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## A PSYCHODYNAMIC APPROACH TO THE DIAGNOSIS OF PSYCHOPATHOLOGY

SIDNEY J. BLATT AND KENNETH N. LEVY

The purpose of diagnosis is straightforward: to understand better the dynamics and circumstances that result in people being in emotional distress and how best to treat them. Although the purpose of diagnosis is important and direct, the "how to" of diagnosis remains controversial and elusive. Despite considerable misgivings (e.g., Carson, 1991; Millon, 1991a; Widiger, 1992) about the various editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) developed by the American Psychiatric Association (APA), this diagnostic taxonomy continues to dominate the mental health field (Jampala, Zimmerman, Sierles, & Taylor, 1992; Maser, Kaelber, & Weise, 1991; Setterberge et al., 1991). Most insurance companies structure their reimbursements according to this diagnostic taxonomy, the DSM provides the basic taxonomic structure used in most clinical centers, most scientific journals require that distinctions in clinical research be made according to this diagnostic system, and many funding agencies, especially the National Institute of Mental Health, require that this diagnostic system be an integral part of most clinical research designs. These funding agencies not only often insist that this categorical taxonomic sys-

tem be an inherent part of the research design, but they also actively encourage the inclusion of one or more of the structured clinical interviews that have been derived from the *DSM* system. Given the central role that the *DSM* has come to have in clinical practice, research, and teaching, it is essential that researchers systematically examine its basic assumptions as well as some criticisms that have been directed at this nosological system.

In this chapter we consider several criticisms that have been made of the *DSM* model, particularly as they pertain to the diagnosis of Axis II personality disorders. We then propose an alternative diagnostic structure that we believe has greater potential validity than the fourth edition of the *DSM* (*DSM-IV*; APA, 1994) as well as clearer etiological and therapeutic implications.

### THE DEVELOPMENT OF THE *DSM*

Beginning around 1970, clinical investigators in academic psychiatry and psychology in the United States began to feel increasing dissatisfaction with the imprecision of psychiatric diagnostic criteria. This renewed interest in diagnosis, nosology, and classification culminated in the publication of the third edition of the *DSM* (*DSM-III*; APA, 1980). The *DSM-III* was an immediate bestseller and was used by virtually every mental health professional in the United States to guide diagnosis, justify third-party reimbursement, or both. The manual received considerable praise in academic psychology and clinical psychiatry for providing a detailed lexicon, or taxonomy, that established common definitions of various psychopathological states that enabled investigators and clinicians to have greater consistency (reliability) in their diagnoses. The *DSM* system, however, also has engendered considerable controversy. Although the various editions of the *DSM* have brought a degree of reliability to the diagnosis of mental illness, they also illustrate many of the problems inherent in contemporary clinical practice and clinical research.

Several clinicians and clinical investigators have expressed serious reservations about the *DSM* approach to the diagnosis of mental disorders (e.g., Blatt, 1991a; Carson, 1991, 1994; Chodoff, 1986; Kaplan, 1983; Milon, 1981, 1991a; Persons, 1986; Vaillant, 1984; Wakefield, 1992). These problems include the following: (a) lack of a cohesive theory; (b) the forced demarcation between normal and abnormal; (c) excessive concern with signs and symptoms; (d) the use of categorical rather than dimensional distinctions; (e) arbitrary threshold or cutoff points for establishing categorical diagnoses; (f) a lack of dimension of intensity in considering the presence of many of the symptoms; (g) a high degree of overlap or comorbidity between seemingly distinct disorders; (h) viewing the diagnostic categories as separate and independent entities and failing to consider the

possible relations among various diagnostic categories; (i) treating various categories as equivalent and not establishing a hierarchy of superordinate and subordinate disorders; (j) excessive concern with interrater reliability at the expense of validity; (k) insufficient attention to issues of validity; (l) failure to consider psychological defense mechanisms; and (m) a lack of continuity with consideration of issues of therapeutic intervention and questions of etiology. Also, a given symptom can serve multiple systems (Werner & Kaplan, 1963) or have multiple functions and meanings (A. Freud, 1965b). Thus, sole reliance on manifest symptoms may result in an inordinate number of both false-positive and false-negative diagnoses. Furthermore, developmental psychopathologists such as Cicchetti (1987) and Rutter and Shaffer (1980) criticized the *DSM* for lacking a developmental perspective. Finally, Winokur, Zimmerman, and Cadoret (1988), in a provocative editorial titled "Cause the Bible Tells Me So," noted that the *DSM* approach created an atmosphere in which establishing new sets of diagnostic criteria has almost become a cottage industry in American psychiatry. Almost every type of disruptive behavior gets a diagnostic label. These various problems with the *DSM* are particularly apparent and best exemplified in Axis II in the conceptualization and assessment of personality disorders (Plutchik, Conte, & Karasu, 1994; Skodal, 1989).

Benjamin (1994), Blatt (1991a, 1995a), and Carson (1991, 1994) suggested that much may be gained by liberating clinical research from the numerous attempts to conduct research on the basis of clinicians' ratings of the *DSM* diagnostic categories and instead to begin to identify dimensional variables that link the diagnoses of psychopathology to basic concepts in personality theory. In this chapter, we propose a dimensional approach to classification, one that we believe can improve reliability and increase the validity of the diagnosis of personality disorders as well as psychopathology more generally. We propose establishing diagnoses organized around impairments in the structure of mental representations, especially around concepts of the development of self-definition (identity) and interpersonal relatedness (concepts of the object) as two fundamental dimensions of personality organization. We demonstrate that these two personality dimensions of self-definition and relatedness provide an empirical basis for integrating the various Axis II personality disorders in a parsimonious and systematic fashion, an integration that has important implications for understanding the etiology of various disorders and for guiding therapeutic intervention. This theoretically based classification, founded on fundamental conceptual dimensions of self-definition and relatedness, has empirical support, holds promise for increasing the reliability and validity of diagnoses, and has implications for guiding therapy and treatment as well as for understanding the etiology of a wide range of functional disorders and psychological disturbances, especially depression and personality disorders.

In 1935, the APA developed a diagnostic system that was based on Kraepelin's (1899, 1913/1971) influential textbooks. They submitted this system to the American Medical Association for inclusion in its Standards Classified Nomenclature of Disease. Several weaknesses in the system, however, became apparent when there was an attempt to use it more extensively in treating soldiers during World War II. First, the Kraepelin system was developed for hospitalized patients and did not generalize to the acute conditions observed among soldiers who had been in combat. Ironically, another problem with the Kraepelin-based system was that it did not consider psychoanalytic theory, which had become popular in the United States at that time. Because of these problems with the Kraepelin-based system, military hospitals and Veterans Administration hospitals each developed their own classification systems. These systems were often discordant and created communication difficulties. In 1951, the United States Public Health Services commissioned representatives from the APA to standardize the diagnostic systems used in the United States, which resulted in the first edition of the *DSM* (*DSM-I*; APA, 1952). The *DSM-I* was a glossary describing various diagnostic categories that were based on Adolf Meyer's developmental psychobiological views. The *DSM-I* described 108 separate disorders. Many of these disorders were described as reactions to environmental conditions that could result in emotional problems. The second edition of the *DSM* (*DSM-II*; APA, 1968) was based on a classification of mental disease derived from the 8th revision of the *International Classification of Diseases* (World Health Organization, 1975). The *DSM-II* distinguished between neurotic disorders and psychotic disorders and specified 182 different disorders. Except for the description of the neuroses, which were strongly influenced by psychodynamic thought, the *DSM-II* did not provide a theoretical framework for understanding nonorganic mental disorders. Descriptions of various psychiatric disorders in the *DSM-II* were based on the best clinical judgment of a committee of experts and its consultants (Widiger, Frances, Pincus, Davis, & First, 1991).

