TR 87-30
V

THE INTERPERSONAL DIMENSION OF PSYCHOPATHOLOGY

S. A. O'DOWD

In its own intrinsic structure subjectivity is already, and in the most profound sense, intersubjective.

Gabriel Marcel, The Mystery of Being.

Thesis submitted in partial fulfillment of the requirements for the M. A. (Clinical Psychology), Rhodes University, Grahamstown, December 1986.

ABSTRACT.

It is argued that two large groups of disorders can be distinguished in the field of psychopathology, (1) which divide between them the psychoses, neuroses and personality disorders; (2) the dynamics of which are those of Klein's paranoid-schizoid and depressive positions, respectively; and (3) which are distinguished by nine basic contrasts in symptomatology and dynamics, all of which are expressive of the opposition self-centred/other-centred. These three hypotheses form the <u>interpersonal model of psychopathology</u>, and are supported by argument from works of Foulds, Jung, Abraham, Fairbairn, Klein, Angyal, Winnicott and Heidegger. It is suggested that the interpersonal model can facilitate the dialogue between psychoanalysis and phenomenology.

CONTENTS.

Preface. i

1: Beyond the medical model: the two axes of psychopathology. 1

1.1: The medical and hierarchical models of psychopathology. 1

1.2: From hierarchy to wholeness. 5

1.3: The scope and limits of this work. 19

2: The two groups in classical psychoanalysis. 21

2.1: Jung's comparison of hysteria and schizophrenia. 21

2.2: Abraham's comparison of obsessive-compulsive neurosis and psychotic depression. 24

2.3: Conclusion. 26

3: Fairbairn's group of schizoid disorders. . 29

3.1: Disorders of the schizoid position. 29

3.2: The etiology and dynamics of the schizoid position. 34

3.3: Fairbairn's ethical focus. 38

4: The Kleinian theory of the psychoses. 41

4.1: Anxieties and object relations. 42

4.2: The schizoid position. 47

4.3: The paranoid position. 49

4.4: The manic position. 52

4.5: The depressive position. 55

4.6: Conclusions. 59

5: Angyal's theory of the neuroses. 62

5.1: The basic assumptions of Angyal's theory. 63

5.2: The etiology and dynamics of vicarious living. 65

5.3: The etiology and dynamics of noncommitment. 69

5.4: The self-centred/other-centred polarity in Angyal's work. 75

6: The two groups of personality disorders. . 78

6.1: Groups and levels of personality disorders. 79

6.2: The dynamics of the two groups of personality disorders. 82

6.3: Conclusion. 84

7: Winnicott and Heidegger: beyond the self-centred/other-centred polarity. 86

7.1: Winnicott: boundary and space. 87

7.2: Heidegger: inauthentic and authentic being. 91

8: Conclusions and questions. 95

8.1: The basis of the interpersonal model of psychopathology. 97

8.2: The theoretical status of the axis of relatedness. 106

8.3: The Kleinian move towards phenomenology. 109

Footnotes. 116

References. 118

PREFACE.

Psychoanalysis is a discipline founded in interpersonal relations. Thus the therapeutic relationship is both its source of data and the place where its theories are put to the test. In the light of this it is ironical that psychoanalysis has in fact tended to underemphasise the interpersonal dimension in its theories, especially its theories of psychopathology. In conceptualizing psychopathology psychoanalysis has from its early days until very recently stuck rather rigidly to a developmental theory which states in essence that disorders can be ranked in order of decreasing severity, which order corresponds to the sequence of developmental stages, fixations at and/or regressions to which cause the various disorders.

The 'orthodox' psychoanalytic view conceptualizes interpersonal relations as part of this developmental model: the infant starts in a state of primary narcissism, relating only to itself, and forms relations with others only in the course of development. This view justified Freud's (1916/17) distinction bewteen transference neuroses and narcissistic neuroses (psychoses). With the latter, Freud argued, the individual has retreated into narcissism and cannot form a therapeutic relationship, and only the former are treatable by psycho- m analysis. Subsequent experience has not supported this distinction; it is now widely accepted that the earliest developmental stages involve not an absence of relatedness but a fusion of self and other (Jacobson, 1954; Mahler et al., 1975; Winnicott, 1965, 1965a), and that the psychoanalysis of the psychoses, although difficult, is by no means impossible (Rosenfeld, 1965).

Phenomenology, in contrast, has always seen relatedness as central to human existence (Heidegger, 1927) and to psychopathology (Boss, 1979). However, it was Buber (Brice, 1984) who came closest to making the distinction which is the focus of this work, between self-centred and other-centred relatedness. To grasp this distinction we can refer back to the therapeutic relationship. As is well known, in any successful psychoanalysis the patient develops a transference, responding to the analyst according to the habits and expectations of childhood. The analyst can react in one of two ways: he or she may be overwhelm-ed by personal responses to the transference expectations, succumbing to the counter-transference and in effect obscuring the patient's needs. This is a self-centred mode of response. Alternatively, the analyst may be able to grasp the significance of what is happening for the patient, thus adopting an other-centred position.

Lest the reader be tempted to equate self-centredness with narcissism and see it as a necessarily less adaptive, more regressed mode, let us take another example. If the two were not analyst and patient but lovers, and the one still adopted a consistently other-centred position, this would come in time to seem unsatisfying and evasive to the other, obscuring the one's personal reactions and feelings. In Buber's terms, the full mutuality of the I-Thou relationship is lost if either the I is overvalued (as in narcissism) or the Thou (as in dependency) (Brice, 1984).

As they are treated in this work, the self-centred and other-centred modes of relatedness are not seen in developmental terms, but rather as constituting a second axis, cutting across the developmental axis. Thus the field of psychopathology is structured by both the develop-

mental axis and the axis of relatedness. The particular focus of this work is on the latter, on what phenomena in the field of psychopathology it can account for, and on how the axis of relatedness can be conceptualized. The central argument is, firstly, that while different levels of severity of pathology (the 'vertical' axis) can be related to different developmental stages, there is also a 'horizontal' division of the field into self-centred and other-centred groups of disorders, a division which applies at all levels of severity. Thus a division into two 'horizontal' groups can be made in the psychoses (Chapter 4), neuroses (Chapter 5) and the personality disorders (Chapter 6).

Secondly, it is argued that the dynamics of the two groups of disorders are those of the two libidinal positions: Fairbairn's (1940, 1941) schizoid and depressive (Chapter 3), or Klein's (1935, 1946) paranoid-schizoid and depressive (Chapter 4). Thus the concept of libidinal position means for the horizontal groups what developmental stage means for the vertical levels: it is the central concept in the account of the dynamics of the various disorders. This conception obviously entails seeing the libidinal positions in a non-developmental way, as each having an influence at all levels of severity; this contradicts the original view of Fairbairn and Klein, but is quite consistent with the view of contemporary Kleinians such as Meltzer (1978) and Rey (Note 2).

Thirdly, it is argued that the contrasting phenomena of the two groups of disorders express a constant and fundamental theme: the contrast between self-centred and other-centred relatedness. To demonstrate this, nine different contrasts between the two groups

are identified, in the spheres of affect and cognition (Chapter 2), ethics (Chapter 3), anxieties, modes of identification, defences and motivation (Chapter 4), etiology (Chapter 5), and interpersonal boundaries (Chapter 7). As each contrast is isolated, it is shown to express the self-centred/other-centred polarity. The implication of this is that the paranoid-schizoid position is characterized by self-centred relatedness and the depressive by other-centred relatedness, and that the horizontal axis of psychopathology is indeed an axis of modes of relatedness - the interpersonal dimension of psychopathology.

Finally, it is argued in Chapter 7 that the polarization of relatedness into self-centred and other-centred forms is central to psychopathology, and equally, the key to integration is overcoming the self/other polarity. In Chapter 8 the evidence is reviewed as a whole, and various issues arising from the argument are touched on, including its relevance to the debate between psychoanalysis and phenomenology.

If the model of psychopathology sketched above is at all valid, then it has a number of significant practical applications. Firstly, it allows one to conceptualize psychopathology in a way that can be more fully related to the therapeutic situation than the developmental model on its own. The latter tends to restrict the view of the therapeutic relationship to one between a more integrated, more 'adult' therapist and a more 'childish' patient, a view with dangerous authoritarian overtones. Not that one can ever deny the potential power of the therapist - that would be irresponsibly naive. But the concept of an axis of relatedness allows one to see in add-

ition to this the modes of relatedness adopted by the therapist and client, and in this perspective the therapist and patient meet more as equals. More generally, the concept of modes of relatedness can provide a bridge between the understanding of individual psychopathology and family and social forms. These issues are beyond the scope of this work, but they do serve to illustrate the importance of the undertaking. This is not to say that the model presented here can be justified by these possibilities which it opens up - on the contrary, the approach is to justify it solely in terms of the data of individual psychopathology.

This work owes a great deal to the intellectual hospitality of the Rhodes Psychology Department: the attitude there which is open to phenomenology, psychoanalysis and analytical psychology, to their disagreements and to the potential for fruitful debate between them. I have here, in a small way, attempted to express this spirit, and carry the debate further. More specifically, I am most grateful to my supervisor, Les Todres, for the patience he showed with the endless and voluminous drafts, the close attention he gave to them, and for his constant, understated challenge to grasp the phenomenological perspective on the matter, while not excluding other understandings. With this said, the responsibility for any errors or limitations of the work is, of course, mine. Much thanks also to Carol Cheesman, who typed the manuscript in total more than twice.

CHAPTER 1: BEYOND THE MEDICAL MODEL: THE TWO AXES OF PSYCHOPATHOLOGY

1.1: The medical and hierarchical models of psychopathology.

The medical model of psychopathology aims to divide the range of psychopathology into discrete syndromes or disorders which can be distinguished - on the analogy of physical disease - in terms of etiology, symptomatology, course and prognosis. Syndromes may be grouped into larger categories, such as neurosis and psychosis, just as physical diseases may be grouped as cancers, respiratory diseases etc., but the emphasis remains on identifying discrete disease entities.

Psychoanalysis has always had an ambivalent relation to the medical model. On the one hand, it has accepted the notion of discrete syndromes, and indeed Freud (1895, 1909) made important contributions to the delineation of the various neuroses, while in the psychoses Freud and his colleagues accepted the divisions of the medical model (paranoia, manic-depressive psychosis and dementia praecox or schizophrenia) and developed distinct psychoanalytic accounts of each (Freud, 1911; Abraham, 1908, 1911, 1924). On the other hand, in one important respect psychoanalysis went beyond the medical model, in proposing a _developmental model_ for the whole of psychopathology. From the start psychoanalysis has attempted to account for the range of disorders in terms of fixations at and/or regressions to discrete _developmental stages_ (Freud, 1905, 1913, 1923); the classical account of this model is Abraham's (1924). This implies a _hierarchy of levels or strata in the mind laid down at successive stages of development_,

and a hierarchy of disorders ranked by severity, the more severe involving disturbance reaching down to 'lower' or more fundamental levels. There is no analogy for this conception in physical medicine. Certainly a primary disease in one organ may have secondary effects in others, but there is nothing that indicates a single hierarchy of organs or a single ranking of diseases by severity. Indeed the developmental and disease models have quite different empirical implications. The latter implies that each disorder has its own specific etiology, course and treatment, while the former implies that an exacerbation of a condition regressed to one level may provoke further regression, with one disorder shading into another (Freud, 1913).

This contrast is worthy of deeper consideration. The developmental model may be understood in two ways, which Freud did not clearly distinguish. A regression may be thought to involve a complete abandonment of higher levels of functioning, a literal return to an earlier developmental stage. This manifestly does not occur: even schizophrenics, classically the most regressed of the mentally disordered, retain elements of adult understanding and functioning. Alternatively, one may regard a regression or fixation as disrupting higher levels of functioning rather than eliminating them, subjecting them to pathological distortion. This is at face value a much more likely occurance, and it implies that a person with a disorder at one level will show pathological distortions at all higher levels, i.e. will also show the symptoms of 'less regressed' pathologies. Note that this implication does not follow only from the full developmental model. In fact, it assumes only that there is a hierarchy of levels of functioning in the psyche, with 'higher' levels dependent on the integrity of 'lower' levels. Whether or not the levels are est-

ablished at successive stages of development, the notion of a hierarchy of levels implies that:

(H1) disturbances of 'lower' or more fundamental levels are inclusive of those of 'higher' levels.

The medical model does not carry this implication. Physcial medicine does have a notion of primary and secondary diseases, but the functions of the body are so interrelated that secondary effects can emerge in a variety of directions. There is no implication of a single hierarchy of more inclusive diseases, and the medical model in psychiatry carries no such implication. Moreover, the notion of secondary disturbance implies that the secondaries will clear up as the primary disease is dealt with. The developmental or more limited hierarchical model has a different implication: that in the process of recovery that person must work their way up the hierarchy, so that:

(H2) disorders will remit in order as the person re-establishes sound functioning at successive levels.

These two differing implications of the medical and hierarchical models have been subjected to a quite rigorous empirical test by Foulds (1976)(1). Foulds constructed a Delusions - Symptoms - States Inventory for the purposes of this research, which distinguishes 12 sets of symptoms corresponding to recognized psychiatric disorders, which are grouped in four levels of severity (Table 1). The four levels are: (I) Dysthymic states, (II) Neurotic symptoms, (III) Integrated delusions and (IV) Delusions of disintegration. The first two levels will be referred to as broadly neurotic and the latter two as broadly psychotic. With regard to discrete disorders, Foulds divided hysteria into conversion and dissociative types, obsessive-compulsive neurosis into obsessive and compulsive disorders, and manic-depressive psychosis into mania and psychotic depression. His

results fully confirmed these divisions.

Level of severity	Disorders
I. Dysthymic states.	Anxiety, Neurotic depression, Hypomania.
II. Neurotic symptoms.	Conversion, Dissociative, Obsessive, Compulsive, Phobic.
III. Integrated delusions.	Paranoia, Mania, Psychotic depression.
IV. Delusions of disintegration.	Schizophrenia.

Table 1: Levels of severity and disorders in Foulds' hierarchy.

Once the assignment of symptoms to the disorders had been validated, the Inventory was administered to a total of 480 psychiatric in-patients, out-patients and day-patients, and 254 normal subjects. Overall, 93,3% of the subjects conformed to the hierarchical pattern (i.e. if they had a disorder at one level they also had a disorder at each higher level) with concordance rates for specific groups varying from 91,5% to 97,8%; these results are significant at the 0,1% level at least.

Foulds retested 68 of the in-patients to investigate the nature of movement on the hierarchy. On the first retest 92,6% conformed to the hierarchy, and on the second retest 91,2%; these figures are very close to the concordance rate for the whole group of in-patients on the original test. Of those who conformed to the hierarchy on the first retest, 90% had moved up or down the hierarchy, without, of course, breaking the pattern. This strongly confirms the prediction of the hierarchical model that exacerbation and remission involve movements down or up the hierarchy, and are not confined to exacerbation or remission of the symptoms of one dis-

crete disorder, as predicted by the medical model. In sum, both of the predictions ((H1) and (H2) above) of the hierarchical model were confirmed against those of the medical model.

If the hierarchical model is correct, and the 'lower' classes of psychopathology are inclusive of the 'higher' classes, then the appearance of traditional discrete disorders in isolation must be relatively rare. This fact has been widely noted, and has led some to conclude that no divisions within the field of psychopathology are meaningful. Foulds (1976) reports that in his study, taking no account of the hierarchy 87% of the subjects presented with more that one disorder - indeed a negative result. However, if subjects were classified only at their most severe level of disorder - i.e. treating lower level disorders as inclusive of those at higher levels - the proportion of 'mixed' cases fell to 42%[2]. Only 7% of the cases could not be clearly identified by level in the hierarchy. Thus the hierarchy is almost universally applicable, and accounts for about half of the 'mixing' of discrete disorders. In sum, it seems that the notion of discrete disorders verges on the meaningless, the basic hierarchy is highly reliable, and that within the levels of the hieiarchy there is fairly clear differentiation but also considerable overlap. This last point we will return to below, for the implication is that the hierarchical model is correct so far as it goes, but not complete, for it does not explain all the mixing of discrete disorders.

1.2: From hierarchy to wholeness.

It is worth pausing at this point to consider the broader implic-

ations of the above results. Why should the medical model fail so dramatically? The assumption that distinguishes this model from the hierarchical one is that the functions that are disturbed in the discrete disorders are relatively independent, so that disturbance in one area does not necessarily entail disturbance in another. This assumption is clearly not supported by Foulds' results: higher levels of functioning are clearly dependent on lower or more fundamental levels. The notion of primary and secondary disturbance does point to interaction of functions, but Foulds' results and the hierarchical model point to more than this. Secondary physical diseases will often remit with or even before the primary disease has completely cleared up, whilst Foulds' results and the hierarchical model imply that more fundamental functions must be sound before the healing of less fundamental functions can properly begin. This implies not just the interaction of functions, but their interdependence. In philosophical parlance, the medical model assumes externally related functions (interactive but not interdependent) whilst the results imply internally related functions (interactive and interdependent). In other words, the psyche has an intrinsic wholeness which the medical model cannot grasp.

Of the major schools of clinical psychology those that have most clearly grasped this intrinsic wholeness are the so-called 'depth' psychologies - psychoanalysis, analytical psychology and phenomenology (in the broad sense encompassing existential and humanistic psychologies), although, as we shall see shortly, they have important differences in how wholeness is conceived. Classical behaviourism denies wholenss, seeing each behaviour as governed by its own particular contingencies. Certainly one kind of behaviour can provide and/or

elicit from the environment stimuli for other kinds of behaviour (e.g. killing a prey as a discriminative stimulus for eating it), but such are external relations between behaviours. The hierarchical model implies rather that some behaviours are a necessary part of the performance of more complex behaviours (e.g. eye-hand coordination as a necessary part of gathering food). This kind of internal relation between levels of behaviour is assumed throughout in Piaget's cognitive theory (Inhelder & Piaget, 1958), and is acknowledged by cognitive behaviourism, which also recognized the value of Piaget's work (Guidano and Lioti, 1985).

In Piaget's cognitive hierarchy, the lower levels involve less abstract thought than the higher. Significantly, in the psychoanalytic developmental model, developmental progress involves the abstract, rational secondary process gaining ascendence over the concrete, irrational primary process (Freud, 1911a). Concrete thinking is a hallmark of psychosis; a contemporary psychoanalyst Hildebrand (Note 1) has suggested that at all levels of regression the degree of emotional disturbance is matched by the loss of cognitive integration, of the capacity for abstraction and rationality. Such a conclusion is also supported by cognitive behaviourism, although psychoanalysts and cognitive behaviourists continue to disagree on whether the affective or cognitive dimension of disturbance is primary.

In talking of a partial convergence of psychoanalysis and cognitive behaviourism on the theme of a hierarchy of cognitive/affective levels, we are dealing with a strictly limited view of human wholeness. The interdependency or interrelatedness of the levels acts in one direction only (the higher dependent on the lower but not vice versa):

a degree of separation is acknowledged. Accordingly, the psychoanalytic developmental model holds that in some respects psychical functions are separable. In Freud's (1923a) theory, superego development is dependent on ego development, but not vice versa, and the same applies to ego development and the original existence of the id. Such uni-directional interdependency is what is required to account for the hierarchical levels of Foulds' results; what is needed to account for the rest of the mixing of discrete disorders we will consider shortly.

A hierarchical model must have some developmental implications: the more fundamental functions must develop before those that depend on them. However, this does not mean that all pathological regressions are caused by developmental fixations, and that current frustrations serve primarily as precipitating factors - as Freud at times argued (1912, 1916/17). All one can say with any certainty is that the same basic hierarchy is unfolded in development and distorted in pathology. To my mind talk of causes of psychopathology is misleading: the same genetic inheritance or similar environmental traumas in different individuals can have widely different effects. It seems much safer and more meaningful to examine simply the structure of psychopathology and its relation to the total structure of human being, and to ask what the significance of various pathological distortions is. In sum, we can say that the field of psychopathology reveals a 'vertical', hierarchical structure of uni-directional interdependencies of levels of cognitive and emotional integration, on which the gross severity of the pathology depends; and that the same basic structure probably unfolds in the developmental process.

These admittedly sketchy suggestions must suffice as far as the vertical, hierarchical axis is concerned - for our real concern here is with what this does not explain. To examine how much of the total mixing of disorders the hierarchical model predicts, Foulds focussed on between-level and within-level mixing. He excluded Level IV in this case, for here there is but one disorder (schizophrenia) and no within-level mixing is possible. Of those subjects presenting at the remaining three levels, 87% presented with more than one disorder. However, only 42% presented with more than one disorder at their lowest level; so, of the mixed cases, a shade over half (58%) can be uniquely identified by class within the level of maximal severity - i.e. by a single area of greatest weakness. This still leaves the 42% of the mixed cases which presented with two or more disorders at the lowest level. To understand this half of the interrelatedness of the discrete disorders, and by the same token, another aspect of the structure of the field of psychopathology as a whole, the hierarchy is no use, and we must turn elsehwere.

