American Handbook of Psychiatry

Other Character-Personality Syndromes

Schizoid, Inadequate, Passive–Aggressive, Paranoid, Dependent

Leon Salzman

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This group of disorders is characterized by maladaptive patterns of behavior that are not sufficiently definite or severe to be considered neurotic or psychotic syndromes. While there are generally no particular symptoms associated with each of these syndromes, the disorders involve an exaggeration or accentuation of the individual's personality structure, so that they may be incapacitating or so extreme as to focus attention on these character traits and thereby create anxiety. In contrast to the neuroses where the symptoms are ego-alien, in the character disorders the behavior or character traits are in general ego-syntonic and only occasionally maladaptive.

In recent years, this type of problem has constituted the major bulk of the psychotherapeutic practice of psychiatrists and psychologists, in spite of the fact that these character traits can be assets. The absence of crises or severe anxiety makes the seeking-out and follow-through in psychotherapy more difficult. In therapy, the character traits themselves constitute the resistance to the elaboration, clarification, and alteration of the character

disorders. This observation was a major contribution of Wilhelm Reich to psychoanalytic theory and practice.

In general, the diagnostic categories that delineate these patients are defined by the characteristic ways in which the individual functions and deals with his anxiety. While these patterns may not constitute the total personality structure, the label generally applies to the predominant defense mechanism which characterizes the individual's functioning and which is producing difficulties in his living sufficient to require psychiatric assistance. Consequently, the labels refer not to any disorder as such, but to the prevailing technique that the individual uses to deal with his anxieties.

The Diagnostic and Statistical Manual of the American Psychiatric Association describes this category as follows:

> V. Personality Disorders and Certain Other Non-Psychotic Mental Disorders (301-304) 201— Personality Disorders
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> This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns, often recognizable by the time of adolescence or earlier. Sometimes the pattern is determined primarily by malfunctioning of the brain, but such cases should be classified under one of the non-psychotic organic brain syndromes rather than here.

Character Disorder Syndromes

It is useful to conceive of these syndromes as part of a spectrum ranging from the normal to the psychotic. The characteristic or enduring pattern which becomes involved in the character disorder is often the typical technique that the individual uses to deal with stress. A variety of other mechanisms may also be employed, but these disorders are labeled by the major defense pattern that is utilized. Therefore, these syndromes are not pure instances of a particular character structure, but generally do contain defense techniques of a wide variety. In addition, the syndromes represent disorders of functioning where the particular patterns of behavior have become more pronounced and intrusive than they might be in a more healthy adaptation, but less extreme and disruptive than they might be in a neurotic or psychotic disorganization of functioning.

This situation can be exemplified in examining the range of obsessional functioning extending from the normal to the neurotic. At one extreme is a minimum of obsessional patterns, such as minor rituals or rigid prescribed modes of behaving that are barely noticeable under ordinary circumstances. At the other extreme, the patterns are so pervasive and intrusive, such as extreme doubting, procrastination, or indecision, as to interfere with productive living. In the first instance, which we might view as normal, these obsessional defenses may even enhance one's performance. At the opposite extreme, they may produce neurotic or psychotic behavior and may seriously impair one's capacity for living. Between these two extremes are the more or

less obsessional defenses, which can be identified as the cluster of behavioral patterns we call the obsessional personality.

Differentiating between manifestations of obsessional traits of behavior and an obsessional personality is a matter of consistency and the extent of the pattern's involvement with the individual's total life. While admittedly such a distinction is extremely difficult to make, it is important in our concerns about managing such problems. The label "obsessional personality" refers to a widespread, fairly cohesive set of obsessional traits in a person whose behavior patterns are fixed and durable, and can be predicted with some degree of accuracy. The consistency and durability of such behavior involves a more integrated and pervasive use of obsessional mechanisms than is generally found in the occasional bits of obsessional behavior that might occur in all personality structures.

The distinction between the obsessional personality and the obsessional neurotic is in the area of differing functional capacity. As long as an individual remains productive, even though he might be involved in extensive rituals or other obsessive behavior, he would not be considered neurotic. The label "neurotic" refers not only to a clinical syndrome characterized by specific, definable limits, but also to behavior that becomes maladaptive or runs counter to the community's standard for what is acceptable. The individual might behave strangely or impress some people as

being odd, but as long as he is integrated and functioning effectively he need not be considered neurotic.

