related ego function is judgment, which involves the ability to anticipate the consequences of actions. As with control and regulation of instinctual drives, judgment develops in parallel with the growth of secondary process thinking. The ability to think logically allows assessment of how contemplated behavior may affect others. Relation to Reality. The mediation between the internal world and external reality is a crucial function of the ego. Relations with the outside world can be divided into three aspects: the sense of reality, reality testing, and adaptation to reality. The sense of reality develops in concert with an infant's dawning awareness of bodily sensations. The ability to distinguish what is outside the body from what is inside is an essential aspect of the sense of reality, and disturbances of body boundaries, such as depersonalization, reflect impairment in this ego function. Reality testing, an ego function of paramount importance, refers to the capacity to distinguish internal fantasy from external reality. This function differentiates persons who are psychotic from those who are not. Adaptation to reality involves persons' ability to use their resources to develop effective responses to changing circumstances on the basis of previous experience with reality. Object Relationships. The capacity to form mutually satisfying relationships is related in part to patterns of internalization stemming from early interactions with parents and other significant figures. This ability is also a fundamental function of the ego, in that satisfying relatedness depends on the ability to integrate positive and negative aspects of others and self and to maintain an internal sense of others even in their absence. Similarly, mastery of drive derivatives is also crucial to the achievement

of satisfying relationships. Although Freud did not develop an extensive object relations theory, British psychoanalysts, such as Ronald Fairbairn (1889–1964) and Michael Balint (1896–1970), elaborated greatly on the early stages in infants' relationships with need-satisfying objects and on the gradual development of a sense of separateness from the mother. Another of their British colleagues, Donald W. Winnicott (1896–1971), described the transitional object (e.g., a blanket, teddy bear, or pacifier) as the link between developing children and their mothers. A child can

separate from the mother because a transitional object provides feelings of security in her absence. The stages of human development and object relations theory are summarized in Table 4.1-2. Table 4.1-2 Parallel Lines of Development Synthetic Function of the Ego. First described by Herman Nunberg in 1931, the synthetic function refers to the ego's capacity to integrate diverse elements into an overall unity. Different aspects of self and others, for example, are synthesized into a consistent representation that endures over time. The function also involves organizing, coordinating, and generalizing or simplifying large amounts of data. Primary Autonomous Ego Functions. Heinz Hartmann described the so-called primary autonomous functions of the ego as rudimentary apparatuses present at birth that develop independently of intrapsychic conflict between drives and defenses. These functions include perception, learning, intelligence, intuition, language, thinking, comprehension, and motility. In the course of development, some of these conflict-free aspects of the ego may eventually become involved in conflict. They will develop normally if the infant is raised in what Hartmann referred to as an average expectable environment. Secondary Autonomous Ego Functions. Once the sphere where primary autonomous function develops becomes involved with conflict, so-called secondary autonomous ego functions arise in the defense against drives. For example, a child may develop caretaking functions as a reaction formation against murderous wishes during the first few years of life. Later, the defensive functions may be neutralized or deinstinctualized when the child grows up to be a social worker and cares for homeless persons.

Defense Mechanisms At each phase of libidinal development, specific drive components evoke characteristic ego defenses. The anal phase, for example, is associated with reaction formation, as manifested by the development of shame and disgust in relation to anal impulses and pleasures. Defenses can be grouped hierarchically according to the relative degree of maturity associated with them. Narcissistic defenses are the most primitive and appear in children and persons who are psychotically disturbed. Immature defenses are seen in adolescents and some nonpsychotic patients. Neurotic defenses are encountered in obsessivecompulsive and hysterical patients as well as in adults under stress. Table 4.1-3 lists the defense mechanisms according to George Valliant's classification of the four types. Table 4.1-3 Classification of Defense Mechanisms

Theory of Anxiety Freud initially conceptualized anxiety as "dammed up libido." Essentially, a physiological increase in sexual tension leads to a corresponding increase in libido, the mental representation of the physiological event. The actual neuroses are caused by this buildup. Later, with the development of the structural model, Freud developed a new theory of a second type of anxiety that he referred to as signal anxiety. In this model, anxiety operates at an unconscious level and serves to mobilize the ego's resources to avert danger. Either external or internal sources of danger can produce a signal that leads the ego to marshal specific defense mechanisms to guard against, or reduce, instinctual excitation. Freud's later theory of anxiety explains neurotic symptoms as the ego's partial failure to cope with distressing stimuli. The drive derivatives associated with danger may not have been adequately contained by the defense mechanisms used by the ego. In phobias, for example, Freud explained that fear of an external threat (e.g., dogs or snakes) is an externalization of an internal danger. Danger situations can also be linked to developmental stages and, thus, can create a developmental hierarchy of anxiety. The earliest danger situation is a fear of disintegration or annihilation, often associated with concerns about fusion with an external object. As infants mature and recognize the mothering figure as a separate

person, separation anxiety, or fear of the loss of an object, becomes more prominent. During the oedipal psychosexual stage, girls are most concerned about losing the love of the most important figure in their lives, their mother. Boys are primarily anxious about bodily injury or castration. After resolution of the oedipal conflict, a more mature form of anxiety occurs, often termed superego anxiety. This latency-age concern involves the fear that internalized parental representations, contained in the superego, will cease to love, or will angrily punish, the child. Character In 1913, Freud distinguished between neurotic symptoms and personality or character traits. Neurotic symptoms develop as a result of the failure of repression; character traits owe their existence to the success of repression, that is, to the defense system that achieves its aim through a persistent pattern of reaction formation and sublimation. In 1923, Freud also observed that the ego can only give up important objects by identifying with them or introjecting them. This accumulated pattern of identifications and introjections also contributes to character formation. Freud specifically emphasized the importance of superego formation in the character construction. Contemporary psychoanalysts regard character as a person's habitual or typical pattern of adaptation to internal drive forces and to external environmental forces. Character and personality are used interchangeably and are distinguished from the ego in that they largely refer to styles of defense and of directly observable behavior rather than to feeling and thinking. Character is also influenced by constitutional temperament; the interaction of drive forces with early ego defenses and with environmental influences; and various identifications with, and internalizations of, other persons throughout life. The extent to

which the ego has developed a capacity to tolerate the delay of impulse discharge and to neutralize instinctual energy determines the degree to which such character traits emerge in later life. Exaggerated development of certain character traits at the expense of others can lead to personality disorders or produce a vulnerability or predisposition to psychosis. CLASSIC PSYCHOANALYTIC THEORY OF NEUROSES The classic view of the genesis of neuroses regards conflict as essential. The conflict can arise between instinctual drives and external reality or between internal agencies, such as the id and the superego or the id and the ego. Moreover, because the conflict has not been worked through to a realistic solution, the drives or wishes that seek discharge have been expelled from consciousness through repression or another defense mechanism. Their expulsion from conscious awareness, however, does not make the drives any less powerful or influential. As a result, the unconscious tendencies (e.g., the disguised neurotic symptoms) fight their way back into consciousness. This theory of the development of neurosis assumes that a rudimentary neurosis based on the same type of conflict existed in early childhood. Deprivation during the first few months of life because of absent or impaired caretaking figures can adversely affect ego development. This impairment, in turn, can result in failure to make appropriate identifications. The resulting ego difficulties create problems in mediating between the drives and the environment. Lack of capacity for constructive expression of drives, especially aggression, can lead some children to turn their aggression on themselves and become overtly self-destructive. Parents who are inconsistent, excessively harsh, or overly indulgent can influence children to develop disordered superego functioning. Severe conflict that cannot be managed through symptom formation can lead to extreme restrictions in ego functioning and fundamentally impair the capacity to learn and develop new skills. Traumatic events that seem to threaten survival can break through defenses when the ego has been weakened. More libidinal energy is then required to master the excitation that results. The libido thus mobilized, however, is withdrawn from the supply that is normally applied to external objects. This withdrawal further

diminishes the strength of the ego and produces a sense of inadequacy. Frustrations or disappointments in adults may revive infantile longings that are then dealt with through symptom formation or further regression. In his classic studies, Freud described four different types of childhood neuroses, three of which had later neurotic developments in adult life. This well-known series of cases shown in tabulated form in Table 4.1-4 exemplifies some of Freud's important conclusions: (1) neurotic reactions in the adult are associated frequently with neurotic reactions in childhood; (2) the connection is sometimes continuous but more often is separated by a latent period of nonneurosis; and (3) infantile sexuality, both fantasized and real, occupies a memorable place in the early history of the patient.

Table 4.1-4 Classic Psychoneurotic Reactions of Childhood Certain differences are worth noting in the four cases shown in Table 4.1-4. First, the phobic reactions tend to start at about 4 or 5 years of age, the obsessional reactions between 6 and 7 years, and the conversion reactions at 8 years. The degree of background disturbance is greatest in the conversion reaction and the mixed neurosis, and it seems only slight in the phobic and obsessional reactions. The course of the phobic reaction seems little influenced by severe traumatic factors, whereas traumatic factors, such as sexual seductions, play an important role in the three other subgroups. It was during this period that Freud elaborated his seduction hypothesis for the cause of the neuroses, in terms of which the obsessive-compulsive and hysterical reactions were alleged to originate in active and passive sexual experiences. TREATMENT AND TECHNIQUE The cornerstone of psychoanalytic technique is free association, in which patients say whatever comes to mind. Free association does more than provide content for the analysis: It also induces the necessary regression and dependency connected with establishing and working through the transference neurosis. When this development occurs, all the original wishes, drives, and defenses associated with the infantile neurosis are transferred to the person of the analyst. As patients attempt to free associate, they soon learn that they have difficulty saying whatever comes to mind, without censoring certain thoughts. They develop conflicts about their wishes and feelings toward the analyst that reflect childhood conflicts. The transference that develops toward the analyst may also serve as resistance to the process

of free association. Freud discovered that resistance was not simply a stoppage of a patient's associations, but also an important revelation of the patient's internal object relations as they were externalized and manifested in the transference relationship with the analyst. The systematic analysis of transference and resistance is the essence of psychoanalysis. Freud was also aware that the analyst might have transferences to the patient, which he called countertransference. Countertransference, in Freud's view, was an obstacle that the analyst needed to understand so that it did not interfere with treatment. In this spirit, he recognized the need for all analysts to have been analyzed themselves. Variations in transference and their descriptions are contained in Table 4.15. The basic mechanisms by which transferences are effected—displacement, projection, and projective identification—are described in Table 4.1-6. Table 4.1-5 Transference Variants

#### Table 4.1-6 Transference Mechanisms

Analysts after Freud began to recognize that countertransference was not only an obstacle but also a source of useful information about the patient. In other words, the analyst's feelings in response to the patient reflect how other persons respond to the patient and provide some indication of the

patient's own internal object relations. By understanding the intense feelings that occur in the analytic relationship, the analyst can help the patient broaden understanding of past and current relationships outside the analysis. The development of insight into neurotic conflicts also expands the ego and provides an increased sense of mastery.

REFERENCES Bergmann MS. The Oedipus complex and psychoanalytical technique. *Psychoanalytical Inquir.* 2010;30(6):535. Breger L. *A Dream of Undying Fame: How Freud Betrayed His Mentor and Invented Psychoanalysis.* New York: Basic Books; 2009. Britzman DP. *Freud and Education.* New York: Routledge; 2011.

# 02 - 4.2 Erik H. Erikson

## 4.2 Erik H. Erikson

Cotti P. Sexuality and psychoanalytic aggrandisement: Freud's 1908 theory of cultural history. *Hist Psychiatry*. 2011;22:58. Cotti P. Travelling the path from fantasy to history: The struggle for original history within Freud's early circle, 1908- 1913. *Psychoanalysis Hist*. 2010;12:153. Freud S. The Standard Edition of the Complete Psychological Works of Sigmund Freud. 24 vols. London: Hogarth Press; 1953-1974. Gardner H. Sigmund Freud: Alone in the world. In: *Creating Minds: An Anatomy of Creativity Seen Through the Lives of Freud, Einstein, Picasso, Stravinsky, Eliot, Graham, and Ghandi*. New York: Basic Books; 2011:47. Hoffman L. One hundred years after Sigmund Freud's lectures in America: Towards an integration of psychoanalytic theories and techniques within psychiatry. *Histor Psychiat*. 2010;21(4):455. Hollon SD, Wilson GT. Psychoanalysis or cognitive-behavioral therapy for bulimia nervosa: the specificity of psychological treatments. *Am J Psychiatry*. 2014;171:13-16. Meissner WW. Classical psychoanalysis. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Vol. 1. Philadelphia: Lippincott Williams & Wilkins; 2009:788. Meissner WW. The God in psychoanalysis. *Psychoanal Psychol*. 2009;26(2):210. Neukrug ES. Psychoanalysis. In: Neukrug ES, ed. *Counseling Theory and Practice*. Belmont, CA: Brooks/Cole; 2011:31. Perlman FT, Brandell JR. Psychoanalytic theory. In: Brandell JR, ed. *Theory & Practice in Clinical Social Work*. 2nd ed. Thousand Oaks, CA: Sage; 2011:41. Tauber AI. *Freud, the Reluctant Philosopher*. Princeton, NJ: Princeton University Press; 2010. Thurschwell P. *Sigmund Freud*. 2nd ed. New York: Routledge; 2009.

4.2 Erik H. Erikson Erik H. Erikson (Fig 4.2-1) was one of America's most influential psychoanalysts. Throughout six decades in the United States, he distinguished himself as an illuminator and expositor of Freud's theories and as a brilliant clinician, teacher, and pioneer in psychohistorical investigation. Erikson created an original and highly influential theory of psychological development and crisis occurring in periods that extended across the entire life cycle. His theory grew out of his work first as a teacher, then as a child psychoanalyst, next as an anthropological field worker, and, finally, as a biographer. Erikson identified dilemmas or polarities in the ego's relations with the family and larger social institutions at nodal points in childhood, adolescence, and early, middle, and late adulthood. Two of his psychosexual historical studies, *Young Man Luther* and *Gandhi's Truth* (published in 1958 and 1969 respectively), were widely hailed as profound explorations of how crucial circumstances can interact with the crises of certain great persons at certain moments in time. The interrelationships of the psychological development of the person and the historical developments of the times were more fully explored in *Life History and the Historical Moment*, written by Erikson in 1975.