Psychoanalysis can ask this question, but requires phenomenology to find the dialectic that answers it. Psychoanalytic developmental theory acknowledges that the hierarchical model is not complete without an understanding of so-called object relations. Thus Freud:

> the developmental disposition to a neurosis is only complete if the phase of development of the ego at which fixation occurs is taken into account as well as that of the libido (1913: 143).

Libido (later joined by the death instinct, Thanatos to libido's Eros) is for Freud precisely what draws us into relationships with others. To return to the graphic metaphor, to the vertical

axis of integration we must add a horizontal axis of relatedness - an interpersonal dimension to psychopathology.

Precisely at this point, however, psychoanalysis runs into serious difficulties. Freud to the last maintained several different views of the development of object relations (Balint, 1968)[3]. One, taken up by Abraham (1924) and ego psychology (Jacobson, 1954; Mahler et al, 1975) holds that only the narcissistic id-ego relation is primary, and ego-object relations emerge in the developmental process. This theory, at least in its older form, collapses the self-other axis (axis of relatedness) onto the hierarchy, placing the id-ego relation and birth of the self beneath ego-other relations on the hierarchy. Another theory has been taken up by the appropriately named object relations school, stating that a primary object relation develops, 'leaning on' the self-preservative nutriative instinct, and thus termed 'anaclitic'. In this theory, the axis of relatedness is independent of the axis of integration. In graphic terms, each level of integration is a whole field of relatedness to others.

Whereas psychoanalysis has come gradually, and not without a struggle, to acknowledge the fundamental importance of relatedness, it has always been the point of departure for phenomenology. Phenomenological psychology takes as its object of study human experience, and reminds us that experience (conscious or unconscious) is constituted as a relation between subject and object, so that relatedness is primary and the differentiation between subject and object is secondary. For Merleau-Ponty experience is a perceptual field (1951) in which self and other are constituted in a play of recognition and self-recognition (1960, 1964). For Heidegger (1927) experience is in-

herently relational, for it is being-in-the-world; human being in Da-sein, being there, dwelling in experience, caring for the world it reveals.

Rich food for thought here, not sparse conceptual sbhemas, and indeed an absence of abstraction. Being is as it is, Heidegger (1927) urges us; by implication: not because of some abstract set of causal principles. Here cognition is reduced to recognition and the revealing and concealing of what is takes precedence over abstract notions of evidence, proof, truth and falsity. A recognition cannot be false as such - only mistaken. To mistake is presumptious, willful: here we encounter, appropriately, not causal necessity but existential freedom and the abuses of it.

Time to pause again and reflect. Psychoanalysis as a whole is quite fundamentally ambivalent about whether to opt for a one-dimensional hierarchical model, or accept the primacy of object relations and with it the existential-phenomenological dimension of all levels of the hierarchy. Not surprisingly, it is the object relations school within psychoanalysis that has responded to the phenomenological dialogue: notably current commentators on Klein and Winnicott (Mackay, 1981; Meltzer, 1981; Eigen, 1981). In a separate development Kohut (1977) has responded to American phenomenological humanism, the broad Rogerian tradition; an ongoing Jung-Klein interchange has led to substantial developments, particularly among Jungians (Lambert, 1981); and points of convergence between Jung and phenomenology have been noted (Carafides, 1974; Brooke, 1983).

This emerging dialogue must not be allowed to continue as a one-way

enrichment of psychoanalysis and analytical psychology by phenomenology. Unfortunately, on the obvious challenge that phenomenology ignores the hierarchical dimension, and with it the phenomenology and clinical challenge of regression (c.f. Balint, 1968), phenomenology remains obdurate, often rejecting the dimension outright (e.g. Boss, 1979). Those phenomenologists that have risen to the challenge have tended to take it up in terms of the phenomenology of consciousness versus the unconscious (Merleau-Ponty, 1960a; Richardson, 1965; Ricoeur, 1970; Olokowski, 1982-3); their results are tantalizing but somehow stalled. Perhaps the problem has been posed in the wrong terms and 'the unconscious' is in a sense a red herring, but again this issue is peripheral to our concerns here.

What is of interest is the major contribution object relations theory can make to our understanding of the axis of relatedness. Klein (1935, 1940, 1946) introduced to psychoanalysis the concept of _libidinal position_, precisely defined by her colleague and commentator Segal as a

> specific configuration of object relationships, anxieties and defences which persist through life (1964: ix).

Klein's current South American followers elaborate as follows:

> Viewed thus, positions imply not only a chronological sequence but also a continuous mobility which persists through life. Their motive force is the progressive modification and resolution of _anxiety_ situations, leading to the establishment of successive types of _object relationships_ in degrees of increasing _integration_ which lay the foundation for the establishment of growth and which act as pillars to mental stability (Bianchedi et al., 1984: 393).

Bianchedi et al. are still using the language of necessity here, speaking of the necessary conditions of integration; the hierarch-

ichal axis of integration is still their focus. However, with Meltzer (1978) this emphasis is complemented by one on the simultaneous presence of and choice between the libidinal positions and the values they represent.

This emphasis on choice and values in Meltzer grows out of the already strong interpersonal emphasis in Klein. For Klein there are two basic libidinal positions: the depressive (Klein, 1935, 1940) and the paranoid-schizoid (Klein, 1946). Not only is each characterized by a specific form of object relations, but the basic anxiety that dominates each has a definite interpersonal significance. In the paranoid-schizoid position, the anxiety concerns persecution by others, and hence the danger is to the self, whilst in the depressive position the self's own aggression threatens the other. Similarly, for Fairbairn (1940, 1941) the schizoid fears loss of the self and the depressive loss of the other[4]. The former is, if you like, a 'self-centred' position and the latter 'other-centred'. Boss (1962) defined anxiety as arising from a threat to one's integrity - in our terms, from a threat of dis-integration. The exploration of the most basic anxieties by Klein and Fairbairn then makes it clear that relatedness is the foundation of integration, for the basic anxieties arise from threats to relatedness, from the loss of self or other.

Both Klein and Fairbairn placed their libidinal positions in a developmental sequence. Meltzer (1978), following Bion (1963, 1970) argues that this was a mistake, and that the two libidinal positions and the choice between them are present at all levels of integration.

Meltzer's view, supported by Rey (Note 2), is adopted here, so that whereas level of integration is the crucial concept for understanding the vertical, hierarchical axis, libidinal position is crucial for understanding the axis of relatedness. Understood in this way, the axis of relatedness takes on a much greater significance. It is no longer an axis connecting self to other, but an axis on which are ranged self-centred and other-centred forms of the self/other relation. Whereas the self/other relation is always implicated in psychopathology, self-centred and other-centred forms of relatedness are rooted in different libidinal positions and are thus - as we shall see shortly - involved in different disorders.

The focus of this work is on how the axis of relatedness can help us to understand the field of psychopathology. Firstly, if levels of integration correspond to levels of severity of pathology, then there must be some other division of the field of psychopathology corresponding to the distinction between the two libidinal positions. In other words:

> (H3) There are two groups of disorders whose dynamics correspond to those of the two libidinal positions.

Moreover, if we assume that the two libidinal positions are both present at all levels of integration, it follows that:

> (H4) The two groups of disorders divide between them all levels of the hierarchy.

Finally, the brief account of libidinal positions given above highlights the fact that the schizoid or paranoid-schizoid position is self-centred and the depressive other-centred. Thus:

> (H5) The contrasting phenomena of the two groups express the self-centred/other-centred polarity.

In a sense (H5) is part of (H3), but it has been singled out because

this polarity emerges as the most important contrast between the two groups and because it expresses directly the concept of an axis of relatedness.

More specifically, then, the focus of this work is on evaluating these three hypotheses. As they focus on the axis of relatedness, they can be termed the interpersonal model of psychopathology. This model does not contradict, but complements, the hierarchical and developmental models, with their focus on the axis of integration. In the remainder of this section the interpersonal model is evaluated in the light of Foulds' study, in which considerable support for them is found. The implications of this for the concept of wholeness and its relation to libidinal positions are then discussed. Finally, in section 1.3 an outline of the rest of the work and the approach used in it is given.

In addition to distinguishing the four levels of severity, Foulds distinguished two horizontal groups of disorders. He did this by means of a personality measure, of what he called intropunitiveness and extrapunitiveness, that is, whether the subject directs blame or attributes guilt primarily to self or others. He found that scores on both measures increased regularly with the level of severity. He also found that each level could be divided into groups of more intropunitive and more extrapunitive disorders, and that individuals with intropunitive disorders regularly scored higher on a measure of anxiety and depression. Specifically, his conclusion was that

> Hysterics, Paranoiacs, Manics and one possible group of Schizophrenics are less anxious or depressed and less self-blaming than other groups within their respective classes (levels) (1976: 147).

Thus these disorders form the extrapunitive group, and the remainder the intropunitive group. Schizophrenia, the single disorder on Level IV, was divided between the two groups.

The full bi-axial schema, showing the division of the field of psychopathology into levels and groups is shown in Table 2 below.

Groups:	Extrapunitive	Intropunitive
Levels:		
I	Hypomania	Anxiety Neurotic depression
II	Conversion Dissociative	Obsessive Compulsive Phobic
III	Mania Paranoia	Psychotic depression
IV	Schizophrenia	Schizophrenia

Table 2: Groups and levels in the field of psychopathology.

Table 2 directly confirms (H4), for each level is divided between the two groups. The basis on which Foulds makes this division supports (H5), for in a simple and direct sense extrapunitiveness (blaming others) is self-centred and intropunitiveness (self-blame) is other-centred. This in turn implies that the extrapunitive group of disorders is rooted in the paranoid-schizoid position and the intropunitive group in the depressive. If this is indeed the case then (H3) is also confirmed. Foulds' results support (H3) in two respects. Firstly, he found that the intropunitive group were more depressed than the extrapunitive, and secondly, for Klein (1935, 1946), guilt and self-blame are central to depressive dynamics while in the paranoid-schizoid position the person tends to split bad feelings off and project them onto others. Overall, the fit is rather impressive.

To return to the question of wholeness and the mixing of discrete disorders, the above results focus our attention on the concept of libidinal positions, which appear to be able to account for the division of the field of psychopathology into two horizontal groups. As far as mixing is concerned, the mixing of disorders within groups is now entirely explicable, for the disorders in each groups now appear as varying expressions of the basic conflicts of the two libidinal positions. Equally, mixing between the two groups is explicable, because the two libidinal positions are both constantly present and interacting.

Foulds (1976) found that disorders within any one level were more likely to mix if the person also had a disorder on the next level down. This suggests that as a composite pathology is exacerbated it tends to spread sideways as well as down, reinforcing the idea that the field of psychoapathology is interrelated in both dimensions. In the pure developmental model there is only one disorder at each level (Abraham, 1924); Foulds results not only imply that there is a second axis of psychopathology, but in showing that mixing also occurs along this axis, his work points to an interrelatedness of the field that goes beyond the uni-directional interdependency of levels entailed by the developmental model. The question arises of how this interrelatedness is to be understood.

Klein (1935) originally associated libidinal positions with discrete disorders, before she arrived at the fundamental distinction between the paranoid-schizoid and depressive positions. Now a lib-

idinal position has the attributed of a person - anxieties, defences and object-relations - and represents a whole way of life, a mode of being. This illustrates a more general point about Kleinian thinking, in which it is accepted that parts of the personality such as the ego and its internal objects

> interact in a personified way, they assume roles, are endowed with intentions, experience sensations and personal feelings, and carry out meaningful actions...(Bianchedi et al., 1984: 395).

Vygotsky (1962) took a similar approach when he argued that the p psyche is a structure of units, that is, parts of the whole which retain all the essential attributes of the whole. This notion of units expresses in a rigorous way the idea of internal relations introduced above. That composite pathologies tend to be mixtures of discrete disorders along both dimensions illustrates the same point: individual pathologies are two-dimensional forms, like the field of psychopathology as a whole.

What emerges from the interpersonal model, then, is a vision of wholeness which goes distinctly beyond that entailed by the hierarchical model alone. This understanding of wholenss does not naively underestimate psychopathology, as eome do - indeed it implies that a disorder in any part of the personality must distort the whole, through its internal relatedness (cf. section 6.1) - and can account for the full extent of the mixing of the discrete disorders reported by Foulds.

1.3: The scope and limits of this work.

As mentioned above, this work seeks to justify, in a preliminary way, the interpersonal model of psychopathology, as stated in (H3) to (H5) above, which can be summarized as follows:

> (H3/4/5) There are two groups of disorders which divide between them all levels of the hierarchy, the dynamics of which are rooted in the two libidinal positions, and the contrast between which expresses the self-centred/other-centred polarity.

The specific points are dealt with as follows. The distinction between the two groups was first made - although not quite explicitly - in classical psychoanalysis (Chapter 2), and related to the two libidinal positions by Fairbairn (Chapter 3) and Klein (Chapter 4). The two groups can be shown to divide between them the psychoses (Chapter 4), neuroses (Chapter 5) and personality disorders (Chapter 6). Contrasts between the two groups can be found in the areas of affect and cognition (Chapter 2), ethics (Chapter 3), anxieties, defences, modes of identification and motivation (Chapter 4), etiology (Chapter 5), and finally interpersonal boundaries (Chapter 7). All nine of these contrasts are shown, as they are identified, to express the basic self-centred/other-centred polarity. In Chapter 7 it is shown further that overcoming this polarity is necessary for attaining integration and authenticity. Finally, in Chapter 8 the evidence is reviewed as a whole, and various questions raised but not answered by the work are discussed.

The method used in the rest of the work can be described as informally phenomenological. A number of authors in classical psychoanalysis, object relations theory and phenomenology are considered in a way

that thematizes the two groups of disorders, their underlying libidinal positions, and the self-centred/other-centred polarity. The phenomenological method is particularly appropriate for the interpersonal model. The self-centred/other-centred polarity is not a concept of another order to which the nine contrasts are reduced; rather it _emerges from_ the nine contrasts, as the theme commom to them, and its definition is best left implicit, as precisely this common theme.

CHAPTER 2: THE TWO GROUPS IN CLASSICAL PSYCHOANALYSIS

In this Chapter it is argued that the two horizontal groups of disorders were clearly identified in classical psychoanalysis, although their significance was not realized because it could not be within the dominant developmental model. Jung (1907), writing well before the break with Freud, detailed substantial analogies in the clinical presentation of hysteria and schizophrenia (section 2.1) and Abraham (1911, 1924) demonstrated the close connections between psychotic depression and the obsessive-compulsive neurosis, arguing in terms of the dynamics of the two disorders as well as their symptomatology (section 2.2). These two analogies cut across the neurosis/psychosis distinction, creating two horizontal groups representing the cores of the groups identified by Foulds (cf Table 2, p16)*. When the essential features of the two groups identified by Jung and Abraham are compared (section 2.3) strong contrasts emerge in the spheres of affect and cognition, and the nature of these contrasts is suggestive of the self-centred/other-centred polarity stressed in section 1.2. Finally, certain divergencies between the division of the groups in classical psychoanalysis and in Foulds' study are considered.

2.1: Jung's comparison of hysteria and schizophrenia.

Jung (1907) makes this comparison under four headings which we will

*References like this (with a 'p') refer to pages of this text.

consider in turn.

A. Disturbance of emotions.

> The emotional indifference so striking in many cases of dementia praecox bears a certain resemblance to the 'belle indifference' of many hysterics, who describe their complaints with smiling serenity and thus make an inadequate impression, or speak with equanimity of things that ought to touch them profoundly (1907: 70).

There are two different aspects to this disturbance of emotions: on the one hand, there is blunting or emotional apathy, and on the other, inappropriate affect (incongruity of ideational content and affect) which can include blunting, but also inappropriate elation, used to defend against distressing feelings. It was this splitting of ideas and affect that led Bleuler to coin the term 'schizophrenia'. The states of elation which Jung describes as ranging from "boisterous merriment" to "explosive excitement" (1907: 71) can be compared with hypomania and mania, which Foulds includes with hysteria in his extrapunitive group. Jung notes that such defensive elation is highly unstable, and may be very rapidly replaced by a more appropriate, although often extreme, emotional outburst. At times such responses appear as delayed reactions, separated by hours or days from what they are a response to.

B. Abnormalities of character. In this area Jung notes that both hysterics and schizophrenics have a strong tendency to affectation: mennerisms, eccentric behaviour and the desire to seem original, expressed in speech, gesture and action (1907: 75). Thus the whole manner of the person has a 'staged', false flavour, which can be seen as a generalization of inappropriate affect. Also,

such acts are put on for effect, for the impression they make on the other. The traits of the DSM-III Histrionic Personality Disorder are evident here. In Chapter 6 we will see that Angyal desribes a typical 'false self' development in hysteria and related disorders as part of a pattern of vicarious living, living through others. With the self in danger the other becomes the reference point! Jung's description of mannerisms and eccentricity reminds one also of the DSM-III Scizotypal Personality Disorder, the old simple schizophrenia.

C. Intellectual disturbance. Here Jung (1907) mentions the remarkable suggestability of hysterics and especially catatonic scizophrenics, and also disturbances of consciousness and attention. Suggestability can be related back to the tendency to adopt mannerisms and strike poses: the self is insecure and poorly defined and thus looks for definition from others. Consciousness may be disturbed by gross, persistent delusions or hallucinations, and also by very brief 'lapses' of consciousness or 'ecstatic' hallucinations (hysteria) or "the abrupt blockings, momentary 'thought-deprivation', and the lightning-like hallucinatory irruption of bizarre impulses" (1907: 79) in scizophrenia. These very sudden changes can be compared to the unstable affect mentioned above. Attention is constantly distracted, according to Jung, without patients necessarily losing their train of thought. This is comparable with the manic 'flight of ideas' in which the thread of associations is clear, in contrast to the more bizarre 'loosened associations' of acute scizophrenic episodes. Presumably the milder distractability noted by Jung in scizophrenics applies to their more stable periods.

Under his final heading, Jung (1907) compares the stereotypies of

schizophrenia with obsessional actions. Jung in this work included obsessional neurosis within hysteria, though the comparisons noted above apply to hysteria strictly defined. Significantly, <u>of the disorders from the depressive or intropunitive group (Table 2, p 16) found in schizophrenia in Foulds' study, the two commonest were the obsessive and compulsive disorders</u>. This may be related to Klein's (1932) view that obsessional defences are often deployed against persecutory anxiety, the basic anxiety of the paranoid-schizoid or extrapunitive group.

In sum, Jung highlights a number of themes common to hysteria and schizophrenia, some of which also invite comparison with manic and schizoid states which Foulds and Fairbairn respectively include in the extrapunitive or schizoid group. Common themes in symptoms discussed are <u>appearances</u> (emotional appearance inappropriate to the situation, and putting on appearances - the false self) and intellectual disturbances focussed on <u>consciousness and attention themselves</u>, rather than their objects. Thus the common thread throughout is that <u>the problem is with the self</u>, with the <u>falseness</u> of its affect and appearances and the disturbance of <u>intentionality</u> in the intellectual sphere [(5)]. The significance of these features in relation to those of Abraham's group is discussed in section 2.3 below.

<u>2.2: Abraham's comparison of obsessive-compulsive neurosis and psychotic depression.</u>

Turning now to Abraham, we find that he early on outlined the core of the second group of disorders, pointing out the interrelated nat-

ure of anxiety, depression and obsessional neurosis. He noted that "the affect of depression is as widely spread among the neuroses and psychoses as is that of anxiety. The two are often present together or successively in one individual" (1911: 137). This claim is precisely confirmed by Foulds' (1976) study: he found that the states of anxiety and depression are the two commonest disorders, and also the two that mix most commonly. Concerning the dynamics of anxiety and depression, Abraham noted:

> Anxiety and depression are related to each other in the same way as are fear and grief. We fear a coming evil; we grieve over one that has occurred. A neurotic will be attacked with anxiety when his instinct strives for a gratification which repression prevents him from attaining; depression sets in when he has to give up his sexual aim without having obtained gratification. He feels himself unloved and incapable of loving, and therefore he despairs of his life and future (1911: 137-8).

Translated into the terms of object relations theory, anxiety and depression both arise from situations which prevent our desire from reaching the other. Thus Freud in his late revision of his concept of anxiety defined it as a 'signal' of impending danger, most importantly of 'internal dangers':

> Internal dangers...have a common characteristic, namely that they involve separation from, or loss of, a loved object, or a loss of its love - a loss or separation which might in various ways lead to an accumulation of unsatisfied desires and so to a situation of helplessness (1926: 233).

The analogy with his (1917) theory of melancholia is obvious. The central issue is the loss of the other and its consequences. In neurotic anxiety and depression, the loss or separation is (at least in part) due to repression, which thus - as van den Berg (1980) points out - comes between self and others.

Abraham also saw a close analogy between psychotic depression and obsessional neurosis:

> Even in my first analysis of a depressive psychosis I was immediately struck by its structural similarity with an obsessional neurosis (1911: 139).

The common theme he saw as intense ambivalence: these patients fear that their intense aggression will be directed at those they love, and hence will cause a loss of the loved object. Depressive persons faced with a loss beyond their control will accordingly feel somehow responsible for it, as though their aggression caused it, or at least find their aggression interfering with their love and mourning of its loss (Abraham, 1911, 1924; Freud, 1917). Once again, the problem is posed in relation to the other. Ambivalence is also associated with intellectual disturbances, involving doubt and indecisiveness (Abraham, 1911) and, of course, obsessive thought. With both of these intellectual disturbances, the problem is with the objects of thought and judgement concerning them.