It is common to find even severe character-disordered individuals functioning effectively in settings in which their "queerness" and unconventional attitudes may be noticed by all. Either because of the sympathetic good will of the community or colleagues, or because of their contributions or value to the community, since they are generally regarded as good workers, they may be retained on the job. It is only when some untoward event or personal crisis occurs and aggravates their characterological patterns that these individuals require psychiatric assistance.

Such an instance was true in the case of an electronics engineer who was a totally undisciplined worker. He would arrive at and depart from his plant according to his own schedule, and on many occasions he would work through the night. He was meticulously precise, and had some hand-washing compulsions, as well as a total inability to settle for anything less than a perfect performance at the job. While his lack of discipline tended to disrupt the laboratory routine, the management was extremely sympathetic and even increased his hourly pay. Periodically, his preciseness and passion for order would resolve some hitherto unsolvable circuitry problem.

Shortly after his marriage, his performance became more erratic and unreliable. As his professional behavior became more extreme and undisciplined, his performance on the job became markedly disruptive. What had been considered merely odd and queer was now labeled as a character disorder that required therapy.

Another instance is that of a mathematician whose job did not require him to punch a timeclock or to follow a set routine. However, he was expected periodically to file a report on the current status of his project. He worked in a large "think tank" with a great number of brilliant scientists and technicians. While he was unusually talented and respected by his superiors, his character structure and typical personality tendencies soon became apparent and disruptive. His indecisiveness, procrastination, and anxiety about perfect performance made it impossible for him to complete any task. While such difficulties were evident in every aspect of his life, he had managed a fairly successful career until he was hired by this high-level scientific laboratory that made concrete demands on him. He came to therapy on his own volition, finally acknowledging that his indecisiveness was too extreme to be rationalized even as scientific caution. Thus, what were for a long time only personality traits congealed into a typical character structure produced sufficient complications in his living to require therapy, even though no particular neurotic or psychotic development could be identified.

While most of the existing categories of character-personality syndromes are of this order, that is, the less extreme manifestations of defined neurotic or psychotic disorders, some are not. The paranoid, cyclothymic, schizoid, obsessive-compulsive, or hysteric personality character syndromes are examples of the above. However, other personality character syndromes are merely descriptive entities unrelated to specific neurotic or psychotic disorders. Such categories as the explosive-asthenic, antisocial, or passive-aggressive character disorders are recognizable entities by virtue of the prevailing techniques and ways of orienting the individual in satisfying his needs.

Personality types are therefore defined either in terms of the underlying psychodynamics or the persistence and intrusiveness of the major integrating trait of the individual. At other times, the personality may be delineated by the community's reaction to such behavior, such as in the antisocial or psychopathic personality. It is apparent that these categories do not represent disease entities of illness as defined by a medical model of cause, pathology, and specific treatment. The cluster of traits that have a dynamic relationship to one another can often be ascribed to particular developmental experiences or to somatic origins, but our diagnostic manual does not limit its categories to such personalities.

Personality Character Syndromes

Schizoid Personality

The behavior pattern of such individuals is described in the APA Diagnostic Manual as follows:

> This behavior pattern manifests shyness, oversensitivity, seclusiveness, avoidance of close or competitive relationships, and often eccentricity. Autistic thinking without loss of capacity to recognize reality is common, as is daydreaming and the inability to express hostility and ordinary aggressive feelings. These patients react to disturbing experiences and conflicts with apparent detachment.

These individuals have a tendency to avoid close or long-term relationships. They have a limited repertory of adaptive techniques and their typical maneuver for adaptation is withdrawal, both interpersonally and psychically. Such personalities may have genetic and constitutional ingredients as an integral part of the syndrome, and this disposition may account for the experiential effects which are manifested so early in their lives. The beginnings may be noted in infancy where individual variations, such as autism, may be noted, and the tendency to move away from any difficulties rather than meeting them. In the developmental years, they tend to avoid socializing with peers and other children, as well as adults, or else tend to limit their contacts to known members of their immediate family. This type of schizoid personality is called the “shut-in personality,” and while it does not necessarily precede schizophrenia, it frequently does. Those who become schizoid are shy, well-behaved, and easily managed children,