FIGURE 4.2-1 Erik Erikson (1902-1994). Erik Homburger Erikson was born June 15, 1902 in Frankfurt, Germany, the son of Danish parents. He died in 1994. His father abandoned his mother before he was born, and he was brought up by his mother, a Danish Jew, and her second husband, Theodor Homburger, a German-Jewish pediatrician. Erikson's parents chose to keep his real

parentage a secret from him, and for many years he was known as Erik Homburger. Erikson never knew the identity of his biological father; his mother withheld that information from him all her life. The man who introduced the term “identity crisis” into the language undoubtedly struggled with his own sense of identity. Compounding his parents’ deception about his biological father—their “loving deceit,” as he called it—was the fact that, as a blond, blue-eyed, Scandinavian-looking son of a Jewish father, he was taunted as a “goy” among Jews, at the same time being called a Jew by his classmates. His being a Dane living in Germany added to his identity confusion. Erikson was later to describe himself as a man of the borders. Much of what he was to study was concerned with how group values are implanted in the very young, how young people grasp onto group identity in the limbo period between childhood and adulthood, and how a few persons, like Gandhi, transcend their local, national, and even temporal identities to form a small band of people with wider sympathies who span the ages. The concepts of identity, identity crisis, and identity confusion are central to Erikson’s thought. In his first book *Childhood and Society* (published in 1950) Erikson observed that “the study of identity...becomes as strategic in our time as the study of sexuality was in Freud’s time.” By identity, Erikson meant a sense of sameness and continuity “in the inner core of the individual” that was maintained amid external change. A sense of identity, emerging at the end of adolescence,

is a psychosocial phenomenon preceded in one form or another by an identity crisis; that crisis may be conscious or unconscious, with the person being aware of the present state and future directions but also unconscious of the basic dynamics and conflicts that underlie those states. The identity crisis can be acute and prolonged in some people. The young Erikson did not distinguish himself in school, although he did show artistic talent. On graduation, he chose to spend a year traveling through the Black Forest, Italy, and the Alps, pondering life, drawing, and making notes. After that year of roaming, he studied art in his home city of Karlsruhe and later in Munich and Florence. In 1927 Peter Blos, a high school friend, invited Erikson to join him in Vienna. Blos, not yet a psychoanalyst, had met Dorothy Burlingham, a New Yorker who had come to Vienna to be psychoanalyzed; she had brought her four children with her and hired Blos to tutor them. Blos was looking for a fellow teacher in his new school for the children of English and American parents and students of his new discipline of psychoanalysis. Erikson accepted his offer. Blos and Erikson organized their school in an informal manner—much in the style of the so-called progressive or experimental schools popular in the United States. Children were encouraged to participate in curriculum planning and to express themselves freely. Erikson, still very much the artist, taught drawing and painting, but he also exposed his pupils to history and to foreign ways of life, including the cultures of the American Indian and Eskimo. During that period Erikson became involved with the Freud family, friends of Mrs. Burlingham. He became particularly close to Anna Freud, with whom he began psychoanalysis. Anna Freud, who had been an elementary school teacher, was at that time formulating the new science of child psychiatry, trying to turn attention from the adult’s corrective backward look to a neurosis-preventative study of childhood itself. Under Anna Freud’s tutelage Erikson began more and more to turn his attention to childhood, both his own and that of the children whom he saw in the classroom. Analysis was not then the rigidly structured procedure into which it later developed; Erikson met with Miss Freud daily for his analytic hour and frequently saw her socially as well, as part of the circle of Freud’s followers and associates. Still undecided about his future, Erikson continued to teach school, at the same time studying psychoanalysis at the Vienna Psychoanalytic Institute. He also studied to become accredited as a Montessori teacher. In 1929 he married Joan Mowast Serson, an American of Canadian birth, and he was hastily made a

full member, rather than an associate member, of the Vienna Psychoanalytic Society—unorthodoxy that allowed him to leave a Vienna threatened by fascism immediately after his graduation in 1933. Earlier, Erikson had met the Viennese Hanns Sachs, cofounder along with Otto Rank of the psychoanalytically oriented journal *Imago*. Sachs—who had settled in Boston, where he was associated with the Harvard Medical School—was sure that Erikson would be welcome at Harvard and suggested that he make Boston his home. After a brief stay in Denmark, the Eriksons moved to Boston, where he became the city's only child analyst. He held positions at the Harvard Medical School and at Massachusetts General Hospital, served as a consultant at the Judge Baker Guidance Center, and maintained a private practice. Erikson was much influenced by Cambridge's circle of young social scientists, including anthropologists Margaret Mead and Ruth Benedict. Exposure to the views of those vigorous thinkers helped to shape his theories of child psychology and his cross-cultural approach to human development. Classical psychoanalysis had traditionally concerned itself with pathology and with treating disturbed people, but Erikson found himself more and more interested in the normal personality and in applying his own observations about how young people function and how childhood play affects character formation. Although he remained in the Boston area only three years, he established a solid reputation as a skilled clinician and researcher before moving to Yale University's Institute of Human Relations. There he furthered an interest sparked at Harvard in the work of American anthropologists. In 1938 he traveled to South Dakota to study the children of the Sioux Indians of the Pine Ridge Reservation. His observations about how communal and historical forces powerfully influence child rearing became an important contribution to psychology and to the study of humans in society. In 1939 Erikson moved to a post at Berkeley, from which he studied the Yurok

Indians, a group of salmon fishers. He left Berkeley in 1950 after refusing to sign what he called a vague, fearful addition to the loyalty oath. He resettled at the Austen Riggs Center in Stockbridge, Massachusetts, working with young people. In 1960 he was appointed to a professorship at Harvard. After his retirement from Harvard, Erikson in 1972 joined Mount Zion Hospital in San Francisco as senior consultant in psychiatry. Until his death in 1994 he continued to focus on many of his earlier interests, examining the individual in this historical context and elaborating on concepts of the human life cycle, especially those of old age.

**EPIGENETIC PRINCIPLE** Erikson's formulations were based on the concept of epigenesis, a term borrowed from embryology. His epigenetic principle holds that development occurs in sequential, clearly defined stages, and that each stage must be satisfactorily resolved for development to proceed smoothly. According to the epigenetic model, if successful resolution of a particular stage does not occur, all subsequent stages reflect that failure in the form of physical, cognitive, social, or emotional maladjustment.

**Relation to Freudian Theory** Erikson accepted Freud's concepts of instinctual development and infantile sexuality. For each of Freud's psychosexual stages (e.g., oral, anal, and phallic), Erikson described a corresponding zone with a specific pattern or mode of behavior. Thus, the oral zone is associated with sucking or taking-in behavior; the anal zone is associated with holding on and letting go. Erikson emphasized that the development of the ego is more than the result of intrapsychic wants or inner psychic energies. It is also a matter of mutual regulation between growing children and a society's culture and traditions.

**Eight Stages of the Life Cycle** Erikson's conception of the eight stages of ego development across the life cycle is the centerpiece of his life's work, and he elaborated the conception throughout his subsequent writings (Table 4.2-1). The eight stages represent points along a continuum of development in which physical, cognitive, instinctual, and sexual changes combine to trigger an internal crisis the resolution of which results

in either psychosocial regression or growth and the development of specific virtues. In *Insight and Responsibility* Erikson defined virtue as “inherent strength,” as in the active quality of a medicine or liquor. He wrote in *Identity: Youth and Crisis* that “crisis” refers not to a “threat of catastrophe, but to a turning point, a crucial period of increased vulnerability and heightened potential, and therefore, the ontogenetic source of generational strength and maladjustment.” Table 4.2-1 Erikson’s Psychosocial Stages

Stage 1: Trust versus Mistrust (Birth to about 18 Months). In *Identity: Youth and Crisis*, Erikson noted that the infant “lives through and loves with” its mouth. Indeed, the mouth forms the basis of its first mode or pattern of behavior, that of incorporation. The infant is taking the world in through the mouth, eyes, ears, and sense of touch. The baby is learning a cultural modality that Erikson termed to get, that is, to receive what is offered and elicit what is desired. As the infant’s teeth develop and it discovers the pleasure of biting, it enters the second oral stage, the active-incorporative mode. The infant is no longer passively receptive to stimuli; it reaches out for sensation and grasps at its surroundings. The social modality shifts to that of taking and holding on to things. The infant’s development of basic trust in the world stems from its earliest experiences with its mother or primary caretaker. In *Childhood and Society*, Erikson asserts that trust depends not on “absolute quantities of food or demonstrations of love, but rather on the quality of maternal relationship.” A baby whose mother can anticipate and respond to its needs in a consistent and timely manner despite its oral aggression will learn to tolerate the inevitable moments of frustration and deprivation. The defense mechanisms of introjection and projection provide the infant with the means to internalize pleasure and externalize pain such that “consistency, continuity, and sameness of experience provide a rudimentary sense of ego identity.” Trust will predominate over mistrust, and hope will crystallize. For Erikson, the element of society corresponding to this stage of ego identity is religion, as both are founded on “trust born of care.”

In keeping with his emphasis on the epigenetic character of psychosocial change, Erikson conceived of many forms of psychopathology as examples of what he termed aggravated development crisis, development, which having gone awry at one point, affects subsequent psychosocial change. A person who, as a result of severe disturbances in the earliest dyadic relationships, fails to develop a basic sense of trust or the virtue of hope may be predisposed as an adult to the profound withdrawal and regression characteristic of schizophrenia. Erikson hypothesized that the depressed patient’s experience of being empty and of being no good is an outgrowth of a developmental derailment that causes oral pessimism to predominate. Addictions may also be traced to the mode of oral incorporation. Stage 2: Autonomy versus Shame and Doubt (about 18 Months to about 3 Years). In the development of speech and sphincter and muscular control, the toddler practices the social modalities of holding on and letting go, and experiences the first stirrings of the virtue that Erikson termed will. Much depends on the amount and type of control exercised by adults over the child. Control that is exerted too rigidly or too early defeats the toddler’s attempts to develop its own internal controls, and regression or false progression results. Parental control that fails to protect the toddler from the consequences of his or her own lack of self-control or judgment can be equally disastrous to the child’s development of a healthy sense of autonomy. In *Identity: Youth and Crisis*, Erikson asserted: “This stage, therefore, becomes decisive for the ratio between loving good will and hateful self-insistence, between cooperation and willfulness, and between self-expression and compulsive self-restraint or meek compliance.” Where that ratio is favorable, the child develops an appropriate sense of autonomy and the capacity to

“have and to hold”; where it is unfavorable, doubt and shame will undermine free will. According to Erikson, the principle of law and order has at its roots this early preoccupation with the protection and regulation of will. In *Childhood and Society*, he concluded, “The sense of autonomy fostered in the child and modified as life progresses, serves (and is served by) the preservation in economic and political life of a sense of justice.” A person who becomes fixated at the transition between the development of hope and autonomous will, with its residue of mistrust and doubt, may develop paranoid fears of persecution. When psychosocial development is derailed in the second stage, other forms of pathology may emerge. The perfectionism, inflexibility, and stinginess of the person with an obsessive-compulsive personality disorder may stem from conflicting tendencies to hold on and to let go. The ruminative and ritualistic behavior of the person with an obsessive-compulsive disorder may be an outcome of the triumph of doubt over autonomy and the subsequent development of a primitively harsh conscience. Stage 3: Initiative versus Guilt (about 3 Years to about 5 Years). The child’s increasing mastery of locomotor and language skills expands its participation in the outside world and stimulates omnipotent fantasies of wider exploration and

conquest. Here the youngster’s mode of participation is active and intrusive; its social modality is that of being on the make. The intrusiveness is manifested in the child’s fervent curiosity and genital preoccupations, competitiveness, and physical aggression. The Oedipus complex is in ascendance as the child competes with the same-sex parent for the fantasized possession of the other parent. In *Identity: Youth and Crisis*, Erikson wrote that “jealousy and rivalry now come to a climax in a final contest for a favored position with one of the parents: the inevitable and necessary failure leads to guilt and anxiety.” Guilt over the drive for conquest and anxiety over the anticipated punishment are both assuaged in the child through repression of the forbidden wishes and development of a superego to regulate its initiative. This conscience, the faculty of self-observation, self-regulation, and self-punishment, is an internalized version of parental and societal authority. Initially, the conscience is harsh and uncompromising; however, it constitutes the foundation for the subsequent development of morality. Having renounced oedipal ambitions, the child begins to look outside the family for arenas in which it can compete with less conflict and guilt. This is the stage that highlights the child’s expanding initiative and forms the basis for the subsequent development of realistic ambition and the virtue of purpose. As Erikson noted in *Childhood and Society*, “The ‘oedipal’ stage sets the direction toward the possible and the tangible which permits the dreams of early childhood to be attached to the goals of an active adult life.” Toward this end, social institutions provide the child with an economic ethos in the form of adult heroes who begin to take the place of their storybook counterparts. When there has been an inadequate resolution of the conflict between initiative and guilt, a person may ultimately develop a conversion disorder, inhibition, or phobia. Those who overcompensate for the conflict by driving themselves too hard may experience sufficient stress to produce psychosomatic symptoms. Stage 4: Industry versus Inferiority (about 5 Years to about 13 Years). With the onset of latency, the child discovers the pleasures of production. He or she develops industry by learning new skills and takes pride in the things made. Erikson wrote in *Childhood and Society* that the child’s “ego boundaries include his tools and skills: the work principle teaches him the pleasure of work completion by steady attention and persevering diligence.” Across cultures, this is a time when the child receives systematic instruction and learns the fundamentals of technology as they pertain to the use of basic utensils and tools. As children work, they identify with their teachers and imagine themselves in various occupational roles. A child who is unprepared for this stage of psychosocial development, either through insufficient resolution of previous stages or by current interference, may develop a