2.3: Conclusion.

The essential features of the two groups identified by Jung and Abraham point up contrasts in the spheres of affect and cognition. In Jung's group there is a problem within affect itself, in its blunting, inappropriateness and instability, whilst in Abraham's group the problem is ambivalence between affects. In the sphere of cognition Jung highlighted disorders of attention and consciousness which we brought together in the concept of the subject's intentionality or orientation to the task of thinking. Abraham, in contrast, stressed doubt and indecision about the objects of thought and judgement con-

cerning them.

Placing these two contrasts side by side it is clear that the theme common to both of them is the self-centred/other-centred polarity. The disturbance within affect itself attacks affect at its source, leaving the other not sure that the subject has any genuine feelings. The conflicting poles of the ambivalence between affects are each genuine enough, but the conflict leaves the subject uncertain as to what to feel about the other. The contrast in the sphere of cognition expresses the polarity directly, between the subject's intentional orientation and the objects of thought.

The theme of loss of the other in the depressive group was stated explicitly by Abraham and Freud who went some way into the dynamics of these disorders. For a treatment of schizoid dynamics and an explicit statement of the schizoid fear of loss of the self we must wait for Fairbairn (Chapter 3).

Finally, these two core groups identified in classical psychoanalysis must be compared to Foulds' extrapunitive and intropunitive groups (Table 2, p 16). The fit is not perfect, in a number of respects. Firstly, Abraham's (1911, 1924) discussion of psychotic depression refers to the so-called manic-depressive psychosis, a category he took over from psychiatry. For Foulds (1976) mania and psychotic depression are distinct disorders, and he notes that they mix less often than psychotic depression and paranoia. In this connection it is interesting to note that both Abraham (1924) and Freud explained mania in terms of specific dynamics, distinct from (although related to) those of depression. Moreover, we noted in section 2.1 manic

and hypomanic features in Jung's description of his hysteria/schizophrenia group, consistent with Foulds' grouping of mania and hypomania with hysteria. The clarification of manic dynamics and the reasons for its placement in the extrapunitive or schizoid group must wait for the discussion of Klein (Chapter 4).

Secondly, Freud (1909) compared phobias to conversion hysteria, and proposed the term anxiety hysteria for them, which is still in use. He noted that "in the clinical cases that we meet with, this 'anxiety hysteria' may be combined with 'conversion hysteria' in any proportion" (1909: 274). Foulds (1976: Table 7), however, found that phobia mixes more frequently with obsessive and compulsive disorders than with conversion hysteria, and classed it as an intropunitive disorder. Jung (1907), writing before Freud (1909) did not consider phobias. The DSM-III classes them with the anxiety disorders, which tends to support Foulds' view. From our point of view, the situation is ambiguous: in phobia the problem is the other (phobic object) and yet the overt anxiety is about harm to the self. Significantly, for Klein (1932) phobias are generated by both persecutory (self-centred) and depressive (other-centred) anxiety, and Foulds (1976: Table 7) noted that phobia and conversion hysteria mix more frequently than any other intropunitive/extrapunitive pair of Level III disorders. Phobia, it seems, represents a borderline case among the intropunitive disorders.

Finally, Jung (1907) did not consider the by now well-known problem of depression in the schizophrenic, and thus did not approach the problems related to Foulds' (1976) division of schizophrenia between the extrapunitive and intropunitive groups. We will find this a persistent problem, though some light is thrown on it in Chapter 4.

CHAPTER 3: FAIRBAIRN'S GROUP OF SCHIZOID DISORDERS.

Jung's (1907) theme of a close connection between hysteria and schizophrenia was an overriding concern of Fairbairn's (1940, 1941). The reasons for considering his work are threefold. Firstly, (section 3.1), he grouped along with hysteria and schizophrenia the schizoid state (comparable to the DSM-III's Brief Reactive Psychosis) and also schizoid personality disorders; his work reinforces the suspicion, raised in section 2.1, that mania belongs here too, although he maintained the traditional linkage of it to psychotic depression. Secondly (section 3.2), he was the first to give an account of the etiology and dynamics of the schizoid disorders, and introduced the notion of a schizoid position that underlies the whole group. Here, at the more metatheoretical level, his work falters; Klein's more adequate view of the basic position of the schizoid disorders is treated in Chapter 4. However, Fairbairn must be credited for having made it quite explicit that the central schizoid fear is of loss of the self, i.e. the schizoid position is self-centred. Finally his work highlights a contrast between the two positions in the sphere of ethics, which restates and further clarifies the central theme of modes of relatedness (section 3.3).

3.1: Disorders of the schizoid position.

In his first (1940) treatment of the schizoid position, Fairbairn

listed the "overtly schizoid conditions" as schizophrenia, the schizoid character (i.e. personality disorder), psychopathic personalities of a schizoid type, which he said "may well comprise the majority of cases of psychopathic personality (not excluding epileptic personalities)" (1940: 4), and finally the transient schizoid state, "a category under which...a considerable portion of adolescent 'nervous breakdown' fall" (1940: 4). In addition, he argued, may neurotics have "features of a basically schizoid nature" (1940: 4). Among the neuroses, Fairbairn singled out hysteria for its particularly close relation to schizoid states, noting that "the personality of the hysteric invariably contains a schizoid factor in greater or lesser degree, however deeply this may be buried" (1940: 6), and more specifically that "the dissociation phenomena of 'hysteria' involve a split in the ego fundamentally identical to that which confers upon the term 'schizoid' its etymological significance" (1944: 92).

Fairbairn included under dissociative phenomena "somnambulism, the fugue, dual personality and multiple personality", and among the schizoid states, depersonalization and derealization, as well as "the feeling of 'artificiality' (whether referred to self or the environment)", the "plate-glass feeling" and déjà vu (1940: 5). This covers the whole of the DSM-III category of Dissociative Disorders, with the exception of psychogenic amnesia, and with some inclusions (somnambulism, déjà vu).

On the close connection between hysteria, especially dissociative, and schizophrenia, Foulds' results fully support Fairbairn. In

Foulds' Table 15 (1976: 105) dissociative hysteria appears as the broadly neurotic disorder (Levels I and II of Table 1, p 4) most likely to be mixed with schizophrenia. Within the broad neurotic class, dissociative and conversion hysteria mix in very similar proportions, whilst dissociative hysteria mixes more with all the psychotic disorders (Levels III and IV). Dissociative hysteria appears as the more regressed of two closely associated disorders, the one closer to the buried schizoid psychotic anxiety. If we think of the disorders of intentionality we noted in Jung's (1907; section 2.1) account, this conclusion is confirmed: conversion creates a constant distraction of attention, whilst dissociation - more disturbingly - actually splits consciousness.

The feeling of artificiality mentioned above was for Fairbairn part of a typical and profound disturbance of affect in schizoids. He saw schizoids as fundamentally unable (or afraid) to give, and thus repressing affect (1940: 15), and adopting a variety of defences including playing roles (1940: 16). This allows the schizoid

> to express quite a lot of feeling and to make what appear to be quite impressive social contacts; but, in so doing, he is really giving nothing and losing nothing, because, since he is only playing a part, his own personality is not involved (1940: 16).

Here the schizoid personality shades into Winnicott's false self and Jung's hysterical affected behaviours (section 2.1). However - unlike the hysteric - the schizoid does not coquetishly strike poses and affect uniqueness; schizoids believe that they are different - the 'odd man out' - and have more secretive ideas of grandeur, seeking to project an aura of mystery while remaining aloof and disdainful (Fairbairn, 1940). Again, they tend to disparage others and treat

them with contempt, rather than semi-playfully manipulating them, as histrionic personalities do. Thus schizoid and histrionic personalities are distinct, although clearly related.

Fairbairn's 'schizoid state' can be compared to the DSM-III Brief Reactive Psychosis (BRP), and in fact, I would argue, identified with it. BRP is commonest in adolescence and early adulthood; Fairbairn regarded many adolescent 'nervous breakdowns' as schizoid states. The psychotic features of BRP (particularly loosening of associations, hallucinations and grossly disorganized or catatonic behaviour) resemble schizophrenia rather than depression, and Fairbairn made the same comparison for schizoid states. The DSM-III characterizes BRP by "emotional turmoil", involving "rapid shifts from one dysphoric affect to another" (DSM-III: 200), which reminds one of the instability of affect stressed by Jung (1907; section 2.1) in his hysteria/schizophrenia comparison. As an associated feature of BRP the DSM-III mentions "perplexity and a feeling of confusion" (DSM-III: 200); in the next Chapter we will see that Rosenfeld and Klein chatacterized schizoid states as 'confusional states'. Finally, the DSM-III notes that "individuals with Paranoid, Histrionic, Narcissistic, Schizotypal or Borderline Personality Disorders are thought to be particularly vulnerable to BRP" (DSM-III: 201), and we find on examination of Fairbairn's description of schizoid personalities that it includes many crucial traits of this '<u>schizoid group</u>' of personality disorders.

Fairbairn, as we saw above, stresses particularly psychopathic persoanlities (DSM-III's Anti-social) as part of the schizoid group.

Antisocial personalities are not, according to the DSM-III, particularly prone to BRP. However, antisocial, histrionic and narcissistic or borderline traits are commonly associated with Narcissistic and Borderline Personality Disorders, thus suggesting that these two form the core of the schizoid group of personality disorders. Fairbairn (1940) saw the basic schizoid dilemma as an inability to love or to give. Accordingly, schizoids may substitute exhibitionistic showing for giving, overvalue their thoughts and person, adopting a "secretive and mysterious air" (1940: 22) and denigrate and devalue others. Central to all of this is "a narcissistic inflation of the ego" (1940:22), and the essential traits of the DSM-III Narcissistic Personality Disorder are quite evident.

Concerning the Borderline Personality Disorder, the evidence is fairly clear. Fairbairn argues that the schizoid's inability to love creates a profound sense of emptiness and futility (1941: 51); a chronic sense of emptiness and boredom is characteristic of the DSM-III's Borderline. Fairbairn (1940) also mentions the schizoid's hostility and rudeness, which might be compared to DSM-III's "inappropriate, intense anger, or lack of control of anger" (322). The affective instability of the Borderline reminds one of Jung's (1907) discussion of hysterical/schizophrenic traits (section 2.1).

Withdrawal as a way of coping with inability to love finds its pure expression in the DSM-III Schizoid Personality Disorder, which accordingly should be included in the schizoid group. The inclusion of the Histrionic and Schizotypal Personality Disorders in the schizoid group was suggested in section 2.1. To return

briefly to the Antisocial Personality Disorder, the DSM-III notes that "almost invariably there is a markedly impaired capacity to sustain lasting, close, warm and responsible relationships" (DSM-III: 318) which points again to a primary disturbance of loving and giving.

The Paranoid personality should perhaps also be included in this group, because such personalities are prone to BRP. We will discover below that while Fairbairn gave a central place to paranoid dynamics in his account of the schizoid position, he did not include paranoia in his schizoid group, one of the unsatisfactory features of his system. Equally, he scarcely mentions mania, other than as part of the manic-depressive psychosis, despite the fact that he stresses ideas of grandeur in the schizoid picture and speaks even of an "attitude of omnipotence" (1940: 6). Clarification of the states of paranoia and mania must wait for Chapter 4 on Klein; the personality disorders are considered further in Chapter 6.

At the same time, Fairbairn must be given credit for having confirmed Jung's schizophrenia/hysteria connection and for extending the notion of a group of psychopathologies with this core into the area of personality disturbance.

3.2: The etiology and dynamics of the schizoid position.

We will approach the dynamics of the schizoid disorders and the schizoid position that underlies them through a consideration of their etiology, for this helps one to grasp the dynamics as lived processes.

First, a general note about etiology. Fairbairn came close to the realization that the two horizontal groups of psychopathologies tend to run in families. He compared his schizoid and depressive groups to Kretschmer's schizothymic and cyclothymic groups, defined by clusters of inherited traits which predispose individuals to schizophrenia and manic-depressive psychosis, respectively. Fairbairn commented that whereas Kretschmer

> regards the temperamental difference between the types as based essentially on constitutional factors...my view is that psychopathological factors arising during the period of infantile dependence make at any rate a considerable contribution to the temperamental difference (1941: 57; emphasis added).

While distinct genetic factors in schizophrenia and manic-depressive psychosis have been found (in the latter case, interestingly, distinguishing unipolar and bipolar types), in my estimation Fairbairn's statement could be strengthened to give greater weight to 'psychic inheritance' while not denying the genetic factors.

In Fairbairn's view infantile dependence is characterized by primary identification, which leads infants to take on many of the characteristics of their parents, particularly their bad or pathological characteristics. Fairbairn described particularly well three patterns of this psychic inheritance in the case of schizoid disorders and traits. We will find that they together state the basic themes of love is bad and bad must be loved, both threatening the loss of the self.

One way in which love can be seen as bad is when it is not freely available and therefore has to be taken: here Fairbairn picks out

the mother

> who fails to convince her child by spontaneous and genuine expressions of affection that she herself loves him as a person. Both possessive mothers and indifferent mothers fall under this category. Worst of all perhaps is the mother who conveys the impression of both possessiveness and indifference - e.g. the devoted mother who is determined at all costs not to spoil her only son (1940: 13; emphasis added).

The closeness of this description to Angyal's (Chapter 5) account of the parenting promoting the pattern of vicarious living is striking. Under such circumstances love is experienced as destructive and selfish because it means taking from the other: taking the love that is not given from the indifferent other and the love that is not given from the possessive one. By identifying with this style the child must in turn come to dread giving, feeling that giving means losing, depleting oneself. Here the schizoid dread of loss of self takes on a quite concrete form. The narcissist defends against this dreaded giving by hoarding good, exhibitionism and denigrating others, the schizoid personality by pure withdrawal, while the borderline feels already emptied.

The second pattern involves real or fantasied active rejection by the other. Fairbairn notes that the child's anger at rejection can easily exacerbate the rejection in reality - and one might add, in fantasy; here the child's temperament and reactions can play a significant role. But however rejection arises, it makes expression of love a dangerous business, threatening for the child "humiliation over the depreciation of his love...shame over the display of needs which are disregarded or belittled". The child is reduced to a state of "worthlessness, destitution or beggardom". He feels bad

in the sense of "inferior" and "demanding too much". "At a still deeper level (or at a still earlier stage) the child's experience is one of, so to speak, exploding ineffectively and being completely emptied of libido" (1944: 113); again the root anxiety is loss of the self. This form of schizoid anxiety speaks directly to the borderline, whilst narcissistic personalities show

> cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness in response to criticism, indifference of others, or defeat (DSM-III: 319).

One might say that we have in action here the characteristically schizoid superego, a conscience that acts negatively by punishment rather than reward.

Indeed, for Fairbairn (1941, 1944) in the schizoid position there is no guilt-producing superego, but in its place an internalized rejecting object. How this object, the split off rejecting part of the (m)other, comes to be loved and taken in is central to the third aspect of schizoid etiology. The crux of this matter is that "the child would rather be bad himself than have bad objects" (1943: 65), and hence takes on or internalizes the rejecting aspects of its objects. Fairbairn sketches graphically the kind of moral degradation (or tragic self-sacrifice!) that is involved when a child is forced into this position. The child's original motive

> in becoming bad is to make his objects 'good'. In becoming bad he is really taking upon himself (here taking can be justified - S.O'D) the burden of badness which appears to reside in his objects. By this means he seeks to purge them of their badness...The sense of outer security resulting from this process of internalization is, however...purchased at the price of inner insecurity; and his ego is henceforth left at the mercy of a band of internal fifth collumnists or persecutors (1943: 65).

The problem is internal - with the self.

Fairbairn placed great metatheoretical stress on this aspect of schizoid etiology, seeing the internalized bad object as defining the schizoid position. For Klein, as we shall see below (Chapter 4) the situation is much more complex; her work highlights the considerable oversimplification of Fairbairn's theory of the schizoid position. For now it must suffice to note that Fairbairn made most constructive use of this notion of a persecutory conscience in his understanding of antisocial behaviour (Fairbairn, 1943). Here he joined Klein (1930) in the perceptive and positive view that antisocial behaviour is typically motivated not by an underactive conscience, but by one that is excessively harsh and rejecting, driving the person to seek disapproval and punishment to expiate the guilt for an already assumed badness.

3.3: Fairbairn's ethical focus.

Fairbairn's work stands out in the psychoanalytic field for its uniquely close focus on ethics. Indeed, he understood the distinction between the schizoid and depressive positions in essentially ethical terms. Thus he described the schizoid's fear that love is destructive as creating a state of unconditional badness, and contrasted it with the depressive fear of destroying love with hate, which he characterized as conditional badness (Fairbairn, 1943). Unconditional badness creates, as we have seen, a profound sense of futility and fear of loss of self; conditional badness, in contrast,

gives rise to guilt about harm to and possible loss of the other.

From this it is already evident that in Fairbairn's ethics the depressive position is valued more highly than the schizoid. This is consistent with Fairbairn's developmental view in which the schizoid position is more primitive and/or regressed than the depressive, and his rooting psychopathy in the schizoid position. His account of schizoid object-relations is also consistent with this valuation: there is the schizoid tendency to take rather than give, and also the tendency to treat others as partial objects, that is, "as less than persons with an inherent value of their own" (1940: 12). A number of problems are raised here, centred around the dominance of the developmental model in Fairbairn's thinking, which are touched on in Chapter 8.

For the moment we can restate Fairbairn's ethical contrast in less value-laden terms, which highlight an analogy with the contrasting disturbances of affect noted in Chapter 2. For the schizoid love is bad and bad must be loved: here there is a disturbance within values. In contrast, depressive guilt and self-criticism are indicative of clear values which have been transgressed. Values are, of course, central to the self-concept, which must be threatened with disintegration if values are in their very nature confused. Conversely, transgression of values poses the problem in the other-centred mode: even if it is self-injury which is involved (as in a suicide attempt) the self appears as the injured object of a transgression.

To make this distinction quite clear, we must remember the coupling of the self-centred mode with extrapunitiveness and the other-centred with intropunitivenss (section 1.2). Transgression of values rebounds on the self (guilt, intropunitiveness); confusion of values poses it with the self, and rebounds on the other (antisocial behaviour, extrapunitiveness). Thus, to sum up, _Fairbairn's work highlights a contrast between the two basic positions and groups of disorders in the ethical sphere, a contrast of confusion of values versus transgression of values, and this contrast again expresses the basic self-centred/other-centred polarity_.

CHAPTER 4: THE KLEINIAN THEORY OF THE PSYCHOSES

In this and the followingtwo Chapters, the focus moves from the two groups of disorders in general to how they divide specific types of disorders: the psychoses (in this Chapter), the personality disorders (Chapter 5) and the neuroses (Chapter 6). In sections 4.2 to 4.5 of this Chapter, the views of Klein and her follower Rosenfeld on schizophrenia, paranoia, mania and psychotic depression are outlined, and related to Foulds' (1976) results concerning the psychotic disorders (Levels III and IV of Table 2, p 16), and to the DSM-III diagnostic criteria for these disorders.

In addition to giving a comprehensive understanding of the psychoses, Kleinian theory brings out no less than four further basic contrasts between the two groups of disorders. For the Kleinians the two groups are understood as rooted in the paranoid-schizoid and depressive positions respectively. Firstly, in terms of Segal's definition of a libidinal position as "a specific configuration of object relationships, anxieties and defences" (1964: ix; emphasis added), each of these three factors distinguishes the two positions and the two groups. The first two are dealt with in section 4.1; the third, which can only be elucidated through a critical discussion of Kleinian work, is left for section 4.5. Finally, there emerges also from Kleinian work a contrast between the two positions and groups (not made quite explicit) in the conative sphere, a contrast of vicissitudes of energy or motivation; this is related closely to the

contrast of defences, and is treated in section 4.6.

4.1: Anxieties and object relations.

Before considering anxieties and object relations it is necessary to clear up an ambiguity in Klein's usage of the term 'libidinal position'. When she first introduced the term (Klein, 1935), she distinguished between the paranoid, depressive, manic and obsessional positions, thus identifying positions with discrete disorders. Fairbairn (1940, 1941) took over the concept of the depressive position and contrasted it to his schizoid position. Klein (1946) accepted his contribution, with reservations, and renamed her paranoid position paranoid-schizoid. She later (1952) argued that mania makes use of paranoid-schizoid mechanisms, thus arriving at her final view (similar to Fairbairn's) of two basic positions.

There is in fact something to be said for both her usages of the term position. The former emphasizes that a discrete disorder, although it may involve only part of a person's existence, is nevertheless a constellation of anxieties, defences and object-relations - in a word, a whole way of being - to which the wholistic concept of position is applicable. The latter usage highlights groups of disorders, with their distinct basic anxieties and object relations (see below). Both usages can be preserved if we refer in the former case to specific positions and in the latter to basic positions. This serves to emphasise that we are dealing here with a unit structure (see p 18) in which parts and whole alike are fully human forms.