although they are markedly sensitive to rejection or displeasure. They are rarely aggressive or assertive, but can easily imagine real or fantasied assaults on themselves. There is a tendency towards some grandiose feelings of omnipotence, which may be expressed or remain detached and aloof, and they give the appearance of being disinterested, isolated, and resigned to their state. In childhood and adolescence, this type of individual appears to be the outsider; a non-competitor who does not make physical contact and remains distinct and isolated from his group. He may be talented and very bright in school, and have a large number of hobbies that separate and distinguish him from his peers. Emotionally, such individuals appear to be detached, cold, and uninvolved in people, although they may be intensely committed or involved in intellectual projects or pursuits. Such intensity may result in considerable personal success and achievement, yet they remain odd and isolated in spite of it. They generally find some kind of solace in philosophical movements or in idealistic enterprises that do not require involvement with other people, only with ideas. Mature sexuality is postponed because of their inability to form any kind of intimate relationship, particularly with the opposite sex. Consequently, they often limit their nonsexual intimacies to people of the same sex, and often set up homosexual relations when the gonadal pressures push for some sexual outlet. They are not necessarily homosexual, even though they may limit their activity, being unable to initiate heterosexual relationships. These difficulties are aggravated

by the disturbed relations within the family, which also prevent the resolution of their adolescent ties to the family, and they therefore have difficulty in making moves towards separation and individuation. If they marry, they tend to remain uninvolved, and the communication with the partners is limited. Such marriages may be successful if the partners do not make excessive demands on each other, both socially or sexually. The best relationships under these circumstances are those in which the marital partners live separate lives while sharing some mutual activities. Schizoid characters seek out therapy generally because some crisis disrupts what are their minimal patterns of functioning. Whether it is the death of a person involved in their integration in the real world, or the disruption or interruption of a fragile or tenuous intimacy, it is an event that prevents the individual from functioning.

Treatment is therefore difficult since the ego resources are limited. The danger of a schizophrenic disintegration is always present, so that caution and concern must be an integral part of the treatment process.

Inadequate Personality

This type of personality is not directly related to any psychiatric syndrome or mental disorder, and describes a type of individual who cannot meet or cope with life's demands and requirements. He is unable to meet the

challenges of living, either on social or professional terms, and therefore represents a description of an immature development without any particular psychopathology. The APA Diagnostic Manual describes the category as follows:

> This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual and physical demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability and lack of physical and emotional stamina.

This description could be applied to the diagnosis of simple schizophrenia and in fact is often confused with it. However, the capacity to relate and to be motivated is available in these individuals and, even though their personal resources are few, they are more amenable to individual psychotherapy than the schizophrenic. In addition, their relationships are more involved and intense, and while they appear to have little drive or interest, they do not energetically pursue isolation and noninvolvement as the schizoid individual does.

The assignment of this label to a particular individual is often a reflection of a value judgment of the interviewer. His standards and goals for successful living will play an essential role in the determination of such a character syndrome. The highly motivated, ambitious, and active psychiatrist might label as an “inadequate personality” the less energetic and less

competitive adolescent or adult who seems content to remain at a minimum level of functioning. The psychiatrist who adopts the cultural norms for achievement, success, work, and participation as psychiatric norms may confuse prejudice with scientific judgment, since his unneurotic, unambitious patient may be a healthy, uncompetitive individual rather than one who has neurotic fears of failure. What appears to be inadequate in the West may be appropriately healthy in the East. Consequently, this category has many cultural issues and may reflect the parental concern for a child who does not conform. This discrepancy is often the reason for the referral of these individuals for therapy. Unless the patient can accept his behavior as maladaptive for him, and not merely an instance of not conforming to the existing "system" or establishment, no change or movement can occur.

Clinically and objectively, the inadequate personality is generally deficient in emotional and physical energy, and at times resembles the classical descriptions of neurasthenia. He is socially inept, incapable, and disinterested in planning and carrying out activities of any kind. He lacks the push and the incentive to pursue even minor activities, and has an overly optimistic expectation that things will work out well without any effort or participation on his part. In this regard, he resembles the oral receptive character described by Freud, or the receptive character of Fromm, who is carefree, indifferent, and permanently optimistic. He expects to be nourished by some magical helper, and therefore feels no need for activity towards

pursuing independent goals or establishing a base for future financial security. He has an expectation of an eternal, never-ending source of nourishment and care.

Consequently, his responses to all sorts of stimuli are weak, and his social adjustment is marginal. He tends to drift from job to job, unable to set up strong, meaningful relationships, and tends to be overlooked in the crowd since he makes no particular impact on anything or anyone. The diagnosis is generally made in terms of his inability to make proper and adequate social relationships or to make any occupational adjustments. Being affectively shallow, he displays little enthusiasm, interest, or drive in any direction, which conveys the impression of a mental defective or a simple schizophrenic.