In reaction to the inability to achieve acceptable levels of reliability with the *DSM-II* and a growing dissatisfaction with the psychodynamic approach to the neuroses, the APA sought to establish a more empirical foundation (e.g., Akiskal, 1989; Goodwin & Guze, 1984; Klerman, 1986; Spitzer, Williams, & Skodol, 1980) for psychiatric diagnoses, resulting in the third edition of the *DSM* (*DSM-III*; APA, 1980) and its revision (*DSM-III-R*; APA, 1987). These editions of the *DSM* attempted to establish a "multi-axial, theoretically neutral system" that placed a wide range of descriptive symptoms into 265 separate categories or disorders. In attempts "to resolve various diagnostic issues, the task force relied, as much as possible, on research evidence relevant to various kinds of diagnostic validity" (APA, 1980, p. 3). Concepts of reliability and validity from the psychometric tradition within psychology were influential in shaping the



organization of the DSM-III. Extensive field trials were conducted to deal with unacceptable levels of reliability (Spitzer & Fleiss, 1974). Because of the lack of sufficient research, however, the committee deliberations were often "unstructured," and "many decisions continued to be based primarily on the best clinical judgment and experience of the committee members" (Widiger et al., 1991, p. 281). The task force repudiated psychodynamic theory as the basis for developing a diagnostic taxonomy and tried instead to remain theoretically neutral in its deliberations.

The DSM-III task force used primarily descriptive symptom criteria to create a multi-axial diagnostic classification system (see, e.g., Williams, 1985a, 1985b), separating personality and specific mental disorders (Axis II) from other mental disorders (Axis I; Maser et al., 1991). The classificatory system was polythetic (Millon, 1991a), in that not all symptoms or diagnostic criteria for a given disorder were necessary for making a diagnosis. Thus, the classificatory system created prototypical descriptions of particular disorders on the basis of a cluster of symptoms, and these rapidly became the concrete signs of particular discrete categories (Maser et al., 1991). Because there were "many instances in which the criteria were not entirely clear, were inconsistent across categories, or were even contradictory" (APA, 1987, p. xvii), the APA revised the DSM-III in 1987 (DSM-III-R). Field trials were conducted that attempted to establish concurrent and descriptive validity of "clinicians' diagnoses . . . rather than simply [addressing] . . . the reliability of the diagnoses" (Widiger et al., 1991, p. 282).

Critics, however, remained skeptical about whether the expert committees in the DSM-III-R, as in the DSM-III, were objective and comprehensive in their consideration of the empirical and clinical literature (Widiger et al., 1991). The refinements of the DSM-III-R were based on the implicit assumption that the major differentiations in the DSM-III, which have been primarily determined by the largely intuitive consensus of expert committees, clearly identified the main dimensions of psychopathology and that all that was needed was some fine-tuning of these fundamental categories with the hope that they would be based on empirical research. The more or less systematic reviews of the literature and research data on these previously established categories resulted in some fine-tuning of the criteria used for various diagnostic groups. Thus, the most recent version, the DSM-IV, is essentially a continuation of the same diagnostic system as the DSM-III and DSM-III-R, with all their problems and limitations and with little promise of breaking out of the confines of this established system:

The clear and present danger is that DSM-IV will result in merely more tinkering on a superficial level with operational criteria that tend over time to approach the status of revealed truths, notwithstanding their often patently arbitrary nature and the unproductiveness of their outcomes. (Carson, 1991, p. 304)

## CRITIQUE OF THE DSM APPROACH

The development of the *DSM-III* and its successors (including the *DSM-IV*) represented a major point in American psychiatry (and psychology), returning to a basically Kraepelinian taxonomic system and, more broadly, to a medical model (Wilson, 1993). Although the efforts in constructing the *DSM-IV* were directed at maximizing research input and controlling subjective distortions, major methodological problems place serious constraints on the *DSM-IV*, as they did on the *DSM-III* and the *DSM-III-R*. As mentioned previously, these problems include the use of a taxonomic system derived from traditional and possibly outdated categories of psychopathology, insufficient attention to issues of validity of the diagnostic concepts, and preoccupation with acceptance and use of the diagnostic system by psychiatric clinicians (Carson, 1991).

### The Neglect of Theory and Construct Validity

In its attempts to establish an atheoretical nomenclature, the *DSM* established both inclusive and exclusive operational criteria on the basis of the manifest symptoms of psychopathology. This descriptive approach intentionally tried to avoid considering any assumptions of etiology or any implications about the nature of therapeutic intervention. The APA wanted the *DSM* to be atheoretical because the "inclusion of etiological theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations" (APA, 1980, p. 7).

Definitions of various disorders "are described at the lowest order of inference necessary" (APA, 1980, p. 7) to reduce theoretical bias. Observations, however, always have some inherent theoretical bias (Weimer, 1979) and are never theoretically neutral. The theoretical assumptions of the *DSM* and the various forms of psychopathology defined in terms of manifest symptoms often reflect an assumption of an underlying biological basis for many disturbances (Nelson-Grey, 1991; Schacht, 1985; Schacht & Nathan, 1977). The *DSM* eschewed more inferential dimensions (e.g., personality styles) and assumed that psychopathologies (or disordered behaviors) are a set of finite and discontinuous "underlying functional entities" that can best be described in the "taxonomic system of the classical categories" (Carson, 1991, p. 302; Blashfield & Livesley, 1991; Millon, 1991a).

The attempt to repudiate any theoretical bias in the *DSM* resulted in the construction of a taxonomic system influenced by unexpected, discordant, and inconsistent forces, a virtual potpourri of diverse theoretical biases influenced the formulation of Axis I disorders. Robin's (1966) conceptions, for example, as opposed to Millon's (1991b) or Hare's (1983), influenced the criteria for antisocial disorder, Millon's ideas influenced the

criteria for avoidant personality, and recommendations by Frances (1980) influenced the formulation of the criteria for narcissistic personality. As Carson (1991) has noted, one should heed Kurt Lewin's admonishment that nothing is as dangerous as a theory unrecognized as such. The idea of an atheoretical nosology is inherently an untenable position. Millon (1991a) and Carson (1991) emphasized that theory is not only unavoidable but that it is essential in the development of taxonomies. Furthermore, Loevinger (1957) argued that a theoretical model of psychopathology is essential to guide the construction of methods of assessment that are both reliable and valid.

A theory-based diagnostic system could specify the various theoretical principles that define the basic dimensions of disorders, thus allowing for the investigation of construct validity, and validity is central to the development of any taxonomic system. Blashfield and Livesley (1991) and Carson (1991) considered the almost uniform disregard of construct validity as being the most fundamental deficiency of the various versions of the DSM, including the DSM-IV. The DSM fails to establish networks of correlated variables that could, in the aggregate, affirm the concepts to which any proposed diagnosis must be assumed to refer. The evaluation of diagnostic constructs needs to be integrated with theoretical formulations (Skinner, 1981); otherwise, a particular diagnosis "conveys almost nothing about the presumed entity that can be described without referring back to these same terms or their close synonyms" (Carson, 1991, p. 304). Thus, the disavowal of theory places undue emphasis on direct clinical experience, which "may prove [to be] seriously debilitating to the construction of a coherent taxonomic diagnostic system" (Carson, 1991, p. 305). Carson (1990) expressed concern that the DSM-IV will be a mere repatching and repair of the DSM-III "in which validity considerations are . . . sacrificed in favor of a trivial type of 'reliability' . . . [and] merely continue an ultimately unproductive illusion" (p. 12).

### Excessive Focus on Reliability at the Expense of Validity

The DSM-I and the DSM-II were plagued by low reliability (Spitzer, 1975; Spitzer & Fleiss, 1974). Those working on the DSM-III and its subsequent editions specifically attempted to correct this problem of reliability (L. N. Robins & Helzer, 1986; Spitzer et al., 1980). The DSM, however, has been excessively focused on the issue of interrater reliability to the neglect of validity (Carson, 1991; Faust & Miner, 1986; Vaillant, 1984). Reliability is a necessary but not sufficient condition for validity. Overemphasis on reliability can trivialize phenomena and result in premature abandonment of potentially important discoveries and ideas. Carson (1991) noted that if a diagnosis yields little or nothing more in

the way of useful information beyond that which is already contained in the definition, any gain is merely illusory. Thus, impressive interrater reliability can often be only cosmetic.