sense of inferiority and inadequacy. In the form of teachers and other role models, society becomes crucially important in the child's ability to overcome that sense of inferiority and to achieve the virtue known as competence. In *Identity: Youth and Crisis*, Erikson noted: "This is socially a most decisive stage. Since industry involves doing things beside and with others, a first sense of division of labor and of differential opportunity, that is,

a sense of the technological ethos of a culture, develops at this time." The pathological outcome of a poorly navigated stage of industry versus inferiority is less well defined than in previous stages, but it may concern the emergence of a conformist immersion into the world of production in which creativity is stifled and identity is subsumed under the worker's role. Stage 5: Identity versus Role Confusion (about 13 Years to about 21 Years). With the onset of puberty and its myriad social and physiological changes, the adolescent becomes preoccupied with the question of identity. Erikson noted in *Childhood and Society* that youth are now "primarily concerned with what they appear to be in the eyes of others as compared to what they feel they are, and with the question of how to connect the roles and skills cultivated earlier with the occupational prototypes of the day." Childhood roles and fantasies are no longer appropriate, yet the adolescent is far from equipped to become an adult. In *Childhood and Society*, Erikson writes that the integration that occurs in the formation of ego identity encompasses far more than the summation of childhood identifications. "It is the accrued experience of the ego's ability to integrate these identifications with the vicissitudes of the libido, with the aptitudes developed out of endowment, and with the opportunities offered in social roles." The formation of cliques and an identity crisis occur at the end of adolescence. Erikson calls the crisis normative because it is a normal event. Failure to negotiate this stage leaves adolescents without a solid identity; they suffer from identity diffusion or role confusion, characterized by not having a sense of self and by confusion about their place in the world. Role confusion can manifest in such behavioral abnormalities as running away, criminality, and overt psychosis. Problems in gender identity and sexual role may manifest at this time. Adolescents may defend against role diffusion by joining cliques or cults or by identifying with folk heroes. Intolerance of individual differences is a way in which the young person attempts to ward off a sense of identity loss. Falling in love, a process by which the adolescent may clarify a sense of identity by projecting a diffused self-image onto the partner and seeing it gradually assume a more distinctive shape, and an overidentification with idealized figures are means by which the adolescent seeks self-definition. With the attainment of a more sharply focused identity, the youth develops the virtue of fidelity—faithfulness not only to the nascent self-definition but also to an ideology that provides a version of self-in-world. As Erik Erikson, Joan Erikson, and Helen Kivnick wrote in *Vital Involvement in Old Age*, "Fidelity is the ability to sustain loyalties freely pledged in spite of the inevitable contradictions of value systems. It is the cornerstone of identity and receives inspiration from confirming ideologies and affirming companionships." Role confusion ensues when the youth is unable to formulate a sense of identity and belonging. Erikson held that delinquency, gender-related identity disorders, and borderline psychotic episodes can result from such confusion. Stage 6: Intimacy versus Isolation (about 21 Years to about 40 Years). Freud's famous response to the question of what a normal person should be able to do

well, "Lieben und arbeiten" (to love and to work), is one that Erikson often cited in his discussion of this psychosocial stage, and it emphasizes the importance he placed on the virtue of love within a balanced identity. Erikson asserted in *Identity: Youth and Crisis* that Freud's use of the term love referred to "the generosity of intimacy as well as genital love; when he said love and work, he

meant a general work productiveness which would not preoccupy the individual to the extent that he might lose his right or capacity to be a sexual and a loving being." Intimacy in the young adult is closely tied to fidelity; it is the ability to make and honor commitments to concrete affiliations and partnerships even when that requires sacrifice and compromise. The person who cannot tolerate the fear of ego loss arising out of experiences of self-abandonment (e.g., sexual orgasm, moments of intensity in friendships, aggression, inspiration, and intuition) is apt to become deeply isolated and self-absorbed. Distantiation, an awkward term coined by Erikson to mean "the readiness to repudiate, isolate, and, if necessary, destroy those forces and persons whose essence seems dangerous to one's own," is the pathological outcome of conflicts surrounding intimacy and, in the absence of an ethical sense where intimate, competitive, and combative relationships are differentiated, forms the basis for various forms of prejudice, persecution, and psychopathology. Erikson's separation of the psychosocial task of achieving identity from that of achieving intimacy, and his assertion that substantial progress on the former task must precede development on the latter have engendered much criticism and debate. Critics have argued that Erikson's emphasis on separation and occupationally based identity formation fails to take into account the importance for women of continued attachment and the formation of an identity based on relationships. Stage 7: Generativity versus Stagnation (about 40 Years to about 60 Years). Erikson asserted in *Identity: Youth and Crisis* that "generativity is primarily the concern for establishing and guiding the next generation." The term generativity applies not so much to rearing and teaching one's offspring as it does to a protective concern for all the generations and for social institutions. It encompasses productivity and creativity as well. Having previously achieved the capacity to form intimate relationships, the person now broadens the investment of ego and libidinal energy to include groups, organizations, and society. Care is the virtue that coalesces at this stage. In *Childhood and Society* Erikson emphasized the importance to the mature person of feeling needed. "Maturity needs guidance as well as encouragement from what has been produced and must be taken care of." Through generative behavior, the individual can pass on knowledge and skills while obtaining a measure of satisfaction in having achieved a role with senior authority and responsibility in the tribe. When persons cannot develop true generativity, they may settle for pseudoengagement in occupation. Often, such persons restrict their focus to the technical aspects of their roles, at which they may now have become highly skilled, eschewing greater responsibility for the organization or profession. This failure of generativity can lead to profound personal stagnation, masked by a variety of

escapisms, such as alcohol and drug abuse, and sexual and other infidelities. Mid-life crisis or premature invalidism (physical and psychological) can occur. In this case, pathology appears not only in middle-aged persons but also in the organizations that depend on them for leadership. Thus, the failure to develop at midlife can lead to sick, withered, or destructive organizations that spread the effects of failed generativity throughout society; examples of such failures have become so common that they constitute a defining feature of modernity. Stage 8: Integrity versus Despair (about 60 Years to Death). In *Identity: Youth and Crisis*, Erikson defined integrity as "the acceptance of one's one and only life cycle and of the persons who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions." From the vantage point of this stage of psychosocial development, the individual relinquishes the wish that important persons in his life had been different and is able to love in a more meaningful way—one that reflects accepting responsibility for one's own life. The individual in possession of the virtue of wisdom and a sense of integrity has room to tolerate the proximity of death and to achieve what

Erikson termed in *Identity: Youth and Crisis* a “detached yet active concern with life.” Erikson underlined the social context for this final stage of growth. In *Childhood and Society*, he wrote, “The style of integrity developed by his culture or civilization thus becomes the ‘patrimony’ of his soul.... In such final consolidation, death loses its sting.” When the attempt to attain integrity has failed, the individual may become deeply disgusted with the external world and contemptuous of persons as well as institutions. Erikson wrote in *Childhood and Society* that such disgust masks a fear of death and a sense of despair that “time is now short, too short for the attempt to start another life and to try out alternate roads to integrity.” Looking back on the eight ages of man, he noted the relation between adult integrity and infantile trust, “Healthy children will not fear life if their elders have integrity enough not to fear death.”

**PSYCHOPATHOLOGY** Each stage of the life cycle has its own psychopathological outcome if it is not mastered successfully. **Basic Trust** An impairment of basic trust leads to basic mistrust. In infants, social trust is characterized by ease of feeding, depth of sleep, smiling, and general physiological homeostasis. Prolonged separation during infancy can lead to hospitalism or anaclitic depression. In later life, this lack of trust may be manifested by dysthymic disorder, a depressive disorder, or a sense of hopelessness. Persons who develop and rely on the defense of projection—in which, according to Erikson, “we endow significant persons with the evil which actually is in us”—experienced a sense of social mistrust in the first years of life and are likely to develop paranoid or delusional disorders. Basic mistrust is

a major contributor to the development of schizoid personality disorder and, in most severe cases, to the development of schizophrenia. Substance-related disorders can also be traced to social mistrust; substance-dependent personalities have strong oral dependency needs and use chemical substances to satisfy themselves because of their belief that human beings are unreliable and, at worst, dangerous. If not nurtured properly, infants may feel empty, starved not just for food but also for sensual and visual stimulation. As adults, they may become seekers after stimulating thrills that do not involve intimacy and that help ward off feelings of depression. **Autonomy** The stage in which children attempt to develop into autonomous beings is often called the terrible twos, referring to toddlers’ willfulness at this period of development. If shame and doubt dominate over autonomy, compulsive doubting can occur. The inflexibility of the obsessive personality also results from an overabundance of doubt. Too rigorous toilet training, commonplace in today’s society, which requires a clean, punctual, and deodorized body, can produce an overly compulsive personality that is stingy, meticulous, and selfish. Known as anal personalities, such persons are parsimonious, punctual, and perfectionistic (the three P’s). Too much shaming causes children to feel evil or dirty and may pave the way for delinquent behavior. In effect, children say, “If that’s what they think of me, that’s the way I’ll behave.” Paranoid personalities feel that others are trying to control them, a feeling that may have its origin during the stage of autonomy versus shame and doubt. When coupled with mistrust, the seeds are planted for persecutory delusions. Impulsive disorder may be explained as a person’s refusing to be inhibited or controlled. **Initiative** Erikson stated: “In pathology, the conflict over initiative is expressed either in hysterical denial, which causes the repression of the wish or the abrogation of its executive organ by paralysis or impotence; or in overcompensatory showing off, in which the scared individual, so eager to ‘duck,’ instead ‘sticks his neck out.’” In the past, hysteria was the usual form of pathological regression in this area, but a plunge into psychosomatic disease is now common. Excessive guilt can lead to a variety of conditions, such as generalized anxiety disorder and phobias. Patients feel guilty because of normal impulses, and they repress these impulses, with resulting symptom formation. Punishment or severe prohibitions during the stage of initiative versus guilt can produce sexual

inhibitions. Conversion disorder or specific phobia can result when the oedipal conflict is not resolved. As sexual fantasies are accepted as unrealizable, children may punish themselves for these fantasies by fearing harm to their genitals. Under the brutal assault of the developing superego, they may repress their wishes and begin to deny them. If this pattern is carried forward, paralysis, inhibition, or impotence can result. Sometimes, in fear of not being able to live up to what others expect, children may develop psychosomatic

disease. Industry Erikson described industry as a "sense of being able to make things and make them well and even perfectly." When children's efforts are thwarted, they are made to feel that personal goals cannot be accomplished or are not worthwhile, and a sense of inferiority develops. In adults, this sense of inferiority can result in severe work inhibitions and a character structure marked by feelings of inadequacy. For some persons, the feelings may result in a compensatory drive for money, power, and prestige. Work can become the main focus of life, at the expense of intimacy. Identity Many disorders of adolescence can be traced to identity confusion. The danger is role diffusion. Erikson stated: Where this is based on a strong previous doubt to one's sexual identity, delinquent and outright psychotic incidents are not uncommon. If diagnosed and treated correctly, those incidents do not have the same fatal significance that they have at other ages. It is primarily the inability to settle on an occupational identity that disturbs young persons. Keeping themselves together, they temporarily overidentify, to the point of apparent complete loss of identity, with the heroes of cliques and crowds. Other disorders during the stage of identity versus role diffusion include conduct disorder, disruptive behavior disorder, gender identity disorder, schizophreniform disorder, and other psychotic disorders. The ability to leave home and live independently is an important task during this period. An inability to separate from the parent and prolonged dependence may occur. Intimacy The successful formation of a stable marriage and family depends on the capacity to become intimate. The years of early adulthood are crucial for deciding whether to get married and to whom. Gender identity determines object choice, either heterosexual or homosexual, but making an intimate connection with another person is a major task. Persons with schizoid personality disorder remain isolated from others because of fear, suspicion, the inability to take risks, or the lack of a capacity to love. Generativity. From about 40 to 65 years, the period of middle adulthood, specific disorders are less clearly defined than in the other stages described by Erikson. Persons who are middle aged show a higher incidence of depression than younger adults, which may be related to middle-aged persons' disappointments and failed expectations as they review the past, consider their lives, and contemplate the future. The increased use of alcohol and other psychoactive substances also occurs during this time.

