Psychoanalytic Diagnosis

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Book Notes
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Chapter Three – Developmental Levels of Organization

It has long been assumed that the earlier the developmental obstacle, the more disturbed the person. This belief is a great over-simplification, and in some ways, it is simply wrong.

Nonetheless, we can benefit from conceiving a continuum of overall mental functioning, from more disturbed to more whole.

Developmental Capacity vs Character Style

We have two important ways of understanding psychological disturbance:

1. The first conceptualizes a person's degree of healthy psychological growth or pathology (psychotic, borderline, neurotic).

2. The second identifies the person's type of character (schizoid, depressive, masochistic, etc.)

The first determines how disturbed a person is; the second determines in what particular way a person is disturbed.

Conceptualizing someone's unmet developmental challenges can help in understanding that person.

There is a correlation between one's level of ego development and self-other differentiation on one hand, and the health or pathology of one's personality on the other.

Before the advent of psychiatry, it could be said that sane people agreed more or less about what constitutes reality; insane people deviated from this consensus.

People with hallucinations, delusions, and thought disorders were regarded as insane.

Historical View of Neurosis vs Psychosis

A neurotic person knew at some level that their problem was in their own head; the psychotic person believed it was the world that was out of kilter.

The neurotic was viewed as suffering because their ego defenses were too automatic and inflexible; the psychotic was viewed as suffering because their ego defenses were too weak, leaving them helplessly overwhelmed by the primitive material of the id.

These distinctions had important clinical implications. It was if the neurotic person was like a pot on the stove with the lid on too tight, making the therapist's job to let some steam escape; the psychotic person's pot was boiling over, necessitating that the therapist let the lid back on and turn down the heat.

This way of conceptualizing degree of pathology is not without its usefulness; but it falls short of a comprehensive and clinically nuanced ideal.

Ego Psychology Diagnosis: Symptom Neurosis, Neurotic Character, Psychosis

Clients with *symptom neurosis* feel on the side of the therapist in opposing a problematic *part* of the self. They rarely require a long time to develop a shared perspective.

In contrast, someone whose problems are complexly woven into their personality may easily feel alone and under attack. Distrust will be inevitable, and must be patiently endured by both parties until the therapist has earned the client's confidence.

Therapy sessions with someone with a *character* rather than a symptom problem could be expected to be less exciting, less surprising, and less dramatic.

The therapist must content themselves with a more prosaic process, doing a painstaking unraveling of all the threads that had created the emotional knot that the client has until now believed was just the way things had to be. Then there must be the slow working out of new ways of thinking and handling feelings.

In the development of personality disorders, there are long patterns of identification, learning, and reinforcement. There is more of a 'strain trauma' than a 'shock trauma' to address.

When working with character issues, one could expect periods of occasional boredom, impatience, irritability, and demoralization, understanding that this is a part of the process when a client must struggle with difficult and protracted tasks.

The distinction between neurotic symptoms and neurotic character remains important.

For a long time, the categories of symptom neurosis, character neurosis, and psychosis constituted the main constructs by which we understood personality difference on the dimension of severity of disorder.

Yet it also became apparent that such an overall scheme of classification was both incomplete and misleading.

One drawback was its implication that all character problems are more pathological than all neuroses. Yet some stress-related neurotic reactions are more crippling to a person's capacity to cope than some hysterical and obsessional personality disorders.

Yet is also true that some character disturbances seem to be much more severe and primitive in quality than anything that could reasonably be called "neurotic".

Thus, a problem can be characterological, and of any level of severity. The lines between character "traits", "styles" and "disorders" can be quite blurry.

Object Relations Diagnosis: The Delineation of Borderline Conditions

There is a middle ground between neurosis and psychosis, a psychological '*borderland*'. Therapists began noticing that some clients appeared character disordered, but in a particularly chaotic way.

These clients lacked the consistency of neurotic level people, and they seemed to be miserable on a much grander and less comprehensible scale than neurotics.

They were too sane to be considered crazy, and too crazy to be considered sane. They lived on the border between neurosis and psychosis.

The concept of a borderline level of personality attained widespread acceptance in the 1970's. This development has had mixed effects: *It has legitimized a valuable psychoanalytic concept, but at the price of losing its original meaning as a level of functioning.*

A lot has been sacrificed by equating the term 'borderline' with a particular character type.

Borderline personality has come to be generally viewed as a 'stable instability' on the border between neurotic and psychotic ranges, characterized by a lack of identity integration and reliance on primitive defenses, without overall loss of reality testing. (Kernberg, 1975)

People with borderline traits were understood to be fixated in dyadic struggles between total enmeshment, which they feared would obliterate their identity, and total isolation, which they equated with traumatic abandonment.

- It is useful to view people with a vulnerability to psychosis to be unconsciously pre-occupied with the issues of the early symbiotic phase (especially trust).

The most prevalent kind of anxiety for people in the psychotic range is fear of annihilation.