Moreover, although the diagnosis of *DSM-III-R* and *DSM-IV* disorders have somewhat better interrater reliability than previous versions of the *DSM* (Akiskal, 1989; Fogelson, Nuechterlein, Asarnow, Subotnik, & Talovic, 1991; Onstad, Skre, Torgersen, & Kringlen, 1991; Spitzer, Foreman, & Nee, 1979; Williams, Gibbon, First, & Spitzer, 1992), the level of reliability is not really substantially better than had been achieved much earlier with the *DSM-II* (Kirk & Kutchins, 1992; Kutchins & Kirk, 1986). Furthermore, the reliability of personality disorders (Axis II) in particular has greatly lagged behind that of Axis I disorders (Frances, 1980; Mellsop, Varghese, Joshua, & Hicks, 1982; Plutchik et al., 1994; Werry, Methven, Fitzpatrick, & Dixon, 1983). Frances (1980) noted that "as a group [the personality disorders] ... attain the lowest reliability of any major category" (p. 1050). In fact, none of the *DSM-III* Axis II disorders has even adequate reliability (average = .41).

Reliability studies using case studies or interviews (e.g., Faust & Ziskin, 1988; Kutchins & Kirk, 1986; Lipton & Simon, 1985; Mattison, Cantwell, Russell, & Will, 1979) have shown only modest reliability in the use of the taxonomic system of the *DSM-III* and the *DSM-III-R*. Some suggested that this lack of adequate reliability was a result of a failure to use the *DSM-III* manual effectively. For example, much better reliability has been achieved when the diagnoses were based on systematic, comprehensive interviews conducted by adequately trained staff (e.g., Hyler, Williams, & Spitzer, 1982; Loranger, Susman, Oldham, & Russakoff, 1987; Pföhl, Coryell, Zimmerman, & Stangl, 1986; Skodol, Rosnick, Kellman, Oldham, & Hyler, 1988; Widiger, Frances, Warner, & Bluhm, 1986). Thus, the *DSM-III* and the *DSM-III-R* led to the development of structured interviews for particular diagnostic categories that resulted in increased reliability. This achievement of acceptable levels of reliability has been challenged, however (e.g., Kutchins & Kirk, 1986; Perry, 1992), and Carson (1991) has argued that it gives the deceiving "appearance of precision and diagnostic certitude" (p. 304). The primary validating criteria for these structured interviews are clinicians' diagnoses, and this "reliance on clinicians' diagnoses as the only external validity ha[s] a number of limitations" (Widiger et al., 1991, p. 282) (Kendler, 1990; Perry, 1990). Perry (1992) found that Axis II interviews and self-report measures demonstrated considerable interrater reliability for interviews and good internal consistency for self-report measures. The average kappa between any two measures, however, was unacceptably low (.25), as was the average kappa in test-retest studies using the same measures, even over periods as brief as 2 weeks.

These various attempts to ensure adequate diagnostic reliability in the *DSM-III* and the *DSM-III-R*, and now the *DSM-IV*, created a fragmented taxonomic system that does not address the "daunting problem of a validity" (Carson, 1990). Agreement among a committee of experts and a demonstration of reliability among judges is insufficient evidence of the validity of a diagnostic taxonomy. Operational criteria can lead to the reliability of relatively trivial distinctions that add little to the field (Carson, 1991). As Block (1989) noted, behavioral methods of assessment can often create a set of well-organized measures of trivial matters that have tangential or limited substantive significance for establishing meaningful psychopathological taxonomies (cited in Millon, 1991a, p. 245). In summary, the reports of acceptable levels of reliability in the use of the *DSM* taxonomic categories have not been augmented by consistent indications of construct validity.

#### Categorical Versus Dimensional Approaches

The use of categorical distinctions is another major problem in the taxonomic system of the *DSM*. One of the most fundamental problems of the *DSM-IV* has been the "inability or unwillingness of institutionalized psychiatry to renounce . . . explicit[ly] . . . the firmly bounded categorical format [as the] conceptual undergirding [of] the taxonomic effort . . . [in order] to maintain the medical disease metaphor [to avoid being] drummed out of the corps as 'real doctors'" (Carson, 1994, p. 4). Carson (1994, 1996) concluded that it would be "tragic folly for professional psychology to follow in this ill-conceived and short-sighted preservation of a defunct and unworkable idea" (1994, p. 4).

As Widiger (1992) noted, research on the etiology, pathology, prognosis, and treatment of psychopathology would be more informative if it were based on continuous dimensions rather than on categorical distinctions. Although Williams and Spitzer (1983) acknowledged that a categorical approach does not accurately represent clinical reality, they, like many others (e.g., Frances, 1980; Gunderson, Links, & Reich, 1991; Millon, 1981), argued that categories are familiar and acceptable to clinicians: "Categorical diagnosis is the standard and, with all its problems, it remains the more useful method in everyday clinical psychiatric practice" (Frances, 1982, p. 524). Although Gunderson et al. (1991, p. 296) also emphasized that a categorical system is more suitable for the clinical practitioner, they acknowledged that a dimensional taxonomic system, one based on underlying continuous distributions, might provide more powerful predictions about etiology, pathology, prognosis, and treatment than a categorical approach. Although categorical diagnoses may initially appear to be easier to use (e.g., Frances, Widiger, & Fryer, 1990; Gunderson et al., 1991; Millon,

1981), ultimately they are more complex and cumbersome than most dimensional models (Widiger, 1992). Categories can provide clear and vivid descriptions and prototypes (Frances, 1982; Widiger & Frances, 1985), but they also can create an illusionary sense of apparent simplicity that does not acknowledge the actual complexities of clinical phenomena (Widiger, 1992). In a categorical system, for example, patients can meet criteria for a particular diagnostic category in many ways.

Some investigators have attempted to create dimensional variables by using the number of DSM criteria met for a particular disorder as the essential variable. Several researchers have compared these "dimensional criteria" with categorical distinctions and found better reliability with these dimensional variables. Morey (1988), for example, conducted a cluster analysis of these dimensional variables and found that the clustering essentially re-created the DSM-III-R categories. Cloninger (1989), using admixture analysis with personality disorder data, found that underlying the relatively distinct subgroups appear to be "multiple dimensions of personality that were normally distributed" (p. 140). Cloninger (1989) concluded that "psychiatric disorders are not totally discrete, and this may be consistent with extreme syndromes that develop superimposed on . . . underlying dimensional variation" (p. 140). At the extremes, categorical distinctions are congruent with dimensional analyses, but the identification of underlying dimensions would offer much greater flexibility in the study of psychopathology. As Widiger (1982) concluded, "little to no empirical data . . . support the categorical model . . . [although] most . . . empirical finding[s], consistently favor the dimensional model" (p. 296). It should be stressed, however, that the "dimensional" variables used in most of the studies just discussed are based on a simple summation of the DSM criteria met for each diagnostic category; therefore, these studies are essentially only extensions of the established DSM criteria within the existing categorical system.

The continuation of the categorical model in the DSM-IV appears to be a function of its apparent relative ease and simplicity (Millon, 1981), the continuation of the medical tradition of identifying discrete diseases (Carson, 1991; Gunderson et al., 1991; Schacht, 1985), and the belief that basic biological and genetic dimensions eventually will be identified for many of these disorders (e.g., Akiskal, 1981; L. N. Robins & Helzer, 1986). Ultimately, it may be more productive in research as well as in clinical practice to define dimensions that underlie various forms of psychopathology, dimensions that are independent of the existing category structure and its multiple symptomatic criteria. The use of such dimensions may facilitate the identification of common processes existing in a number of diagnostic categories, thereby providing the basis for specifying the relationships among what are now considered to be separate disorders and, even further, for establishing hierarchical formulations in which certain phenomena can

be considered subclasses within a broader conceptual system (e.g., Blatt, 1991a, 1995a; Watson, Clark, & Harkness, 1994). It might be possible, for example, to view a wide range of disruptive behavior, such as conduct disorder, promiscuity, substance abuse, and so forth, as possible expressions of depression (Blatt, 1991b).