Integrity. Anxiety disorders often develop in older persons. In Erikson's formulation, this development may be related to persons' looking back on their lives with a sense of panic. Time has run out, and chances are used up. The decline in physical functions can contribute to psychosomatic illness, hypochondriasis, and depression. The suicide rate is highest in persons over the age of 65. Persons facing dying and death may find it intolerable not to have been generative or able to make significant attachments in life. Integrity, for Erikson, is characterized by an acceptance of life. Without acceptance, persons feel despair and hopelessness that can result in severe depressive disorders. TREATMENT Although no independent eriksonian psychoanalytic school exists in the same way that freudian and jungian schools do, Erikson made many important contributions to the therapeutic process. Among his most important contributions is his belief that establishing a state of trust between doctor and patient is the basic requirement for successful

therapy. When psychopathology stems from basic mistrust (e.g., depression), a patient must reestablish trust with the therapist, whose task, as that of the good mother, is to be sensitive to the patient's needs. The therapist must have a sense of personal trustworthiness that can be transmitted to the patient. Techniques For Erikson, a psychoanalyst is not a blank slate in the therapeutic process, as the psychoanalyst commonly is in Freudian psychoanalysis. To the contrary, effective therapy requires that therapists actively convey to patients the belief that they are understood. This is done through both empathetic listening and by verbal assurances, which enable a positive transference built on mutual trust to develop. Beginning as an analyst for children, Erikson tried to provide this mutuality and trust while he observed children recreating their own worlds by structuring dolls, blocks, vehicles, and miniature furniture into the dramatic situations that were bothering them. Then, Erikson correlated his observations with statements by the children and their family members. He began treatment of a child only after eating an evening meal with the entire family, and his therapy was usually conducted with much cooperation from the family. After each regressive episode in the treatment of a schizophrenic child, for instance, Erikson discussed with every member of the family what had been going on with them before the episode. Only when he was thoroughly satisfied that he had identified the problem did treatment begin. Erikson sometimes provided corrective information to the child—for instance, telling a boy who could not release his feces and had made himself ill from constipation that food is not an unborn infant. Erikson often turned to play, which, along with specific recommendations to parents, proved fruitful as a treatment modality. Play, for Erikson, is diagnostically revealing and thus helpful for a therapist who seeks to promote a cure, but it is also curative in its

own right. Play is a function of the ego and gives children a chance to synchronize social and bodily processes with the self. Children playing with blocks or adults playing out an imagined dramatic situation can manipulate the environment and develop the sense of control that the ego needs. Play therapy is not the same for children and adults, however. Children create models in an effort to gain control of reality; they look ahead to new areas of mastery. Adults use play to correct the past and to redeem their failures. Mutuality, which is important in Erikson's system of health, is also vital to a cure. Erikson applauded Freud for the moral choice of abandoning hypnosis, because hypnosis heightens both the demarcation between the healer and the sick and the inequality that Erikson compares with the inequality of child and adult. Erikson urged that the relationship of the healer to the sick person be one of equals "in which the observer who has learned to observe himself teaches the observed to become self-observant." Dreams and Free Association As with Freud, Erikson worked with the patient's associations to the dream as the "best leads" to understanding the dream's meaning. He valued the first association to the dream, which he believed to be powerful and important. Ultimately, Erikson listened for "a central theme which, once found, gives added meaning to all the associated material." Erikson believed that interpretation was the primary therapeutic agent, sought as much by the patient as by the therapist. He emphasized free-floating attention as the method that enabled discovery to occur. Erikson once described this attentional stance by commenting that in clinical work, "You need a history and you need a theory, and then you must forget them both and let each hour stand for itself." This frees both parties from counterproductive pressures to advance in the therapy and allows them both to notice the gaps in the patient's narrative that signal the unconscious. Goals Erikson discussed four dimensions of the psychoanalyst's job. The patient's desire to be cured and the analyst's desire to cure is the first dimension. Mutuality exists in that patient and therapist are motivated by cure, and labor is divided. The goal is always to help the patient's ego get stronger

and cure itself. The second dimension Erikson called objectivity-participation. Therapists must keep their minds open. "Neuroses change," wrote Erikson. New generalizations must be made and arranged in new configurations. The third dimension runs along the axis of knowledge-participation. The therapist "applies selected insights to more strictly experimental approaches." The fourth dimension is tolerance-indignation. Erikson stated: "Identities based on Talmudic argument, on messianic zeal, on punitive orthodoxy, on faddist sensationalism, on professional and social ambition" are harmful and tend to control patients. Control widens the gap of inequality between the doctor and the patient and makes realization of the recurrent idea in Erikson's thought—mutuality—difficult. According to Erikson, therapists have the opportunity to work through past

unresolved conflicts in the therapeutic relationship. Erikson encouraged therapists not to shy away from guiding patients; he believes that therapists must offer patients both prohibitions and permissions. Nor should therapists be so engrossed in patients' past life experiences that current conflicts are overlooked. The goal of therapy is to recognize how patients have passed through the various stages of the life cycle and how the various crises in each stage have or have not been mastered. Equally important, future stages and crises must be anticipated, so that they can be negotiated and mastered appropriately. Unlike Freud, Erikson does not believe that the personality is so inflexible that change cannot occur in middle and late adulthood. For Erikson, psychological growth and development occur throughout the entire span of the life cycle. The Austen Riggs Center in Stockbridge, Massachusetts, is a repository of Erikson's work and many of his theories are put into practice there. Erik's wife, Joan, developed an activities program at the Austen Riggs Center as an "interpretation-free zone," where patients could take up work roles or function as students with artists and craftsmen, without the burden of the patient role. This workspace encouraged the play and creativity required for the patients' work development to parallel the process of their therapy.

REFERENCES Brown C, Lewis MJ. Psychosocial development in the elderly: An investigation into Erikson's ninth stage. *J Aging Stud.* 2003;17:415-426. Capps D. The decades of life: Relocating Erikson's stages. *Pastoral Psychol.* 2004;53:3-32. Chodorow NJ. The American independent tradition: Loewald, Erikson, and the (possible) rise of intersubjective ego psychology. *Psychoanal Dialogues.* 2004;14:207-232. Crawford TN, Cohen P, Johnson JG, Sneed JR, Brook JS. The course and psychosocial correlates of personality disorder symptoms in adolescence: Erikson's developmental theory revisited. *J Youth Adolesc.* 2004;33(5):373-387. Friedman LJ. Erik Erikson on identity, generativity, and pseudospeciation: A biographer's perspective. *Psychoanalytic History.* 2001;3:179. Hoare CH. Erikson's general and adult developmental revisions of Freudian thought: "Outward, forward, upward". *J Adult Dev.* 2005;12:19-31. Kivnick HQ, Wells CK. Untapped richness in Erik H. Erikson's rootstock. *Gerontologist.* 2014;54:40-50. Newton DS. Erik H. Erikson. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry.* 8th ed. Vol. 1. Philadelphia: Lippincott Williams & Wilkins; 2005:746. Pietikainen P, Ihanus J. On the origins of psychoanalytic psychohistory. *Historical Psychol.* 2003;6:171. Shapiro ER, Fromm MG. Eriksonian clinical theory and psychiatric treatment. In: Sadock BJ, Sadock VA, eds. *Comprehensive Textbook of Psychiatry.* 7th ed. New York: Lippincott Williams & Wilkins; 2000. Slater C. Generativity versus stagnation: An elaboration of Erikson's adult stage of human development. *J Adult Dev.* 2003;10:53. Van Hiel A, Mervielde I, De Fruyt F. Stagnation and generativity: Structure, validity, and differential relationships with adaptive and maladaptive personality. *J Pers.* 2006;74(2):543. Westermeyer JF. Predictors and characteristics of Erikson's life cycle model among men: A 32-year longitudinal study. *Int J*



# 03 - 4.3 Other

## Psychodynamic Schools

### 4.3 Other Psychodynamic Schools

Aging Hum Dev. 2004;58:29–48. Wulff D. Freud and Freudians on religion: A reader. Int J Psychol and Rel. 2003;13:223. 4.3 Other Psychodynamic Schools The men and women discussed in this chapter contributed to psychiatric thought and practice in the early and middle years of the 20th century. Many of these theories of psychopathology evolved as direct offshoots of Freudian psychoanalysis. This, however, derived from various aspects of psychology, such as learning theory and quantitative methods of personality assessment. The theories selected for the discussion in this section have stood the test of time and are most relevant for psychiatry. Brief synopses of the theories that exert the greatest influence on current psychiatric thought are listed below in alphabetical order of their proponent. Each of these theories contains insights that merit consideration because they enhance our understanding of the complexities of human behavior. They also illustrate the diversity of theoretical orientation that characterizes psychiatry today.

**KARL ABRAHAM (1877–1925)** Karl Abraham, one of Sigmund Freud's earliest disciples, was the first psychoanalyst in Germany. He is best known for his explication of depression from a psychoanalytic perspective and for his elaboration of Freud's stages of psychosexual development. Abraham divided the oral stage into a biting phase and a sucking phase; the anal stage into a destructive-expulsive (anal-sadistic) phase and a mastering-retentive (anal-erotic) phase; and the phallic stage into an early phase of partial genital love (true phallic phase) and a later mature genital phase. Abraham also linked the psychosexual stages to specific syndromes. For example, he postulated that obsessional neurosis resulted from fixation at the anal-sadistic phase and depression from fixation at the oral stage.

**ALFRED ADLER (1870–1937)** Alfred Adler (Fig. 4.3-1) was born in Vienna, Austria, where he spent most of his life. A general physician, he became one of the original four members of Freud's circle in 1902. Adler never accepted the primacy of the libido theory, the sexual origin of neurosis, or the importance of infantile wishes. Adler thought that aggression was far more important, specifically in its manifestation as a striving for power, which he believed to be a masculine trait. He introduced the term masculine protest to describe the tendency to move from a passive, feminine role to a masculine, active role. Adler's theories are collectively known as individual psychology.

FIGURE 4.3-1 Alfred Adler. (print includes signature). (Courtesy of Alexandra Adler.) Adler saw individuals as unique, unified biological entities whose psychological processes fit together into an individual lifestyle. He also postulated a principle of dynamism, in which every individual is future-directed and moves toward a goal. Adler also emphasized the interface between individuals and their social environment: the primacy of action in the real work over fantasy. Adler coined the term inferiority complex to refer to a sense of inadequacy and weakness that is universal and inborn. A developing child's self-esteem is compromised by a physical defect, and Adler referred to this phenomenon as organ inferiority. He also thought that a basic inferiority tied to children's oedipal longings could never be gratified. Adler was one of the first developmental theorists to recognize the importance of children's birth order in their families of origin. The firstborn child reacts with anger to the birth of siblings and struggles against giving up the powerful position of only child. They tend not to share and become conservative. The second-born child must constantly strive to compete with the firstborn. Youngest children feel secure because they have never been displaced. Adler thought that a child's sibling position results in lifelong influences on character and lifestyle. The primary therapeutic approach in adlerian therapy is encouragement, through which Adler believed his patients could overcome feelings of inferiority. Consistent human relatedness, in his view, leads to greater hope, less isolation, and greater affiliation with society. He believed that patients needed to develop a greater sense of their own dignity and worth

and renewed appreciation of their abilities and strengths. FRANZ ALEXANDER (1891-1964) Franz Alexander (Fig. 4.3-2) emigrated from his native Germany to the United States, where he settled in Chicago and founded the Chicago Institute for Psychoanalysis. He wrote extensively about the association between specific personality traits and certain psychosomatic ailments, a point of view that came to be known as the specificity hypothesis. Alexander fell out of favor with classic analysts for advocating the corrective emotional experience as part of analytic technique. In this approach, Alexander suggested that an analyst must deliberately adopt a particular mode of relatedness with a patient to counteract noxious childhood influences from the patient's parents. He believed that the trusting, supportive relationship between patient and analyst enabled the patient to master childhood traumas and to grow from the experience. FIGURE 4.3-2 Franz Alexander. (Courtesy of Franz Alexander.) GORDON ALLPORT (1897-1967) Gordon Allport (Fig. 4.3-3), a psychologist in the United States, is known as the founder of the humanistic school of psychology, which holds that each person has an inherent potential for autonomous function and growth. At Harvard University, he taught the first course in the psychology of personality offered at a college in the United States.

FIGURE 4.3-3 Gordon Allport. (© Bettmann/Corbis.) Allport believed that a person's only real guarantee of personal existence is a sense of self. Selfhood develops through a series of stages, from awareness of the body to self-identity. Allport used the term proprium to describe strivings related to maintenance of self-identity and self-esteem. He used the term traits to refer to the chief units of personality structure. Personal dispositions are individual traits that represent the essence of an individual's unique personality. Maturity is characterized by a capacity to relate to others with warmth and intimacy and an expanded sense of self. In Allport's view, mature persons have security, humor, insight, enthusiasm, and zest. Psychotherapy is geared to helping patients realize these characteristics. MICHAEL BALINT (1896-1970) Michael Balint was considered a member of the independent or middle group of object relations theorists in the United Kingdom. Balint believed that the urge for the primary love object underlies virtually all psychological phenomena.

Infants wish to be loved totally and unconditionally, and when a mother is not forthcoming with appropriate nurturance, a child devotes his or her life to a search for the love missed in childhood. According to Balint, the basic fault is the feeling of many patients that something is missing. As with Ronald Fairbairn and Donald W. Winnicott, Balint understood this deficit in internal structure to result from maternal failures. He viewed all psychological motivations as stemming from the failure to receive adequate maternal love. Unlike Fairbairn, however, Balint did not entirely abandon drive theory. He suggested that libido, for example, is both pleasure seeking and object seeking. He also worked with seriously disturbed patients, and like Winnicott, he thought that certain aspects of psychoanalytic treatment occur at a more profound level than that of the ordinary verbal explanatory

interpretations. Although some material involving genital psychosexual stages of development can be interpreted from the perspective of intrapsychic conflict, Balint believed that certain preverbal phenomena are reexperienced in analysis and that the relationship itself is decisive in dealing with this realm of early experience. ERIC BERNE (1910–1970) Eric Berne (Fig. 4.3-4) began his professional life as a training and supervising analyst in classic psychoanalytic theory and technique, but ultimately developed his own school, known as transactional analysis. A transaction is a stimulus presented by one person that evokes a corresponding response in another. Berne defined psychological games as stereotyped and predictable transactions that persons learn in childhood and continue to play throughout their lives. Strokes, the basic motivating factors of human behavior, consist of specific rewards, such as approval and love. All persons have three ego states that exist within them: the child, which represents primitive elements that become fixed in early childhood; the adult, which is the part of the personality capable of objective appraisals of reality; and the parent, which is an introject of the values of a person's actual parents. The therapeutic process is geared toward helping patients understand whether they are functioning in the child, adult, or parent mode in their interactions with others. As patients learn to recognize characteristic games played again and again throughout life, they can ultimately function in the adult mode as much as possible in interpersonal relationships. FIGURE 4.3-4 Eric Berne. (Courtesy of Wide World Photos.) WILFRED BION (1897–1979)

Wilfred Bion expanded Melanie Klein's concept of projective identification to include an interpersonal process in which a therapist feels coerced by a patient into playing a particular role in the patient's internal world. He also developed the notion that the therapist must contain what the patient has projected so that it is processed and returned to the patient in modified form. Bion believed that a similar process occurs between mother and infant. He also observed that "psychotic" and "nonpsychotic" aspects of the mind function simultaneously as suborganizations. Bion is probably best known for his application of psychoanalytic ideas to groups. Whenever a group gets derailed from its task, it deteriorates into one of three basic states: dependency, pairing, or fight-flight. JOHN BOWLBY (1907–1990) John Bowlby is generally considered the founder of attachment theory. He formed his ideas about attachment in the 1950s while he was consulting with the World Health Organization (WHO) on the problems of homelessness in children. He stressed that the essence of attachment is proximity (i.e., the tendency of a child to stay close to the mother or caregiver). His theory of the mother-infant bond was firmly rooted in biology and drew extensively from ethology and evolutionary theory. A basic sense of security and safety is derived from a continuous and close relationship with a caregiver, according to Bowlby. This readiness for attachment is biologically driven, and Bowlby stressed that attachment is reciprocal.