Klein's understanding of the basic anxieties (persecutory in the paranoid-schizoid position and depressive in the depressive position) brings out the self-centred/other-centred polarity quite explicitly:

> persecutory anxiety relates predominantly to the annihilation of the <u>ego</u>; depressive anxiety is predominantly related to the harm done to the internal and external loved <u>objects</u> by the subject's destructive impulses (1948: 34; emphasis added).

Thus the two basic anxieties are comparable to Fairbairn's fear of loss of self and loss of other in his schizoid and depressive po-itions, respectively. Klein in this (1948) paper stressed that the two anxieties in fact both appear in both the paranoid-schizoid and depressive positions but dominate in the positions to which they were originally related.

As far as object relations are concerned, Klein distinguished their forms in the two basic positions on two main grounds. Firstly, she (like Fairbairn - section 3.3) saw the object in the paranoid-schizoid position as a <u>part-object</u>. This means not only that the other (like the self) is here split into good and bad, but also that the prototype of such object relations is the infant's first attachment to the breast. Splitting is considered in relation to defences in section 4.5.

What is important for now is the distinction which Klein made between two <u>modes of identification</u> which characterize object relations in the two basic positions. Freud stated that "identification is the original form of emotional tie with an object" (1921: 65), and Fairbairn followed him in speaking of primary identification (section 3.2).

For Klein, likewise, the object relations of the basic libidinal pos-

itions are characterized by identification, but she enriches the concept, making a distinction between _projective_ and _introjective identification_. Klein did not make explicit the distinction between these two _modes of identification_ and projection and introjection _per se_. However, it seems to me that a distinction is necessary, for Klein did make it clear that introjection and projection are both constantly active, while _projective identification dominates the paranoid-schizoid position_, and _introjective identification comes to the fore in the depressive_ (Klein, 1952, 1955). Moreover, I think it is fair to say that _whereas introjection and projection are defences, the modes of identification characterize different forms of relatedness_. It is possible that in making this distinction I am going beyond what Klein intended, but it still seems to me worthwhile for the way it clarifies the distinction between the two basic positions and the various defences deployed within them (see sections 4.2 to 4.5 below).

Klein's clearest account of the phenomenology of the modes of identification is given in her (1955) discussion of a novel by Julian Green entitled _If I were You_. To illustrate introjection and projection and the correspondence between inner and outer that their combined action creates, she cites the following passage:

> Whenever he stared like this into the all-enveloping night he had a sensation of being lifted gently above the world...It was almost as if by the very effort of gazing into space a sort of gulf in himself, corresponding to the giddy depths into which his imagination peered, was being opened (quoted in Klein, 1955: 152).

The central theme of the book is projective identification: the hero

Fabian makes a pact with the devil whereby he is able to change himself into other people, literally put himself into them, and in this way express various aspects of his personality and fantasies. Thus he not only projects parts of himself into others, but fully identifies with what he has projected. In extreme schizoid states such as fugue and multiple personality the fantasy of changing oneself into another can be quite consciously realized; in more neurotic and every-day forms projective identification corresponds, I would argue, to what Angyal calls <u>vicarious living</u> - living through others (see Chapter 6).

It is not surprising that projective identification dominates the paranoid-schizoid or self-centred position; <u>this mode of identification is obviously self-centred, for the other is experienced in the image of (parts of) the self</u>. For Klein (1946) projective identification is associated with <u>splitting</u> - what is projected is first split off from the self. Projective identification of bad parts of the self is typically a violent process in fantasy, in which the parts are forced into the other to gain control over her or him. Alternatively, good parts may be projected and identified with, a process typically associated with the idealization of the other (Klein, 1952). <u>Projective identification is closely associated with the schizoid fear of loss of the self</u>. Parts may be projectively identified because the subject feels unable to contain them, and yet projective identification also brings the fear of depleting the self.

Concerning introjective identification, Klein again takes an example

from the novel:

> Fabian lays his father's gold watch on the table; he has a great affection for it and particularly likes it because of 'its opulance and glossiness and the clearly marked figures on its face'. In a vague way this watch also gives him a feeling of confidence. As it lies on the table among his papers he feels that the whole room acquires an air of great order and seriousness....I would conclude that the watch has some qualities of a fatherly nature such as order and seriousness which it imparts to his room and in a deeper sense to Fabian himself; in other words, the watch stands for the good internalized father whom he wishes to feel present (Klein, 1955: 152-3).

Introjective identification dominates the depressive or other-centred position; consistently, Klein speaks of introjected objects. Even in identifying with the introjected good father, Fabian experiences him as a presence; thus introjective identification is identification in the other-centred mode. Hence this mode of identification is closely linked to the depressive fear of loss of the other: it may be used as a defence against it, seeking to preserve as an internal presence what has been lost externally, while at the same time any loss must diminish the quality of presence on which this mode of identification depends.

In Klein's work it is possible to distinguish three specific psychotic positions: the paranoid-schizoid, manic and depressive; Rosenfeld (1949, 1950) motivated a distinction (which he did not make quite explicit) between the schizoid and paranoid positions, and his central point here was accepted by Klein (1957). Thus we arrive at four specific psychotic positions, corresponding to Foulds' four broadly psychotic disorders (schizophrenia, paranoia, mania

and psychotic depression); these are dealt with in turn in the following four sections.

4.2: The schizoid position.

Klein at first (1940, 1952) regarded splitting as a dominant and primary feature of the self-centred position, but could account for it only in terms of the innate death instinct leaving the infant no choice but to split off and project aggression. Subsequently, Rosenfeld (1950) identified in acute schizophrenic states the central theme of confusion:

> under certain external and internal conditions when aggressive impulses temporarily predominate, states may arise in which love and hate impulses and good and bad objects cannot be kept apart and are thus felt to be mixed up or confused. These infantile states of confusion are...related to the confusional schizophrenic states of the adult...(and are) associated with extreme anxiety, because when libidinal and destructive impulses become confused, the destructive impulses seem to threaten to destroy the libidinal impulses. Consequently the whole self is in danger of being destroyed (1950 53).

Here we have the most primitive self-centred anxiety, and an obvious parallel with Fairbairn's account of the schizoid's perception that good is bad and bad is good and consequent dread of loss of self (section 3.2). For Rosenfeld (1950) splitting arises as a defence against such confusional states, a view Klein (1957) subsequently accepted.

Rosenfeld (1950) focussed on confusion of loving and hateful impulses caused by an excess of hate; Klein (1957) added to this the notion of confusion between self and other resulting from excessive projective identification. These two factors promoting confusion can

be related to Fairbairn's views on the etiology of schizoid states (section 3.2). Fairbairn, you will recall, singled out in this regard indifferent and possessive parents. Indifferent parents will often respond only to rage and other forms of aggression, thus promoting Rosenfeld's confusion of impulses. Possessive parents can be thought of as projectively identifying with their children, hence reinforcing this mode in the children as they identify with the parents, and promoting Klein's confusion of persons.

These two forms of confusion are particularly applicable, I would argue, to the self-centred neuroses and personality disorders. To them one can add the factor emphasized by Bateson and others in the etiology of schizophrenia: the confusion of communication, which by putting the child in a 'double bind' must create confusion of impulses.

We are now in a position to throw some light on Foulds' division of schizophrenia between the extrapunitive and intropunitive groups. In her (1960) Note on depression in the schizophrenic Klein wrote:

> depressive anxiety and guilt...in so far as they already occur in the paranoid-schizoid position, refer also to a part of the ego, namely that part which is felt to contain the good object and therefore be the good part (1960: 265).

One might also add that anxiety about the self refers to the other which is felt to contain the self, through projective identification. The essential point is this: if one assumes that schizophrenia is characterized by confusional anxiety then there seems to be no reason why this sould not encompass confusion between good and bad objects as well as between good and bad impulses, and thus divide

into other-centred and self-centred forms, corresponding to Foulds' intropunitive and extrapunitive schizophrenia. This is only a hypothesis, of course, but one worthy of further consideration[6]. Schizophrenia poses a host of complex problems which cannot be dealt with here. Rosenfeld (1965) has explored the dynamics of schizophrenia in some detail, stressing splitting and projective identification. Bion (1963, 1970) has gone some way to explain the genesis of schizophrenic hallucinations (cf Meltzer, 1978).

4.3: The paranoid position.

Once the splitting defence has adequately secured the subject against confusional anxiety, the self-centred dilemma diverges into two forms, which characterize the paranoid and manic positions. In paranoia it is the excess of aggression which is the central problem, accompanied by the use of projection as a defence:

> Experiences of a painful nature, frustrations from internal and external sources, which are felt as persecution, are primarily attributed to external and internal persecutory objects. In all such experiences, persecutory anxiety and aggression reinforce each other. For while the infant's aggressive impulses through projection play a fundamental part in his building up of persecutory figures, these very figures increase his persecutory anxiety and in turn reinforce his aggressive impulses against the external and internal objects felt to be dangerous (Klein, 1948: 32).

At the very concrete level of infantile pre-verbal experience and psychotic regression, aggression is fantasied in terms of biting and devouring (oral), tearing and smashing (muscular), and attacking with dangerous, poisonous faeces and urine (anal and urethral

sadism): "In phantasy the excreta are transformed into dangerous weapons: wetting is regarded as cutting, stabbing, burning, drowning, while the faecal mass is equated with weapons and missiles" (1930: 219-20).

Gross smashing and destroying of objects are more primitive fantasies and can be related to confusional anxiety (things are smashed into bits and become mixed up), while paranoia can be related to "hidden assaults by the most refined methods which sadism can devise, (in which) the excreta are equated with poisonous substances" (1930: 220). This insidious, subtle nature of the aggressive fantasies underlying paranoids' persecutory anxieties leads them to develop "a very strong and acute power of observation of the external world and of real objects", and to "look at people mainly from the point of view of whether they are persecutors or not" (1935: 271).

One should not think that good objects have no role to play in the paranoid's world; good objects are treated primarily as allies against the persecutors, rather than as deserving of love in their own right (Klein, 1932: 262). This brings us to the connections between paranoia, narcissism and homosexuality, made by Freud (1911, 1922), Klein (1932) and Rosenfeld (1949). Freud's (1911) view was that paranoia is a conversion of homosexual libido, but Klein (1932) and Rosenfeld (1949) reversed the emphasis, treating the homosexuality as a defence against paranoia.

It seems to me that in the paranoid position splitting is primarily between self and others, with good reserved largely for the self

and bad projected into others. A consequence of this splitting must be an elimination of the ambiguity and rich contrasts created by the copresence of good and bad in self or others, and a corresponding impoverishment of affect. Accordingly, the DSM-III notes that paranoids are typically cold, humourless and lacking in warm, tender feelings. The reservation of good for the self can be related to the grandiosity noted by the DSM-III as an associated feature of paranoid disorders. The narcissism involved here can be related to Klein's (1932) observation that others are trusted and loved primarily as allies or extensions of the self in the fight against persecutors; here we see the motivation for homosexual love (and narcissistic object choice more generally) as a defence in paranoia. This feature of seeking allies is obviously pertinent in the DSM-III's Shared Paranoid Disorder.

However, Rosenfeld (1949) notes that homosexuality may serve as a direct defence against bad feelings and persecutory anxiety as well: homosexual acts may serve in fantasy to appease persecutors, or as a means of projecting bad into the other. It seems that the narcissistic element in paranoia is pervasive, encompassing aggression as well as love. This aspect of paranoid narcissism can be related to the fixation on the cogendered rival in the DSM-III's Conjugal Paranoia. Indeed, there is a marked and generalized preference for sameness and predictability in paranoids: their delusions are typically stable, they seek confirmation for them in all situations and are thus hypersensitive to criticism and exagerate their difficulties, and often prefer the predictability of mechanical things to the ambiguity of human contact (DSM-III). This central feature

can be related to the general self-centred mode of projective identification and the specific splitting between self and others, resulting in a world of minimal ambiguity.

4.4: The manic position.

Klein's views on the manic position changed somewhat in the course of her work. She earlier (1935) placed the manic position in developmental sequence after the depressive, and spoke of it as a way of resolving depressive and persecutory anxieties. Later, however, (Klein, 1946) she stressed that the defences used in the manic position - particularly splitting, idealization and denial, and omnipotent control - are characteristic of the paranoid-schizoid position, and "are, in some measure, maintained when the depressive position arises, but they are now predominantly used to counteract depressive anxiety" (1946: 73). Hence for the later Klein the manic defences bridge the two basic positions, but retain their essentially paranoid-schizoid character. Among these essential characteristics are the depreciation of objects and denial of their importance; hence the manic position is self-centred. Equally, guilt concerning the object is denied, and in depreciation aggression is directed to the object, and thus in Foulds' terms, the manic position is extrapunitive. The significance of its relation to the depressive position is explored under 4.6 below.

For Klein the "sense of omnipotence ... is what first and foremost characterises mania" (1935: 277; emphasis in original); this is com-

parable to Foulds' (1976) stress on delusions of grandeur as the essential feature. For the DSM-III, when a delusional element enters into mania, it is grandeur that is involved. Omnipotence, Klein (1935) suggested, is utilized to obtain mastery and control over objects, in order to neutralize the persecutory power of bad objects and to omnipotently repair damaged good objects. Omnipotence is closely associated with the denial of difficulties and thus objects may be killed in fantasy and then omnipotently resuscitated. Denial of danger allows for the "excessive involvement in activities which have a high potential for painful consequences which is not recognized" (DSM-III: 208).

Omnipotence can be equally used to triumph in fantasy over rivals, and to reverse the relation with the parents. Fantasies of triumph are associated also with the depreciation of and contempt for objects and denial of their importance, which can seriously impede the process of reparation (Klein, 1940) (on reparation, see under 4.5 below). Here the irritable, aggressive aspect of mania is highlighted, which may accompany or substitute for the sense of elation (DSM-III).

The converse of depreciation is idealization, in which the good aspects of self and others, and of experience generally, are grossly exaggerated. Splitting is of course involved here; split off bad is not projected onto the other as in paranoia, but rather denied. Again, good objects are not treated as allies against the bad, but rather greedily incorporated. The greedy assimilation of good experience (the bad aspects of which are denied) can be seen in the excessive involvement in risky activities such as "buying sprees, sexual indiscretions, foolish business investments, reckless driving" (DSM-III: 209).

> The hunger for objects, so characteristic of mania, indicates that the ego has retained one of the defence mechanisms of the depressive position: the introjection of good objects. The manic subject denies the different forms of anxiety associated with this introjection (anxiety, that is to say, lest he should destroy his good objects by the process of introjection) (Klein, 1935: 278).

However, this manic introjection must be distinguished from depressive introjective identification, in which the object is retained as an internal <u>presence</u>, for the manic subject "also sets going cannabilistic fantasies relating to the internalised loved objects" (1935: 257). In contrast to the situation in depression where the introjected good objects are installed in the ego ideal, in mania they are assimilated to the ego, and "the ego and ego ideal come to coincide" (1935: 257). This feature can be related to the absence of guilt and restrictions in the manic state.

Another aspect of the manic state must be taken into account to fully understand this form of introjection. Klein argued that in mania "that which is first of all denied is psychic reality" (1935: 277); thus the scene of greedy assimilation is not the internal world, but external reality: it is as if manic subjects eat their way into the position of the other, assimilating and supplanting the other at the same time. I would suggest that this is in fact a form of <u>projective identification</u>, in which the self is projected <u>over</u> rather than into the other. Certainly, it is a <u>self-centred</u> form of identification in which the other is assimilated to the self, not retained as an internal presence. In this view the distinction between the modes of identification and simple introjection and projection is reinforced, for whilst both paranoia and mania utilze projective (self-centred) identification, in paranoia projection of

bad dominates and in mania introjection of good.

4.5: The depressive position.

In the depressive position, splitting diminishes and takes on a different form.

> The ego, although earlier methods of splitting continue in some degree, now divides the complete object into an uninjured live object and an injured and endangered one (perhaps dying or dead) (Klein, 1952: 74).

That is, good and bad parts are now united in a whole object, and the central depressive anxiety involves the fear that the good parts will be damaged or destroyed by the bad, linked as always to the subject's own aggressive impulses (Klein, 1935, 1940). Thus depressive anxiety is centred on the loss or destruction of the other. Splitting is now utilized primarily as a defence against this anxiety, by splitting off the object in its injured or damaged aspect.

> Both in children and in adults suffering from depression, I have discovered the dread of harbouring dying objects (especially the parents) inside one and an identification of the ego with objects in this condition (Klein, 1935: 266).

This central anxiety about the copresence of good and bad can be related back to the theme of ambivalence which Abraham highlighted in depression (section 2.2).

Another important defence here is the introjection of good, to reinforce the internal objects against bad and to diminish the subject's own aggression by identification with the good presence. However, this defence may miscarry because of the ambivalence between loving introjection and aggressive, destructive incorporation (Klein, 1935),

especially if the subject's greed is excessive. Klein defined greed as

> an impetous and insatiable craving exceeding what the subject needs and what the object is able and willing to give. At an unconscious level, greed aims primarily at scooping out, sucking dry and devouring the breast: that is to say, its aim is destructive introjection (1957: 181).

Greed is likely to be exacerbated, and also ambivalence, if the infant is faced with inconsistent parenting; this is also likely to reinforce the fear that good will disappear or be destroyed. Inconsistent parenting is related by Angyal to the pattern of non-committment; in Chapter 6 I will argue that this represents the other-centred dilemma at the neurotic level.

The loss of appetite and more generally the loss of interest and libido characteristic of depression (DSM-III) can be understood as defences against greed and destructive introjection. This illustrates a more general pattern stressed by Klein (1935, 1940): the hatred of the id and its desires in the depressive position. This can be seen to underlie the loss of interest, libido and energy - psycho-motor retardation in extreme cases -, insomnia (the id and the unconscious dominate the sleeping state), and problems with memory and concentration (which depend crucially on the basic arousal of the nervous system).

This brings us in turn to the issue of repression in the depressive position. Klein stated earlier (1952) that repression comes into play as the genital stage of libido is reached; she later appeared to modify this view, stating that:

> splitting is to some extent overcome during the depressive

position and...repression of impulses and fantasies gradually takes it place (1957: 234).

However, her last word on the matter (1958) was that repression begins to operate in about the second year (in the anal stage). (For Klein both the paranoid-schizoid and depressive positions are equivalent to phases at the first, oral stage). Klein (1952) also stated that splitting underlies repression, and repression is a less rigid, less disintegrative form of splitting.

There is considerable confusion here, deriving to a large extent from Klein's continued use of the pure developmental model. What seems to me of enduring value is Klein's observation that splitting acts primarily between good and bad (i.e. vertically), whilst repression divides conscious and unconscious (a horizontal barrier); this distinction has been made explicit by Kohut (1971). If one accepts this view then the hatred of the id in the depressive position is certainly an attempt at repression, even if it is not successful. In support of this, one can cite the well-established view of Freud, accepted by Klein, that "repression is mostly directed by the judging, criticising faculties - the super-ego" (Klein, 1927: 170); for Klein (1935) the super-ego comes to the fore in the depressive position bringing with it the sense of guilt about damage to good objects, replaing the persecutory object of the paranoid-schizoid position <u>against which</u> splitting must be directed.

However, it must be clearly stated that to define repression in these terms - as specific to the other-centred position - is not consistent with the psychoanalytic tradition, in which repression is specific, if anything, for hysteria (Laplanche, 1974). The

issues raised in this connection are too complex to go into here; it must suffice to say that for the purposes of this work, repression and horizontal disintegration are attempts to stifle unacceptable impulses (depression) or to undo them (obsessive-compulseive neurosis) - in other words, this is the intropunitive mode of defence. Splitting or vertical disintegration is defined as the attempt to express unacceptable impulses separately (by dissociating or converting them), which means that no specific attempt is made to protect the other from them - thus the mode of defence is extrapunitive.

Klein (1933, 1935) fully accpeted Freud's view that the superego develops through introjection - in other words, morality is a social inheritance. The harsh and forgiving faces of the conscience thus correspond to the bad and good aspects of the introjects. Guilt, as concern for the other, is associated with depressive anxiety (Klein, 1948), and gives rise to two contrasting tendencies. If aggression dominates the picture, guilt leads to harsh self-criticism and ruminations of regret - central features of depressive disorders (DSM-III); here we have the intropunitive aspect of the depressive position. On the other hand, love motivates reparation, the desire to repair or heal the damaged object, to make good the harm done to it. For Klein (1935) the desire to make reparation often motivates recourse to manic activity and fantasies of omnipotence; the manic position allows also for denial of damage done and/or depreciation of the damaged object, and escape from self-criticism through identification with the super-ego.

4.6: Conclusions.

If one makes a distinction between the schizoid and paranoid positions, a Kleinian account of Foulds' psychotic disorders (Levels III and IV) becomes possible. Not only do the dynamics of the four positions account well for the symptoms of the four disorders, but their pattern of mixing is explicable as well. Firstly, for Klein (1957) an exacerbation of either greed or projective identification will lead to confusional states, i.e. a subject may regress from either depression, mania or paranoia (Level III) down to schizophrenia (Level IV). Secondly, Foulds (1976) found that there was significant mixing of both paranoia and mania with psychotic depression, but none between paranoia and mania (1976: Table 5). For Klein (1935) paranoia comes developmentally before the depressive position and mania afterwards. The implication of this is that the resolution of psychotic anxiety involves a passage from the self-centred position to the other-centred and back again, which undercuts Fairbairn's view (section 3.3) that the other-centred position is unambiguously more integrated than the self-centred, and indeed Klein's own tendency to think in these terms. We will return to this notion of the journey back in relation to Heidegger (section 7.2).