### Arbitrary Cutoff Points

A major dilemma in the *DSM* system is the establishment of threshold cutoff points. The rules regarding the cutoffs for a disorder are almost entirely arbitrary (Carson, 1991; Clark, 1994). The number of criteria that must be met to establish a diagnosis is usually established by consensus opinion of an expert advisory committee. For instance, individuals need to meet five of eight criteria to be diagnosed with borderline personality disorder, but why not four or six criteria? These thresholds profoundly influence the frequency of particular diagnoses and the reported co-occurrence of disorders (Widiger, Frances, Spitzer, & Williams, 1988). Whether the number of criteria to reach a threshold is four, five, or six clearly makes a difference in estimating both clinical and population prevalence (Morey, 1988). It is unclear where one should establish the cutoff for the various symptomatic expressions included in each diagnostic prototype or category: These various cutoff scores in the *DSM* are established arbitrarily without theoretical or empirical justification. As Widiger (1992) noted, "no empirical study has ever documented the validity of the current thresholds with respect to an external validator" (p. 292). Thus, there is considerable disagreement about the definition of the point at which a normal, or even a maladaptive, personality trait becomes clinically significant. In addition to the fact that the thresholds established for meeting criteria for various categorical diagnoses are arbitrary, these thresholds also do not usually include an intensity dimension. The presence of a specific symptomatic criteria is often counted toward meeting the threshold for a particular diagnostic category independent of whether the symptom is intense, pervasive, and persistent or relatively mild and transient. The use of these arbitrary thresholds contributes to poor interrater reliability.

### The Problem of Comorbidity

Another significant problem facing the *DSM* system is the frequent occurrence of multiple diagnoses of conceptually distinct diagnoses, euphemistically termed *comorbidity*. The frequency of comorbidity in using the *DSM* indicates that these categorical distinctions are not derived from



relatively mutually exclusive, basic invariants. Rather, one is more "impressed by the extraordinary and obstinate heterogeneity of the ... diagnostic groupings in terms of putative genotypal correlates" (Carson, 1991, pp. 302-303).

Interestingly, the DSM system not only permits, but in fact encourages, the use of multiple diagnoses. Thus, a patient can simultaneously meet criteria for several different disorders. This issue of multiple diagnosis, or comorbidity, creates considerable classificatory and conceptual difficulties. Carson (1994) critically commented that the concept of comorbidity is not "a discovery pertaining to the nature of psychopathology or its organization [but] . . . a necessary, but profoundly trivial, consequence of reifying hard boundaries that do not exist except in the minds of classifiers" (p. 4).

Much research has shown considerable overlap among a number of independent and discrete DSM diagnoses, especially among the personality disorders, where the problem of comorbidity is particularly acute (Dahl, 1986; Kass, Skodol, Charles, Spitzer, & Williams, 1985; Livesley & Jackson, 1986, 1991; Morey, 1988; Nurnberg et al., 1991; Oldham et al., 1992; Pfohl et al., 1986; Widiger, Trull, Hurt, Clarkin, & Frances, 1987; Zimmerman & Cornell, 1989). Numerous researchers (e.g., Dahl, 1986; Morey, 1988; Pfohl et al., 1986) have found extensive overlap among the DSM personality disorders. Different investigators have reported that the average number of diagnosable personality disorders for an individual patient ranges from 2.8 to 4.6 (Widiger & Frances, 1994). Semistructured interview studies (e.g., Skodol et al., 1988; Widiger et al., 1986), for example, indicate an average overlap of four personality diagnoses per patient. It is not uncommon for patients to meet criteria for as many as five, six, seven, or even more DSM personality disorders (Plutchik et al., 1994). Frances et al. (1990) posited that the occurrence of comorbidity in the DSM-IV is not determined by some natural order in the nature of psychopathology but is a consequence of the extensive numbers of imprecise and overlapping categories or diagnoses established within the DSM-III and DSM-IV.

#### The Proliferation of Personality Disorders and the Validity of Personality Disorder Clusters

The number of different personality disorders included in the various editions of the DSM has increased with each revision. Six personality disorders were defined initially in the DSM-I (APA, 1952), and this was increased to 7 in the DSM-II (APA, 1968) with the inclusion of a "cyclothymic," or depressive, personality disorder. The number of personality disorders grew to 11 in 1980 with the development of the DSM-III, and now in the DSM-IV the list has grown to 13.

Partly because of the extensive overlap among these Axis II person-

ality disorder diagnoses, the authors of the *DSM-III*, on an intuitive (non-empirical), nontheoretical) basis, recommended that personality disorders be clustered into three broad categories labeled the *dramatic* (the narcissistic, antisocial, borderline, and histrionic personality disorders), the *anxious* (the obsessive-compulsive, avoidant, dependent, and passive-aggressive personality disorders), and the *eccentric* (the paranoid, schizotypal, and schizoid personality disorders). Empirical evidence, however, has generally failed to support these three clusters. Plutchik et al. (1994), for example, used a paired comparison method and the circumplex model to evaluate clinicians' ratings of the personality disorders described in the *DSM-III-R*, plus a dysthymic personality disorder, and found some support for the "eccentric" cluster, but no support for "dramatic" and "anxious" clusters. Rather, they found an "anxious-depressed" cluster that included avoidant, dependent, self-defeating, and dysthymic disorders and an "aggressive" clustering of sadistic, narcissistic, and antisocial disorders. They also found that the histrionic and borderline personality disorders were near each other in a circumplex model and near the dysthymic diagnosis and therefore appeared to fit into the anxious-depressive cluster. On the basis of this evaluation of clinicians' application of the definitions and criteria of the basic categorical system of Axis II in the *DSM-III-R*, Plutchik et al. concluded that comorbidity is a "narrow way" of describing a more fundamental structuring of personality disorders. Their data suggest that the various personality disorders of Axis II are not discrete categories but appear to be organized into several major clusters and that the nature of these clusters remains unclear.

Despite the claim by the *DSM* that personality disorders fall into three broad categories, or clusters, little empirical evidence supports the similarity of the disorders within these clusters. Millon (1981) noted that this organization lacks any clear utility, in part because of the lack of a theoretical structure. In a comprehensive review of the literature on the latent pattern of Axis II psychopathology, including studies using factor-analytic, cluster, and multidimensional scaling techniques, Widiger et al. (1987) found no support for the three-cluster Axis II scheme adopted in the *DSM-III-R*. In a recent study of the latent structure of Axis II psychopathology, Moldin, Rice, Erlenmeyer-Kimling, and Squires-Wheeler (1994), like Plutchik et al. (1994), using confirmatory factor-analytic methods, found a different three-factor structure than the one proposed by the *DSM*. They concluded that the three-cluster structure in the *DSM* does not reflect the optimal classification scheme. Together, these studies raise questions about the distinctiveness of Axis II categories and the validity of the wide range of personality disorders listed in the *DSM-III-R* and the *DSM-IV* and the three clusters that have been suggested as a superordinate classification for Axis II.

## AN ALTERNATIVE TO THE DSM-IV BASED ON A MODEL OF PERSONALITY DEVELOPMENT

An alternative to the atheoretical model of psychiatric disease that provides the fundamental structure for much of the DSM is to develop a model of personality development and to consider how various disturbances could derive from disruptions of normal developmental processes. Specification of continuities between normal personality development and various forms of psychopathology would allow investigators to empirically evaluate many of the assumptions of this approach. Research could be conducted on various dimensions of normal personality development as well as on the degree to which various clinical disturbances could be differentiated on the basis of these dimensions. In addition, such a model could have clear etiological and therapeutic implications that could be systematically evaluated in clinical research.