Maternal bonding and care giving are always intertwined with the child's attachment behavior. Bowlby felt that without this early proximity to the mother or caregiver, the child does not develop a secure base, which he considered a launching pad for independence. In the absence of a secure base, the child feels frightened or threatened, and development is severely compromised. Bowlby and attachment theory are discussed in detail in Section 2.2.

**RAYMOND CATTELL (1905–1998)** Raymond Cattell obtained his Ph.D. in England before moving to the United States. He introduced the use of multivariate analysis and factor analysis—statistical procedures that simultaneously examine the relations among multiple variables and factors—to the study of personality. By examining a person's life record objectively, using personal interviewing and questionnaire data, Cattell described a variety of traits that represent the building blocks of personality. Traits are both biologically based and environmentally determined or learned. Biological traits include sex, gregariousness, aggression, and parental protectiveness. Environmentally learned traits include cultural ideas, such as work, religion, intimacy, romance, and identity. An important concept is the law of coercion to the biosocial mean, which holds that society exerts pressure on genetically different persons to conform to social norms. For example, a person with a strong genetic tendency toward dominance is likely to receive social encouragement for restraint, whereas the naturally submissive person will be encouraged toward self-assertion.

**RONALD FAIRBAIRN (1889–1964)** Ronald Fairbairn, a Scottish analyst who worked most of his life in relative isolation, was one of the major psychoanalytic theorists in the British school of object relations. He suggested that infants are not primarily motivated by the drives of libido and aggression but are by an object-seeking instinct. Fairbairn replaced the Freudian ideas of energy, ego, and id with the notion of dynamic structures. When an infant encounters frustration, a portion of the ego is defensively split off in the course of development and functions as an entity in relation to internal objects and to other subdivisions of the ego. He also stressed that both an object and an object relationship are internalized during development, so that a self is always in relationship to an object, and the two are connected with an affect.

**SÁNDOR FERENCZI (1873–1933)** Although Sándor Ferenczi, a Hungarian analyst, had been analyzed by Freud and was influenced by him, he later discarded Freud's techniques and introduced his own method of analysis. He understood the symptoms of his patients as related to sexual and physical abuse in childhood and proposed that analysts need to love their patients in a way that compensates for the love they did not receive as children. He developed a procedure known as active therapy, in which he encouraged patients to develop an awareness of reality through active confrontation by the therapist. He also experimented with mutual analysis, in which he would analyze his patient for a session and then allow the patient to analyze him for a session.

**VIKTOR FRANKL (1905–1997)** An Austrian neurologist and philosopher, Viktor Frankl's distinctive view of human nature and psychopathology was profoundly shaped by his experience in Nazi concentration camps. There he came to the conclusion that even the most appalling circumstances could be endured if one found a way of making them meaningful. He described his experience in *Man's Search for Meaning*, a book that has been read by millions around the world. Frankl was both a humanist and an existentialist. He believed that human beings shared with other animals somatic and psychological dimensions, but that humans alone also had a spiritual dimension that confers both freedom and responsibility. People find meaning in their lives through creative and productive work, through an appreciation of the world and others, and by freely adopting positive attitudes even in the face of suffering. Those who fail to find meaning face alienation, despair, and existential neuroses. Traditional societies provided a framework of meaning in religion and shared cultural values; in modern society, people must find

their own sources of meaning, and Frankl attributed many social problems, such as drug abuse and suicide, to their failures to do so. Because of the spiritual dimension, human beings show self-transcendence and self-distancing. The former refers to the capacity to put other values (for example, the well-being of a loved one) above self-interest. The latter is the ability to take an external perspective, as seen in a sense of humor. These capacities form the basis for therapeutic interventions in

Frankl's version of psychotherapy known as logotherapy. Logo therapy is derived from the Greek word *logos*, which means thought or reason and Frankl believed that man instinctively attempts to find universal understanding and harmony in life experiences. ANNA FREUD (1895–1982) Anna Freud (Fig. 4.3-5), the daughter of Sigmund Freud, ultimately made her own set of unique contributions to psychoanalysis. Although her father focused primarily on repression as the central defense mechanism, Anna Freud greatly elaborated on individual defense mechanisms, including reaction formation, regression, undoing, introjection, identification, projection, turning against the self, reversal, and sublimation. She was also a key figure in the development of modern ego psychology in that she emphasized that there was "depth in the surface." The defenses marshaled by the ego to avoid unacceptable wishes from the id were in and of themselves complex and worthy of attention. Up to that point, the primary focus had been on uncovering unconscious sexual and aggressive wishes. She also made seminal contributions to the field of child psychoanalysis and studied the function of the ego in personality development. She founded the Hampstead child therapy course and clinic in London in 1947 and served as its director. FIGURE 4.3-5 Anna Freud. (Courtesy of the National Library of Medicine.)

ERICH FROMM (1900–1980) Erich Fromm (Fig. 4.3-6) came to the United States in 1933 from Germany, where he had received his Ph.D. He was instrumental in founding the William Alanson White Institute for Psychiatry in New York. Fromm identified five character types that are common to, and determined by, Western culture; each person may possess qualities from one or more types. The types are (1) the receptive personality is passive; (2) the exploitative personality is manipulative; (3) the marketing personality is opportunistic and changeable; (4) the hoarding personality saves and stores; and (5) the productive personality is mature and enjoys love and work. The therapeutic process involves strengthening the person's sense of ethical behavior toward others and developing productive love, which is characterized by care, responsibility, and respect for other persons. FIGURE 4.3-6 Erich Fromm. (© Bettmann/Corbis.) KURT GOLDSTEIN (1878–1965) Kurt Goldstein (Fig. 4.3-7) was born in Germany and received his M.D. from the University of Breslau. He was influenced by existentialism and Gestalt psychology— every organism has dynamic properties, which are energy supplies that are relatively constant and evenly distributed. When states of tension-disequilibrium occur, an

organism automatically attempts to return to its normal state. What happens in one part of the organism affects every other part, a phenomenon known as holocoenosis. FIGURE 4.3-7 Kurt Goldstein. (Courtesy of New York Academy of Medicine, New York.) Self-actualization was a concept Goldstein used to describe persons' creative powers to fulfill their potentialities. Because each person has a different set of innate potentialities, persons strive for self-actualization along different paths. Sickness severely disrupts self-actualization. Responses to disruption of an organism's integrity may be rigid and compulsive; regression to more primitive modes of behavior is characteristic. One of Goldstein's major contributions was his identification of the catastrophic

reaction to brain damage, in which a person becomes fearful and agitated and refuses to perform simple tasks because of the fear of possible failure. KAREN HORNEY (1885–1952) German born physician-psychoanalyst Karen Horney (Fig. 4.3-8), who emphasized the preeminence of social and cultural influences on psychosexual development, focused her attention on the differing psychology of men and women and explored the vicissitudes of marital relationships. She taught at the Institute of Psychoanalysis in Berlin before immigrating to the United States. Horney believed that a person's current personality attributes result from the interaction between the person and the environment and are

not solely based on infantile libidinal strivings carried over from childhood. Her theory, known as holistic psychology, maintains that a person needs to be seen as a unitary whole who influences, and is influenced by, the environment. She thought that the Oedipus complex was overvalued in terms of its contribution to adult psychopathology, but she also believed that rigid parental attitudes about sexuality led to excessive concern with the genitals. FIGURE 4.3-8 Karen Horney. (Courtesy of the Association for the Advancement of Psychoanalysis, New York.) She proposed three separate concepts of the self: the actual self, the sum total of a person's experience; the real self, the harmonious, healthy person; and the idealized self, the neurotic expectation or glorified image that a person feels he or she should be. A person's pride system alienates him or her from the real self by overemphasizing prestige, intellect, power, strength, appearance, sexual prowess, and other qualities that can lead to self-effacement and self-hatred. Horney also established the concepts of basic anxiety and basic trust. The therapeutic process, in her view, aims for self-realization by exploring distorting influences that prevent the personality from growing. EDITH JACOBSON (1897–1978) Edith Jacobson, a psychiatrist in the United States, believed that the structural model

and an emphasis on object relations are not fundamentally incompatible. She thought that the ego, self-images, and object images exert reciprocal influences on one another's development. She also stressed that the infant's disappointment with the maternal object is not necessarily related to the mother's actual failure. In Jacobson's view, disappointment is related to a specific, drive-determined demand, rather than to a global striving for contact or engagement. She viewed an infant's experience of pleasure or "unpleasure" as the core of the early mother-infant relationship. Satisfactory experiences lead to the formation of good or gratifying images, whereas unsatisfactory experiences create bad or frustrating images. Normal and pathological development is based on the evolution of these self-images and object images. Jacobson believed that the concept of fixation refers to modes of object relatedness, rather than to modes of gratification. CARL GUSTAV JUNG (1875–1961) Carl Gustav Jung (Fig. 4.3-9), a Swiss psychiatrist, formed a psychoanalytic school known as analytic psychology, which includes basic ideas related to, but going beyond, Freud's theories. After initially being Freud's disciple, Jung broke with Freud over the latter's emphasis on infantile sexuality. He expanded on Freud's concept of the unconscious by describing the collective unconscious as consisting of all humankind's common, shared mythological and symbolic past. The collective unconscious includes archetypes—representational images and configurations with universal symbolic meanings. Archetypal figures exist for the mother, father, child, and hero, among others. Archetypes contribute to complexes, feeling-toned ideas that develop as a result of personal experience interacting with archetypal imagery. Thus, a mother complex is determined not only by the mother-child interaction but also by the conflict between archetypal expectation and actual experience with the real woman who functions in a motherly

role.

FIGURE 4.3-9 Carl Gustav Jung (print includes signature). (Courtesy of National Library of Medicine, Bethesda, MD.) Jung noted that there are two types of personality organizations: introversion and extroversion. Introverts focus on their inner world of thoughts, intuitions, emotions, and sensations; extroverts are more oriented toward the outer world, other persons, and material goods. Each person has a mixture of both components. The persona, the mask covering the personality, is the face a person presents to the outside world. The persona may become fixed, and the real person hidden from himself or herself. Anima and animus are unconscious traits possessed by men and women, respectively, and are contrasted with the persona. Anima refers to a man's undeveloped femininity, whereas animus refers to a woman's undeveloped masculinity. The aim of Jungian treatment is to bring about an adequate adaptation to reality, which involves a person fulfilling his or her creative potentialities. The ultimate goal is to achieve individuation, a process continuing throughout life whereby persons develop a unique sense of their own identity. This developmental process may lead them down new paths away from their previous directions in life. OTTO KERNBERG (1928–PRESENT) Otto Kernberg is perhaps the most influential object relations theorist in the United States. Influenced by both Klein and Jacobson, much of his theory is derived from his clinical work with patients who have borderline personality disorder. Kernberg places great emphasis on the splitting of the ego and the elaboration of good and bad selfconfigurations and object configurations. Although he has continued to use the structural model, he views the id as composed of self-images, object images, and their associated

affects. Drives appear to manifest themselves only in the context of internalized interpersonal experience. Good and bad self-representations and object relations become associated, respectively, with libido and aggression. Object relations constitute the building blocks of both structure and drives. Goodness and badness in relational experiences precede drive cathexis. The dual instincts of libido and aggression arise from object-directed affective states of love and hate. Kernberg proposed the term borderline personality organization for a broad spectrum of patients characterized by a lack of an integrated sense of identity, ego weakness, absence of superego integration, reliance on primitive defense mechanisms such as splitting and projective identification, and a tendency to shift into primary process thinking. He suggested a specific type of psychoanalytic psychotherapy for such patients in which transference issues are interpreted early in the process. MELANIE KLEIN (1882–1960) Melanie Klein (Fig. 4.3-10) was born in Vienna, worked with Abraham and Ferenczi, and later moved to London. Klein evolved a theory of internal object relations that was intimately linked to drives. Her unique perspective grew largely from her psychoanalytic work with children, in which she became impressed with the role of unconscious intrapsychic fantasy. She postulated that the ego undergoes a splitting process to deal with the terror of annihilation. She also thought that Freud's concept of the death instinct was central to understanding aggression, hatred, sadism, and other forms of "badness," all of which she viewed as derivatives of the death instinct. FIGURE 4.3-10 Melanie Klein. (Courtesy of Melanie Klein and Douglas Glass.)

Klein viewed projection and introjection as the primary defensive operations in the first months of life. Infants project derivatives of the death instinct into the mother and then fear attack from the "bad mother," a phenomenon that Klein referred to as persecutory anxiety. This anxiety is intimately associated with the paranoid-schizoid position, infants' mode of organizing experience in

which all aspects of infant and mother are split into good and bad elements. As the disparate views are integrated, infants become concerned that they may have harmed or destroyed the mother through the hostile and sadistic fantasies directed toward her. At this developmental point, children have arrived at the depressive position, in which the mother is viewed ambivalently as having both positive and negative aspects and as the target of a mixture of loving and hateful feelings. Klein was also instrumental in the development of child analysis, which evolved from an analytic play technique in which children used toys and played in a symbolic fashion that allowed analysts to interpret the play. HEINZ KOHUT (1913–1981) Heinz Kohut (Fig. 4.3-11) is best known for his writings on narcissism and the development of self-psychology. He viewed the development and maintenance of self-esteem and self-cohesion as more important than sexuality or aggression. Kohut described Freud's concept of narcissism as judgmental, in that development was supposed to proceed toward object relatedness and away from narcissism. He conceived of two separate lines of development, one moving in the direction of object relatedness and the other in the direction of greater enhancement of the self.