Finally, this inclusion of mania in the self-centred position involves its detachment from the composite manic-depressive or bipolar disorder, a category the DSM-III maintains. The artificiality of this category is clearly demonstrated in Foulds' study: he found that in the pathologies rooted at Level III there was more

mixing between paranoia and psychotic depression (17% of the combined group) than between mania and psychotic depression (8%) (1976: Table 5). The placing of mania by Foulds and Klein in the extrapunitive or self-centred position also clears up the problem of the delusions of grandeur and states of irritability noted by Jung and Fairbairn in their investigations of the hysteria/schizophrenia or schizoid spectrum of disorders (Chapter 2 and 3).

A further basic polarity between the two positions has been revealed, between the outbursts of the extrapunitive disorders (states of elation and irritability, hysterical fits, lability of affect) and the inhibitions of the intropunitive (depressive loss of interest, energy and libido, obsessive-compulsive restrictions and undoing, phobic avoidance).

This global contrast confirms the meaningfullness of the distinction between splitting and repression as defined here: the former allows for outbursts of bad, whilst the latter seeks to inhibit them. What is at stake here is a basic conative factor: the will either to dispose of bad by splitting and projective identification or to hold it within with introjective identification and repression. This conative contrast between the self-centred and other-centred positions complements the affective, cognitive and ethical contrasts identified in Chapter 2 and 3. Overall, the implication is that classical psychoanalysis erred in seeing conative factors as fundamental and moreover reducing them to energy terms; this perspective suggests rather that conative, affective, ethical and cognitive aspects are all rooted in the fundamental modes of relatedness.

The contrasts between the two basic positions identified in Kleinian theory - particularly the contrast of projective and introjective identification - bring out very clearly the fact that *each position is a complete mode of relatedness between the self and other*. In other words, *the axis of relatedness* (on which the two groups are ranged) *passes not simply from self to other but from self-centred relatedness to other-centred relatedness*.

CHAPTER 5: ANGYAL'S THEORY OF THE NEUROSES.

This Chapter is concerned with Angyal's posthumous work Neurosis and treatment: a holistic theory (1965). In this work Angyal distinguishes two basic patterns of neurotic conflict, which he calls the pattern of vicarious living and the pattern of noncommitment. He holds that these patterns account for the dynamics of hysterical and obsessive-compulsive neurosis respectively, but are of a more general significance, dividing between them the broad spectrum of neurotic conflict, including cases on the one hand which present with no classical neurotic symptoms and on the other hand cases which involve significant personality disturbance. The central argument of this Chapter is that Angyal's two patterns represent the self-centred and other-centred conflicts of the neurotic level.

Angyal's account of the etiology of the pattern of vicarious living is strikingly similar to Fairbairn's description of schizoid etiology; he also gives a clear account of the etiology of noncommitment. Thus we are able to identify an eighth contrast between the two basic positions; in the sphere of etiology. Beyond this, it will be suggested that Angyal effectively restates the main themes of the Kleinian theory of the basic positions (Chapter 4) at the neurotic level.

In section 5.1 the basic assumptions of Angyal's theory are very briefly reviewed, and it is suggested that he assumed a wholeness

in the personality akin to that which we associated with the interpersonal model in section 1.2. Then, in sections 5.2 and 5.3 the etiology and dynamics of the two patterns are reviewed, and compared with the Kleinian theory of the basic positions. Finally, the contrasts between the two patterns are related to the self-centred/other-centred polarity, in section 5.4.

5.1: The basic assumptions of Angyal's theory.

Angyal's (1965) work, as its title indicates, stresses the inherent wholeness of the personality, its organization as a system of fully interdependent parts. Consistent with this, Angyal argues that any neurotic disturbance must affect the whole personality.

> Neurosis is not a partial disturbance limited to just one province of the personality. Neurosis is a sweeping condition. It is, in fact, a way of life - self-destructive, to be sure, but nonetheless an organization with its own goals, attitudes and motivations...(1965: 71).

At the same time, however, the whole personality is also healthy (1965: 104). That is, the personality in conflict (and, to an extent, any personality) forms an ambiguous gestalt, in which the patterns of health and disorder can both be traced throughout.

> In an ambiguous Gestalt, the parts do not belong independently to one pattern or the other. All parts belong to both patterns and have their function assigned to them by the currently dominant system principle (1965: 104).

A corollary of this view is that disorder is not simply dis-integration, but rather unhealthy organization, and that the worse a disorder becomes the more organized it becomes, within its unhealthy

pattern.

Two points must be made reflecting on the above. Fristly, of all the authors reviewed in this work, Angyal states most clearly and forcefully that the psyche is a whole, in the sense defined in section 1.2 of being internally related or having a unit structure. Angyal's conception is consistent with the Kleinian view that any disorder is rooted in a libidinal position, which is an orientation of the total personality. Secondly, Angyal's concept of the ambiguous gestalt, although clearly consistent with internal relatedness, is not obviously consistent with the hierarchical and developmental models, which seem to imply that some disorders are more localized than others. Note, however, that the Kleinian model has the same ambiguous implication as Angyal's, for the basic positions are both potential bases of pathology and potential "pillars to mental stability" (Bianchedi et al., 1984: 393).

Angyal places great stress on relatedness. Thus he argues that neurosis is a failure of relatedness (1965: Chs 6 & 7). As regards etiology, he reasons that

> (A) characteristic of early mental states...is the absense of differentiation, of a clear distinction between the 'I' and the world, the subject and the object; to the young child, they are one...The original unity of the organism and its environment is disrupted in the process of birth, and probably very soon after that the child begins to develop an awareness of his separateness, a growing differentiation between the 'I' and the 'non-I'...Although the experience of isolation brought about by the dissolution of the original unity is the primary source fo anxiety, it cannot be considered pathogenic in it-

> self. In fact, this isolation represents an opportunity to become human; it requires the child to re-relate himself to the world by exercising the two basic human trends, mastery and love...If opportunities for mastery and for experiencing love are too meagre...the world remains alien and the child's state of isolation persists. This persisting heightened isolation is the basis of neurosis (1965: 73-65; emphasis added).

This account is consistent with the Kleinian view that infantile experiences are central in the etiology of all disorders. In its detail it is comparable with Winnicott's view (section 7.1), although as we shall see, he adds the subtlety of treating persisting lack of differentiation as well as persisting isolation as pathogenic.

A final general point must be made, to introduce the discussion of the two basic neurotic patterns.

> Specific dynamic patterns are distinguishable in neurosis, but they cannot be viewed as forming separate, mutually exclusive classes in one or other of which all patients could be placed. I find it more useful to think of these patterns as dimensions to neurosis, i.e. as present in all cases, although in varying degree (1965: 135).

The same point is implicit in the Kleinian notion of the constant co-presence of the basic positions and in Foulds' evidence for the ubiquitous mixing of discrete disorders. Bearing this in mind we will consider the two patterns separately.

5.2: The etiology and dynamics of vicarious living.

The central dynamic of the vicariously living person is that

> feeling empty and worthless, he sets out to change or 'create' himself - through imitation, by living up to some borrowed standards, or by allying himself with a valued person - and to restore his self-esteem by obtaining attention and approval... the most painful emotional state is the 'anxiety of nothingness' which results from self-obliteration and may appear as fear of death or of fatal disease (1965: 190-1).

This bears comparison with Jung's (1907) description of the hysteric's concern with appearances (section 2.1) and Fairbairn's notion of the schizoid fear of loss of self (Chapter 3). Before exploring this dynamic further, it is worth examining its etiology.

You will recall that Fairbairn stressed indifferent and possessive parenting in the etiology of the schizoid position; Angyal mentions both of these, and a number of other factors.

> Among the early situations most frequently uncovered in therapy (of vicarious living - S.O'D) are those that are apt to produce a sense of insignificance in the child, a feeling that he does not matter. Being belittled or disregarded, having one's wishes or contributions discounted, not being responded to by an emotionally withdrawn significant adult fall into this category (1965: 139).

These are variations on the theme of indifference. Over solicitude has similar effects, whether motivated by the parents's anxiety for the child or a desire to counteract her or his own feelings of inadequacy by being superior to the child.

> In either case the child cannot escape the conclusion that he is weak, too incompetent to cope with a difficult and dangerous world, and must rely on parents for help and protection. The right to be oneself, to live one's own life, is traded in for safety (1965: 140).

In addition to these two, Angyal mentions experiences "that imply

to the child that his parents or his teachers are not satisfied with him essentially as he is but want him to be different" (1965: 141; emphasis in original), and experiences "of being cast into a false role by the parents and being faced with expectations he cannot fulfill without totally disregarding himself" (1965: 141). The latter situation can arise when "the circumstances of the child's life seem to conspire to cast him into a role unnatural for his age and temperament" (1965: 141), as when the child is forced to assume the role of a 'parental child'.

The common theme running through all of these etiological factors is the implication that the child is not good enough or acceptable as he is. The response, naturally enough, is 'sweeping repression' of all that is spontaneous and genuine, and the adoption of a 'pseudo-personality'.

> By whatever method this substitute personality is built, it is a flimsy and vulnerable formation, which, to be maintained must receive constant validation from the outside. This is why, in vicarious living, relationships to people are of central importance, and why the patients so strikingly demonstrate the general human struggle for closeness, for acceptance by others (1965: 142).

From this derives the familiar hysterical theme of attention-seeking. With the very basis of the self-concept endangered, the need for acceptance and approval from others reaches such a pitch that manners, attitudes and styles can be taken over wholesale from others by imitation. Idealization is often involved in this: either it is idealized others that are imitated, or traits are adopted in service of an internal ideal.

The dynamics of the self-centred position (Chapter 4) are clearly in evidence here. The 'sweeping repression' of the spontaneous and genuine self can be regarded as a splitting defence, especially in the light of Kohut's (1971) view that splitting creates vertical fractures in the personality and Winnicott's (1965a) argument that splitting underlies the true self/false self development. The phenomena of imitation can be related to projective identification: in flight from a crumbling self the person, as it were, takes refuge through identifying with the other. The fact that idealization is associated with this is again consistent with the Kleinian view. In this connection it is significant that while Klein (1945) criticised Fairbairn's conception of the schizoid position on a number of grounds, she felt that his suggestion of a connection between hysteria and schizophrenia was valid.

In addition to simple hysteria, Angyal distinguished two further variants of the pattern of vicarious living. In hysteria with negative defences a negative, hostile and aggressive attitude is added as a defence against the weak self-concept and concommitant suggestability and openness to influence.

> The cause of this indiscriminately absorptive adjustment can be projected outward and experienced as an external threat of coercion, as violation of one's person (1965: 149).

In Kleinian terms, when splitting and projective identification are used to defend against bad, persecutory anxiety results.

Secondly, in borderline hysteria, a psychotic element enters the picture.

> The hysterical forms of expression are cultivated and cher-

> ished, and the resources of imagination are mobilized and recklessly used to form and uphold a vicarious existence in an almost delusional fashion...The outstanding themes of these fantasies are love and personal importance or power, all of spectacular quality and of grand dimensions

Here there are clear features of the narcissistic personality disorders, and the grandiose delusions of mania. Significantly, the two exacerbated forms of hysteria appear to lead into the paranoid and manic positions, the two self-centred positions on Level III (cf Chapter 4).

Note that, consistent with Angyal's view that exacerbation of disorder involves its increasing organization, these two exacerbated forms of hysteria involve, respectively, the addition of the negative defences and the more thorough and committed development of the false self.

5.3: The etiology and dynamics of noncommitment.

For Angyal the pattern of noncommitment underlies the obsessive compulsive neurosis, and also a range of neurotic conditions without classical symptoms. He stresses that his view of the obsessive-compulsive neurosis differs more from the classical analytic view than his view of hysteria does. On his first point of difference, the conception of this work is in full support. Angyal states:

> I do not believe that the obsessive-compulsive pattern ... represents a more regressive condition than the hysterical dimension of neurosis (1965: 156).

Following Foulds (1976), we have placed both hysteria and the

obsessive-compulsive neurosis on Level II (Table 2, p 16).

The second point requires a little discussion. For Angyal as for Abraham (1911; section 2.2) the most salient feature of obsessive-compulsive neurosis is <u>ambivalence</u>:

> My main thesis about the pattern of noncommitment is that it is the outcome of an abiding confusion as to whether the world is basically friendly or inimical. This painful state of uncertainty leads the person to respond to significant people with both hostility and love and results in an unceasing search for ways to dispel confusion and gain an unequivocal orientation to the world (1965: 157).

But where psychoanalysis has tended to stress abnormally strong aggression (rooted in an anal-sadistic fixation (Freud, 1909)) as underlying this orientation, Angyal stresses environmental influences and natural defences against them.

This brings us to the question of the etiology of noncommitment.

> In the childhood of people who develop this pattern one traumatic factor always stands out: the <u>inconsistent behaviour</u> of a significant adult or adults that made it impossible for the child to discover even moderately reliable ways of gaining acceptance (which the hysteric is usually able to do at the price of self-obliteration) (1965: 157; emphasis added).

Inconsistency may take the form of sharp changes in the others' moods and responses, unpredicatable and erratic discipline, or actual contradictions in the others' demands and in their own attitudes and behaviour.

For Angyal, such inconsistency results in ambivalence between love

and hate via a deeper ambivalence between trust and mistrust.

> Given the uncertainty as to whether the world is friendly or hostile, it is safer to act on the negative assumption than to let oneself be lulled into a false security (1965: 162).

Hence the overt hostility and guardedness of the noncommitted person.

From the persepective of this work Angyal's formulation has the advantage of making it very clear that this is an other-centred delimma. Angyal's general emphasis on environmental factors in etiology is a very useful antidote to the general tendency in psychoanalysis to underestimate or oversimplify them. And yet in this instance Angyal appears to have overstated his case. Thus when he discusses etiology of vicarious living he adds the important qualification that the child's own attitude can easily exacerbate the experience of being overlooked or belittled, but makes no equivalent qualification in relation to the etiology of noncommitment. And yet there can be no doubt that some children are from birth more aggressive, harder suckers or biters, and more restless, and that such traits can make otherwise attentive parents at times lose patience or lose it more easily, thus exacerbating inconsistency. It would seem to me safer to allow for an interaction of constitutional and environmental factors in any discussion of etiology. This point must be borne in mind when we relate Angyal's discussion of the dynamics of noncommitment to the Kleinian understanding of the other-centred or depressive position.

Turning now to these dynamics, Angyal argues firstly, like Abraham (1911; section 2.2), that ambivalence leads to chronic doubt and indecision. He sees two dynamics at play here: on the one hand

> the noncommitted person is unable to be wholeheartedly involved in anything. Because the double orientation of hate and love pervades all areas of life, none of his actions is backed up by his whole personality, and he is to some extent uncertain about everything (1965: 165).

On the other hand, the negative pole of the doubt or uncertainty is constantly fed by the noncommitted person's considerable aggression.

> The issues about which obsessional doubt arises often have connotations of danger and aggression...neglecting to lock the door may allow burglars to enter, failing to turn off the gas may cause a fire (1965: 165).

Secondly, the noncommitted person shows pervasive inhibition of action and emotion: "he moves, as it were, in a dense medium of inhibition, because almost anything he tries to undertake also activates the opposite tendency" (1965: 166). As a result of these constant counter-impulses, the person finds that every action requires extra effort, and suffers from chronic tension, resulting, among other things, in insomnia. Here the pattern shades into the area of depression. There is also particularly strong inhibition of feelings and expressions of love, and a general tendency (known to psychoanalysis as the defence of isolation) to repress emotions while retaining in consciousness the associated ideas.

Aggression is distinctly less repressed by the noncommitted person than love.

> These patients feel at home with aggression, which, in the world visualized in their prevalent orientation, is justifiable and the only safe course to take (1965: 170).

Aggression may be overt, rationalised in the form of compulsive criticism and faultfinding, or disguised in the form of fears of hurting others, often by extremely unlikely or impossible means. Finally,

aggression may take the form of compulsive disobedience and intolerance of restrictions. Angyal accepts that the aggressive urges of obsessive-compulsive neurotics often find expression in anal fantasies and practices. However, in contradistinction to the classical analytic view, he does not see this in terms of regression to a stage dominated by anal eroticism, but because of the association of toilet training with "the first aquaintance with the ideas of good and bad, with orders and prohibitions, and the first real possibility of fighting the supposedly hostile surroundings" (1965: 173).

Fourthly, severe guilt is always present in the noncommitted person. Guilt may appear

> either openly or as compulsions and obsessions with a special content: doing penances, compulsive handwashing and other purification rituals, various forms of magically undoing what has been done. The phenomena of reaction formation in which hostility turns into friendliness can also be viewed as expressions of guilt (1965: 180; emphasis in original).

In full agreement with Klein (section 2.5) Angyal understands the dynamic of guilt as a result of ambivalence and particularly the fear that aggression may be directed at a loved or potentially friendly person.

> Guilt is often felt consciously, but it is seldom felt in its full impact or placed where it truly belongs (1965: 181).

It may be displaced onto more minor matters, or dealt with by isolation. Or again, the desire for self-abnegation, humiliation and subjection may appear as a way of propitiating the anger of those aggressed.

Finally, Angyal notes that a number of defences are used in the attempt to avoid or overcome the basic ambivalence. One defence of this sort that Angyal describes is unmistakably splitting.

> One way of dealing with the confused image of the good-bad world is to divide it sharply in two, ascribing goodness to one part, and badness to the other; one can then respond to them differentially (1965: 185).

However, this defence is rarely dominant, and not particularly successful in the noncommitted person.

> Unlike the hysteric who, by suppression and exaggeration, can easily make things look black or white, the noncommitted person rarely succeeds in his desperate struggle to achieve a lasting separation of his two orientations. Again and again the positive and negative images are blurred or reversed... (1965: 186).

Alternatively, the person may attempt to reconcile the opposites, often in an intellectual way, leading to a pedantic desire to always fully explore both sides of the story.

It should by now be evident that Angyal's major departure from the psychoanalytic understanding of obsessive-compulsive neurosis is in his rejection of Freud's (1909) hypothesis of a fixation at and/ or regression to the anal stage. In this respect many subsequent psychoanalysts have concurred: Klein deemphasised the notion of psycho-sexual stages in favour of libidinal positions, Fairbairn (1941) rejected it completely, and Mahler et al. (1975) replaced it with a new developmental theory. Beyond this, Angyal's differences with Klein are matters of emphasis: he stressed that the noncommitted person feels justified in being aggressive, having experienced inconsistent parenting and continuing to perceive the world as untrustworthy. Yet he acknowledges the fear of harming loved others and

the associated guilt. Klein (1935, 1940; section 4.5) makes this the central point and underestimates the environmental factors. Angyal, in contrast, overemphasized aggression; I would suggest that noncommitted persons do not in general feel 'at home' and justified in their aggression, for on his own account it is also a cause of painful guilt and fear. It is surely more consistent to argue that they feel <u>ambivalent</u> about it. This may not be immediately obvious, because of the defence against guilt, but it is likely to represent the deeper situation.

At the same time the importance of the environmental factors identified by Angyal should not be underestimated. It seems to me that an appreciation of their role must be crucial in therapy. If Angyal is correct in suggesting that noncommitted persons experience the world as hostile, then <u>interpretation of their aggression as essentially their own affair (i.e. as irrational or unjustified) must be perceived as an attack, confirming the 'transference expectation' and inhibiting therapeutic progress</u> (cf Weiss, 1971; Sampson, 1976). At the same time, it seems to me that to dissove the noncommitted pattern clients must fully experience their loss of the good that freely expressed love can bring, and accept responsibility for and repair the damage done (to self and others) by their aggression - that is, <u>they must work through the depressive position</u>.

5.4: The self-centred/other-centred polarity in Angyal's work.

Angyal related the contrast between his two patterns quite directly to the self-centred/other-centred polarity.

> The central neurotic strategy is focussed on one or other of the two poles of the personal world. The vicariously living person concentrates on the subject pole; feeling empty or worthless, he sets out to change or 'create' himself...The noncommitted person concentrates on the object pole of the world; the hostile world must be forced to yeild the satisfaction he craves...(1965, 190-1).

The same theme emerges in the contrasting etiological factors identified by Angyal. The various means by which the self-concept of the future vicarious liver is undermined clearly place the problem with the self. These parents appear consistent and rational, and the child must feel that it is not acceptable because of what it is. The inconsistency of the parents of future noncommitted persons, in contrast, does not clearly indicate that the child is at fault, and puts the parents themselves in an obviously bad light - so the problem is with the other.