- It is useful to view people with a borderline personality organization as being focused on separation-individuation themes.

The most prevalent kind of anxiety for people in the borderline range is separation anxiety – a panic that deals with early attachment needs.

- It is useful to view people with neurotic structure as more 'oedipal', capable of experiencing conflicts that feel more internal to them.

The most prevalent kind of anxiety for people in the neurotic range involves anxiety related to more unconscious conflict, especially the fear of enacting guilty wishes.

Overview of the Neurotic – Borderline – Psychotic Spectrum

Characteristics of Neurotic Level Personality Structure

The term 'neurotic' now seems to be reserved by therapists for people so emotionally healthy that they are considered rare and unusually gratifying clients.

We currently use the term 'neurotic' to denote a high level of capacity to function despite emotional suffering.

Neurotic level clients rely primarily on the more mature or second-order defenses. While the presence of primitive defenses does not rule out the diagnosis of neurotic level of character structure, the absence of mature defenses does.

Ordinarily, overwhelming affects and primitive ways of dealing with them are not characteristic of persons in the neurotic level of functioning.

Neurotic people have:

- *An integrated sense of identity.*
- *An inner experience of continuity of self over time.*
- *A sense of continuity with the child they used to be.*
- *The ability to project themselves into a future.*
- *A solid sense of being in touch with what most people call 'reality'.*

The neurotic client and therapist live subjectively in more or less the same world.

The therapist will feel no compelling pressure to be complicit in seeing life through a lens that feels distorting.

The neurotic client does not seem to demand the therapist's implicit validation of their ways of perceiving.

This is contrasted with the paranoid character at the borderline or psychotic level, who will put intense pressure on the therapist to join their conviction that their difficulties are external in origin. Without validation, they may feel unsafe with the therapist.

Compulsive clients in the neurotic range may say that their repetitive rituals are crazy but that they feel anxious if they neglect them; compulsive clients in the borderline or psychotic range sincerely believe themselves to be protected in some elemental way by acting on their compulsions, and often have elaborate rationalizations for them.

A client in the neurotic range who has a cleaning compulsion will be embarrassed to admit how often she cleans, while a client in the borderline or psychotic range will feel that anyone who cleans less often is an unclean person.

Neurotic level people:

- Have more or less traversed Erikson's first two stages of *basic trust* and *basic autonomy*. They have made some progress towards identity integration and have a sense of initiative.

- Seek therapy not because of problems with security or agency, but because they keep running into conflicts between what they want and obstacles to attaining it, and they suspect this is of their own making.

- Will be able to establish a sound working alliance quickly with their therapist. Their mutual antagonist will be the problematic *part* of themselves.

- Do not elicit overwhelming counter-transferences in the therapist, positively or negatively; neither the wish to kill nor the wish to save.

Characteristics of Psychotic-Level Personality Structure

At the psychotic end of the spectrum, people are much more internally desperate and disorganized.

It is not difficult to diagnose someone who is in an overt state of psychosis: they express hallucinations, delusions, and ideas of reference, and their thinking strikes the listener as illogical.

There are many people walking around, however, whose basic psychotic-level internal confusion does not surface conspicuously unless they are under considerable stress.

These people live in a symbiotic-psychotic internal world, in a consistently paranoid-schizoid state. They can function, sometimes quite effectively, but they strike one as confused and deeply terrified, and their thinking feels disorganized or paranoid.

To understand the subjective world of the psychotic, one must first appreciate the defenses they tend to use: *withdrawal, denial, omnipotent control, primitive idealization and devaluation, primitive forms of projecting and introjecting, splitting, extreme dissociation, acting out, and somatization.*

These defensive processes are pre-verbal and pre-rational; they protect one against a level of "nameless dread" so overwhelming that even the frightening distortions that the defenses themselves may create are a lesser evil than that state of terror.

- *People who struggle with psychosis have a core, immobilizing dread of their fantasized superhuman potential for destructiveness.*

- *People whose personalities are organized at an essentially psychotic level have grave difficulties with identity – so much so that they may not be fully sure that they exist, much less whether their existence is satisfying.*

When asked to describe themselves or other important people in their lives, they tend to be vague, tangential, concrete, or observably distorting.

One feels that a client with an essential psychotic personality is not anchored in reality.

They are often confused by and estranged from the assumptions about "reality" that are conventional within their culture.

People with psychotic tendencies have trouble getting perspective on their psychological problems. They lack the "reflective functioning" that is critical to cognitive maturation.

In an effort to reduce their anxieties, they often tend to parrot what they have been told about themselves.

They suffer a boundary confusion about what they experiences as inside and outside of themselves.

- *The critical thing for therapists to appreciate is that close to the surface in people with psychotic-level psychologies, one finds both mortal fear and dire confusion.*

The nature of the primary conflict in people with a potential for psychosis is *literally existential*: life vs death, existence vs obliteration, safety vs terror.