The onset and development of such restricted personality structure seem to be related to deprivation of a realistic nature involved in poverty, and social disadvantage or sensory deprivation at all levels of social and financial status. There is a widespread inhibitory process that seems to dampen even the minimal thrusts and drives towards fulfillment. Even the pleasure-seeking activities are reduced in the overriding inhibitory restraints on effective and assertive action. A vicious circle is initiated, sustained, and enlarged when inability to achieve and obtain gratification from activities maintains the state of inadequacy. This leads to a widening circle of inaction, which interferes

with further learning and maturation.

Passive-Aggressive Personality

This personality structure is frequently applied to individuals who attempt to fulfill their needs by controlling and manipulating others through a passive, non-doing kind of behavior. Such passivity is experienced by others as pushing and maneuvering, and therefore the totality of their behavior is described as aggressive. In this connection, aggression should not be confused with hostility, even though aggression is associated with hostility manifested covertly or overtly. These individuals may be hostile, but the label "passive-aggressive" must be understood as a way of achieving, fulfilling, or experiencing, in which passivity or non-doing mobilizes others into action. They generally are not hostile, although this group can be subdivided into subtypes in which hostility or extreme dependency is present, or where the expansive driving elements are in preponderance.

Characteristically, however, such individuals attempt to achieve their goals by achieving good will and acceptance through their passive, noncompetitive strivings. In this regard, they resemble the self-effacing personality described by Horney.

The APA Diagnostic Manual describes them as follows:

> This behavior pattern is characterized by both passivity and aggressiveness. The aggressiveness may be expressed passively for example by obstructionism, pouting, procrastination, intentional inefficiency, or stubbornness. This behavior commonly reflects hostility which the individual feels he dare not express openly. Often the behavior is one expression of the patient's resentment at failing to find gratification in a relationship with an individual or institution upon which he is over-dependent.

This personality type also resembles the oral and anal aggressive character types, who resent the demands made upon them and respond by active and willful refusal. There is an ease in regressing to a dependent state if their demands are unmet. At times, they resemble the stubborn, defiant anal aggressive tendencies in which one's needs are met by a tug of war whereby the other person is forced to yield. In this sense, this personality type is an exaggeration of a developmental trait that was the major way of fulfilling needs in early childhood. They could force action by their passive, defiant, and resistant behavior.

The personality type is closely related to the dependent personality, and his behavior is often explained as compliant and passive, because he is dependent and afraid to lose or destroy his benefactors. He cannot irritate or antagonize those individuals upon whom his sources of emotional and physical needs depend. Yet, his passive behavior often does precisely that, because of his cringing, spineless behavior. Under such circumstances, a crisis may occur, and these relationships may produce regressive reactions of a

more infantile, passive, demanding kind. There may be passive threats of personal injury if their needs are not met.

At other times, if fulfillment is difficult, they become obstinate and petulant, and attempt to press their advantage by displays of childish pouting and complaining.

Generally, they appear to accept their life situations, but privately they are very dissatisfied, and they accumulate grievances to demonstrate their unfulfilled and unrequited demands for love and acceptance. At these times, they may passively and covertly sabotage a job or relationship by their procrastinating, obstructionistic behavior. Unable to directly assert their needs or feelings, they covertly blame others. In therapy, unless this issue is resolved, it will result in a typical impasse in which to fulfill their demands is to accede to their pathology, while to refuse it is to reject them. This is the double-bind which often presents itself in treating this syndrome. Sometimes, the aggressive features of these individuals predominate, and they will be aggressively critical, hostile, demanding, and obnoxious. They relate almost exclusively in a contentious and contrary manner, which is rationalized in terms of a need to defend themselves against an unfriendly world. This tendency to overpower the environment is a way of providing some measure of security and self-esteem in the face of expected rejection and derogation. The passive quality in such aggressive behavior is often manifested by their

reluctance to confront situations directly, but rather to achieve some dominance and authority by covert maneuvers under conditions where their aggressiveness has little chance of being challenged.

Dependent Personality

This type of individual relates to others by the plea of total helplessness and powerlessness. He strongly resembles the oral characters of Freud, the receptive characters described by Fromm, and fits into Horney's classification of the self-effacing character structure. Individuals of this type are unwilling, and ultimately become incapable of any independent judgment or decision. Rather than threaten their dependent relationships, they eschew any choice, decision, or judgment that does not arise from or is supported by their mainstay.