Thus far Angyal's treatment is exemplary, expressing the self-centred/other-centred polarity more clearly than Fairbairn's or Klein's. However, when one attempts to relate this contrast of etiological factors back to his general description of the etiology of neurosis (section 6.1) a problem arises. Angyal, you will recall, saw the basic neurotic state as a failure to re-relate after the loss of primal unity. But it seems to me that while this applies directly to the essential inability of the noncommitted person to enter stable and positive relationships, i.e. to achieve commitment in relationships, the vicariously living person who is constantly attempting to become like others is attempting to prolong the primal unity and has not acknowledged isolation. We will disocver in the next Chapter that Winnicott has in effect stated precisely this, in a formulation of the nature of interpersonal boundaries in the two

basic positions and their associated groups of pathologies.

To conclude, for our purposes Angyal has made two important contributions: he has given an account of the two basic positions which is largely consistent with the Kleinian understanding of them, but which captures particularly well their expression at the neurotic level, and he has identified very clearly the environmental factors in the etiology of the two basic positions and their associated groups of disorders.

CHAPTER 6: THE TWO GROUPS OF PERSONALITY DISORDERS.

Foulds (1976) excluded personality disorders from his study, making a theoretical distinction between personality deviance and personal symptomatology (to which his hierarchy applies). Considering the relations between these two categories Foulds concluded that they are essentially independent, i.e. neither is necessarily inclusive of the other. However, we have already identified a schizoid or self-centred group of personality disorders (Chapter 3) which suggests that the division into two groups applies here too. In section 6.1 the way the personality disorders are grouped in the DSM-III is examined, and also data given there on the mixing of personality disorders and their association with other disorders. On this basis it is argued that there are indeed self-centred and other-centred groups of personality disorders, and moreover both groups can be organized in a rough hierarchy of four levels. Thus there is a parallel field of personality disorders, with axes of relatedness (groups) and integration (levels). This confirms Foulds' suggestion that personality deviance and personal symptomatology are essentially independent dimensions of pathology. The implication is that the total field of psychopathology has in fact three orthogonal axes, the third being that of personal symptomatology/personality deviance, so that the bi-axial structure of groups and levels appears in two parallel forms ranged along this third axis.

In section 6.2 the dynamics of the two groups are briefly considered,

and found to correspond to those of the schizoid (self-centred) and depressive (other-centred) positions in the field of personal symptomatology. In section 6.3 it is argued that this fully confirms the notion that the axis of relatedness (in its full dynamic significance) divides personality deviance as well as personal symptomatology into two groups.

6.1: Groups and levels of personality disorders.

The DSM-III groups its eleven personality disorders into three clusters: the Paranoid, Schizoid and Schizotypal "often appear 'odd' or eccentric"; the Histrionic, Narcissistic, Antisocial and Borderline "often appear dramatic, emotional or erratic", and finally the Avoidant, Dependent, Compulsive and Passive-Aggressive "often appear anxious or fearful" (DSM-III: 307). Considering the reasons for these groupings, it is clear that the common features of the first two clusters are phenomenologically closer to each other than either are to the common features of the third cluster. Consistently, the first two clusters together make up the schizoid group of personality disorders identified in Chapter 3, and the prominent anxiety of the third cluster is exactly what we would expect of a depressive group of personality disorders, given the close association of anxiety and depression noted by Abraham (1911) and confirmed by Foulds (1976) (section 2.2). This division of the personality disorders into two groups will be confirmed from a dynamic point of view in the next section.

In addition it is possible to organize the personality disorders

into a rough hierarchy of four levels of severity (Table 3). The indices of severity used are the mixing of personality disorders (i.e. personality disorders tend to be inclusive of others) and the various other complications which tend to develop from them. The data on these two points are taken from the DSM-III.

Starting with the schizoid group (Schizoid, Schizotypal, Paranoid, Narcissistic, Borderline, Histrionic and Antisocial) one of these - the Antisocial - has but one complication (Substance Use Disorder), and is not commonly associated with other personality disorders. Antisocial personalities, of course, have made a complete extrapunitive adjustment; they can be placed on Level I of the hierarchy. The Histrionic personality disorder is also not commonly associated with other personality disorders, but is prone to a range of complications: Substance Use Disorder, Conversion and Dissociative Disorders, Major Depression and BRP; clearly a more severe disorder (from the subject's point of view), it can be placed on Level II. The Borderline and Narcissistic personality disorders are often inclusive of each other and of the Histrionic and Antisocial, while the Borderline is often associated also with the Schizotypal; following Foulds' principle that more inclusive disorders are more severe, they should be placed on Level III. This covers the "dramatic, emotional or erratic" cluster and leaves the "'odd' or eccentric" cluster. All three of these are linked in some way to schizophrenia - the Schizotypal (which replaces the old simple schizophrenia), the Schizoid (which may be predisposed to schizophrenia), and the Paranoid (which may be predisposed to Paranoid Disorders and Paranoid Schizophrenia) - and are thus appropriately placed on Level IV. Of

these the Paranoid and Schizotypal are prone to BRP.

Level	Group Schizoid Extrapunitive	Depressive Intropunitive
I	Antisocial	Avoidant
II	Histrionic	Compulsive Passive-Aggressive
III	Borderline Narcissistic	Dependent
IV	Schizoid Paranoid Schizotypal	

Table 3: Groups and Levels of personality disorders.

Four personality disorders - the Avoidant, Compulsive, Passive-Aggressive and Dependent - are left over. All except the Avoidant are prone to Major Depression and none to BRP, and all "often appear anxious or fearful". Given that Foulds (1976) found that intropunitive disorders score more highly on a measure of anxiety and depression than extrapunitive disorders, it is logical to place these four in the intropunitive or depressive group.

Of the four, the Avoidant is the most integrated, associated only with Social Phobia, and can be placed on Level I. On Level II, the Compulsive - mirroring the Histrionic - is prone to Obsessive-Compulsive Disorder, Hypochondriasis and Major Depression, and the Passive-Aggressive to Major Depression and Alcohol Abuse. Clearly the most disturbed (Level III) is the Dependent, prone to Major Depression and associated with the Avoidant, Schizotpyal, Histrionic and Narcissistic personality disorders.

6.2: The dynamics of the two groups of personality disorders.

In the psychoanalytic literature the term 'borderline' is often used broadly, to cover most if not all of what is meant here by the schizoid group of personality disorders. Thus Rinsley:

> Subsumable under the borderline rubric is a wide spectrum of personality disorders otherwise classified as schizoid, inadequate, infantile, narcissistic, hysterical, cyclothymic, sociopathic, and so on (1979: 66).

In his discussion of The Structural diagnosis of the borderline personality organization (1979), Kernberg is somewhat more restrictive. Thus he excludes "most typical hysterical personalities," but includes "the hypomanic personality and the cyclothymic personality with strong hypomanic trends" (1979: 102), as well as the paranoid, schizoid, narcissistic and antisocial personalities. Significantly, he excludes also "most obsessive-compulsive personalities and the 'depressive personality'" (1979: 103).

Against this background we can take what Kernberg and Rinsley say about the dynamics of the borderline as representative of the schizoid group of personality disorders as a whole. It is not surprising, then that the dynamics that they desribe are those of Klein's paranoid-schizoid position, or the self-centred position. Thus Kernberg (1979) mentions splitting, primitive idealization, projection and projective identification, denial, omnipotence and devaluation. The inclusion of the last three, which for Klein characterise the specific manic position within the broad basic paranoid-schizoid (self-centred) position (section 4.4) is consistent with

Kernberg's inclusion of hypomanic personalities within his borderline group. For Kernberg, what distinguishes borderline personalities from psychotics is their maintenance of reality testing despite the use of these 'primitive' defences.

It must be stated, however, that for Kernberg these borderline mechanisms, which he describes as "defensive operations centred around splitting" (1979: 107), are distinctly more regressed than the neurotic repressive defences. Rinsley (1979) who takes a more Fairbairnian view of splitting and part-object relations, includes hysteria in his borderline group. Both Rinsley and Kernberg emphasise the lack of self/other differentiation and fantasies of merger with the other in the borderline group; this is consistent with what Winnicott has to say about interpersonal bounderies in the basic schizoid position (section 7.1).

The depressive personality disorders have not been studied as a group. Nevertheless, the basic depressive dynamics are quite evident from their symptomatology as detailed in the DSM-III. Thus, firstly, all four are characterized by low self-esteem, low self-confidence and/or harsh self-judgement, i.e. by the intropunitive style. As we have come to expect (see especially section 3.3) this style is associated with a perception that the problem is with the other: the Avoidant sees the other as rejecting, the Dependent feels that the other should take charge, and yet is afraid to make demands, the Compulsive must constantly struggle to control and organize others, and the Passive-Aggressive to defy them. As in Angyal's pattern of noncommitment, the world is seen as threatening and hostile. Thirdly, all four use a basic inhibitory style of defence

(which was contrasted to the splitting style in section 4.5): the Avoidant avoids others; the Compulsive is generally overcontrolled and inhibits particularly warm and tender emotions; the Dependent inhibits self-assertion, and the Passive-Aggressive the direct expression of diagreement and aggression.

6.3: Conclusion.

The argument in this Chapter for a division of the personality disorders is certainly less rigorous and powerful than the arguments for the division of the psychoses (Chapter 4) and neuroses (Chapter 5). Yet it has an obvious <u>prima facie</u> validity, being supported by three converging lines of evidence. Firstly, the division advanced here is consistent with the grouping of the personality disorders in the DSM-III into three clusters, with two of these clusters (the "dramatic, emotional and erratic" and the "'odd' or eccentric") assigned to the self-centred group, and the third "anxious or fearful") to the other-centred group.

Secondly, the data given by the DSM-III on the mixing of personality disorders and their common complication also supports this division. Self-centred personality disorders (in particular, the Borderline and Narcissistic) mix with, or are commonly associated with traits of, only other self-centred personality disorders. Of the other-centred group, only the Dependent personality disorder commonly mixes, with the Avoidant, Histrionic, Borderline and Schizotypal. The latter three are clsssified in the self-centred group, suggesting that the Dependent represents a borderline case in the other-centred group.

In all other respects it clearly belong there. With regard to complications, five of the seven self-centred personality disorders are prone to BRP, while none of the other-centred group are; three of the latter four are prone to Major Depression.

Finally, there is evidence that the dynamics of the two groups of personality disorders are those of the two basic libidinal positions. Thus the self-centred personality disorders have been grouped under the broad 'borderline' rubric, and shown to have the typical paranoid-schizoid dynamics of splitting, projective identification, idealization and denial. In contrast, the other-centred group show typical symptoms of depressive conflicts such as guilt and self-recrimination, anxiety and perception of the world as hostile and dangerous. Moreover, all of them experience the problem with the other. These dynamics, inferred from the DSM-III symptoms, are clearly less well established than the dynamics of the self-centred group.

In sum, despite a number of reservations about the evidence, there is a clear _prima facie_ case for a division of the personality disorders between the two groups, on the grounds of symptomatology, mixing and dynamics.

CHAPTER 7: WINNICOTT AND HEIDEGGER: BEYOND THE SELF-CENTRED/OTHER-CENTRED POLARITY.

Having in the previous Chapters dealt with the two groups of disorders, their corresponding libidinal positions, and the self-centred/other-centred polarity in the psychoses, neuroses and personality disorders, the focus now moves to the area of so-called normality, and to the question of how the self-centred/other-centred polarity can be overcome to achieve balanced relatedness. Our guides here are Winnicott and Heidegger. For Winnicott (section 7.1), (A) the basic libidinal positions and their corresponding disorders can be distinguished in terms of the interpersonal boundaries involved (i.e. in terms of unclear vs rigid boundaries), giving us a ninth contrast between the two groups. Moreover, (B) the key to integration, and also play, creativity and cultural development lies in a development which transcends the self/other distinction: the formation of a 'third area' or potential space which partakes of both self and other, internal and external.

Heidegger (section 7.2) was not concerned with psychopathology as such, but with problems of authenticity and inauthenticity in everyday life. He describes the dominant mode of modern Western culture as the mode of 'everyman' or the 'they', in which authentic expression of self is subordinated to concerns about 'what one does' or 'what one thinks'. I will argue that this mode is strongly biased to the other-centred pole, and that the journey from this mode to

authentic being involves balancing true other-centred care with self-centred resolve. Heidegger's work opens a new horizon for the interpersonal model, suggesting that the axis of relatedness has a strong cross-cultural significance, taking one beyond the limits of this work.

7.1: Winnicott: boundary and space.

A. Interpersonal boundaries in the basic libidinal positions.

Winnicott accepted Klein's notion of two basic libidinal positions, although his interpretation of them differed on some points from Klein's for reasons we cannot go into here. For Winnicott, in the intrauterine and early post-partum state, the infant does not distinguish 'me' from 'not-me', self from other. Rather, the infant and mother form a 'unit', and the mother's 'holding' provides the boundary for both (Winnicott, 1965). This state can be compared to Klein's notion of projective identification, in which the self is split and the parts projected into the containing other. Consistently, Winnicott stressed that in this state, the infant also lacks unity and continuity, because of predominant splitting (1965a).

In this state - corresponding to Klein's paranoid-schizoid position - the infant is particularly vulnerable to impingement: lacking its own boundary, failure of maternal holding can lead to traumatic over-stimulation. Impingement exacerbates splitting to a pathological degree, and leads to a familiar range of disorders: infantile autism and schizophrenia, latent schizophrenia and schizoid states. Winnicott (1965a) held that splitting is the extreme of dissociation,

on this basis hysteria could be included. Accordingly, Gaddini (1978) argues that traumatization in this position leads to somatization disorders.

In fact Winnicott also saw the false self as a pathological development from this position, and as we saw in Chapter 5, for Angyal the false self pattern is central in hysteria. The etiological factor here is not impingement but the mother's failure to recognize and respond sensitively to the infant's communications, substituting her own ideas of what is going on (Winnicott, 1965a). This is clearly consistent with Angyal's account of the etiology of hysteria (section 5.2) and also Fairbairn's stress on indifference and overprotectiveness (section 3.2). The false self is also described as a 'caretaker self' (Winnicott, 1965a), for it takes over the role of the mother in protecting and holding the hidden real self. Hence the weakness of interpersonal boundaries is perpetuated in two ways: the false self is compliant, becoming what others expect is to be (not differentiating), and also takes over the role of the other in regard to the real self.

Winnicott, like Fairbairn, concentrated on this group of disorders. However, he did acknowledge the depressive position, which he called the 'stage of concern' (1965a). In moving towards this position, the infant passes from the original merger with the object, in which the 'not-me' is not perceived, through attachment to transitional objects, which are 'not-me', but still not really separate, (see under (B) below) to an acknowledgement of separate others in the stage of concern. Placing the emphasis differently to Klein, Winnicott stressed the potential for constructive aggression in this

stage, and the importance of the infant discovering that it can murder and destroy others in fantasy and rediscover them alive and well in reality. It is clear that here the emphasis is on clear, hard boundaries. The infant separates from its internal (fantasy) objects, by destroying and reviving them, and at the same time separates fantasy and reality as it discovers that its fantasied attacks leave real objects unharmed. The constructive concern for others that develops out of this, is comparable to Klein's notion of reparation.

In conclusion, from Winnicott's work we can identify a ninth contrast between the two groups of pathologies and their corresponding libidinal positions, a contrast between the unclear boundaries of the (paranoid-schizoid) state of merger with the other, and the hard boundaries of the (depressive) state in which the loss of the object can be contemplated.

B. Transcending the self-centred/other-centred polarity: the potential space. Winnicott's most important and original contribution to psychoanalysis was his (1974) account of the 'third area' or potential space mediating between the two basic positions, and making possible play, creativity and culture. The potential space arises "between me-extentions and not-me" (1974: 118), and in it subjective and objective can mingle. This is necessary for play, in which "the child manipulates external phenomena in the service of the dream and invests chosen external phenomena with dream meaning and feeling" (1974: 60). Winnicott felt that dreaming is also situated in the potential space, mingling experience and fantasy; and he distin-

guished both playing and dreaming from pure fantasy or day-dreaming. Pure fantasy, not enriched by the elements of reality brought into play and dreaming, must become stagnant, unchallenging, and uncreative. Creativity Winnicott saw as an extention of play; once again it involves engaging an inner vision with an external form and medium. More generally, he saw culture as a whole as rooted in the potential space, and appropriately so, for culture is a medium of individual expression, and also a social form, transcending individuals. Developmentally, the potential space begins to form in the transition period between the two basic libidinal positions. At this stage, infants often (although not invariably) form attachments to transitional objects, such as blankets and soft toys, which are 'not-me' but not yet fully other, for their meaning is created from the infant's investment in them, just as they often become saturated with the infant's smell. Transitional objects are among the first phenomena of the potential space (Winnicott, 1974).

Play, creativity and cultural pursuits are among the most direct expressions of the integrated human potential. Deep mutual loving is another, which requires also integrating one's own fantasies and desires with the reality of the other. What emerges is the notion that the polarization of relatedness into the self-centred or other-centred mode is central to psychopathology, and that overcoming the self/other polarity through developing the potential space is central to integration.

7.2: Heidegger: inauthentic and authentic being.

For Heidegger (1927) as for Marcel subjectivity is necessarily and inherently intersubjective. This is because a human being is not a self-enclosed psyche, but a being-in-the-world, an open realm in which aspects of the world are revealed or concealed. Since the world contains others, this being is necessarily a being-with-others. This presence of others is not like the presence of things, for we are immediately aware of their awareness, of the presence of their Da-sein, or being-there, open to the world.

The presence of others has, moreover, particularly powerful effects. Their presence easily, inevitably, comes to crowd out authentic selfhood. Through being-with-others we "come to exist not in and on our own terms, but in reference to, in respect of others" (Steiner, 1978: 89). Heidegger (1927) calls this alienated self (in German) das Man, meaning at once 'one' and 'they'. In the jumble of being-with-others

> The being that is us is eroded into commonality; it subsides to a 'oneness' within and among a collective, public heard-like 'theyness'...The others to whom we consign ourselves are not definite, sovereign presences: on the contrary, any other can represent them. What is decisive is just that inconspicuous domination by others which has already been taken over unawares from Dasein as being-with (Steiner, 1978: 90: quoting Heidegger, 1927; emphasis in original).

In this mode personal responsibility is lost in deference to what they do and what they think, and personal expression is lost in the 'passing along' of clichèd opinions and values.

I would suggest that this is a masterly depiction of the other-centred

mode, not exacerbated to a fully pathological degree, but dominant in an everyday sense that yet stifles creativity and authenticity. In place of the anxiety and guilt of other-centred pathology there appears here a milder but still stifling fear (furcht) for this mode is lived

> in a hollow scaffolding of imposed, anonymous values. In inauthentic existence we are constantly afraid (of other men's opinion, of what 'they' will decide for us, of not coming up to the standards of material or psychological success even though we have done nothing to establish or verify such standards) (Steiner, 1978: 92).

This mode comes on Dasein unawares because it is rooted in the unconscious process of introjective identification with others, originally the parents, instilling values not of our choosing, and endlessly and compulsively repeated in the introjection of fresh gossip, the latest novelties and new figures of admiration (e.g. movie and pop stars).

For Heidegger this process is not pathological but inevitable, and necessary to provide a starting-point for the search for authentic selfhood. We are called to this search in moments of restlessness and dis-ease, when we are faced with the uncanny (unheimlich): that which cannot be reduced to familiar expectations and habitual reactions, and evokes in us awe and wonder at the depth and mystery of Being. This realization that there is more to the world than we can ever assimilate to the familiar evokes authentic other-centredness, which Heidegger calls care (sorge). Caring-for or concern-with depend on a realization of the uniqueness and depth of things and people, a perception which allows one to become truly engaged with

them, rather than carelessly consuming and forgetting them in an endless, restless series.

Not that this is an easy change to make. Facing the uncanny depth of Being releases angst, the authentic counterpart of furcht (fear). Angst cannot be allayed by compliance with received standards: on the contrary, it calls us to face our own depth and uniqueness with resolve. Moreover, angst focusses us on our unique mortality, our indiviudal being-towards-death; death, which each of us must face alone, and in so doing question who we are and realize that we have not the time to answer this question fully, and must remain in awe of our own depths. What is involved here, of course, is the integration of the self-centred mode in an authentic way, for the anxiety of individual death (loss of the self) is the central self-centred anxiety. Resolve, equally, requires centering in oneself, drawing up one's deepest resources and focussing one's energies. Achieving authenticity thus entails integrating both authentic other-centredness (care) and authentic self-centredness (resolve).

Heidegger's vision is of interest to us for two reasons: firstly, it extends the analysis of the self-centred/other-centred dialectic into the field of phenomenology, suggesting that the interpersonal model can facilitate constructive debate between psychoanalysis and phenomenology, a theme taken up in section 8.3 below. Secondly, Heidegger's treatment of the dilemmas of relatedness takes us onto the cross-cultural terrain. He saw at the heart of modern inauthenticity a simple forgetting of Being, a loss of wonder and awe at how things simply are, and found this forgetting to be ubiquitous in

the Western cultural tradition from Classical Greece to the present day. To find inspiration and a language to express a different vision he had to go back to the pre-Socratics.

Significantly, Klein (1963) argued that the rise of Classical Greek culture involved a shift from a paranoid-schizoid cultural mode to a depressive one, confirming the suspicion that the Western Great Tradition is other-centred. This opens up a promising field for further research on the interpersonal model, discussed further in section 8.1.