Blatt and colleagues (Blatt, 1974, 1990, 1991a, 1995a; Blatt & Blass, 1990, 1992, 1996; Blatt & Shichman, 1983) have proposed such a life span developmental model of personality development and have described how many forms of psychopathology, from schizophrenia to the neuroses, derive from disruptions of this fundamental normal developmental process at different points in development.<sup>1</sup> This model of personality development identifies two fundamental dimensions in personality development: (a) a relatedness dimension that involves the development of the capacity to establish increasingly mature and mutually satisfying interpersonal relationships and (b) a self-definitional dimension that involves the development of a consolidated, realistic, essentially positive, differentiated, and integrated self-identity. In normal personality development, these two developmental processes evolve in an interactive, reciprocally balanced, mutually facilitating fashion throughout the life cycle. Various forms of psychopathology can be viewed as deriving from disruptions of these normal developmental processes. Thus, disorders are no longer viewed as separate and discrete diseases but as functional disturbances that evolve from disruptions of normal developmental sequences. Because various forms of psychopathology are considered as evolving from disruptions in fundamental developmental processes at different developmental periods, disorders are no longer considered in isolation, but the relationship among different disorders can be identified. Different forms of psychopathology can be interrelated because they emerge from disruptions of the same fundamental developmental processes but at different points in development. In addi-

<sup>1</sup>Blatt (1974, 1991a, 1995a) and Blatt and colleagues (Blatt & Auerbach, 1988; Blatt & Shichman, 1983; Blatt & Wild, 1976; Blatt, Wild, & Ritzler, 1975) also have considered the relationship of these formulations to *Diagnostic and Statistical Manual of Mental Disorders* Axis I diagnoses, but these issues are beyond the primary considerations of this chapter, which focuses on the personality disorders in Axis II.

tion, this theoretical model of various forms of psychopathology has therapeutic as well as etiological implications.

### THEORETICAL BACKGROUND OF THE TWO-CONFIGURATIONS APPROACH

These formulations of two fundamental developmental processes in personality development—the development of increasingly mature reciprocal interpersonal relatedness and the development of an effective sense of self—are consistent with a wide range of personality theories ranging from fundamental psychoanalytic conceptualizations to basic empirical investigations (e.g., Angyal, 1941, 1951; Bakan, 1966; Balint, 1959; Blatt, 1974, 1991a, 1991b, 1995a; Blatt & Shichman, 1983; Erikson, 1950; S. Freud, 1930/1957c; Guisinger & Blatt, 1994; McAdams, 1980, 1985; Shor & Sanville, 1978; Wiggins, 1991). These theorists, who have very different perspectives and often use different terms, have identified two fundamental processes that they consider to be central in personality organization and development: the development of satisfying interpersonal relationships and of a well-differentiated and integrated sense of self.

These two processes—interpersonal relatedness and self-definition—constitute two fundamental developmental lines throughout the life cycle that develop in a coordinated, integrated way. Personality develops through the complex interaction between these two fundamental developmental lines: (a) an anaclitic, or relatedness, developmental line involving the capacity to establish increasingly mature and mutually satisfying interpersonal relationships and (b) an introjective, or self-definitional, developmental line leading to a consolidated, realistic, essentially positive, differentiated, and integrated self-identity. These two developmental processes normally evolve in an interactive, reciprocally balanced, mutually facilitating fashion from birth through senescence. An increasingly differentiated, integrated, and mature sense of self depends on establishing satisfying interpersonal relationships, and, conversely, the continued development of increasingly mature and satisfying interpersonal relationships depends on the development of a more mature self-concept and identity. An increasingly differentiated and integrated sense of self leads to more mature forms of interpersonal relatedness, and, in turn, more mature forms of relatedness contribute to a more differentiated sense of self (Blatt, 1991a, 1995a; Blatt & Blass, 1990, 1996; Blatt & Shichman, 1983). In normal development, these two processes develop in a coordinated dialectic interaction. Throughout life, from infancy to senescence, progress in one developmental line facilitates development of the other.

Various forms of psychopathology no longer have to be considered as separate and independent disorders that are assumed to derive primarily

from distortions of neurobiological processes; now they can be viewed as evolving from disruptions of this fundamental, dialectic, psychological process (Blatt, 1991a, 1995a; Blatt & Shichman, 1983). The dimensions of relatedness and self-definition (communion and autonomy or anacletic and introjective) evolve in normal development in an integrated form so that the individual ideally develops both an active commitment to interpersonal relatedness and a viable sense of self. Biological predispositions and disruptive environmental events, however, can disturb this integrated developmental process in complex ways and lead to exaggerated emphasis on one mode at the expense of the other. Mild deviations result in unique character styles that are within the normal range. More extensive deviations (i.e., a marked exaggerated emphasis on one developmental line at the expense of the other), however, occur in psychopathology. Most forms of psychopathology involve a distorted and exaggerated emphasis on one of these two developmental lines and the defensive avoidance of the other. These exaggerated preoccupations with one of these developmental dimensions defines two different configurations of psychopathology, each containing several types of disorders ranging from relatively severe to relatively mild forms of psychopathology. Thus, the differentiation of anacletic and introjective personality configurations provides a basis for defining different types of psychopathology and for considering the relationships among them (Blatt & Shichman, 1983). Blatt and colleagues (e.g., Blatt, 1991a, 1995a; Blatt & Auerbach, 1988; Blatt & Shichman, 1983) as well as Beck (1993; Beck & Freeman, 1990) suggested that these two personality dimensions are related to a broad range of psychopathology, especially to the personality disorders (see also Pilkonis, 1988).

On occasion, severe and repeated untoward events disrupt the complex, normal, dialectic developmental process. Some individuals—depending on biological predispositions, cultural factors, gender, basic capacities and vulnerabilities, and cultural and family patterns—attempt to compensate for these serious developmental disruptions by exaggerating one developmental line, fixating either on relatedness or on the sense of self. The normal dialectic developmental process is disrupted somewhere in the life cycle, and, if no subsequent ameliorating circumstances and experiences occur, these patterns are continually repeated and become consolidated as distorted modes of adaptation. The earlier in the developmental process these disruptions occur and the more extreme the distortions, the more severe the psychopathology.

As a consequence of major disruption of the normal, dialectic developmental processes of relatedness and self-definition, some individuals, more often women, become excessively preoccupied with relatedness at the expense of development of the sense of self. If this developmental disruption occurs early in the life cycle, it can lead to the development of an infantile character, manifested as excessive concern for need gratification,

such as constantly wanting to be held, cared for, attended to, and fed. If this disruption of the dialectic developmental process occurs somewhat later in the life cycle, a more organized kind of hysterical disorder can develop in which the person is concerned not only with being held, cared for, and loved but also with being able to express as well as receive love. Some patients more often function at the infantile level, using denial as their primary defense; their concerns are primarily dyadic in structure, and they strive to be accepted and cared for, like the young child with his or her mother. Other patients are at the developmentally higher hysterical level, using repressions as their primary avoidant defense; their primary concerns are about being able to love as well as being loved and involve triadic configurations and oedipal themes (i.e., striving for the attention and love of one parent in competition with the other). At both the infantile and the developmentally more advanced hysterical levels, the issues relate primarily to libidinal attachment (i.e., concerns about being loved, intimate, and close). Most often, however, patients have a complex admixture of both infantile and hysterical features. These various forms of anaclitic psychopathology share a basic preoccupation with libidinal issues and a similar defensive style with a predominant use of avoidant defense such as denial and repression. Infantile and hysteria disorders can occur occasionally in a relatively pure form, but they are not isolated disorders or diseases, they are interrelated forms of anaclitic psychopathology. They represent relative end points on a continuum of anaclitic psychopathology (Blatt, 1974, 1995a; Blatt & Shichman, 1983). Oedipal themes of the hysterical character are often found in infantile character disorders, and oral themes of the infantile character are often found in the hysterical person as well. It is not uncommon to find a blend of oral and genital psychosexual preoccupations (Marmor, 1953) because both of these libidinal preoccupations involve interpersonal relatedness.