FIGURE 4.3-11 Heinz Kohut. (Courtesy of New York Academy of Medicine, New York.) In infancy, children fear losing the protection of the early mother-infant bliss and resort to one of three pathways to save the lost perfection: the grandiose self, the alter ego or twinship, and the idealized parental image. These three poles of the self manifest themselves in psychoanalytic treatment in terms of characteristic transferences, known as self-object transferences. The grandiose self leads to a mirror transference, in which patients attempt to capture the gleam in the analyst's eye through exhibitionistic self-display. The alter ego leads to the twinship transference, in which patients perceive the analyst as a twin. The idealized parental image leads to an idealizing transference, in which patients feel enhanced self-esteem by being in the presence of the exalted figure of the analyst. Kohut suggested that empathic failures in the mother lead to a developmental arrest at a particular stage when children need to use others to perform self-object functions. Although Kohut originally applied this formulation to narcissistic personality disorder, he later expanded it to apply to all psychopathology. JACQUES LACAN (1901–1981) Born in Paris and trained as a psychiatrist, Jacques Lacan founded his own institute, the Freudian School of Paris. He attempted to integrate the intrapsychic concepts of Freud with concepts related to linguistics and semiotics (the study of language and symbols). Whereas Freud saw the unconscious as a seething cauldron of needs, wishes, and instincts, Lacan saw it as a sort of language that helps to structure the world. His two principal concepts are that the unconscious is structured as a language and the unconscious is a discourse. Primary process thoughts are actually uncontrolled freeflowing sequences of meaning. Symptoms are signs or symbols of underlying processes. The role of the therapist is to interpret the semiotic text of the personality structure. Lacan's most basic phase is the mirror stage; it is here that infants learn to recognize themselves by taking the perspective of others. In that sense, the ego is not part of the self but, rather, is something outside of, and viewed by, the self. The ego comes to represent parents and society more than it represents the actual self of the person. Lacan's therapeutic approach involves the need to become less alienated from the self and more involved with others. Relationships are often fantasized, which distorts reality and must be corrected. Among his most controversial beliefs was that the resistance to understanding the real relationship with the therapist can be reduced by shortening the length of the therapy session and that psychoanalytic sessions need to be standardized not to time but, rather, to content and process. KURT LEWIN (1890–1947) Kurt Lewin received his Ph.D. in Berlin, came to the United States in the 1930s, and taught at Cornell, Harvard, and the Massachusetts Institute of

Technology. He adapted the field approach of physics to a concept called field theory. A field is the totality of coexisting, mutually interdependent parts. Behavior becomes a function of persons and their environment, which together make up the life space. The life space represents a field in constant flux, with valences or needs that require satisfaction. A hungry person is

more aware of restaurants than someone who has just eaten, and a person who wants to mail a letter is aware of mailboxes. Lewin applied field theory to groups. Group dynamics refers to the interaction among members of a group, each of whom depends on the others. The group can exert pressure on a person to change behavior, but the person also influences the group when change occurs. ABRAHAM MASLOW (1908–1970) Abraham Maslow (Fig. 4.3-12) was born in Brooklyn, New York, and completed both his undergraduate and graduate work at the University of Wisconsin. Along with Goldstein, Maslow believed in self-actualization theory—the need to understand the totality of a person. A leader in humanistic psychology, Maslow described a hierarchical organization of needs present in everyone. As the more primitive needs, such as hunger and thirst, are satisfied, more advanced psychological needs, such as affection and self-esteem, become the primary motivators. Self-actualization is the highest need. FIGURE 4.3-12 Abraham H. Maslow. (© Bettmann/Corbis.) A peak experience, frequently occurring in self-actualizers, is an episodic, brief occurrence in which a person suddenly experiences a powerful transcendental state of consciousness—a sense of heightened understanding, an intense euphoria, an integrated nature, unity with the universe, and an altered perception of time and space. This powerful experience tends to occur most often in the psychologically healthy and can produce long-lasting beneficial effects.

KARL A. MENNINGER (1893–1990) Karl A. Menninger was one of the first physicians in the United States to receive psychiatric training. With his brother, Will, he pioneered the concept of a psychiatric hospital based on psychoanalytic principles and founded the Menninger Clinic in Topeka, Kansas. He also was a prolific writer; *The Human Mind*, one of his most popular books, brought psychoanalytic understanding to the lay public. He made a compelling case for the validity of Freud's death instinct in *Man Against Himself*. In *The Vital Balance*, his magnum opus, he formulated a unique theory of psychopathology. Menninger maintained a lifelong interest in the criminal justice system and argued in *The Crime of Punishment* that many convicted criminals needed treatment rather than punishment. Finally, his volume titled *Theory of Psychoanalytic Technique* was one of the few books to examine the theoretical underpinnings of psychoanalysts' interventions. ADOLF MEYER (1866–1950) Adolf Meyer (Fig. 4.3-13) came to the United States from Switzerland in 1892 and eventually became director of the psychiatric Henry Phipps Clinic of the Johns Hopkins Medical School. Not interested in metapsychology, he espoused a commonsense psychobiological methodology for the study of mental disorders, emphasizing the interrelationship of symptoms and individual psychological and biological functioning. His approach to the study of personality was biographical; he attempted to bring psychiatric patients and their treatment out of isolated state hospitals and into communities and was also a strong advocate of social action for mental health. Meyer introduced the concept of common sense psychiatry and focused on ways in which a patient's current life situation could be realistically improved. He coined the concept of *ergasia*, the action of the total organism. His goal in therapy was to aid patients' adjustment by helping them modify unhealthy adaptations. One of Meyer's tools was an autobiographical life chart constructed by the patient during therapy.

FIGURE 4.3-13 Adolf Meyer. (From the National Library of Medicine, Bethesda, MD.) GARDNER MURPHY (1895–1979) Gardner Murphy (Fig. 4.3-14) was born in Ohio and received his Ph.D. from Columbia University. He was among the first to publish a comprehensive history of psychology and made major contributions to social, general, and educational psychology. According to Murphy, three essential stages of personality development are the stage of undifferentiated wholeness, the stage of differentiation, and the stage of integration. This development is frequently uneven, with both regression and progression occurring along the way. The four inborn human needs are visceral, motor, sensory, and emergency-related. These needs become increasingly specific in time as they are molded by a person's experiences in various social and environmental contexts. Canalization brings about these changes by establishing a connection between a need and a specific way of satisfying the need.

FIGURE 4.3-14 Gardner Murphy. (Courtesy of New York Academy of Medicine, New York.) Murphy was interested in parapsychology. States such as sleep, drowsiness, certain drug and toxic conditions, hypnosis, and delirium tend to be favorable to paranormal experiences. Impediments to paranormal awareness include various intrapsychic barriers, conditions in the general social environment, and a heavy investment in ordinary sensory experiences. HENRY MURRAY (1893–1988) Henry Murray (Fig. 4.3-15) was born in New York City, attended medical school at Columbia University, and was a founder of the Boston Psychoanalytic Institute. He proposed the term personology to describe the study of human behavior. He focused on motivation, a need that is aroused by internal or external stimulation; once aroused, motivation produces continued activity until the need is reduced or satisfied. He developed the Thematic Apperception Test (TAT), a projective technique used to reveal both unconscious and conscious mental processes and problem areas.

FIGURE 4.3-15 Henry Murray. (Courtesy of New York Academy of Medicine, New York.) FREDERICK S. PERLS (1893–1970) Gestalt theory developed in Germany under the influence of several men: Max Wertheimer (1880–1943), Wolfgang Köhler (1887–1967), and Lewin. Frederick "Fritz" Perls (Fig. 4.3-16) applied Gestalt theory to a therapy that emphasizes the current experiences of the patient in the here and now, as contrasted to the there and then of psychoanalytic schools. In terms of motivation, patients learn to recognize their needs at any given time and the ways that the drive to satisfy these needs may influence their current behavior. According to the Gestalt point of view, behavior represents more than the sum of its parts. A gestalt, or a whole, both includes, and goes beyond, the sum of smaller, independent events; it deals with essential characteristics of actual experience, such as value, meaning, and form.

FIGURE 4.3-16 Fritz Perls. (Courtesy of the National Library of Medicine.) SANDOR RADO (1890–1972) Sandor Rado (Fig. 4.3-17) came to the United States from Hungary in 1945 and founded the Columbia Psychoanalytic Institute in New York. His theories of adaptational dynamics hold that the organism is a biological system operating under hedonic control, which is somewhat similar to Freud's pleasure principle. Cultural factors often cause excessive hedonic control and disordered behavior by interfering with the organism's ability for self-regulation. In therapy, the patient needs to relearn how to experience pleasurable feelings.

FIGURE 4.3-17 Sandor Rado. (Courtesy of New York Academy of Medicine.) OTTO RANK (1884–1939) An Austrian psychologist and a protégé of Sigmund Freud, Otto Rank (Fig. 4.3-18)

broke with Freud in his 1924 publication, *The Trauma of the Birth*, and developed a new theory, which he called birth trauma. Anxiety is correlated with separation from the mother— specifically, with separation from the womb, the source of effortless gratification. This painful experience results in primal anxiety. Sleep and dreams symbolize the return to the womb.

FIGURE 4.3-18 Otto Rank. (Courtesy of New York Academy of Medicine.) The personality is divided into impulses, emotions, and will. Children’s impulses seek immediate discharge and gratification. As impulses are mastered, as in toilet training, children begin the process of will development. If will is carried too far, pathological traits (e.g., stubbornness, disobedience, and inhibitions) may develop. WILHELM REICH (1897–1957) Wilhelm Reich (Fig. 4.3-19), an Austrian psychoanalyst, made major contributions to psychoanalysis in the area of character formation and character types. The term character armor refers to the personality’s defenses that serve as resistance to self-understanding and change. The four major character types are as follows: the hysterical character is sexually seductive, anxious, and fixated at the phallic phase of libido development; the compulsive character is controlled, distrustful, indecisive, and fixated at the anal phase; the narcissistic character is fixated at the phallic state of development, and if the person is male, he has contempt for women; and the masochistic character is long-suffering, complaining, and self-deprecatory, with an excessive demand for love.

FIGURE 4.3-19 Wilhelm Reich. (Courtesy of New York Academy of Medicine.) The therapeutic process, called will therapy, emphasizes the relationship between patient and therapist; the goal of treatment is to help patients accept their separateness. A definite termination date for therapy is used to protect against excessive dependence on the therapist. CARL ROGERS (1902–1987) Carl Rogers (Fig. 4.3-20) received his Ph.D. in psychology from Columbia University. After attending Union Theological Seminary in New York, Rogers studied for the ministry. His name is most clearly associated with the person-centered theory of personality and psychotherapy, in which the major concepts are self-actualization and self-direction. Specifically, persons are born with a capacity to direct themselves in the healthiest way toward a level of completeness called self-actualization. From his person-centered approach, Rogers viewed personality not as a static entity composed of traits and patterns but as a dynamic phenomenon involving ever-changing communications, relationships, and self-concepts.

FIGURE 4.3-20 Carl Rogers. (Courtesy of the National Library of Medicine.) Rogers developed a treatment program called client-centered psychotherapy. Therapists attempt to produce an atmosphere in which clients can reconstruct their strivings for self-actualization. Therapists hold clients in unconditional positive regard, which is the total nonjudgmental acceptance of clients as they are. Other therapeutic practices include attention to the present, focus on clients’ feelings, emphasis on process, trust in the potential and self-responsibility of clients, and a philosophy grounded in a positive attitude toward them, rather than a preconceived structure of treatment. JEAN-PAUL SARTRE (1905–1980) Born in Paris, Jean-Paul Sartre wrote plays and novels before turning to psychology. He was a German prisoner of war from 1940 to 1941 during World War II. Influenced by the ideas of Martin Heidegger, he developed what he called existential psychoanalysis. The reflective self was a key concept in Sartre’s psychology. He recognized that humans alone could reflect on themselves as objects, so that the experience of “being” in humans is unique in the natural world. This capacity to reflect leads humans to impose a meaning on existence. For Sartre, this meaning allows a human being to create his or her own essence. Sartre

denied the realm of the unconscious; he thought that human beings were condemned to be free and to face the fundamental existential dilemma—their aloneness without a god to provide meaning. As a result, each individual creates values and meanings. Neurosis is an escape from freedom, which is the key to maintaining psychological health. Sartre made no distinction between philosophy and psychology. Psychologists, as with philosophers, search for the truth about

the world. Part of this truth, in Sartre's view, was the dialectic between consciousness and being. Consciousness introduces nothingness and is a negation of being-in-itself. Ideals are revealed in actions, not in professed beliefs. B. F. SKINNER (1904–1990) Burrhus Frederic Skinner (Fig. 4.3-21), commonly known as B. F. Skinner, received his Ph.D. in psychology from Harvard University, where he taught for many years. Skinner's seminal work in operant learning laid much of the groundwork for many current methods of behavior modification, programmed instruction, and general education. His global beliefs about the nature of behavior have been applied more widely, it can be argued, than those of any other theorist except, perhaps, Freud. His impact has been impressive in scope and magnitude. FIGURE 4.3-21 B. F. Skinner. (Courtesy of New York Academy of Medicine, New York.) Skinner's approach to personality was derived more from his basic beliefs about behavior than from a specific theory of personality per se. To Skinner, personality did not differ from other behaviors or sets of behaviors; it is acquired, maintained, and strengthened or weakened according to the same rules of reward and punishment that alter any other form of behavior. Behaviorism, as Skinner's basic theory is most commonly known, is concerned only with observable, measurable behavior that can be operationalized. Many abstract and mentalistic hallmarks of other dominant personality theories have little place in Skinner's framework. Concepts such as self, ideas, and ego are considered unnecessary for understanding behavior and are shunned. Through the process of operant conditioning and the application of basic principles of learning, persons are believed to develop sets of behavior that characterize their responses to the world of stimuli that they face in their lives. Such a set of responses is called personality.