While it is often clear that their dependency is a way of controlling and manipulating others, overtly they appear to be powerless and incapable of sustaining themselves without the presence and active support of others. They tend to derive their significance and meaning as individuals only when they identify themselves with a person who is overvalued, or a cause that is generally overly idealized. They therefore go through life with a "clinging vine" adaptation. A parallel situation probably prevailed in the household during their formative years, where the one dominating member of the

household supported the dependent parent and set a pattern for such a maneuver. Under these circumstances, the stronger member took on all the decisions, and permitted the dependent member a pseudo-security through inaction and passivity. This model would be most effectively followed if the dependent parent maintained the position through reasonable and defensible rationalizations.

Such dependent attachments may be rewarding when they stimulate a benevolent response in others, but inevitably this attitude stirs up resentment and anger towards themselves.

While there is some cultural support for such dependencies, it is not experienced by the receiver as a productive or creative relationship. The dependent person covertly resents being dependent, and sometimes belittles and derogates the weakness of those he may be exploiting. Since such feelings may threaten the relationship, they are rarely expressed openly, but reveal themselves in many covert, subtle, and unconscious ways, such as slips of the tongue, accidental encounters, or simply by immobilizing others. There is a marked tendency towards the use of “magical helpers,” either in the form of people or drugs. The typical alcohol or drug addict fits this personality configuration. His willingness to placate and accept a secondary role in living, prevents him from a full assertion of capacities and talents. This awareness is crucial in order to interest him in the therapy of his dependent personality.

His greedy, insatiable, taking orientation leads to much guilt and self-derogation, which can also be utilized as motivating forces in initiating and sustaining the therapeutic process.

The Paranoid Personality

In this syndrome, the patient is characteristically suspicious, argumentative, and hypersensitive in interpersonal relations. He remains completely defensive, and in his defensiveness becomes overaggressive. Interpersonal distance is his usual stance and he may explode with anger and assaultiveness, or disintegrate if situations and relationships are pressed on him. There is great rigidity in his personality structure in order to maintain distance and constancy in his relations with others. When this becomes threatened, he becomes very angry and moves off. His tension and tightness are generally apparent to others, who respond by maintaining distance, both verbal and geographic. Frequently, his intellectual capacities are above average, and he appears to have a heightened memory for all events that he has interpreted as pieces of the malevolent atmosphere that surrounds him. Generally, his orientation is intact and his cognitive capacities unimpaired.

While paranoid personalities may have no delusions, they are constantly involved in referential thinking, which tends to view all life experiences as being imposed on them. They deal with the world as if there

were a pattern and prevailing atmosphere of malevolence towards them. Because of their inability to accept any responsibility for their own feelings or behavior, they tend to externalize or project these feelings and respond as if others were accusing them of the very deficiencies and weaknesses they are trying to avoid recognizing. Generally, the accusations are attributed to individuals or groups that are significantly involved in the defensive attitudes or derogatory feelings in the first place.

These attitudes put them on the defensive, and they are constantly on the alert and easily translate external stimuli into personal references. Such perceptions may be visual, auditory, or kinesthetic, and may be real or imagined, or a misinterpretation of an incidental, accidental, or coincidental event.

Their suspiciousness extends to all areas of living but is particularly notable in their interpersonal relationships, which tend to be fragile and highly inflammable. Emotionally, they appear to be restrained, humorless, with an unwillingness to allow enough flexibility to view any phenomenon in an objective way. Rather, they insist on their views, and stubbornly resist giving up control or expressing minimal doubts and uneasiness. They store up abused feelings, which may explode in angry outbursts at unexpected times or places.

The frequent presence of jealousy protects them from any close involvements. While they may have many superficial relationships, they manage very few close ones. Characteristically, they work hard and are effective at their jobs, even though they may change jobs often because of their paranoid ideas. While there may be gradual personality deterioration, this does not necessarily occur, because the paranoid defensive structure is able to maintain distance and prevent closer involvements that threaten the fragile adaptation. Associated with their paranoid feelings, they may also have grandiose or exaggerated views of their importance or competence. This process of enhancement of self is directly related to the overwhelming sense of inferiority, worthlessness, incompetence, and incapacity. This grandiosity is a rationalization that is called upon to explain the exaggerated interest they feel is focused on them. This suggests and later becomes a conviction that they are of special importance or significance. The grandiose feelings most often precede the development of paranoid ideas and are restrained until the non-recognition of their significance demands explanations, which are easily understood as jealous, hostile, or malevolent orientations towards them. Often the grandiosities are concomitant with and occur side by side with the paranoid feelings, and sometimes seem to follow the paranoid developments.