Some individuals, more often men, deal with severe disruption of the normal dialectic developmental process by exaggerated attempts to consolidate a sense of self. In the extreme, this is expressed in disorders of paranoia, obsessive-compulsiveness, guilt-ridden (introjective) depression, and phallic narcissism. These disorders all express preoccupations with the self ranging from primitive concerns of a fundamental sense of separation in paranoia to more integrated concerns about self-worth in introjective depression and phallic narcissism. The paranoid patient is preoccupied with maintaining a rigid definition of self as distinct and separate from others. Paranoid patients struggle to feel that they exist as a separate entity and that they are not merged and fused in a symbiotic relationship with another (Blatt & Wild, 1976; Blatt et al., 1975). In their struggle to maintain a sense of self in a primitive form, all bad is placed onto the other, all good is attributed to the self, and an isolated embattled distance is maintained from others. Obsessive-compulsive disorders express somewhat higher con-



cerns about the self: concerns about mastery, autonomy, control, prerogatives, and possessions. At a still higher developmental level, individuals are concerned about more internal issues such as self-worth. In introjective depression, the predominant concerns are about one's intent and one's value relative to an idealized value system, with the belief and feeling that one is a failure or has transgressed fundamental moral standards. Phallic narcissism is the reversal of introjective depression in which, through counteraction and overcompensation, the individual seeks to exhibit himself or herself to win endless accolades and approval to defend against intense feelings of guilt, shame, worthlessness, and humiliation. These different forms of introjective psychopathology (i.e., paranoia, obsessive-compulsiveness, guilt-ridden depression, and phallic narcissism) are not separate disease entities but are interrelated modes of adaptation. Paranoid patients often have significant obsessive features and are often defending against powerful feelings of depression and guilt. Likewise, obsessive patients can regressively decompensate and develop paranoid features, and the same is true of someone with a guilt-ridden depression (see also Abraham, 1927/1949; Shapiro, 1965). Thus, introjective forms of psychopathology are interrelated modes of adaptation that occur at different developmental levels along a fundamental continuum. Individual patients can function predominantly at a particular developmental level and progress or regress along this continuum depending on a variety of circumstances.

The dynamics, conflicts, defenses, and cognitive-affective and interpersonal style of the various forms of psychopathology of the introjective configuration share fundamental similarities. Paranoia, obsessive-compulsiveness, introjective depression, and phallic narcissism usually all involve issues of self-reproach, guilt, and preoccupations with self-definition, self-control, and self-worth. All these introjective disorders tend to emphasize cognitive processes, and they share an emphasis on aggression that is directed at others or the self. People with these disorders are much more concerned about self-assertion and aggression than about bonding and relatedness (Blatt, 1990; Blatt & Blass, 1990; Blatt & Shichman, 1983). In all forms of psychopathology in the introjective configuration, defenses are essentially counteractive rather than avoidant. Projection, reversal, intellectualization, doing and undoing, reaction formation, introjection (or identification with the aggressor), and overcompensation all attempt, with varying degrees of effectiveness, to alter or transform impulses and conflicts rather than to avoid (deny or repress) them. Although each of the disorders in the introjective configuration can be viewed as independent and separate, they are interrelated disorders, and, most often, individual patients present a complex admixture of these various disorders (Blatt & Shichman, 1983).

Thus, two primary configurations of psychopathology can be defined primarily by exaggerations of the tasks of each of the two fundamental



developmental lines. Exaggerated and distorted preoccupations about satisfying interpersonal relations, to the neglect of the development of concepts of self, define the psychopathologies of the anaclitic configuration: the infantile and hysterical syndromes. Exaggerated and distorted concerns about the definition of the self, at the expense of establishing meaningful interpersonal relations, define the psychopathologies of the introjective configuration: paranoid, obsessive-compulsive, introjective depressive, and phallic narcissistic disorders.

Each of these two configurations of psychopathology has several evolving levels of organization ranging from more primitive to more integrated attempts to establish meaningful interpersonal relations and a consolidated self-concept. The various levels of psychopathology within the anaclitic and the introjective configurations also define lines along which patients progress or regress. Thus, an individual's difficulties can be specified as being predominantly in one or the other personality configuration, at a particular developmental level, and with a differential potential to regress or progress to other developmental levels within the configuration. In this conceptualization, the various forms of psychopathology are no longer considered as isolated, independent disease entities but as interrelated modes of adaptation organized at different developmental levels within two basic configurations. In contrast to the usual atheoretical diagnostic scheme of the DSM, which is based primarily on differences in manifest symptoms, the diagnostic differentiation between anaclitic and introjective configurations of psychopathology derives from psychodynamic considerations including differences in primary instinctual focus (libidinal vs. aggressive), types of defensive organization (avoidant vs. counteractive), and predominant character style (e.g., emphasis on an object orientation vs. a self-orientation and on affects vs. cognition; Blatt, 1991a, 1995a).

In summary, anaclitic disorders primarily involve issues of interpersonal relatedness such as trust, caring, intimacy, and sexuality and use primarily avoidant defenses (e.g., denial and repression). By contrast, introjective psychopathologies are disorders that primarily involve establishing and maintaining a viable sense of self, autonomy, and self-worth and that use primarily counteractive defenses (e.g., projection, doing and undoing, intellectualization, reaction formation, and overcompensation). Clinical judges, at acceptable levels of reliability, can distinguish between these two primary configurations of psychopathology from clinical case records (e.g., Blatt, 1992; Blatt & Ford, 1994), and several empirically based questionnaires have been developed that systematically assess these two personality dimensions. Beck, Epstein, Harrison, and Emery (1983) developed the Sociotropy-Autonomy Scale (SAS), and Blatt, D'Afflitti, and Quinlan (1976, 1979) developed the Depressive Experiences Questionnaire (DEQ). Research with the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978) also identified two primary factors of dysfunctional attitudes, a need

for approval and perfectionism (Cane, Olinger, Gotlib, & Kuiper, 1986; Imber et al., 1990; Oliver & Baumgart, 1985) that are congruent with and consistently related to these two personality dimensions. Recent research has demonstrated the value of these formulations of a dialectic model of personality development and the two configurations of psychopathology for understanding a broad range of clinical phenomena, including the differentiation between two primary forms of depression, and for identifying an inherent structure for the various types of personality disorders described in Axis II of the DSM.

### IMPLICATIONS FOR DEPRESSION

The differentiation between interpersonally oriented, dependent, anaclitic patients and ideational, perfectionistic, self-critical introjective patients has been particularly useful in identifying two major types of depression. Investigators from both the dynamic (e.g., Arieti & Bemporad, 1978, 1980; Blatt, 1974; Bowlby, 1988a, 1988b) and cognitive-behavioral (Beck, 1983) perspectives have discussed two major types of experiences that result in two types of depression: (a) disruptions of gratifying interpersonal relationships (e.g., the loss of a significant figure) and (b) disruptions of an effective and essentially positive sense of self (e.g., feelings of failure, guilt, and worthlessness).

In the past 20 years, an important shift has occurred from viewing depression primarily as a psychiatric disease or disorder, which may or may not have a biological component such as a depletion of serotonin, to considering depression as a dysphoric affective state that can vary across a wide spectrum from a relatively mild, temporary, and appropriate response to negative life experiences to a severe, persistent, disabling disorder that can involve serious distortions of reality (Blatt, 1974). On the basis of the assumption of a continuity between normal reactions to life experiences and severe clinical disorders, depression can be considered as a complex phenomenon that emerges from two major types of disruptive life events: from severe disruptions of interpersonal relations such as loss or from profound threats to feelings of self-esteem and self-worth. This approach to understanding depression from a phenomenological rather than a symptomatic perspective has emerged as a major trend in both psychology and psychiatry over the past two decades.

Clinical investigators from three independent strands of psychoanalytic thought have noted that excessive vulnerability to these two types of experiences leads to depression. Bowlby (e.g., 1973, 1988a, 1988b), from the object relations and ethological perspectives, discussed the predisposition to depression in anxiously attached and compulsively self-reliant individuals. Blatt and colleagues (e.g., Blatt, 1974; Blatt et al., 1979; Blatt,

Quinlan, & Chevron, 1990; Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982), from the ego-psychoanalytic and cognitive-developmental perspectives, differentiated between a dependent (anaclitic) and a self-critical (introjective) depression. Arieti and Bemporad (1978, 1980), from an interpersonal perspective, distinguished between a dominant other and a dominant goal type of depression. Finally, Beck (1983), from a cognitive-behavioral orientation, also discussed a sociotropic and an autonomous type of depression. All four groups of theorists differentiated between a depression that focuses on interpersonal issues such as dependency, helplessness, and feelings of loss and abandonment and a depression focused on issues of self-definition such as autonomy, self-criticism, self-worth, and feelings of failure and guilt.