HARRY STACK SULLIVAN (1892–1949) Harry Stack Sullivan (Fig. 4.3-22) is generally acknowledged as the most original and distinctive American-born theorist in dynamic psychiatry. When psychiatrists use the term parataxic distortion, apply the concept of self-esteem, consider the importance of preadolescent peer groups in development, or view a patient's behavior as an interpersonal manipulation, they are applying concepts Sullivan first proposed. FIGURE 4.3-22 Harry Stack Sullivan. (Courtesy of the National Library of Medicine.) Sullivan described three modes of experiencing and thinking about the world. The prototaxic mode is undifferentiated thought that cannot separate the whole into parts or use symbols. It occurs normally in infancy and also appears in patients with schizophrenia. In the parataxic mode, events are causally related because of temporal or serial connections. Logical relationships, however, are not perceived. The syntactic mode is the logical, rational, and most mature type of cognitive functioning of which a person is capable. These three types of thinking and experiencing occur side by side in all persons; it is the rare person who functions exclusively in the syntactic mode. The total configuration of personality traits is known as the self-system, which develops in various stages and is the outgrowth of interpersonal experiences, rather than an unfolding of intrapsychic forces. During infancy, anxiety occurs for

the first time when infants' primary needs are not satisfied. During childhood, from 2 to 5 years, a child's main tasks are to learn the requirements of the culture and how to deal with powerful

adults. As a juvenile, from 5 to 8 years, a child has a need for peers and must learn how to deal with them. In preadolescence, from 8 to 12 years, the capacity for love and for collaboration with another person of the same sex develops. This so-called chum period is the prototype for a sense of intimacy. In the history of patients with schizophrenia, this experience of chums is often missing. During adolescence, major tasks include the separation from the family, the development of standards and values, and the transition to heterosexuality. The therapy process requires the active participation of the therapist, who is known as a participant observer. Modes of experience, particularly the parataxic, need to be clarified, and new patterns of behavior need to be implemented. Ultimately, persons need to see themselves as they really are, instead of as they think they are or as they want others to think they are. Sullivan is best known for his creative psychotherapeutic work with severely disturbed patients. He believed that even the most psychotic patients with schizophrenia could be reached through the human relationship of psychotherapy.

DONALD W. WINNICOTT (1896–1971) Donald W. Winnicott (Fig. 4.3-23) was one of the central figures in the British school of object relations theory. His theory of multiple self-organizations included a true self, which develops in the context of a responsive holding environment provided by a good-enough mother. When infants experience a traumatic disruption of their developing sense of self, however, a false self emerges and monitors and adapts to the conscious and unconscious needs of the mother; it thus provides a protected exterior behind which the true self is afforded a privacy that it requires to maintain its integrity.

FIGURE 4.3-23 Donald Winnicott. (Courtesy of New York Academy of Medicine, New York.) Winnicott also developed the notion of the transitional object. Ordinarily a pacifier, blanket, or teddy bear, this object serves as a substitute for the mother during infants' efforts to separate and become independent. It provides a soothing sense of security in the absence of the mother. The case history below illustrates how the different psychodynamic schools discussed in this chapter can be applied to the clinical observations of a patient. Mr. A was a 26-year-old white man who had a history of bipolar I disorder. He was brought in for treatment after not completing the last required course for his advanced degree and being arrested for disturbing the peace. He had consistently lied to his family about where he stood with his coursework and about having skipped an examination that would have qualified him to use his professional degree. He had also not told them that he had been using marijuana almost daily for a number of years and occasionally used hallucinogens. His arrest for disorderly conduct was for swimming naked in an apartment complex in the middle of the night while under the influence of hallucinogens. Mr. A's use of marijuana began early in college but became daily during graduate

school. He was diagnosed as having bipolar I disorder early in his senior year at college after a clear episode of mania. His mood disorder was well controlled on lithium (Eskalith). During graduate school, he was episodically compliant with medications, preferring to try to maintain a state of hypomania. He saw a psychiatrist every 3 to 6 months for medication checks. During his 4 years in graduate school, he had two clear episodes of depression and began taking sertraline (Zoloft), 100 mg per day, with questionable benefit. Mr. A believed that he could be a great writer. He spent most of his time reading and trying to write. He dreamed of going to New York and becoming part of a group of avant-garde writers that would parallel the Algonquin Club of the 1930s or the Beat poets of the late 1940s. This aspiration and his marijuana abuse predated his development of bipolar I disorder. He attended class episodically, nonetheless performing adequately. His last class had no final examination but required a paper. He planned to write this

paper in the form of a play, involving a dialogue between two thinkers from different times and cultures. His professor was very excited about this idea, but Mr. A kept postponing the task until he was forced to extend his schooling by a year. His other major interest during this time involved growing and photographing flowers. Mr. A was born and raised in a large city. His father had been very successful in commercial real estate, and his mother, after raising the children, used the substantial real estate holdings she inherited from her father to set up a business to manage them. Most of the money was placed in a trust for the patient and his siblings. His mother had total financial control of the trusts and doled out the proceeds to the children as they needed them. There was no family history of any psychiatric disorders. The patient described his mother as very loving and caring but to the point of being intrusive and controlling. For example, the mother arranged the initial treatment but then was angry that the psychiatrist had not called her regularly to report on her adult son's progress. She was also critical of various aspects of the treatment as reported to her by her son. The patient's two older siblings had attended prestigious colleges and graduate schools but had returned home to work in the mother's real estate management company. The 30-year-old sister was living in the parents' home. The 35-year-old brother had lived at home for a time but then moved out to a location a few blocks away. There was a younger brother, still in college, who also smoked marijuana excessively. He tried to minimize the patient's problems to the family and tried to protect the patient, who desperately had not wanted to return home. Of note is that none of the children were married, although the two older ones had each had a couple of serious relationships. The children seemed to regard the mother with affectionate amusement and bemusement. The father was seen as a very caring but undemonstrative man who put much energy into keeping the mother from becoming too upset and encouraged the children to do the same. The children often wanted to provoke the mother for her judgmental, detail-oriented intrusiveness. The father discouraged them but occasionally found their provocations amusing. The family viewed itself as very close, with strong values oriented toward

community service and family loyalty. The family belonged to a religious community but expressed their involvement primarily in social service and social action volunteer work, accompanied by very generous financial contributions. The patient had been a very successful debater in high school and recalled his development as very positive but provided few details. He tended to place himself in the role of the outsider, an observer of humanity, which he saw as consonant with the role of a writer. He was proud to have bipolar I disorder and tried to regulate his medications so that he would be hypomanic much of the time, seeing this as enhancing his creativity. He viewed his use of marijuana in the same vein. One of the most distressing aspects to him of his depressive episodes was that marijuana no longer created a feeling of well-being but made him feel worse. His current depressive episode involved no neurovegetative symptoms. Rather, he presented as flat, numb, apathetic, ashamed, anhedonic, and anergic. He was particularly ashamed of being back in his hometown and of living with his parents. The patient ostensibly understood and accepted his illness well and had read much about it. However, the family had responded to the information "with proper treatment, bipolars can live normal lives" as meaning that the information should be kept secret so that he should be treated normally. Mr. A, on the other hand, was very open with friends at graduate school about his illness and his pride in it and the creativity he associated with it. The patient had two long-standing recurrent dreams. One involved him flying. The narrative line varied, but the flying theme recurred. Often, he had other magical powers in his dreams such as the ability to heal, to not be killed by bullets, to save the world or some group of people from mortal danger, and so on. The other recurrent dream was of a hotel lobby. These dreams regularly

began with him entering a hotel lobby to meet a group of people, accompanied by a feeling of dread.

REFERENCES Caldwell L, Joyce A, eds. Reading Winnicott. New York: Routledge; 2011.

DeRobertis EM. Deriving a third force approach to child development from the works of Alfred Adler. *J Hum Psychol*. 2011;51:492.

DeRobertis EM. Winnicott, Kohut, and the developmental context of well-being. *Hum Psychol*. 2010;38(4):336.

Funk R, ed. *The Clinical Erich Fromm: Personal Accounts and Papers on Therapeutic Technique*. New York: Editions Rodopi B.V.; 2009.

Guasto G. Welcome, trauma, and introjection: A tribute to Sandor Ferenczi. *J Am Acad Psychoanal Dynam Psych*. 2011;39(2):337.

Kernberg O. Narcissistic personality disorder. In: Clarkin JF, Fonagy P, Gabbard GO, eds. *Psychodynamic Psychotherapy for Personality Disorders: A Clinical Handbook*. Arlington, VA: American Psychiatric Publishing; 2010:257.

Kirshner LA, ed. *Between Winnicott and Lacan: A Clinical Engagement*. New York: Routledge; 2011.

Kiselica AM, Ruscio J. Scientific communication in clinical psychology: examining patterns of citations and references. *Clin Psychol Psychother*. 2014;21:13-20.

Lachman G. *Jung the Mystic: The Esoteric Dimensions of Carl Jung's Life and Teachings: A New Biography*. New York:

# 04 - 4.4 Positive Psychology

## 4.4 Positive Psychology

Penguin; 2010. Mohl PC, Brenner AM. Other psychodynamic schools. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Vol. 1. Philadelphia: Lippincott Williams & Wilkins; 2009:847. Palombo J, Bendicson HK, Koch BJ. Guide to Psychoanalytic Developmental Theories. New York: Springer; 2009. Pattakos A, Covey SR. Prisoners of Our Thoughts: Viktor Frankl's Principles for Discovering Meaning in Life and Work. San Francisco: Berrett-Koehler; 2010. Paul HA. The Karen Horney clinic and the legacy of Horney. *Am J Psychoanal.* 2010;70:63. Revelle W. Personality structure and measurement: The contributions of Raymond Cattell. *Br J Psychol.* 2009; 100(S1):253. Schwartz J. The vicissitudes of Melanie Klein. Or, what is the case? *Attach New Direc Psychother Relation Psychoanal.* 2010;4(2):105. Stein M, ed. *Jungian Psychoanalysis: Working in the Spirit of Carl Jung.* Chicago: Open Court; 2010.

### 4.4 Positive Psychology

Positive psychology is an umbrella term describing the scientific study of what makes life most worth living. Research findings from positive psychology are intended to provide a more complete and balanced scientific understanding of the human experience. The new field of positive psychology calls for as much focus on strength as on weakness, as much interest in building the best things in life as in repairing the worst, and as much concern with making the lives of normal people fulfilling as with healing pathology. Positive psychology does not replace business-as-usual psychology, which often focuses on people's problems and how to remedy them. Rather, positive psychology intends to complement and extend a problem-focused psychology. The attention of positive psychologists is increasingly turning to deliberate interventions that promote the well-being of individuals and groups, and again, these should be regarded as supplements to existing therapies. Positive psychology studies what goes right in life, from birth to death. It is concerned with optimal experience—people being their best and doing their best. Everyone's life has peaks and valleys, and positive psychology does not deny the low points. Its signature premise is more nuanced: What is good about life is as genuine as what is bad and therefore deserves equal attention from psychologists. Positive psychology assumes that life entails more than avoiding or undoing problems and that explanations of the good life must do more than reverse accounts of distress and dysfunction.

#### EMPIRICAL FINDINGS

Although still a young field, positive psychology already has a canon of established findings worth considering. Indeed, positive psychology is a bottom-up field, very much defined by its empirical results. Discussed below are some of the things that have been learned about positive experiences, positive traits, positive relationships, and positive institutions. When psychologists study self-reported happiness and life satisfaction, usually under the rubric of subjective well-being, they administer numerical rating scales. The

consistent and perhaps surprising result is that most people in most circumstances most of the time score above the scale midpoint, whether they are multimillionaires in the United States or pavement dwellers in Calcutta. This conclusion holds across demographic characteristics like age,

sex, ethnicity, and education, each of which has a surprisingly small association with avowed happiness. The important correlates of happiness are social in nature. In contrast to the modest demographic correlates of happiness and well-being, consider the following robust correlates: Number of friends Being married Being extroverted Being grateful Being religious Pursuing leisure activities Employment (not income) In a study that compared happy people to very happy people, there was one striking difference: good relationships with other people. Of the very happy people in the sample, all had close relationships with others. Psychology research documents very few necessary or sufficient conditions, but these data suggest that good social relationships may be a necessary condition for extreme happiness. People who are successful in life's venues are of course happy, but the less obvious and more interesting finding from experimental and longitudinal research is that happiness actually foreshadows success in academic, vocational, and interpersonal realms. Having good relationships with other people is the most important contributor to a satisfied life and may even be a necessary condition for happiness. Having a "best friend" at work is a strong predictor of satisfaction and even productivity. A good relationship is one in which the amount of positive communication considerably outweighs the amount of negative communication. Positive psychologists have taken a close look at the features of positive communication, describing four ways in which a person can respond to someone else when something happens, including good events such as a raise at work: Active-constructive responding—an enthusiastic response: "That's great; I bet you'll receive many more raises." Active-destructive responding—a response that points out the potential downside: "Are they going to expect more of you now?" Passive-constructive responding—a muted response: "That's nice dear." Passive-destructive responding—a response that conveys disinterest: "It rained all day here."