The development of this personality structure is closely related to the developmental mode of thinking, in which cause is related exclusively to the element of time relationships rather than to the causal agent. In this mode,

which Sullivan called “parataxic,” events are related because of their serial connection rather than any logical relationship.

Events that follow one another are thought to be related, regardless of their true relationship. If the thunder occurs when the door is shut, then the closing of the door is experienced as haying produced the thunder. Similarly, if people laugh when one enters a room, the laughing is experienced as being related to one’s entry into the room. The serial relationship in the parataxic mode of thinking establishes the relationship, not the examination of the true connection between the events. This mode of experiencing is common in human behavior, and it characterizes the distorted experiencing of the paranoid.

Developmentally, the paranoid personality occurs because of marked doubts, insecurities, and uncertainties in a family constellation where firm attachments, identifications, and the ability to separate oneself from the new environment, were most confused and incomplete. The atmosphere tended to reinforce any tendencies to blame others and deny one’s own angry frustration or dependency. The tendency to externalize may be encouraged, and deficiencies and failure attributed to the malevolence of others, while the exaggerated, omnipotent, and grandiose conceptions of oneself are developed covertly. The prevailing doubts lend themselves in later years to the paranoid elaborations based on the feelings of uncertain acceptance of others. Some

theories relate the presence of paranoid feelings to homosexual or latent homosexual patterns. However, in recent years, the difficulty in developing a clear gender identity is viewed as only one part of the massive over-all doubts about oneself. The aggressive assaults and suspicious accusations against others tend to sustain and nourish these doubts since they encourage actual rejection.

These individuals rarely need to come to therapy, except when some outburst takes place. In therapy, the extreme rigidity produces very little ability to correct any distortions. Since they fear and desire close relationships, a therapeutic alliance is extremely difficult to develop, and the presence of distrust and suspicion must be overcome by first raising some doubts about their point of view. When this occurs, then there is some hope of penetrating this rigid system. Since they expect derogatory responses, the therapist must be cautious in offering any tenderness. A straightforward, direct attitude must be adopted and followed.

Treatment

The treatment of the character disorders does not differ essentially from the psychotherapeutic or psychoanalytic treatment of the neuroses. The nature of the character trait which may produce special issues in transference or countertransference phenomena must be taken into account. For example,

the paranoid personality presents special difficulties in the area of trust, while the dependent personality will tend to parentify the transference immediately and throw the burden of the therapy on the therapist. Each personality will present particular issues that will need to be handled according to their manifest or covert presence in the therapeutic work.

In general, the therapy attempts to comprehend the character structure and elucidate its origins and functions. The tendency to establish simple causal relationships between character traits and certain childhood experiences, however, can be very misleading and not conducive to change. The initial impact of the development of character analysis was to alter the stress from the reconstruction of the past to the elucidation of the present modes of behavior of the individual. Although it does not obviate the need for genetic reconstruction, it is primarily concerned with the analysis of the structure of the defenses.

In elaborating the character structure of an individual, it is necessary to get a comprehensive view of how he functions and adapts in the present. This calls for a detailed presentation of his current experiencing in order to identify areas of anxiety and the ways the individual deals with these anxieties. Consequently, therapy proceeds in a more directed fashion, with immediate goals that are clear to the patient. The therapist is generally more active and may direct the patient to areas which he feels might be

illuminating. Such activity is manifested by more frequent questions and interpretations, and a variety of devices, both verbal and nonverbal, designed to encourage the patient to see how his present patterns of behavior are contributing to his difficulties in living. The therapist's role becomes more than a mere facilitant to reliving the past; he becomes a collaborating partner.