Despite their unusual and even frightening aspects, clients in the psychotic range may induce a positive counter-transference.

The therapist can feel subjective omnipotence, parental protectiveness, and deep soul-level empathy toward psychotic clients that toward neurotic ones.

People with psychotic tendencies are:

- *Desperate for respect and hope, and their gratitude is naturally touching.*
- *Particularly appreciate of sincerity.*
- *Appreciative of educational efforts by the therapist.*
- *Relieved when they are normalized and when their pre-occupations are reframed with compassion.*
- *Capable of evoking feelings of strength and benevolence in the therapist.*

Counter-transference with psychotic-level people is remarkably like normal maternal feelings toward infants under a year and a half: *They are wonderful in their attachments, and terrifying in their needs.*

They are not yet oppositional and irritating, but they also tax one's resources to the limit. Therapists can feel eaten alive by the psychotic person's level of need.

This "consuming" feature of their psychology is one reason that many therapists prefer not to work with people who suffer psychoses.

They are also capable of seeing our own limitations and flaws with stunning clarity.

Most therapists lack adequate training in psychotherapy with psychotic clients.

Characteristics of Borderline Personality Organization

One of the most striking features of people with borderline personality organization is their use of primitive defenses.

Because they rely on such archaic and global operations as *denial, projective identification and splitting*, when they are regressed they can be hard to distinguish from psychotic people.
When a therapist confronts a borderline client on using a primitive mode of experiencing, the client will show at least a temporary responsiveness.

Devaluation is an unconscious strategy that is often intended to preserve self-esteem, but which does so at the expense of learning.

Borderline-level people have an experience of self that is likely to be full of inconsistency and discontinuity.

When asked to describe their personalities, they may, like the psychotic, be at a loss for words. When asked to describe important people in their lives, they may respond with anything but a three-dimensional, evocative description of recognizable human beings.

Unlike psychotic people, they rarely sound concrete or tangential to the point of being bizarre, but they do tend to dismiss the therapist's interest in the complexities of themselves and others.

Borderline people:

- *Lack reflective functioning.*
- *Tend not to find meaning in their own and other's behaviors.*
- *They cannot appreciate the separate subjectivity of other people.*
- *They lack 'a theory of mind'.*
- *May become hostile when confronted with the limited continuity of their identity.*
- *Have trouble with affect tolerance and regulation.*
- *Quickly go to anger in situations where others might feel shame, envy or sadness, or some other more nuanced affect.*

Borderline people differ with psychotic people to two ways:

- Their sense of inconsistency and discontinuity lacks the high degree of existential terror. They may have identity confusion, but they know they exist.
- Are more likely to react with hostility to questions about identity of self and others.

Borderline people are similar to psychotic people in that they rely heavily on primitive defenses and suffer a basic defect in sense of self.

However, borderline people demonstrate an appreciation of reality no matter how crazy or florid their symptoms look.

To make a differential diagnosis, investigate the client's appreciation of conventional notions of reality by picking out some unusual feature of their self-presentation, commenting on it, and asking if the client is aware that others might find that feature peculiar.

The borderline person will be able to acknowledge that the feature is unconventional and that outsiders might not understand its significance. The psychotic person will become frightened and confused because the sense that they are misunderstood is deeply disturbing.

The capacity of someone at the borderline level of functioning to observe his or her own pathology is quite limited.

Borderline clients:

- Rarely come to therapy with the agenda of changing their personalities in directions that outsiders readily see as advantageous.
- They lack the sense of what it would be like to be different.
- Just want to stop hurting, or get some critic off their back.
- Perceives interventions that the therapist intends to be helpful as attacks.

The therapist cannot assume a capacity for reflective functioning, as this is a capacity that is mostly lacking.

The therapist cannot assume that they are talking to an observing ego, as this is something the client cannot access, especially when upset.

The therapist learns that they must first just weather the affective storms that seem to keep raging, while trying to behave in ways that the client will experience as different from whatever influences have shaped such a troubled and help-resistant person.

Borderline clients seem caught in a dilemma: When they feel close to another person, they fear engulfment and total control; when they are alone, they feel traumatically abandoned. Neither closeness nor distance yields comfort.

Living with such a basic conflict, one that does not respond immediately to interpretive efforts, is exhausting for all.

They are famous for manifesting help seeking – help rejecting behavior.

Borderline people are *fixated at the rapprochement sub-phase of the separation-individuation process,* where the child has obtained some autonomy yet still needs reassurance that a caregiver remains available and powerful.

Transferences in borderline clients tend to s strong, unambivalent, and resistant to ordinary kinds of intervention. The therapist may be perceived as all good or all bad.

It is naïve to try to make interpretations about their transference, this will be ineffective at best.

Not surprisingly, counter-transference reactions with borderline clients tend to be strong and upsetting. Even when positive, they tend to have a disturbing, consuming quality.

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