Although there are important differences among these four theoretical positions, they have a great deal in common (see Blatt & Maroudas, 1992, for a comprehensive review of these four theoretical positions and their clinical implications). Each of these theoretical positions, using somewhat different terms and based on different theoretical assumptions, differentiates between two major types of depression, not on the basis of the nature of the manifest symptoms of depression but on the nature of the life experiences that seem of importance to depressed individuals and to have precipitated their dysphoric feelings. One type of depression is initiated by disruptions of gratifying interpersonal relationships and is experienced as feelings of loss, abandonment, and loneliness; the other type of depression is initiated by disruptions of an effective and essentially positive sense of self and is experienced as feelings of worthlessness, guilt, failure, and a loss of control.

The differentiation of these two types of depression, as well as the development of procedures to assess them, has led to extensive empirical investigation into the developmental origins, primary characteristics, and aspects of current life situations that characterize these two types of depression in both outpatients and inpatients. Researchers and clinicians now understand some of the developmental antecedents that contribute to the development of these two types of depression (Blatt & Homann, 1992) and the differential vulnerability of each of these types of depressed individuals to different types of stressful life experiences (Blatt & Zuroff, 1992). They also understand more fully the functioning of these two types of individuals when they are clinically depressed and when they are in remission (Blatt et al., 1982).

Blatt and colleagues (Blatt, 1991b; Blatt, Hart, Quinlan, Leadbeater, & Auerbach, 1993; Blatt, Rounsaville, Eyre, & Wilber, 1984; Blatt & Shichman, 1981; Leadbeater, Blatt, & Quinlan, 1995) have demonstrated with both clinical examples and empirical data how these two types of depression are differentially related to various types of disruptive behavior. Somatic preoccupations and sexual promiscuity are often associated with

anaclitic depression (Blatt, 1974; Blatt et al., 1982), whereas delinquency (Blatt, 1991b; Blatt & Shichman, 1981), aggression, and opiate addiction are often associated with introjective depression (e.g., Blatt et al., 1984, 1993). Anaclitic depressed individuals often express their depression in somatic complaints, frequently seeking the care and concern of others, including physicians. Depression in these patients is often precipitated by object loss, and they often make suicidal gestures by taking an overdose of their prescribed antidepressant medication (Blatt et al., 1982). An introjective depression focused on issues of self-worth, self-esteem, failure, and guilt is particularly insidious. Individuals who are highly self-critical and feel guilty and worthless are at considerable risk for serious suicide attempts (Beck, 1983; Blatt, 1974, 1995b; Blatt et al., 1982). Clinical reports as well as accounts in the public media illustrate the considerable suicidal potential of highly talented, ambitious, and successful individuals plagued by intense self-scrutiny, self-doubt, and self-criticism. A powerful need to succeed forces some individuals to work incessantly hard to achieve and accomplish. Some of these individuals, however, are also profoundly vulnerable to the criticism of others and to their own self-scrutiny and judgment. According to Blatt (1995b), a

harsh punitive superego (Freud, 1914/1957a; 1926/1957b) can be a driving force for achievement, but it can also result in little satisfaction in accomplishments, and through a marked vulnerability to experiences of failure and criticism, in an increased susceptibility to ensuing depression and suicide. Because of the need to maintain a personal and public image of strength and perfection, such individuals are constantly trying to prove themselves, are always on trial, feel vulnerable to any possible implication of failure or criticism, and often are unable to turn to others, even the closest of confidants, for help or to share their anguish. (p. 1005)

Researchers and clinicians are now also beginning to understand more fully the differentiated response of these two groups of patients to different types of brief and long-term intensive psychotherapeutic interventions (Blatt, 1992; Blatt & Ford, 1994; Blatt, Quinlan, Pilkonis, & Shea, 1995; Blatt, Zuroff, Quinlan, & Pilkonis, 1996). Research findings (Blatt, Quinlan, et al., 1995) indicate that brief treatment, whether pharmacological or psychological, is relatively ineffective with self-critical, introjective patients. Recent analysis (Blatt, Quinlan, et al., 1995) of data from the extensive multisite study of brief treatment for depression coordinated by the National Institute for Mental Health (the Treatment of Depression Collaborative Research Program) indicates that intense perfectionism or self-criticism assessed by one of the two factors of the DAS (Weissman & Beck, 1978) before treatment had a highly significant ( $p < .0001$ ) negative relationship with therapeutic outcome in all four treatment modalities evaluated in that investigation, regardless of whether the patient received an-

tidepressant medication (imipramine) or placebo, each with clinical maintenance, or participated in either of two forms of brief psychotherapy (interpersonal or cognitive-behavioral therapy). Harsh, critical judgmental superego introjects and negative cognitions of self and others of these introjective patients appeared to markedly limit the effectiveness of all four brief treatment interventions in this extensive and carefully designed investigation. Conversely, patients with relatively lower levels of perfectionism were significantly more responsive to all four forms of brief treatment for depression, including clinical management in conjunction with placebo. These findings suggest that highly self-critical and perfectionistic individuals have identified with harsh, judgmental, parental figures who have set excessively high standards. One of the primary tasks of treatment is to enable these patients to establish new or revised identifications so they can begin to define themselves independently of their highly critical and demanding superego introjects while maintaining contact with the more benign and nurturant dimensions of their parental introjects.

In contrast to the indications that highly self-critical, perfectionist patients are significantly less responsive than other patients to several standard forms of brief pharmacological and psychological outpatient treatment for depression, research findings from several investigations of long-term, intensive, psychodynamically oriented therapy with both outpatients (Blatt, 1992) and with more seriously disturbed inpatients (Blatt & Ford, 1994; Blatt, Ford, Berman, Cook, & Meyer, 1988) indicate that patients who are preoccupied with issues of self-definition, self-control, and self-worth (patients with introjective forms of psychopathology) have significantly greater therapeutic gain than anaclitic patients in long-term intensive treatment. Individuals who are excessively concerned about issues of self-definition and self-worth usually have the intellectual resources and self-reflective capacities necessary to engage constructively in and benefit from extensively long-term, intensive treatment. After an average of 15 months of long-term, intensive treatment of seriously disturbed patients in an open inpatient treatment facility, including at least four-times-weekly dynamically oriented psychotherapy, patients predominantly concerned with issues of self-definition and self-worth (introjective patients) consistently demonstrated significantly greater improvement than anaclitic patients (Blatt & Felsen, 1993; Blatt & Ford, 1994; Blatt et al., 1988). Multiple independent assessments, using various methods of evaluation, indicate that introjective patients, who are predominantly concerned with issues of self-definition and self-worth, consistently showed significantly greater clinical improvement after 15 months of intensive inpatient treatment. In addition, anaclitic and introjective patients appear to change (improve or regress) in different ways. Change in anaclitic patients primarily involves interpersonal dimensions (e.g., interpersonal behavior and the representation of the human figure), whereas change in introjective

patients usually involves self-presentation (e.g., symptoms) and cognitive processes (e.g., thought disorder and intelligence test scores). Thus, these types of patients express therapeutic change in different ways, along dimensions congruent with their basic character structure.

A reanalysis of the data from the Menninger Psychotherapy Research Project (Blatt, 1992), in which the relative effectiveness of long-term psychodynamically informed psychotherapy was compared with psychoanalysis, indicated that introjective outpatients made significantly greater therapeutic gains in intensive (five times weekly) psychoanalysis than when they were treated in long-term, twice weekly psychotherapy (Blatt, 1992). The therapeutic gains of introjective patients in psychoanalysis were significantly greater than anaclitic patients treated in psychoanalysis. Anaclitic patients, by contrast, showed significantly greater improvement in face-to-face psychotherapy than they did in psychoanalysis. It is important to note that although introjective self-critical patients did relatively poorly in brief treatment, they did relatively well in long-term, intensive treatment, including psychoanalysis. It apparently requires a substantial period of time for highly perfectionistic, introjective patients to allow themselves to enter into a therapeutic relationship and to begin to change well-entrenched negative mental representations of the self and others. Thus, research findings from several independent studies of therapeutic change indicate that anaclitic and introjective patients differentially respond to different types of therapy and change in different types of ways.