In this give-and-take framework, transference becomes more than a mere revival of infant-parent relationship. It is viewed as a collection of distortions or characteristic attitudes toward a variety of people who have played meaningful and determining roles in one's life. Irrational attitudes can thus be explored through an understanding of their current adaptive value. Transference in this approach is also a major tool for therapy, since it allows for the most direct observation of the distorted attitudes that are developed in the course of maturing. In the relationship of the "here-and-now," the patient is forced to acknowledge that some of his attitudes toward the therapist do not arise out of a response to the therapist as he is, but to the therapist as the patient personifies him. Such an observation can open the way for a clarification of the distortion. The more current views on transference involve the recognition that many individuals besides the parents share in the development of these distortions. A patient's irrational hatred of the therapist arises not only from a hatred of his father, for example, but probably because of a series of relationships in which the patient has been abused and mistreated by authority figures. This leads him to expect

malevolence from the analyst. In the intimacy of the therapeutic relationship, many opportunities will occur to produce this resentment. Transference would then be more than a mere repetition or transferring of feeling; it would be a dynamic process that represents and reproduces the effect of early experiencing on present behavior. The activity and lack of anonymity that characterize this type of therapeutic approach arise out of the theoretical conception that transference attitudes are more meaningful and revealing when they are produced through contact and experiencing than when they occur in a vacuum of pure fantasy.

Thus, the present tendency is not to limit or inhibit the therapist's activity or to prevent him from revealing facets of his own personality. Face to face encounters in terms of patients sitting up are more frequent and there is not such a strong taboo against activities outside the analytic hour. The role of activity may also involve a limitation of the free association technique which, while undoubtedly useful, can be abused by the patient and the therapist, thus destroying its value as an uncovering instrument. This notion has been supported by most ego analysts who use the free association technique with caution and judgment rather than as a required routine.

When the therapist takes a more active position and role, it becomes apparent that not all the patient's attitudes toward the therapist are irrational. Some of the patient's responses are realistic and rational attitudes

toward the therapist, in terms of the kind of person he really is. While this was considered an artifact in orthodox analytic therapy, it has become apparent that the most stringent efforts of the analyst to remain incognito are largely impossible to achieve. In spite of all the safeguards, patients are able to discover many important pieces of data regarding their analyst through contact with him. There is a current tendency to distinguish transference responses from realistic responses. Such a distinction can serve the important function of increasing the patient's convictions regarding the significance of the transference reactions. It avoids the difficult task of convincing the patient that his attitude is irrational, when objective factors prove otherwise. Indirectly, it has lessened the authoritative atmosphere of the analytic situation and has permitted a realistic appraisal of the analyst, which is a vital need for someone who is already overburdened with distorted conceptions about others.

A most important outgrowth of the increase in activity of the therapist was the recognition and exploration of the role of countertransference in the therapeutic process.

The attitude of the therapist toward the patient can be a very powerful tool in elucidating the character structure of the patient. When the therapist is free, flexible, and willing to become involved and committed to the therapy, his reactions to the patient can illuminate character trends that would go

unnoticed otherwise. Such reactions are most helpful in learning about the subtleties of the patient's activities.

When the goal of therapy extended beyond symptomatic relief to an attempt to reorganize the total character structure, the significance of the current functioning of the individual in his cultural setting became most important. From a characterological point of view, a patient is ill not because of experiences that occurred in childhood, but because such experiences still operate in the present to affect his personality and character structure. A patient may be dependent passive-aggressive or paranoid, for example, or insecure or compulsive, not because he was unloved in childhood or infancy, but because his early experiences had so shaped his personality that in the present he is unable to be independent or to trust others. Consequently, the index of cure is not the degree of recall of early experience or certain traumatic events, but the capacity to function adequately in the present. Some theorists express this capacity in terms of an ability to relate to others without serious perceptual or conceptual distortions. Sullivan described this end state as the capacity to relate with a minimum of parataxic distortions where there is consensual validation of the patient's perceptions. Others describe health as the capacity to love and be loved, or the expression of the full potentialities of the individual. Such goals reflect a value system that conceives of man as capable of fulfilling the potentialities of a humanistic philosophical view of man's capabilities. Consequently, therapy can no longer

evade the issue of values but must recognize its significance in the life of every human being. In addition, the current theoretical formulations recognize that the therapist, himself a product of the established mores and standards, cannot erase them from his own personality, nor should he attempt to do so. This accounts for our current extensive interest in countertransference phenomena. The therapist, being aware of these reactions, can refrain from imposing them on his patients.

The goals of therapy with individuals with personality-character disorders are to elucidate the functions of their particular personality structure, to free them to achieve their potentialities in a more mature and productive fashion. In each instance, the thwarting consequences of their earlier development must be viewed in the present, not only as an academic matter of insight, but also as a basis for a change in their behavior, which will be additional impetus to reconstruct their entire personality.

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