Couples who use active-constructive responding have good marriages. The other responses, if they dominate, are associated with marital dissatisfaction. Although this research has only been done in the context of marriage, it may well generalize to other relationships. Psychology and psychiatry have a long history of either ignoring religion or regarding it with suspicion. However, research findings have begun to accumulate showing that religion has certain benefits in a variety of psychological domains. Internalized religious beliefs may help a person to cope with problems and even avoid physical illness in the first place. Religiousness is robustly associated with longevity, happiness, and other indices of the life lived well. People who are so poor that they cannot meet their basic needs of course are unhappy, but above extreme poverty, increased income has a surprisingly small relationship with life satisfaction. Despite the small contribution of income to well-being, whether or not someone is working is much more strongly related to happiness. People who are employed and engaged in what they do are happy, regardless of the status or compensation associated with their job. Happiness and engagement lead people to regard their work as a calling and to be more productive at whatever they do, take fewer sick days, and even postpone their retirement. According to Aristotle's notion of eudaimonia—being true to one's inner self (demon) —true happiness entails identifying one's virtues, cultivating them, and living in accordance with them. Contrast this notion with the equally venerable idea of hedonism —pursuing pleasure and avoiding pain—that is the foundation for utilitarianism, which in turn provides the underpinning of psychoanalysis and all but the most radical of the behaviorisms. Research shows that eudaimonia consistently trumps pleasure as a predictor of life satisfaction. Those who pursue eudaimonic goals and activities are more satisfied than those who pursue pleasure. This is not to say that hedonism is irrelevant to life satisfaction, just that all things being equal, hedonism contributes less to longterm happiness than does eudaimonia. Although the study of positive

institutions is in its infancy, there is agreement that institutions that allow people to flourish—whether families, schools, workplaces, or even entire societies—share a core of common characteristics: Purpose—a shared vision of the moral goals of the institution, one reinforced by remembrances and celebrations Safety—protection against threat, danger, and exploitation Fairness—equitable rules governing reward and punishment and the means for consistently enforcing them Humanity—mutual care and concern Dignity—the treatment of all people in the institution as individuals regardless of their position Psychologists, at least in the United States, have long believed that the human

condition can be improved by the intelligent application of what they have learned. Positive psychologists are no exception, and many have turned their attention to interventions that make people more happy, hopeful, virtuous, accomplished, and socially involved. In some cases, these applications are running in front of data that would support them, but in other cases, outcome research has been done. Even the most compelling research is not based on follow up that extends beyond a few years, and the research participants are usually motivated and willing volunteers. How well these interventions will generalize—across diverse people and over time—is therefore a research topic of high priority. **POSITIVE PSYCHOLOGY AND CLINICAL WORK** When positive psychology was first described, its stated goal was not to move people from -5 to zero—the goal of conventional psychology and psychiatry—but rather from +2 to +5, within the upper right-hand quadrant of Figure 4.4-1. This emphasis on promotion as opposed to remediation is an important feature of a positive psychology perspective, but it does not do justice to this new field and its potential role in clinical work. **FIGURE 4.4-1** Mental health and mental illness. These are dimensions. Quadrants are shown for the purpose of illustration only. (From Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009:2942, with permission.)

**Positive Psychology's Vision of Psychological Health** In its 1948 constitution, the World Health Organization (WHO) defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” In more recent years, this statement has been expanded to include the ability to lead a life that is socially and economically productive. This definition is an important declaration that health entails more than the absence of illness, but it is circular, inasmuch as “well-being” is a synonym for “health.” Work by positive psychologists makes this definition more concrete and thus useful as a guide for research and intervention. If one can extrapolate from the sorts of topics that have been studied, positive psychology assumes that people are doing well when they experience more positive feelings than negative feelings, are satisfied with their lives as they have been lived, have identified what they do well and use these talents and strengths on an ongoing basis, are highly engaged in what they do, are contributing members of a social community, and have a sense of meaning and purpose in their lives. Physical health and safety, of course, provide an important context for psychological well-being. It is difficult to imagine a cultural group in which these components of the good life are not valued. Respect for human diversity need not entail extreme cultural relativism. Note that this fuller characterization of health reflects the WHO definition and is drawn from research in all of the domains of concern to contemporary positive psychology. The relevant research cautions that health so defined is not unitary. No one can have it all, at least at the same time, given tradeoffs among the psychological states and traits that reflect doing well. Psychological health, therefore, needs to be described with a profile of features and not a single summary score. The fifth edition of the Diagnostic and

Statistical Manual of Mental Disorders [DSM-5] describes hundreds of psychological problems, however there may be just as many different manifestations of the good life. Theory of Psychopathology As a perspective on topics that deserve scientific study, positive psychology has no single theory. Like much of contemporary psychology, it instead relies on midrange theories that draw on a variety of larger perspectives, from evolutionary to behavioral to cognitive to sociocultural models, to make sense of specific phenomena. Different topics are explained with different theories. The eventual integration of psychology may be a worthy goal, but it has not yet been achieved. At this early point in the development of positive psychology, the lack of a consensual or integrated theory is not a problem. The psychological good life is not yet understood, and positive psychologists are still grappling with the right vocabulary to describe it. Accordingly, championing a single theory at the present time would be premature, even counterproductive. It has been argued that positive psychology is a descriptive endeavor, not a

prescriptive one. If this means that positive psychology should be an empirical science— informed by replicable facts—then this claim is reasonable and a defining feature of the entire field. If this means that positive psychology is assumption free or value neutral, the claim becomes much more difficult to defend. After all, positive psychologists make the value judgment that the “good” life is indeed good—that is, desirable, morally and otherwise—and the metatheoretical assumption that the good life can be studied with the conventional methods of psychology. In any event, positive psychology seems no more prescriptive than clinical psychology or psychiatry. It may even be less so, given the theoretical diversity of positive psychology as it now exists. Positive Psychology Assessment Assessment has long been a staple of psychology, and much of it has been tilted— understandably—toward identifying weaknesses, deficiencies, and problems. The positive psychology perspective is that business-as-usual assessment should be expanded (not replaced) by attention to areas of strength and competence. Low life satisfaction can occur in the absence of psychopathology, but it is nonetheless related to psychological and social problems. Conversely, high life satisfaction is linked to good functioning even in the presence of symptoms. Positive psychologists have developed an impressive set of measurement instruments that allow someone doing assessment to break through the zero point of deficiency measures. For example, the healthiest that one can score on a typical measure of depression is zero, but this lumps together people who are blasé with those who are filled with zest and joy. The distinction seems well worth making, and the self-report surveys and interviews developed by positive psychologists allow it. Most of the existing positive psychology measures were developed for research purposes, and they are most valid when aggregated to yield conclusions about groups of people. They can also be used ipsatively (i.e. forced to choose between two options), to describe the psychological characteristics of an individual and how they stay the same or change over time, but the cautious use of these descriptions is a point of discussion and a departure in treatment. None is a strong diagnostic test, and none should be treated as if it were. Such prudence is appropriate for all psychological assessment, but it is worth emphasizing in the special case of positive psychology measures. Positive Psychology Techniques Positive psychologists have demonstrated that brief interventions in the short term can increase happiness, satisfaction, and fulfillment. In some cases, there is also evidence that they can alleviate depression. For example, patients or clients can be asked to count their blessings: Every night for 1 week, set aside 10 minutes before you go to bed. Use that time to write down three things that went really well on that day and why they went well. You may use a journal or your computer to write about the events, but it is important that you have a physical record of what you wrote. It is not enough to do this exercise in your head. The

three things you list can be relatively small in importance or relatively large in importance. Next to each positive event in your list, answer the question, “Why did this good thing happen?” They can also be asked to use their strengths in novel ways. They take the Values in Action Inventory of Strengths (VIA-IS) questionnaire online and identify their most signature strengths of character. Then they are instructed to use these strengths in their daily life: Every day for the next 7 days use one of your top five strengths in a way that you have not before. You might use your strength in a new setting or with a new person. It’s your choice. Outcome research shows that a variety of psychotherapies are effective in alleviating problems and usually equally so, despite the different forms they take. One interpretation of the equal effectiveness of different therapies is that nonspecific factors common to all treatments are responsible. Perhaps the types of strategies being studied by positive psychologists reflect these common factors and give names to them. Strategies like instilling hope and building strengths may be the critical factors in the effectiveness of any therapy. Some qualifications are in order if these techniques are used in the context of treatment. First, the therapist must ascertain a client’s readiness to change in the particular ways requested in the exercise as well as the client’s capacity to make the change. Like any psychotherapeutic procedure, these techniques cannot be imposed on the unwilling or the unable. Second, none of these techniques is akin to a crash diet or an antibiotic. The degree to which they have lasting effects is related to how patients or clients integrate them into their regular behavioral routines. Counting blessings for a week will make a person happier for that week, but only if the person becomes habitually grateful will there be a more enduring effect. Research finds—not surprisingly—that the people who showed lasting benefits were those who continued to use the exercise. Third, these exercises are typically presented as one size fits all, but there is no reason to think that they are equally useful for all patients or clients. Nothing is known about the match of an exercise with a client’s particular presenting problems or goals or with a client’s age, sex, social class, or ethnicity. Fourth, little is known about the parameters of these interventions. For example, how many blessings should one count, and how frequently should this be done? With college students, counting blessings three times a week may be more effective in increasing happiness than counting them more frequently. Is this a general phenomenon or one specific to young adults attending college? Fifth, all interventions run the risk of unintended harm, and although positive psychologists would like to believe that their techniques avoid iatrogenic effects, this assertion cannot be made with thorough confidence. For example, although optimism is related to mental and physical health, it would be simplistic and potentially hazardous to tell patients or clients that positive expectations will solve all their difficulties. Along

these lines, if a positive psychology intervention overemphasizes a client’s choice and responsibility, considerable damage could be done in cases of abuse and victimization, in which self-blame needs to be undone and certainly not encouraged. Interventions based on positive psychology should not preclude the use of existing therapeutic strategies when these are indicated. Positive Psychotherapies Positive psychotherapies are beginning to appear: therapeutic interventions based on the theories and findings of positive psychology. What distinguishes these emerging positive psychotherapies from conventional treatments is that their stated goal is not symptom reduction or relief but rather enhanced happiness, life satisfaction fulfillment, productivity, and the like—one or more components of positive psychology’s vision of the good life. These new therapies target people with psychological problems as well as those without them. In the latter case, positive psychotherapies make contact with life coaching. The possible field of positive psychotherapies is so broad that it needs narrowing, and somewhat arbitrarily, the focus

here is on approaches characterized by an explicit therapeutic alliance between the positive psychologist and the patient or client. This feature goes by many names and has been variously defined, but its recurring themes include collaboration between therapist and client, an affective bond between them, and agreement on the goals and tasks of the intervention. Asking people to write about their goals or to perform acts of kindness, despite beneficial consequences, may or may not be instances of positive psychotherapy—what matters is the relational context of the request. Taking Stock. The unique and explicit goal of emerging positive psychotherapies is to enhance well-being and to promote the good life among those with obvious psychological problems as well as those without them. They are also similar to more established therapies. Positive psychotherapies are short-term, structured interventions for individuals or small groups. Most can be placed in the cognitive-behavioral realm, although their techniques could be integrated easily into other treatment models. Most positive psychotherapies entail out-of-sessions exercises and homework assignments, the results of which are discussed in sessions. A number of positive psychotherapies rely on journal-keeping, and many of these therapies rely on ongoing assessment. Like other cognitive-behavioral interventions, positive psychotherapies take issue with assumptions of the medical model that people in treatment are ill and that their problems are best described as discrete (present-or-absent) entities as in DSM-5. According to positive psychology, people's weaknesses and strengths exist in degrees. As emphasized, research support is still accumulating. Enough outcome studies have been conducted to conclude that positive psychotherapies are more than just promising, with effect sizes in the small to moderate range typical of psychological interventions. Not known in most cases is how positive psychotherapies fare in direct comparison with

conventional treatments for anxiety or depression. In addition, as already mentioned, the boundary conditions of effective positive psychotherapy are unknown. Many positive psychologists would like to believe that a strengths-based approach to change is superior to one that focuses on the remediation of deficiencies, but this hypothesis has yet to be put to serious test. The even-handed suspicion is that attention to both strengths and weaknesses is critical and that no useful purpose is served by regarding these as mutually exclusive therapeutic strategies. REFERENCES Aviezer H, Trope Y, Todorov A. Body cues, not facial expressions, discriminate between intense positive and negative emotions. *Science*. 2012;338:1225. Efklides A, Moraitou D, eds. *A Positive Psychology Perspective on Quality of Life*. New York: Springer Science+Business Media; 2013. Giannopoulos VL, Vella-Brodrick DA. Effects of positive interventions and orientations to happiness on subjective wellbeing. *J Positive Psychol*. 2011;6(2):95. Huffman JC, DuBois CM, Healy BC, Boehm JK, Kashdan TB, Celano CM, Denninger JW, Lyubomirsky S. Feasibility and utility of positive psychology exercises for suicidal inpatients. *Gen Hosp Psychiatry*. 2014;36:88–94. Linley PA, Joseph S, Seligman MEP, eds. *Positive Psychology in Practice*. Hoboken, NJ: Wiley; 2004. Peterson C. *A Primer in Positive Psychology*. New York: Oxford University Press; 2006. Peterson C, Park N. Positive psychology. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009:2939. Reynolds HR. Positive behavior intervention and support: Improving school behavior and academic outcomes. *N C Med J*. 2012;73(5):359. Sheldon KM, Kashdan TB, Steger MF. *Designing Positive Psychology: Taking Stock and Moving Forward*. New York: Oxford University Press; 2011. Snyder CR, Lopez SJ. *Oxford Handbook of Positive Psychology*. 2nd ed. New York: Oxford University Press; 2009. Snyder CR, Lopez SJ, Pedrotti JT. *Positive Psychology: The Scientific and Practical Explorations of Human Strengths*. 2nd ed. Thousand Oaks: Sage; 2010.