### IMPLICATIONS FOR THE PERSONALITY DISORDERS

Recent research (e.g., Goldberg, Segal, Vella, & Shaw, 1989; Levy et al., 1994; Ouimette & Klein, 1993; Ouimette, Klein, Anderson, Riso, & Lizardi, 1994) demonstrates the value of these formulations of a dialectic model of personality development and the two configurations of psychopathology for understanding the various personality disorders in Axis II of the *DSM-III-R* and the *DSM-IV*. Research evidence indicates that the personality disorders can be parsimoniously and systematically integrated into two major clusters that are consistent with the differentiation between anaclitic and introjective disorders.

Goldberg et al. (1989), investigating the relationship of personality disorders using the Millon Clinical Multiaxial Inventory (Millon, 1981) and the DAS, found that the DAS Need for Approval scale was significantly related to dependent personality disorder traits and that the DAS Perfectionism scale was significantly related to negativistic (or passive-aggressive) personality traits. Using two different measures to assess preoccupation with issues of relatedness and self-definition (e.g., dependency and self-criticism [the DEQ; Blatt et al., 1979] and sociotropy and auton-



omy [SAS; Beck, 1983]), and using the Personality Disorder Examination (PDE; Loranger, 1988) to assess personality disorders, several investigators attempted to establish an empirical basis for organizing the 12 different personality disorders by testing whether these personality disorders would cluster into two primary configurations associated with disruptions of interpersonal relatedness or with disruptions in self-definition, self-control, and self-worth. Using the PDE and a structured diagnostic interview to assess the 12 *DSM-III-R* personality disorders within an outpatient sample and the Personality Styles Inventory (PSI; C. J. Robins & Luten, 1991), a revision of the SAS (Beck et al., 1983), and an abbreviated form of the DEQ (R-DEQ; Welkowitz, Lish, & Bond, 1985) to assess the two personality dimensions of relatedness and self-definition, Ouimette et al. (1994) found that several of the personality disorders (dependent, histrionic, and borderline) uniquely correlated with measures of interpersonal relatedness (i.e., with the Dependency factor of the R-DEQ and the Sociotropy factor of the PSI). Several other personality disorders (paranoid, schizoid, schizotypal, antisocial, narcissistic, avoidant, obsessive-compulsive, and self-defeating) assessed on the PDE uniquely correlated with measures of self-definition (i.e., with the Self-Criticism factor of the R-DEQ and the Autonomy factor of the PSI). Levy et al. (1994) reported similar findings between the PDE and the DEQ (Blatt et al., 1976) with an inpatient sample. The findings of both of these studies indicate that the various personality disorders described in Axis II of the *DSM-III-R* can be integrated parsimoniously and systematically in terms of the configurations of anaclitic and introjective psychopathology (i.e., in terms of preoccupation with disruptions primarily of relatedness or primarily of self-definition, self-control, and self-worth).

The overall pattern of results in these studies, consistent with theoretical formulations, indicates that many of the personality disorders described in Axis II of the *DSM* are interrelated disorders that cluster in terms of their relationship to the two fundamental personality dimensions of self-definition and interpersonal relatedness. A number of personality disorders (i.e., histrionic, dependent, borderline) appear to be focused in different ways, and possibly at different developmental levels, with issues of interpersonal relatedness. Furthermore, another set of personality disorders (i.e., avoidant, schizoid, schizotypal, paranoid, obsessive-compulsive, narcissistic) appear to express a preoccupation with establishing, preserving, and maintaining a sense of self, possibly in different ways and at different developmental levels. These results suggest that many of the personality disorders listed in Axis II are interrelated and that these relationships can be defined by the two primary dimensions of personality development—relatedness and self-definition (e.g., Blatt & Blass, 1992, 1996)—as well as by the two primary configurations of psychopathology



—anaclitic and introjective (e.g., Blatt, 1974, 1991a, 1995a; Blatt & Shichman, 1983).

## CONCLUSION

In summary, in this chapter we have presented a theoretical model for understanding psychopathology from a developmental psychodynamic perspective. Rather than conceptualizing various forms of psychopathology primarily on the basis of differences in manifest symptoms, we view various forms of psychopathology as deriving from disruptions in normal psychological development—from disruptions of a complex dialectic interaction between two fundamental developmental lines—between the development of mutually satisfying, reciprocal interpersonal relationships and the development of a differentiated, integrated, essentially positive, and realistic sense of self. These two developmental lines have been identified as being fundamental to personality development and organization in psychoanalytic thought (e.g., Balint, 1959; Freud, 1930/1957c; Loewald, 1962; Shor & Sanville, 1978), in a wide range of nonpsychoanalytic formulations about personality organization (e.g., Angyal, 1951; Bakan, 1966; Spiegel & Spiegel, 1978), and in research investigations of personality development and organization (e.g., McAdams, 1980, 1985; Wiggins, 1991).

Two primary configurations of psychopathology can be defined as deriving from attempts to cope with severe disruptions in this normal dialectic developmental process. Some patients attempt to cope with these developmental disruptions by becoming excessively preoccupied with only one of these developmental issues (relatedness or self-definition) with the defensive avoidance of the other developmental line. This psychodynamic formulation of psychopathology as distortions and disruptions in normal psychological development provides a paradigm that organizes various forms of psychopathology in a more integrated and parsimonious fashion than the distinctions provided by the *DSM*. Research findings indicate, for example, that the various personality disorders described in Axis II of the various versions of the *DSM* cluster primarily around issues of either interpersonal relatedness or self-definition (e.g., Levy et al., 1994; Ouimette et al., 1994). Similarly, these psychodynamic formulations of psychopathology have led to the differentiation of two major forms of depression, a differentiation supported by extensive investigations by psychoanalytic (e.g., Arieti & Bemporad, 1978, 1980; Blatt, 1974; Blatt & Zuroff, 1992; Bowlby, 1973, 1988a, 1988b) and cognitive-behavioral (e.g., Beck, 1983) investigators. The differentiation of these two primary configurations of psychopathology also has contributed to more differentiated investigation of the therapeutic process, with indications that these two types of patients (anaclitic and introjective) respond differently to different types of thera-

peutic intervention (e.g., Blatt, 1992; Blatt, Quinlan, et al., 1995), change in different ways during the treatment process (Blatt & Ford, 1994), and appear to respond to different aspects of the treatment process—to aspects of the interpersonal relationship and to interpretation and insight (Blatt & Behrends, 1987).

The empirical support for the validity of these formulations of two primary configurations of psychopathology suggests that there is much to be gained from attempting to formulate various forms of psychopathology as deriving from disruptions of normal psychological development. Such an approach provides a taxonomy for psychopathology that has a theoretical base as well as considerable empirical support. This approach enables one to define different forms of psychopathology in terms of disruptions of fundamental developmental processes rather than on the basis of somewhat arbitrary clusters of manifest symptoms. This approach also facilitates the investigation of the assumptions about normal personality development and the links between disruptions of this developmental process and various forms of psychopathology. In contrast to the atheoretical diagnostic scheme of the *DSM*, the diagnostic differentiation between anaclitic and introjective configurations of psychopathology derives from psychodynamic considerations, including differences in primary instinctual focus (libidinal vs. aggression); types of defensive organization (avoidant vs. counteractive); and predominant character style (an object or relatedness vs. a self-orientation and a focus on feelings [affect] vs. cognition [thoughts and ideas]). This differentiation of two primary configurations has led to a wide range of empirical research in studies of depression and personality disorders as well as to the investigation of differential responses of different types of patients to both short- and long-term treatment.

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