This also serves to remind us of the limitations of the above reading of Heidegger. Intensely aware that the deep rootedness of the self/other or subject/object polarity in Western thought is embedded in our very langauges, Heidegger struggled endlessly with language itself in his striving to express a vision transcending the polarity (Steiner, 1978). We have accompanied him briefly to the edge of this terrain, but not into it, where his central concerns lay; this is partly due to the limitations of the subject/object language used here. His work suggests, though, that the polarization of relatedness into self-centred and other-centred is widespread, at least in Western culture, part of the 'psychopathology of everyday life'. In this respect he is more critical and less optimistic than Winnicott, and implies that the problem of integration or transcending the polarization of relatedness, is also a social problem, not unrelated to the polarization of human society between East and West, North and South.

CHAPTER 8: CONCLUSIONS AND QUESTIONS

This Chapter contains a summary of the conclusions reached in this work and a brief discussion of some questions it raises but does not answer. The conclusions are dealt with in section 8.1; there are three main points which together provide the rationale for the interpersonal model of psychopathology. (A) There are two groups of disorders, each with important common characteristics, which between them divide the psychoses, neuroses and personality disorders; the division of the field of psychopathology into these two groups is recognized consistently in classical psychoanalysis, object relations theory, and in Foulds' 'objective' study. (B) The dynamics of these groups relate not to developmental stages, but to libidinal positions as understood in object relations theory. (C) No less than nine specific contrasts have been identified between the two positions, all of which are directly or indirectly expressive of the self-centred/other-centred polarity. The polarity emerges from the contrasts as the theme common to them; indeed this is probably the best way of defining the polarity. Finally, (D) the evidence for these conclusions is evaluated.

If the interpersonal model is accepted at least as an hypothesis worthy of investigation, it raises a whole range of theoretical issues. The most direct (section 8.2) concerns the theoretical status of the axis of relatedness (the axis on which the self-centred and other-centred positions are ranged): whether it corresponds to anything accepted in psychoanalysis, and if not, why it has not been recognized before. It is suggested that it has been recognized only

in the work of Fairbairn and the Kleinians, and even then its full significance has not been realized. The main reasons for this are twofold: the axis of relatedness cannot be accomodated within the pure developmental theory, nor within a purely intrapsychic theory.

Phenomenology has avoided both developmental and intrapsychic accounts of psychological phenomena; it is not surprising, then, that the interpersonal model brings psychoanalysis much closer to phenomenology (section 8.3). In particular, in the process of developing the concept of libidinal positions, and freeing it from the developmental model, the Kleinians have (A) substituted description and understanding for explanation; (B) overcome determinism and restored freedom and choice to their central place in human existence, without ignoring the very real constraints on them; and (C) acknowledged the co-constitution of experience by self and other. All three are important themes in phenomenology. However, (D) there remain important differences between Kleinian theory and phenomenology.

Thus it is not suggested that a simple rapprochment of psychoanalysis and phenomenology is now on the cards, for the thrust of the work is that the development is not wrong but limited: it can account for only one of the two axes of the field of psychopathology. The challenge remains to integrate the two models in a comprehensive psychopathology. This is a huge task as it requires a reassessment of the developmental model. It seems to me that the reason why the developmental model has proved so problematic - it has been restated in a number of contradictory forms, e.g. Abraham (1924), Fairbairn (1941), Klein (1932, 1935) and Mahler et al. (1975) - is that it has

been expected to explain too much, and many of its concepts can be usefully transferred to the interpersonal model. However, this question is beyond the scope of this work.

8.1: The basis of the interpersonal model of psychopathology.

The central conclusions of this work, which provide the basis for the interpersonal model of psychopathology, are - as mentioned above - threefold: (A) there are two groups of disorders with important common characteristics, which divide between them the psychoses, neuroses and personality disorders; (B) the dynamics of which are rooted in the basic libidinal positions; and (C) are distinguished by nine contrasts, all of which are expressive of the self-centred/ other-centred polarity. These three conclusions and the evidence for them are dealt with in turn below.

A. The two groups of disorders. When psychoanalysis was still young, and the developmental theory still in its infancy (Jung,1907) and Abraham (1911) pointed out obvious analogies in the symptomatology of hysteria and schizophrenia on the one hand and states of anxiety, depression and the obsessive-compulsive neurosis on the other (Chapter 2). Fairbairn (1940, 1941), confirmed and elaborated Jung's notion of a group of disorders with hysteria and schizophrenia as it its core, adding the schizoid states and a range of personality disorders (Chapter 3). Klein (1935, 1940, 1946, 1952) made a clear distinction between two groups of psychoses: schizophrenia, paranoia and mania on the one hand, and psychotic depression on the other

(Chapter 4). Angyal (1965) confirmed the idea of two groups of neuroses, with hysteria and the obsessive-compulsive neurosis as their paradigm cases.

Putting together this evidence from classical psychoanalysis and object relations theory, a division of the field of psychopathology into two groups emerges, which coincides very closely with Foulds' (1976) division into extrapunitive and intropunitive groups. Thus Jung, Fairbairn and Klein grouped together hysteria, mania, paranoia and schizophrenia. This is Foulds' extrapunitive group, except that Foulds' divided schizophrenia between his two groups (Chapter 1). Klein (1960) acknowledged the phenomenon of depression in schizophrenia, which tends to support Foulds' division of schizophrenia (section 4.2).

Abraham (1911) grouped together states of anxiety, depression and the obsessive-compulsive neurosis, which gives Foulds' intropunitive group with the exception of the phobic neurosis. Psychoanalytic tradition, deriving from Freud (1909), classes phobia as anxiety hysteria, in contradiction to Foulds' position. Klein (1932), however, viewed phobia as expressive of the dynamics of either group, and the DSM-III classes the phobias with the Anxiety Disorders, supporting Foulds' position. The position of phobia is a problem, and deserves further attention.

Overall, however, there is an impressive fit between the two groups as distinguished in classical psychoanalysis and object relations theory, and in Foulds' study. Confirming that the division is

fundamental, there is suggestive evidence that it applies to the personality disorders as well (Chapter 6).

<u>8. The dynamics of the two groups and the basic libidinal positions</u>. Given that the two groups divide between them the psychoses, neuroses and personality disorders, it is clear that <u>the dynamic differences between them cannot be accounted for in terms of the developmental model</u>. The alternative conception, developed by Klein and Fairbairn, is that of <u>libidinal positions</u>. It is true that both Klein and Fairbairn thought of libidinal positions in developmental terms, but involved themselves in manifest contradictions in doing this. Thus Fairbairn (1940, 1941) argued that the schizoid position comes developmentally earlier than the depressive, but is still the basis of hysteria - generally acknowledged to be a less regressed disorder than psychotic depression. This problem has been resolved in subsequent Kleinian writings, in which the two basic libidinal positions are no longer seen developmentally, but as constantly co-present at all developmental levels (Bion, 1963, 1970; Meltxer, 1979). <u>This makes them prima facie ideally suited to account for the two groups of disorders, which divide the field of psychopathology between them at all levels</u>.

A problem that is raised by this view concerns how integration is achieved, for in both Fairbairn and Klein this involves attaining and working through the depressive position. It has been suggested in Chapter 7 that this is not enough, and that on Heidegger's account integration involves a 'journey back' to recover the positive potential of the self-centred (paranoid-schizoid) position, thus securing both "pillars to mental stability". In general the view ad-

vanced here would seem to leave the order in which the positions are worked through open, while stressing their interdependence. This raises very important questions for therapeutics, which could only be resolved through close studies of the therapeutic process.

Fairbairn (1940, 1941) argued that the dynamics of hysteria are rooted in the schizoid position (Chapter 3). When Klein (1946, 1952) elaborated this concept into her paranoid-schizoid position she rooted also schizophrenia, paranoia and mania there, thus encompassing the whole extrapunitive group in this libidinal position (Chapter 4). Klein (1935, 1940) used the concept of the <u>depressive position</u> to account only for the dynamics of depressed states; however, the dynamics she roots there are evident also in Abraham's (1911, 1924) account of states of anxiety and the obsessive-compulsive neurosis (Chapter 2), and in Angyal's (1965) account of the latter disorder (Chapter 5). The same two patterns of dynamics are evident in the two groups of personality disorders (Chapter 6). Hence <u>the dynamics of the two groups of disorders are to be understood not in terms of developmental stages but in terms of libidinal positions</u>.

<u>C. The nine contrasts and the self-centred/other-centred polarity</u>. Segal defined a libidinal position as a "constellation of anxieties, defences and object relations" (1964: ix). We have by implication enriched this concept, discovering no less than nine contrasts between the two groups of disorders and the libidinal positions that underlie them, in the spheres of <u>affect</u> and <u>cognition</u> (Chapter 2), <u>ethics</u> (Chapter 3), <u>anxieties</u>, <u>modes of identification</u>, <u>defences</u> and <u>motivation</u> (Chapter 4), <u>etiology</u> (Chapter 5) and <u>interpersonal boundaries</u> (Chapter 7). This increasing richness also brings with it

greater clarity, for all nine <u>of these contrasts are directly or indirectly expressive of the self-centred/other-centred polarity</u>. To demonstrate this we will consider them in three groups of three (Table 4).

<u>Sphere of contrast</u>	<u>Self-centred pole</u>	<u>Other-centred pole</u>
Cognition (Ch 2).	Intentional orientation to thinking (disorders of attention & consciousness).	Judgement concerning the objects of thought (doubt, indecision).
Anxieties (Ch 4).	Persecutory (on behalf of ego).	Depressive (on behalf of object).
Idenitfication (Ch 4).	Projective identification (of other with self).	Introjective identification (of self with other).
Affect (Ch 2).	Disorder within affect (blunting, lability).	Disorder between affects (ambivalence).
Ethics (Ch 3).	Conflict within values (confusion of values).	Conflict between values and actions (transgression of values).
Etiology (Ch 4).	Disorder within parenting (indifference, overprotectiveness).	Disorder between moments of parenting (inconsistency).
Defences (Ch 4).	Splitting (dissociated expression of bad).	Repression (stifling bad within).
Motivation (Ch 4).	'Wild' energy.	Restricted energy.
Boundaries (Ch 7).	Blurred boundaries.	Rigid boundaries.

<u>Table 4: the nine contrasts and their self-centred and other-centred poles.</u>

The cognitive contrast is between the distractability of the attention noted by Jung in hysteria and schizophrenia and the doubt and indecision noted by Abraham in the obsessive-compulsive neurosis and depression. These clearly express the distinction between the subject's intentional orientation to the process of thought and judgement concerning the objects of thought. In the sphere of anxieties, persecutory anxiety is explicitly anxiety on behalf of the ego, and depressive anxiety on behalf of the object.

Finally, in the sphere of identification, in projective (paranoid-schizoid) identification, the other is experienced like the subject, and in introjective (depressive) identification the subject becomes like the other.

The closely linked contrasts in the spheres of affect, ethics and etiology are slightly indirect in their expression of the self-centred/other-centred polarity, and express most directly the polarity within/between. Thus in the schizoid group we find disorder within affect (blunted and inappropriate affect) and within values (confusion of values), and in the sphere of etiology what might be called defecits within parenting (indifference or overprotectiveness). These all relate to conflict within the subject: the splitting defence and false self development. The global defecit of parenting prompts the child to develop a globally false self, with false affect and values, creating the schizoid fear of loss of the (real) self.

At the other pole we find conflict between affects (ambivalence), between actions and values (transgression of values) and between the

poles of inconsistent parenting. Here the etiological factor - uncertainty about how the other will react - creates ambivalent feelings about the other; ambivalence means that hate must transgress love (be directed at loved others) leading to depressive anxiety and guilt.

The remaining three contrasts, in the spheres of defences, motivation and boundaries are also closely linked, and slightly more indirect in their expression of the basic polarity. On the schizoid side, the splitting defence allows for the (dissociated) expression of conflict-ridden impulses, in hallucinated, dissociated, manic and hypomanic states, which leads to the wild energy that characterizes schizoid motivation, and to the "'odd' or eccentric" or "dramatic, emotional or erratic" behaviour of the schizoid personality disorders. Such wild expression must blur the boundaries between self and others.

On the depressive side, the repressive (inhibiting) defence leads to stifling of energy and inhibited behaviour, which also hardens the boundary between self and other. So far, so good: it is clear that these three polarities are closely and logically interrelated; however, there is nothing obvious here directly expressive of the self-centred/other-centred polarity.

To grasp this expression we must consider the defences, energies and boundaries in relation to the possible dangers to self and other that they do or do not defend against. Then the issue becomes clear: the splitting defence and wild energy can help to relieve the self of difficult impulses and feelings, and blurred boundaries allow them to be unloaded onto others (as in projective identification), but

by the same token, this mode offers no protection to the other. Thus this mode is both self-centred and extrapunitive. Conversely, the depressive mode is aimed at stifling 'bad' within, thus protecting the other, while endangering the self; hence the stance is other-centred and intropunitive.

It is clear enough from the above that the two basic libidinal positions each involve both self and other linked in a mode of relatedness. This justifies the final conclusion of this work, that the two groups of disorders and the libidinal positions which underlie them are to be understood in terms of an interpersonal model of psychopathology.

D. Evaluating the evidence. The body of evidence which supports these conclusions is in some respects impressive. The clinical evidence (Chapters 2 to 7) shows a consistent theme from classical psychoanalysis through to object relations theory, and the way in which the libidinal positions are related to two horizontal groups of disorders strongly confirms the latest developments in Kleinian theory, in which the libidinal positions are no longer seen in developmental terms. This clinical evidence converges with the 'objective' evidence from Foulds' study (Chapter 1).

However, it must be clearly stated that all this evidence is selective: the only authors considered were those whose work supports the interpersonal model. While the range of these is impressive, it is clear that selective choice of evidence carries huge dangers: one can usually find some selective evidence in favour of almost

any theory. It is true that important and enduring new conceptions have been introduced into psychoanalysis on the basis of less evidence, but the fact remains that <u>the interpersonal model as introduced here stands as an hypotheses worthy of further investigation, and by no means as an established theory</u>.

The acid test will come when conclusions deduced from the model are tested against fresh data. One possible direction for such testing merges from the suggestion made in section 7.2, that modern Western culture is predominantly other-centred. This statement derived from Heidegger (1927) must be understood to apply to the Western Great Tradition, most dominant in Classical Greece and Rome and again in the Enlightenment culture. Lasch (1979), commenting on <u>recent</u> (post-war) cultural developments in America diagnoses a culture of narcissism which is clearly self-centred, suggesting a change in cultural mode. Significantly, Lasch relates this cultural shift to an increase in the incidence of self-centred personality disorders. A more rigorous test of the cross-cultural interpretation of the interpersonal model would involve replicating Foulds' study in a range of very different cultures.

In addition to such empirical tests, the interpersonal model raises a host of theoretical issues; the future of the model will depend also on how these are resolved. A few of these issues are touched on in the following sections.

8.2: The theoretical status of the axis of relatedness.

The immediate question that arises from the above concerns the central concept of the interpersonal model - the concept of an axis of relatedness, with self-centred and other-centred poles - whether this concept is equivalent to any recognized and accepted in psychoanalysis, and if not, why not. It is clear, firstly, that the idea of a simple self/other polarity has long been current in psychoanalysis. It is entailed by Freud's (1905) definition of a drive as having a source, aim and object, and as we saw in section 1.2, Freud (1909) argued that in evaluating a person's developmental level, one must take into account the developmental levels of the ego and the object. In ego psychology the idea that self and object representations and their relation must be taken into account at all developmental levels was emphasized by Jacobson (1964) and taken up by Mahler et al. (1975). Fairbairn (1940, 1941) went a step further when he linked the fears of loss of self and loss of the other to the schizoid and depressive positions respectively. However, none of these conceptions grasp the essential point about the axis of relatedness, each pole of which involves self and other linked in a whole mode of relatedness. The idea of a simple self/other polarity falls well short of this.

To clarify this point about the axis of relatedness, one need only consider the juxtapposition of the basic anxieties identified by Klein and Fairbairn (loss of self and loss of other) with Foulds' extrapunitive and intropunitive styles. In the self-centred (schiz-

oid or paranoid-schizoid) position, the person fears loss of the self and tends to blame the other, and in the other-centred (depressive) position, fears loss of the other and blames the self. Thus both self and other are involved in both positions in unique ways.

The closest analogy in Freud is not his simple concept of ego and object in relation, but his (1914) distinction between narcissistic and anaclitic forms of object-choice and object relation. The narcissistic object is chosen because it resembles the self- a self-centred form of object-relation -, whilst the anaclitic object resembles an earlier (need-fulfilling) object (the mother), giving an other-centred object relation. For Rosenfeld (1964) narcissism is associated with projective identification: the other is seen as an extention of the self. On the other hand, Klein's notion of an early attachment to and introjection of the breast can be seen as an extention of Freud's anaclitic theory (cf section 1.2).

It is, of course, Klein's concepts of projective and introjective identification which most clearly express the idea of two fundamental modes of relatedness; these concepts can be seen as extending and clarifying Freud's ideas. However, as noted in section 4.1, Klein did not make the distinction between introjection and projection *per se* and introjective and projective identification quite clear, and since the former two are frequently said by the Kleinians to be constantly active together, the relation of the latter two to the libidinal positions has been obscured. For Klein, the distinction between the two basic libidinal positions

turns more than anything on the contrast of persecutory and depressive anxieties. This contrast does, it is true, imply two modes of relatedness: in the former the other endangers the self and in the latter the self endangers the other, but this aspect is not highlighted. One can only conclude that <u>while the self-centred/other-centred polarity has been recognized since Freud, its fundamental significance has not been highlighted</u>.

There are, I would suggest, two main reasons for this. The first is the dominance of the developmental model in psychoanalytic thinking, which has only recently been challenged by Kleinian writers. Within the developmental model the self-centred/other-centred polarity can be seen at best as secondary. However, this in itself does not explain why the axis of relatedness has not been emphasized more in the context of the recent challenges to the developmental theory.

Here a second, subtler reason comes into play. Freud's metapsychology was consistently <u>intrapsychic</u>: he saw all psychical processes as rooted in the brain. Any individual's psychical reality encompasses, of course, experiences of others, and this gives one the idea of intrapsychic self- and other-representations. But to assume that the subject can adopt an other-centred position seems to imply that the psyche can position itself as it were outside of itself, which is a contradiction in terms. The interpersonal model implies, in the words of Gabriel Marcel, that

> subjectivity is already, and in a most profound sense, genuinely intersubjective (1952: 182).

and this in turn implies that <u>a subject is not an individual</u>, but encompasses a whole interpersonal world. To deny the individuality

of the subject runs against the dominant Western tradition since Classical Greece. Heidegger (1927), a phenomenologist like Marcel, found that he had to go back to the pre-Socratics to escape the bounds of this tradition and find a language to express his insights. From the perspective of the interpersonal model, one could paraphrase Herakleitos and say that <u>one can never meet the same person twice - for a person is reconstituted in each encounter</u>.

It is not surprising, then, that in formulating the theory of libidinal positions the Kleinians have moved significantly towards phenomenology. As will emerge in the next section, it is as though they have taken all the basic steps necessary to formulate the interpersonal model, and it remains only to put them together and draw out their implications, as attempted in this work.

<u>8.3: The Kleinian move towards phenomenology</u>.

In this section three important areas of convergence between Kleinian theory and phenomenology are noted: (A) a move from explanation to <u>description</u> and <u>understanding</u>; (B) a move beyond determinism to a concept of <u>situated freedom</u>; and (C) a recognition of the <u>co-constitution</u> of experience by self and other. It is suggested (D) that in the process of making these changes, Kleinian theory in fact moves beyond an intrapsychic theory and allows for a full conceptualization of the interpersonal model. However, the Kleinians have not emphasized these changes until very recently (e.g. Meltzer, 1979, Bianchedi et al. 1984), probably for political reasons: Kleinian theory stated in even the most Freudian language has proved very hard for

many psychoanalysts to digest. It is also argued that important differences between Kleinian psychoanalysis and phenomenology remain.

a. From explanation to description and understanding. Freud situated his work in the tradition of the natural sciences, and in this way justified the introduction at crucial points of postulates or hypotheses not based on psychological data but on his desire to accomodate psychoanalysis to biology (Freud, 1895, 1920). Prime amongst these postulates was the one that the basic tendency of the psyche is to rid itself of accumulated energy or tension, which wasm central to his veiw of the drives. Moreover, the developmental theory is necessarily reductionist, in the sense that it involves explaining one set of phenomena (states of regression) by reduction to a quite different set (developmental stages).

On this score Klein and early co-workers (Susan Isaacs, Joan Riviere, Paula Heimann) undoubtedly departed from Freud. The central focus of the Kleinians is fantasy (especially unconscious fantasy or phantasy), which they do not define in contrast to 'reality' or 'objective experience'; indeed fantasy is seen as arising from the beginning out of the interplay of inner drives and outer events (Isaacs, 1952). Moreover, fantasy is not a by-product or epiphenomenon of energy processes, but represents the psyche in action. Isaacs (1952) argued that the drives find their first expression in fantasy, and that fantasy links the drives to the ego's mechanisms (of defence, reality-testing etc.). Segal (1964) illustrated, arguing that fantasy forms the core of the personality and is the basis of thinking.

Thus for the Kleinians the field of psychological investigation is the field of experience - centrally the experience of fantasy - and the structures they postulate are structures of experience, not stuctures of another order (e.g. of energy processes) to which experience must be reduced. It is for this reason that the Kleinian approach mis so often desribed as phenomenological (Meltzer, 1979; McKay, 1981) or descriptive rather than explanatory (Bianchedi et al., 1984). Description proceeds to understanding, but this attained not by reductive explanation but by grasping the inner logic or interrelatedness of, for example, a libidinal position. Hence the emphasis on libidinal positions as wholes, as complete modes of existence (Bianchedi et al., 1984). Understanding rather than explanation is, of course, the aim of phenomenological research (Giorgi, 1970).

The same point applies to the interpersonal model. The self-centred/other-centred polarity, which is used to understand the contrasts between the two groups (section 8.1 C) is not a structure of another order to which the contrasts are reduced, but a structure embedded in the contrasts - indeed it may be defined as the theme common to all. This extraction of common themes is again a typical move in phenomenological research (Giorgi, 1970).

B. From determinism to situated freedom. Freud's (1895) concept of quantities of excitation (drive energy or libido) which the psyche must struggle to discharge was the most deterministic aspect of his theory. He called it the economic metapsychology. Bianchedi et al. (1954) argue cogently that Klein thoroughly transformed this economic theory into a theory of 'economic policy'. That is, a person is

constantly faced with choices between various strategies for disposing of good and bad between self and others, internal and external, conscious and unconscious.

There are certainly necessities involved in determining the outcome of various choices - bad projected onto others must make them seem persecutory, harm done to others must engender guilt unless repaired - but the choices themselves remain free. In this way Klein escaped from Freud's determinism. On the other hand, while Meltzer (1979) correctly stresses the ethical themes in Klein's work (a feature shared with Fairbairn's), Fairbairn's ethical dilemmas are posed in abstract terms, and Klein's are related to the concrete and complex issues of economic policy. In other words, Klein posed the problem of choice not in the abstract but in a concrete existential context.

For the Kleinians there are no necessary, impelling motives: actions are motivated by the anticipated outcomes of specific strategies chosen, and can only be understood in context. In phenomenology a very similar concept of situated freedom has been developed capturing both the constant possibility of choice and our 'throwness' into circumstances not of our choosing (Valle and King, 1978).

C. The co-constitution of relatedness. Freud sought in the drive theory a causal account of psychical phenomena. In terms of this theory, the drives within impel the subject to seek objects to facilitate the discharge of drives. Fairbairn's (1940, 1941) theory, in contrast, is teleological: he argued that the libido is not inherently driven to seek releases of tension but inherently object

seeking. Subjects are thus drawn into relations by the attraction of objects. Klein again found a way between the two extremes, accepting that both subject and other contribute to constituting self and other in relation.

In projective identification, the subject's own intentions are attributed to the other, and thus colour the experience of the other, while with introjective identification attributes of the other are assimilated by the subject. Both modes of identification involve reconstituting self and other in the relation through the exchange of attributes, and colour the experience of the relationship itself.

Phenomenology recognizes this sort of phenomenon in the concept of the co-constitution of encounter by both partners in the relationship (King et al., 1978). The Kleinian conception, like Buber's, adds a further subtlety, showing how normal, mutual co-consitution can be pathologically distorted if either libidinal position and either mode of identification dominates a person's approach to relationships, and as a result either self or other is overvalued at the other's expence.

D. The scope and limits of the convergence of Kleinian psychoanalysis and phenomenology. For our purposes, the important positive outcome of this convergence is that it has cleared the way for the conceptualization of the interpersonal model in Kleinian theory. If the modes of relatedness are structures of fantasy, and fantasy arises from the interaction of inner drives and outer circumstances, then the contradiction mentioned in the introduction to this Chapter

falls away: a subject can in fantasy take up an other-centred position, because fantasy encompasses the whole universe of relatedness, self and other, inner and outer.

However, there is no justification for speaking of a complete convergence of Kleinian psychoanalysis and phenomenology, for a number of reasons. Kleinian theory by no means rejects the concepts of regression and developmental stages, but merely limits them and supplements them with the interpersonal perspective, whilst they are given short shrift by many phenomenologists (e.g. Boss, 1979). Also, Kleinian theory maintains such 'vertical' distinctions as those between conscious and unconscious, and primary and secondary process thinking, which are at best problematic in phenomenological terms. The issues raised by these in relation to phenomenology are beyond the scope of this work, but it is clear that we are speaking of a developing convergence and not a synthesis of the two schools, and that a long process of dialogue still lies ahead.

To return, briefly, to the significant convergence that has occured, it seems to me that Kleinian theory has in effect accepted many of the criticisms of classical psychoanalysis made by phenomenology, and with the interpersonal model is in a position to in turn put a challenge to phenomenology. Conceptions of experience transcending the subject/object division, and of the co-constitution of relatedness are essential starting-points for understanding the interpersonal dimension of psychopathology and of psychical structure in general. It was suggested in section 7.2 that the distinction between self-centred and other-centred modes was to an important extent recognized

by Heidegger (1927). The challenge to phenomenology is to work this recognition into the understanding of psychopathology and to recognize the contrasting phenomena of the two groups of disorders. Buber's work is clearly an indispensable starting-point in this process (Brice, 1984). In sum, with the interpersonal model the debate between psychoanalysis and phenomenology can move from its critical phase into a more constructive one.

FOOTNOTES.

1: p 3. It is important to note that in his literature review Foulds (1976) does not consider psychoanalysis at all; thus his study can be taken as a quite independent test of the psychoanalytic developmental model, and, as we shall see in section 1.2, of the psychoanalytic interpersonal model.

2: p 5. These figures, and the method Foulds used to arrive at them, are discussed in more detail on p 9 below.

3: p 10. In addition to the theories of primary narcissism and primary object love mentioned here, Balint (1968) distinguishes a theory of primary auto-eroticism. However, Balint fails to note that Freud came to re-define auto-eroticism as "the sexual activity of the narcissistic stage of allocation of the libido" (1916/17: 465), thus collapsing primary auto-eroticism into primary narcissism. Moreover, Freud (1921) had a fourth theory, also missed by Balint, that the primary relationship is one of identification, which Klein incorporated in her view of primary object-love (cf Chapter 4).

4: p 13. Klein (1935) introduced the depressive position and Fairbairn (1940, 1941) the schizoid position. Klein (1946) accepted some but not all of Fairbairn's views in her concept of the paranoid-schizoid position. Their work is dealt with in Chapters 3 and 4.

5: p 23. The term intentionality is Brentano's, and was taken up by Husserl (1925). Husserl saw the subject's intentionality is in some sense constitutive of the object; the term is used here in a more restrictive sense, covering only the subject's orientation to the object, and not the object itself, whether considered as an object of thought or an object in itself. Cf p 26 below.

6: p 47. One paranoid schizophrenic that I saw in therapy over a period of six months was at first distinctly extrapunitive

and suffered considerable persecutory anxiety. At the same time he showed considerable confusion between self and other, associated with violent and perverse sexual fantasies, some of them incestuous, which involved forcing parts of himself into the other. During this phase of the therapy his most marked response was to an interpretation of these fantasies reframing them as expressing curiosity about the inside of women's bodies. Later in the therapy, the patient became more concerned about men, more intropunitive, and eventually depressed (this was noted by the ward staff). During this phase of the therapy the patient showed considerable confusion about whether an older man he had had a homosexual relationship with was good or bad.

REFERENCE NOTES.

HILDEBRAND, P. (Note 1) The importance of the work of Jean Piaget for the psycho-analyst. Unpublished mimeograph, U.C.T., 1981.

REY, H. (Note 2) Psycho-linguistics, object relations theory and the therapeutic process. Unpublished mimeograph, Cape Town, 1981.

REFERENCES.

ABRAHAM, K. (1908) The psycho-sexual differences between hysteria and dementia praecox. In: Selected papers of Karl Abraham. New York: Basic Books, 1968.

ABRAHAM, K. (1911) Notes on the psychoanalytic investigation and treatment of manic-depressive insanity and allied conditions. In: Selected papers of Karl Abraham. New York: Basic Books, 1968.

ABRAHAM, K. (1924) A short study of the development of the libido, viewed in the light of mental disorders. In: Selected papers of Karl Abraham. New York: Basic Books, 1968.

ANGYAL, A. (1965) Neurosis and treatment: a holistic theory. New York: John Wiley, 1965.

BALINT, A. (1968) The basic fault. London: Tavistock, 1968.

BIANCHEDI, E.T. et al. (1984) Beyond Freudian metpsychology. International Journal of Psycho-Analysis, 65, 389-398.

BION, W. (1963) Elements of psychoanalysis. London: Heinemann, 1963.

BION, W. (1970) Attention and interpretation. London: Tavistock, 1970.

BOSS, M. (1962) Anxiety, guilt and psychotherapeutic liberation. Review of Existential Psychology and Psychiatry, 2(2), 1962, 173-195.

BOSS, M. (1979) Existential foundations of medicine and psychology. New York: Jason Aronson, 1979.

BRICE, C.W. (1984) Pathological modes of human relating and therapeutic mutality. Psychiatry, 47, 1984, 109-123.

BROOKE, R.W. (1983) An empirical phenomenological investigation of being guilty. M.A. Thesis. University of the Witwatersrand, 1983.

CARAFIDES, J.L. (1974) H.Spielberg on the phenomenology of C.G. Jung. Journal of Phenomenological Psychology, 5(1), 1974, 75-80.

DE WAELHENS, A. (1978) Schizophrenia (Trans. W. VER EECKE). Pittsburgh: Dusquesne University Press, 1978.

EIGEN, M. (1981) The area of faith in Winnicott, Lacan and Bion. International Journal of Psycho-Analysis, 62, 1981, 413-433.

FAIRBAIRN, R.W. (1940) Schizoid factors in the personality. In: Psychoanalytic studies of the personality. London: Tavistock, 1952.

FAIRBAIRN, R.W. (1941) A revised psychopathology of the psychoses and psychoneuroses. In: Psychoanalytic studies of the personality. London: Tavistock, 1952.

FAIRBAIRN, R.W. (1943) The repression and return of bad objects. In: Psychoanalytic studies of the personality. London: Tavistock, 1952.

FAIRBAIRN, R.W. (1944) Endopsychic structure considered in terms of object-relationships. In: Psychoanalytic studies of the personality. London: Tavistock, 1952.

FOULDS, A. (1976) The hierarchical nature of personal illness. London: Academic Press, 1976.

FREUD, S. The Pelican Freud Library (Trans J. STRACHEY). Harmondsworth: Penguin. Hereafter: P.F.L.

FREUD, S. The standard edition of the complete psychological works of Sigmund Freud (Trans J. STRACHEY). London: Hogarth. Hereafter: S.E.

FREUD, S. (1895) On the grounds for detaching a particular syndrome from neurasthenia under the descritpion 'anxiety neurosis'. P.F.L., Vol 10.

FREUD, S. (1895a) Project for a scientific psychology. S.E. Vol 1.

FREUD, S. (1896) Letter 52 to Fleiss, November 2, 1896. S.E. Vol 1.

FREUD, S. (1900) The interpretation of dreams. S.E. Vol 5. P.F.L. Vol 4.

FREUD, S. (1905) Three essays on the theory of sexuality. S.E. Vol 7. P.F.L. Vol 7.

FREUD, S. (1909) Analysis of a phobia in a five-year-old boy. P.F.L. Vol 8.

FREUD, S. (1911) Psychoanalytic notes on an autobiographical account of a case of paranoia. P.F.L. Vol 9.

FREUD, S. (1911a) Formulations on the two principles of mental functioning. P.F.L. Vol 11.

FREUD, S. (1912) Types of onset of neurosis. P.F.L. Vol 10.

FREUD, S. (1913) The disposition to obsessional neurosis. P.F.L. Vol 10.

FREUD, S. (1914) On narcissism: an introduction. P.F.L. Vol 11.

FREUD, S. (1916/17) Introductory lectures on psychoanalysis. P.F.L. Vol 1.

FREUD, S. (1917) Mourning and melancholia. P.F.L. Vol 11.

FREUD, S. (1920) Beyond the pleasure principle. P.F.L. Vol 11.

FREUD, S. (1921) Group psychology and the analysis of the ego. S.E. Vol 18. London: Hogarth, 1948.

FREUD, S. (1922) Some neurotic mechanisms in jealousy, paranoia and homosexuality.

FREUD, S. (1923) The infantile genital organazation. In: P.F.L. Vol 7.

FREUD, S. (1923a) The ego and the id. P.F.L. Vol 11.

FREUD, S. (1926) Inhibitions, symptoms and anxiety. P.F.L. Vol 10.

FREUD, S. (1937) Analysis terminable and interminable. S.E. Vol 23.

GADDINI, R. (1978) Transitional object origins and the psychosomatic symptom. In: S.A. GROLNICK & L. BARKIN (eds) Between fantasy and reality. New York: Jason Aronson, 1978.

GIORGI, A. (1970) Psychology as a human science. New York: Harper and Row, 1970.

GUNTRIP, H. (1961) Personality structure and human interaction. London: Hogarth, 1961.

GUIDANO, U.F. & LIOTTI, G. (1983) Cognitive processes and emotional disorders. New York: Guilford, 1983.

HEIDEGGER, M. (1927) Being and time (Trans. J. MACQUARRIE & E. ROBINSON). London: S.C.M. Press, 1962.

HUSSERL, E. (1925) Phenomenological psychology (Trans. J. SCANLON). The Hague: Marthinus Nijhoff, 1977.

INHELDER, B. & PIAGET, J. (1958) The growth of logical thinking (Trans. A. PARSON & S. MILGRAM). New York: Basic Books, 1958.

ISAACS, S. (1952) The nature and function of phantasy. In: Klein, M. et al. Developments in Psychoanalysis. London: Hogarth, 1952.

JACOBSON, E. (1954) The self and the object world. Psychoanalytic study of the child 9, 1954, 75-127.

JUNG, C.G. (1907) The psychology of dementia praecox. In: Collected Works, Vol 3. (Trans. R.F.C. HULL). London: Routledge & Kegan Paul, 1960.

KING, M., VALLE, R.S. & CITRENBAUM, C. (1978) Existential-phenomenological implications for psychotherapy. In: R.S. VALLE & M. KING (eds.) Existential-phenomenological alternatives for psychology.

New York: Oxford University Press, 1978.

KLEIN, M. (1935) A contribution to the psychogenesis of manic-depressive states. In: <u>Love, guilt and reparation</u>. New York: Dell, 1975.

KLEIN, M. (1927) Criminal tendencies in normal children. In: <u>Love, guilt and reparation</u>. New York: Dell, 1975.

KLEIN, M. (1930) The importance of symbol-formation in the development of the ego. In: <u>Love, guilt and reparation</u>. New York Dell, 1975.

KLEIN, M. (1932) <u>The psycho-analysis of children</u>. New York: Dell, 1975.

KLEIN, M. (1933) The early development of conscience in the child. In: <u>Love, guilt and reparation</u>. New York: Dell, 1975.

KLEIN, M. (1940) Mourning and its relation to manic-depressive states. In: <u>Love, guilt and reparation</u>. New York: Dell, 1975.

KLEIN, M. (1946) Notes on some schizoid mechanisms. In: <u>Envy and gratitude</u>. New York: Dell, 1975.

KLEIN, M. (1948) On the theory of anxiety and guilt. In: <u>Envy and gratitude</u>. New York: Dell, 1975.

KLEIN, M. (1955) On identification. In: <u>Envy and gratitude</u>. New York: Dell, 1975.

KLEIN, M. (1957) Envy and gratitude. In: <u>Envy and gratitude</u>. New York: Dell, 1975.

KLEIN, M. (1958) On the development of mental functioning. In: <u>Envy and gratitude</u>. New York: Dell, 1975.

KLEIN, M. (1960) A note on depression in the schizophrenic. In: <u>Envy and gratitude</u>. New York: Dell, 1975.

KLEIN, M. (1963) Some reflections on <u>The Orestia</u>. In: <u>Envy and gratitude</u>. New York: Dell, 1975.

KERNBERG, O.F. (1979) The structural diagnosis of borderline personality organization. In: P. HARTOCOLLIS (ed.) <u>Borderline personality disorders</u>. New York: International Universities Press, 1979.

KOHUT, H. (1971) <u>The analysis of the self</u>. New York: International Universities Press, 1971.

KOHUT, H. (1977) <u>The restoration of the self</u>. New York: International Universities Press, 1977.

LAMBERT, K. <u>Analysis, repair and individuation</u>. London: Academic Press, 1981.

LAPLANCHE, J. (1974) Panel on 'Hysteria Today'. International Journal of Psycho-Analysis, 55, 1974: 459-464.

LASCH, C. (1979) The culture of narcissism. New York: W.W. Norton, 1979.

MACKAY, N. (1981) Melanie Klein's metapsychology: phenomenological and mechanistic perspectives. International Journal of Psycho-Analysis, 62, 1981, 187-197.

MAHLER, M., PINE, F. & BERGMAN, A. (1975) The psychological birth of the human infant. London: Hutchinson, 1975.

MARCEL, G. (1950) The mystery of being, Vol 1. London: The Harvill Press, 1950.

MELTZER, D. (1978) The Kleinian development. Roland Harris Educational Trust, 1978.

MELTZER, D. (1981) The Kleinian expansion of Freud's metapsychology. International Journal of Psycho-Analysis, 62, 1981, 177-185.

MERLEAU-PONTY, M. (1942) The structure of behaviour (Trans. A.L. FISHER). Boston: Beacon, 1963.

MERLEAU-PONTY, M. (1951) The phenomenology of perception. New York: Humanities Press, 1962.

MERLEAU-PONTY, M. (1960a) Preface to Hesnard's L'Oeuvre de Freud. Review of Existential Psychology and Psychiatry, 18 (1/2/3), 1982-3, 67-72.

MERLEAU-PONTY, M. (1960) The child's relations with others. In: The primacy of perception. Northwestern University Press, 1964.

MERLEAU-PONTY, M. (1964) The visible and the invisible (Trans. C. LEFORT). Evanston: Northwestern University Press, 1968.

OLOKOOWSKI, D.E. (1982-3) Merleau-Ponty's Freudianism: from the body of consciousness to the body of flesh. Review of Existential Psychology and Psychiatry, 18 (1/2/3), 1982-3, 97-116.

PIAGET, J. (1971) Structuralism (Trans. C. MASCHLER). London: Routledge & Kegan Paul, 1971.

RICHARDSON, W.J. (1965) The place of the unconscious in Heidegger. Re iew of Existential Psychology and Psychiatry, 5(3), 1965, 265-290.

RICOEUR, P. (1970) Freud and philosophy. New Haven: Yale University Press, 1970.

RINSLEY, D.B. (1979) An object-relations view of the borderline. In: P.HARTOCOLLIS (ed.), Borderline personality disorders. New York: International Universities Press, 1979.

ROSENFELD, H. (1949) Remarks on the relation of male homosezuality to paranoia, paranoid anxiety and narcissism. In: Psychotic states. London: Hogarth, 1965.

ROSENFELD, H. (1950) Notes on the psychopathology of confusional states in chronic schizophrenics. In: Psychotic states. London: Hogarth, 1965.

ROSENFELD, H. (1964) On the psychopathology of narcissism. In: Psychotic states. London, Hogarth, 1965.

ROSENFELD, H. (1965) Psychotic states. London: Hogarth, 1965.

SAMPSON, H. (1976) A critique of certain traditional concepts in the psychoanalytic theory of therapy. Bulletin of the Menninger Clinic, 40(3), 1976, 255-262.

SAUSSURE, F. de (1915) Course in general linguistics (Trans. W. Baskin). London: Oven, 1960.

SEGAL, H. (1964) Introduction to the work of Melanie Klein. London: Heinemann, 1964.

STEINER, G. (1978) Heidegger. Glasgow: Fontana/Collins, 1978.

VALLE, R.S. & KING, M. (1978) An introduction to existential-phenomenological thought in psychology. In: R.S.VALLE & M.KING (eds.) Existential-phenomenological alternatives for psychology. New York: Oxford University Press, 1978.

VAN DEN BERG, J.H. (1980) Phenomenology and psychotherapy. Journal of Phenomenological Psychology, 11(2), 1980, 21-49.

VYGOTSKY, L. (1962) Thought and language. Cambridge, Massachusetts: MIT Press, 1962.

WEISS, J. (1971) The emergence of new themes: a contribution to the psychoanalytic theory of therapy. International Journal of Psycho-Analysis, 52, 1971, 459-467.

WINNICOTT, D.W. (1965) The family and individual development. London: Tavistock, 1965.

WINNICOTT, D.W. (1965a) The maturational process and the facilitating environment. London: Hogarth, 1965.

WINNICOTT, D.W. (1974) Playing and reality. Harmondsworth: Pelican, 1974.